REVISED STATUTES
OF
NEBRASKA

REISSUE OF VOLUME 3A

2021

COMPRISING ALL THE STATUTORY LAWS OF A
GENERAL NATURE IN FORCE AT DATE OF
PUBLICATION ON THE SUBJECTS ASSIGNED
TO CHAPTERS 44 AND 45, INCLUSIVE

Published by the Revisor of Statutes

CERTIFICATE OF AUTHENTICATION

I, Marcia M. McClurg, Revisor of Statutes, do hereby certify that the Reissue of Volume 3A of the Revised Statutes of Nebraska, 2021, contains all of the laws set forth in Chapters 44 and 45, appearing in Volume 3A, Revised Statutes of Nebraska, 2010, as amended and supplemented by the One Hundred Second Legislature, First Session, 2011, through the One Hundred Seventh Legislature, First Special Session, 2021, of the Nebraska Legislature, in force at the time of publication hereof.

Marcia M. McClurg
Revisor of Statutes

Lincoln, Nebraska
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OF NEBRASKA, 2021

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CHAPTER 44
INSURANCE

Article.

Article.

Article.

ARTICLE 1

POWERS OF DEPARTMENT OF INSURANCE

Cross References

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Workers' compensation insurance policies, approval required, see section 48-146.

Section

Section
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44-127.03. Repealed. Laws 1989, LB 319, § 82.
44-127.04. Repealed. Laws 1989, LB 319, § 82.
44-127.05. Repealed. Laws 1989, LB 319, § 82.
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44-101 Insurance; business public in character; deceptive practices prohibited.

Within the intent of this chapter, the business of apportioning and distributing losses arising from specified causes among all those who apply and are accepted to receive the benefits of such service, is public in character, and requires that all those having to do with it shall at all times be actuated by good faith in everything pertaining thereto, shall abstain from deceptive or misleading practices, and shall keep, observe and practice the principles of law and equity in all matters pertaining to such business. Upon the insurer, the insured, and their representatives, shall rest the burden of maintaining proper practices in said business.

Source: Laws 1913, c. 154, § 1, p. 393; R.S.1913, § 3137; Laws 1919, c. 190, tit. V, art. II, § 1, p. 573; C.S.1922, § 7743; C.S.1929, § 44-101; R.S.1943, § 44-101.

An endorsement which is not misleading, ambiguous, or conflicting, which amends an omnibus clause in an uncertified automobile liability insurance policy by limiting the application of the omnibus clause to use of the automobile by a person over the age of twenty-five years, except for the insured or any

resident of his household, is not proscribed by statute, nor is it against public policy. Equity Mut. Ins. Co. v. Allstate Ins. Co., 190 Neb. 515, 209 N.W.2d 592 (1973).

Objectively reasonable expectations of a beneficiary-insured regarding terms and coverage of his insurance contract will be honored. Nile Valley Coop. G. & M. Co. v. Farmers Elevator Mut. Ins. Co., 187 Neb. 720, 193 N.W.2d 752 (1972).

Contracts of mutual insurance company called benefit thrift certificates were insurance contracts. State ex rel. Smrha v. Cosmo. Old Line Life Ins. Co., 137 Neb. 742, 291 N.W. 72 (1940).

The New York standard form of fire insurance policy, as then existing and construed in New York, was adopted as the basis of the Nebraska insurance contract, expressly subject, however, to all provisions of that chapter which modified or were inconsistent with the New York form. Mayfield v. North River Ins. Co., 122 Neb. 63, 239 N.W. 197 (1931).

The classification of insurance as a business public in character, cannot be said to be a classification with no basis therefor, and the legislation is not invalid for that reason. Nye-Schneider-Fowler Co. v. Bridges, Hoye & Co., 98 Neb. 863, 155 N.W. 235 (1915).

The entire Insurance Code is valid, even though there are objectionable parts therein. State ex rel. Martin v. Howard, 96 Neb. 278, 147 N.W. 689 (1914).

44-101.01 Department of Insurance; general powers; director; duties.

The Department of Insurance shall have general supervision, control, and regulation of insurance companies, associations, and societies and the business of insurance in Nebraska, including companies in process of organization. The Director of Insurance shall be the chief administrative officer of the department. The director shall have the power and duty to enforce and execute all the insurance laws of this state and to adopt and promulgate all needful rules and regulations for the purpose of carrying out the true spirit and meaning of Chapter 44 and all laws relating to the business of insurance and, to that end, may authorize and empower an assistant or employee to do any and all things that he or she may do and on his or her behalf, and he or she shall see that all laws respecting insurance companies and insurance agents are faithfully executed. The director or his or her representative shall issue all certificates and licenses as provided for in Chapter 44. If the applicant is an individual, the application for a certificate or license shall include the applicant's social security number. The director and his or her authorized representative shall have the power and authority to do all things and to perform all acts the department is given the power and authority to do.

Source: Laws 1913, c. 154, § 3, p. 396; R.S.1913, § 3139; Laws 1919, c. 190, tit. V, art. III, § 1, p. 576; C.S.1922, § 7745; C.S.1929, § 44-201; R.S.1943, § 44-104; R.R.S.1943, § 81-501; Laws 1969, c. 360, § 3, p. 1284; Laws 1981, LB 113, § 22; Laws 1989, LB 92, § 1; Laws 1997, LB 752, § 109.

The Legislature has granted the director of the Department of Insurance statutory power to perform all acts the department has the power and authority to do. CenTra, Inc. v. Chandler Ins. Co., 248 Neb. 844, 540 N.W.2d 318 (1995).

44-102 Insurance, defined.

For purposes of Chapter 44, unless the context otherwise requires, insurance shall mean a contract whereby one party, called the insurer, for a consideration, undertakes to pay money or its equivalent or to do an act valuable to another party, called the insured, or to his or her beneficiary, upon the happening of the hazard or peril insured against whereby the party insured or his or her beneficiary suffers loss or injury.

Source: Laws 1913, c. 154, § 1, p. 394; R.S.1913, § 3137; Laws 1919, c. 190, tit. V, art. II, § 1, p. 573; C.S.1922, § 7743; C.S.1929, § 44-101; R.S.1943, § 44-102; Laws 1989, LB 92, § 2.

The definition of insurance contains the following elements: (1) The existence of a contract whereby, (2) for a consideration, (3) one party (the insurer) promises to pay money or perform a valuable act for the benefit of the other party (the insured), (4) upon the happening of a stated hazard or peril that results in a loss to the insured. Norwest Corp. v. State, Dept. of Insurance, 253 Neb. 574, 571 N.W.2d 628 (1997).

Insurance is defined. Bankers Life Ins. Co. v. Laughlin, 160 Neb. 480, 70 N.W.2d 474 (1955).

An application for hail insurance which contained all necessary elements of policy was effective as a policy. Schnell v. United Hail Ins. Co., 145 Neb. 768, 18 N.W.2d 112 (1945).

Any insurance company, requiring the payment of fixed premiums in advance, which provide benefits not dependent upon the collection of assessments from other members, and which does not provide for extra assessments if necessary, is not an assessment association. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-102.01 Insurance; service contract excluded.

For purposes of Chapter 44, insurance does not include a service contract. For purposes of this section, service contract means (1) a motor vehicle service contract as defined in section 44-3521 or (2) a contract or agreement, whether designated as a service contract, maintenance agreement, warranty, extended warranty, or similar term, whereby a person undertakes to furnish, arrange for, or, in limited circumstances, reimburse for service, repair, or replacement of any or all of the components, parts, or systems of any covered residential dwelling or consumer product when such service, repair, or replacement is necessitated by wear and tear, failure, malfunction, inoperability, inherent defect, or failure of an inspection to detect the likelihood of failure.

Source: Laws 1990, LB 1136, § 91; Laws 2011, LB535, § 10.

44-103 Terms, defined.

For purposes of Chapter 44, unless the context otherwise requires:

(1) The terms company, corporation, insurance company, or insurance corporation shall include all corporations, associations, partnerships, or individuals engaged as insurers in the business of insurance;

(2) Domestic designates those companies incorporated or formed in this state;

(3) Foreign designates those companies incorporated or formed under the laws of the United States or any other state in the United States and alien designates those companies incorporated or formed under the laws of any country other than the United States;

(4) Admitted company or authorized company designates a company qualified and licensed to transact business under Chapter 44;

(5) Nonadmitted company or unauthorized company designates a company not licensed to transact business in this state under Chapter 44;

(6) Unearned premiums and net value of policies severally shall mean the liability of an insurance company upon its insurance contracts, other than accrued claims, computed by rules of valuation established herein;

(7) Profits of a mutual company shall mean that portion of its cash funds not required for payment of losses and expenses nor set apart for any purpose allowed by law;

(8) Agent or insurance agent shall mean an insurance producer;

(9) Broker or insurance broker shall mean an insurance producer;

(10) Insurance producer or producer shall mean a person required to be licensed under the laws of this state, including the Insurance Producers Licensing Act, to sell, solicit, or negotiate insurance;

(11) Adjuster or insurance adjuster shall mean a person, copartnership, or corporation who undertakes to ascertain and report the actual loss or damage to the subject matter of the insurance due to the hazard or peril insured against;

(12) Director shall mean the Director of Insurance;

(13)(a) Insurable interest shall mean every interest in property or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly damnify the insured.

(b) Insurable interest, in the matter of life and health insurance, exists when the beneficiary because of relationship, either pecuniary or from ties of blood or marriage, has reason to expect some benefit from the continuance of the life of the insured;

(14) Double insurance exists when the same party is insured by several insurers separately in respect to the same subject and interest;

(15) Overinsurance exists when a party having an insurable interest in property has insurance thereon against the same hazard or peril in excess of the actual value of his or her interest therein;

(16) Reinsurance shall mean a contract by which an insurer procures a third party to insure it against loss or liability by reason of such original insurance;

(17) Department shall mean the Department of Insurance;

(18) Rebate shall mean anything of value or the making of an agreement, expressed or implied, that will directly or indirectly diminish any premium below the amount specified in the policy but shall not include the dividend or refund paid or allowed on participating policies nor bonuses paid or allowed directly by any company upon nonparticipating policies which have been in force at least five years;

(19) Stock company shall mean a company with a capital stock that charges a fixed premium and is required to maintain the reserve provided by Chapter 44;

(20) Mutual company shall mean a company without capital stock that charges a fixed premium and is required to maintain the same reserve as a stock company;

(21) Assessment association shall mean a company that meets its losses and expenses from assessment levied upon its members; and

(22) Insurer shall include all companies, exchanges, societies, or associations whether organized on the stock, mutual, assessment, or fraternal plan of insurance and reciprocal insurance exchanges.

Source: Laws 1913, c. 154, § 2, p. 394; R.S.1913, § 3138; Laws 1919, c. 190, tit. V, art. II, § 2, p. 573; C.S.1922, § 7744; C.S.1929, § 44-102; R.S.1943, § 44-103; Laws 1984, LB 801, § 45; Laws 1989, LB 92, § 3; Laws 2001, LB 51, § 22.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

A subsequent innocent purchaser of a stolen vehicle acquires an insurable interest in such vehicle. Howard v. State Farm Mut. Auto. Ins. Co., 242 Neb. 624, 496 N.W.2d 862 (1993).

An insurable interest, in the matter of life and health insurance, exists when the beneficiary because of relationship, either pecuniary or from ties of blood or marriage, has reason to expect some benefit from the continuance of the life of the insured. Ryan v. Tickle, 210 Neb. 630, 316 N.W.2d 580 (1982).

A soliciting agent is deemed an agent of insurance company in all intents and purposes. Heikes v. Farm Bureau Ins. Co., 181 Neb. 827, 151 N.W.2d 336 (1967).

Reinsurance is defined. Bankers Life Ins. Co. v. Laughlin, 160 Neb. 480, 70 N.W.2d 474 (1955).

Person may take out insurance on own life and make benefit payable to whomsoever he pleases even though beneficiary does not have insurable interest. Guardian Nat. Life Ins. Co. v. Edens, 144 Neb. 339, 13 N.W.2d 418 (1944).

44-104 Transferred to section 81-501.

44-105 Certificate of authority; grant; conditions; examination.

Before granting a certificate of authority to any insurance company to issue policies or make contracts of insurance in this state, the Department of Insurance shall be satisfied by such examination as it may cause to be made or such evidence as it may require that such company is duly qualified under the laws of this state to transact business in this state. The department shall examine a corporation which has received a permit from the department to complete its organization as an insurance company whenever it deems it necessary or prudent to protect shareholders, applicants for membership or for insurance, creditors, or the public.

Source: Laws 1913, c. 154, § 8, p. 398; R.S.1913, § 3144; Laws 1919, c. 190, tit. V, art. III, § 1, p. 576; C.S.1922, § 7745; C.S.1929, § 44-201; R.S.1943, § 44-105; Laws 1957, c. 178, § 10, p. 615; Laws 1989, LB 92, § 4.

44-106 Domestic company; books and records required.

The Department of Insurance shall require every domestic insurance company to keep its books, records, accounts and vouchers in such manner that it may readily verify its annual statement, and ascertain whether the company is solvent and has complied with the law.

Source: Laws 1913, c. 154, § 8, p. 398; R.S.1913, § 3144; Laws 1919, c. 190, tit. V, art. III, § 1, p. 576; C.S.1922, § 7745; C.S.1929, § 44-201; R.S.1943, § 44-106.

44-107 Notice to Banking, Commerce and Insurance Committee of the Legislature; hearing.

The Department of Insurance shall notify the chairperson and members of the Banking, Commerce and Insurance Committee of the Legislature prior to submitting any request or application to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services for a state innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act. Such notification shall be made electronically and shall include a copy of the application for the federal waiver. The Banking, Commerce and Insurance Committee of the Legislature shall hold a public hearing on such waiver application.

Source: Laws 2019, LB468, § 4.

44-107.01 Repealed. Laws 1993, LB 583, § 116.

44-107.02 Repealed. Laws 1993, LB 583, § 116.

44-107.03 Repealed. Laws 1993, LB 583, § 116.

44-108 Repealed. Laws 1993, LB 583, § 116.

44-108.01 Repealed. Laws 1993, LB 583, § 116.

44-108.02 Repealed. Laws 1993, LB 583, § 116.

44-108.03 Repealed. Laws 1993, LB 583, § 116.

44-108.04 Repealed. Laws 1993, LB 583, § 116.

44-109 Repealed. Laws 1993, LB 583, § 116.

44-110 Repealed. Laws 1993, LB 583, § 116.

44-111 Repealed. Laws 1993, LB 583, § 116.

44-111.01 Repealed. Laws 1993, LB 583, § 116.

44-112 Department of Insurance; records.

The Department of Insurance shall preserve in a permanent form a record of its proceedings, and the acts and proceedings of its officers, including a concise statement of the results of all investigations or examinations of insurance companies.

Source: Laws 1913, c. 154, § 17, p. 405; R.S.1913, § 3153; Laws 1919, c. 190, tit. V, art. III, § 10, p. 583; C.S.1922, § 7754; C.S.1929, § 44-210; R.S.1943, § 44-112.

44-112.01 Transferred to section 44-6606.

44-113 Department; report; contents.

The Department of Insurance shall transmit to the Governor, ten days prior to the opening of each session of the Legislature, a report of its official transactions, containing in a condensed form the statements made to the department by every insurance company authorized to do business in this state pursuant to Chapter 44, as audited and corrected by it, arranged in tabular form or in abstracts, in classes according to the kind of insurance, which report shall also contain (1) a statement of all insurance companies authorized to do business in this state during the year ending December 31 next preceding, with their names, locations, amounts of capital, dates of incorporation, and of the commencement of business and kinds of insurance in which they are engaged respectively; and (2) a statement of the insurance companies whose business has been closed since making the last report, and the reasons for closing such businesses, with the amount of their assets and liabilities, so far as the amount of their assets and liabilities are known or can be ascertained by the department. The report shall also be transmitted electronically to the Clerk of the Legislature. Each member of the Legislature shall receive a copy of such report by making a request for it to the director. The department may transmit the report by electronic format through the portal established under section 84-1204 after notification of such type of delivery is given to the recipient. The department shall maintain the report in a form capable of accurate duplication on paper.

Source: Laws 1913, c. 154, § 18, p. 405; R.S.1913, § 3154; Laws 1919, c. 190, tit. V, art. III, § 11, p. 583; C.S.1922, § 7755; C.S.1929, § 44-211; R.S.1943, § 44-113; Laws 1969, c. 359, § 2, p. 1268; Laws 1979, LB 322, § 14; Laws 2003, LB 216, § 1; Laws 2012, LB719, § 1; Laws 2012, LB782, § 53.

44-114 Department; fees for services.

In addition to any other fees and charges provided by law, the following shall be due and payable to the Department of Insurance: (1) For filing the documents, papers, statements, and information required by law upon the organization of domestic or the entry of foreign or alien insurers, statistical agents, or

advisory organizations, three hundred dollars; (2) for filing each amendment of articles of incorporation, twenty dollars; (3) for filing restated articles of incorporation, twenty dollars; (4) for renewing each certificate of authority of insurers, statistical agents, or advisory organizations, one hundred dollars, except domestic assessment associations, which shall pay twenty dollars; (5) for issuance of an amended certificate of authority, one hundred dollars; (6) for filing a certified copy of articles of merger involving a domestic or foreign insurance corporation holding a certificate of authority to transact insurance business in this state, fifty dollars; (7) for filing an annual statement, two hundred dollars; (8) for each certificate of valuation, deposit, or compliance or other certificate for whomsoever issued, five dollars; (9) for filing any report which may be required by the department from any unincorporated mutual association, no fee shall be due; (10) for copying official records or documents, fifty cents per page; and (11) for a preadmission review of documents required to be filed for the admission of a foreign insurer or for the organization and licensing of a domestic insurer other than an assessment association, a nonrefundable fee of one thousand dollars.

Source: Laws 1913, c. 154, § 19, p. 406; R.S.1913, § 3155; Laws 1919, c. 190, tit. V, art. III, § 12, p. 584; C.S.1922, § 7756; C.S.1929, § 44-212; Laws 1935, c. 101, § 1, p. 330; C.S.Supp.,1941, § 44-212; R.S.1943, § 44-114; Laws 1955, c. 168, § 2, p. 478; Laws 1965, c. 250, § 1, p. 708; Laws 1969, c. 359, § 3, p. 1269; Laws 1969, c. 360, § 1, p. 1282; Laws 1977, LB 333, § 1; Laws 1980, LB 481, § 31; Laws 1984, LB 801, § 46; Laws 1989, LB 92, § 10; Laws 1991, LB 233, § 42; Laws 2003, LB 216, § 2; Laws 2012, LB887, § 1.

All fees must be paid to State Treasurer. State v. Home Ins. Co., 59 Neb. 524, 81 N.W. 443 (1900); Moore v. State, 53 Neb. 831, 74 N.W. 319 (1898).

44-115 Repealed. Laws 1947, c. 159, § 2.

44-116 Examination; expenses collected; Department of Insurance Cash Fund; created; use; investment.

All money collected by the Department of Insurance for examination of the affairs of domestic, foreign, or alien insurance companies and insurers as defined in and pursuant to the Insurers Examination Act or any other provision of Chapter 44 or for valuing the reserve liabilities of life insurance companies shall be remitted by the department to the State Treasurer for credit to the Department of Insurance Cash Fund, which fund is hereby created. Money in the Department of Insurance Cash Fund may be used for transfers to the General Fund at the direction of the Legislature. Any money in the Department of Insurance Cash Fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

Source: Laws 1913, c. 154, § 21, p. 406; R.S.1913, § 3157; Laws 1919, c. 190, tit. V, art. III, § 14, p. 584; Laws 1921, c. 24, § 2, p. 150; C.S.1922, § 7758; Laws 1923, c. 189, § 1, p. 433; C.S.1929, § 44-214; R.S.1943, § 44-116; Laws 1955, c. 169, § 1, p. 484; Laws 1965, c. 251, § 1, p. 709; Laws 1969, c. 584, § 43, p. 2370; Laws 1983, LB 469, § 2; Laws 1989, LB 92, § 11; Laws 1991, LB 233, § 43; Laws 1993, LB 583, § 11; Laws 1994, LB 1066, § 30.

Cross References

Insurers Examination Act, see section 44-5901.
Nebraska Capital Expansion Act, see section 72-1269.
Nebraska State Funds Investment Act, see section 72-1260.

44-117 Examiners; expenses; payment.

The Director of Administrative Services is, upon presentation of a voucher properly countersigned by the Director of Insurance, authorized to draw warrants against the Department of Insurance Cash Fund for the purpose of paying the salaries and expenses of the personnel of the actuarial and examining staff of the Department of Insurance.

Source: Laws 1913, c. 154, § 21, p. 407; R.S.1913, § 3157; Laws 1919, c. 190, tit. V, art. III, § 14, p. 585; Laws 1921, c. 24, § 2, p. 150; C.S.1922, § 7758; Laws 1923, c. 189, § 1, p. 433; C.S.1929, § 44-214; R.S.1943, § 44-117; Laws 1955, c. 169, § 2, p. 485; Laws 1989, LB 92, § 12.

44-118 Repealed. Laws 1993, LB 583, § 116.

44-119 Actuaries and examiners; appointment.

In order to discharge the responsibilities of the department, including the requirements of the Insurers Examination Act, there shall be appointed a sufficient staff of actuaries and examiners which shall include:

(1) One or more life insurance actuaries;

(2) One or more property and casualty insurance actuaries;

(3) One or more actuarial examiners;

(4) A chief financial examiner and one or more assistant chief financial examiners;

(5) One or more financial examiners;

(6) A chief market conduct examiner; and

(7) One or more market conduct examiners.

The examiners described in subdivisions (3) through (5) of this section hired after March 4, 2003, shall hold office at the will of the director and shall receive such salary as fixed by the director and approved by the Governor based upon the level of credentials for the positions. Each employee who is employed as an examiner on March 4, 2003, may elect to become employed at will. The election to become employed at will may be made at any time upon notification to the director in writing, but once made, such election shall be final. Until the election to be employed at will is made, the employee shall be treated as continuing participation in the State Personnel System.

Source: Laws 1923, c. 189, § 1, p. 433; C.S.1929, § 44-214; R.S.1943, § 44-119; Laws 1947, c. 160, § 1(1), p. 439; Laws 1989, LB 92, § 13; Laws 1993, LB 583, § 12; Laws 2003, LB 85, § 2.

Cross References

Insurers Examination Act, see section 44-5901.

44-119.01 Repealed. Laws 1973, LB 462, § 4.

44-119.02 Repealed. Laws 1971, LB 104, § 1.

44-119.03 Repealed. Laws 1959, c. 266, § 1.

44-119.04 Repealed. Laws 1959, c. 266, § 1.

44-119.05 Repealed. Laws 1961, c. 286, § 1.

44-120 Domestic company; capital stock; impairment; notice to shareholders.

Whenever it appears to the Department of Insurance from any proper showing or from any examination made that the capital stock of any domestic stock insurance company is impaired or that its assets are insufficient to justify its continuance in business, the department, in lieu of proceeding immediately in the manner authorized by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, may at once determine the amount of such impairment or deficiency and thereupon issue a written notice to the company requiring its shareholders to make good the amount of the impairment or deficiency with cash or authorized investments or to reduce its capital stock, not below statutory requirements, within a reasonable time not to exceed ninety days from the service of the notice.

Source: Laws 1913, c. 154, § 9, p. 400; R.S.1913, § 3145; Laws 1919, c. 190, tit. V, art. III, § 2, p. 577; C.S.1922, § 7746; C.S.1929, § 44-202; R.S.1943, § 44-120; Laws 1967, c. 259, § 1, p. 682; Laws 1989, LB 92, § 14; Laws 1989, LB 319, § 62.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

This section is remedial, and provides the first step toward replacement where impairment of capital stock of a stock company has taken place. Clark v. Lincoln Liberty Life Ins. Co., 139 Neb. 65, 296 N.W. 449 (1941).

Where court of competent jurisdiction has by appropriate proceedings taken property into its possession, such property is thereby withdrawn from the jurisdiction of all other courts. Motlow v. Southern Holding & Securities Corp., 95 F.2d 721 (8th Cir. 1938).

Statute is cited as showing legislative intent that city was not entitled to preferred claim for money loaned or deposited with insolvent trust company. City of Lincoln v. Ricketts, 84 F.2d 795 (8th Cir. 1936).

44-121 Domestic company; capital stock; failure to restore; proceedings authorized.

If the amount of any such impairment or deficiency shall not be made good within the time specified in such notice and proof thereof filed with the Department of Insurance, the company shall be proceeded against in the manner authorized and directed by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1913, c. 154, § 9, p. 400; R.S.1913, § 3145; Laws 1919, c. 190, tit. V, art. III, § 2, p. 578; C.S.1922, § 7746; C.S.1929, § 44-202; R.S.1943, § 44-121; Laws 1989, LB 319, § 63.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-122 Domestic company; stock reduction; procedure.

No reduction of stock shall be made except by approval of at least two-thirds of the directors. The directors, after such reduction of stock, may require such shareholder to surrender his or her stock and in lieu thereof may issue a new certificate for such number of shares as each shall be entitled to.

Source: Laws 1913, c. 154, § 9, p. 400; R.S.1913, § 3145; Laws 1919, c. 190, tit. V, art. III, § 2, p. 578; C.S.1922, § 7746; C.S.1929, § 44-202; R.S.1943, § 44-122; Laws 1989, LB 92, § 15; Laws 1999, LB 259, § 1.

44-123 Domestic mutual company; assets; deficiency; notice.

Whenever it shall appear from any proper showing, or from any examination made, that the assets and resources of any domestic mutual insurance company are insufficient to meet the minimum conditions prescribed in section 44-219 as now existing or hereafter amended, the Department of Insurance shall promptly determine the amount of such deficiency, and thereupon issue a written notice and requisition to the directors and officers of such company, requiring them to make good the amount of such deficiency within a reasonable time, not to exceed one hundred eighty days, from the service of such notice and requisition.

Source: Laws 1913, c. 154, § 10, p. 400; R.S.1913, § 3146; Laws 1919, c. 190, tit. V, art. III, § 3, p. 578; C.S.1922, § 7747; C.S.1929, § 44-203; R.S.1943, § 44-123; Laws 1949, c. 136, § 1, p. 355.

This section provides the first step toward replacement where impairment of capital stock of a mutual insurance company has taken place. Clark v. Lincoln Liberty Life Ins. Co., 139 Neb. 65, 296 N.W. 449 (1941).

Mutual insurance company is required to provide reserve fund. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-124 Domestic mutual company; assets; deficiency; service of notice; failure to restore; proceedings authorized.

Such notice and requisition may be served by either registered or certified letter, having affixed the proper postage, and directed to the company at its principal place of business in this state. Upon the service of such notice and requisition, the directors and officers thereof shall forthwith cause such deficiency to be made good and proof thereof to be filed in the office of the Department of Insurance within the time specified in the notice and requisition. If such deficiency shall not be made good within the time specified in the notice and requisition and satisfactory proof thereof filed with the department, such company shall be proceeded against in the manner authorized and directed by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1913, c. 154, § 10, p. 401; R.S.1913, § 3146; Laws 1919, c. 190, tit. V, art. III, § 3, p. 578; C.S.1922, § 7747; C.S.1929, § 44-203; R.S.1943, § 44-124; Laws 1957, c. 242, § 33, p. 846; Laws 1989, LB 319, § 64.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-125 Repealed. Laws 1989, LB 319, § 82.

44-126 Repealed. Laws 1989, LB 319, § 82.

44-127 Repealed. Laws 1989, LB 319, § 82.

44-127.01 Repealed. Laws 1989, LB 319, § 82.

44-127.02 Repealed. Laws 1989, LB 319, § 82.

44-127.03 Repealed. Laws 1989, LB 319, § 82.

44-127.04 Repealed. Laws 1989, LB 319, § 82.

44-127.05 Repealed. Laws 1989, LB 319, § 82.

44-127.06 Repealed. Laws 1989, LB 319, § 82.

44-127.07 Repealed. Laws 1989, LB 319, § 82.

44-127.08 Repealed. Laws 1989, LB 319, § 82.

44-127.09 Repealed. Laws 1989, LB 319, § 82.

44-127.10 Repealed. Laws 1989, LB 319, § 82.

44-127.11 Repealed. Laws 1988, LB 352, § 190.

44-127.12 Repealed. Laws 1977, LB 366, § 16.

44-127.13 Repealed. Laws 1989, LB 319, § 82.

44-127.14 Repealed. Laws 1989, LB 319, § 82.

44-127.15 Repealed. Laws 1989, LB 319, § 82.

44-127.16 Repealed. Laws 1989, LB 319, § 82.

44-127.17 Repealed. Laws 1989, LB 319, § 82.

44-127.18 Repealed. Laws 1989, LB 319, § 82.

44-127.19 Repealed. Laws 1989, LB 319, § 82.

44-127.20 Repealed. Laws 1989, LB 319, § 82.

44-127.21 Repealed. Laws 1989, LB 319, § 82.

44-127.22 Repealed. Laws 1989, LB 319, § 82.

44-127.23 Repealed. Laws 1989, LB 319, § 82.

44-127.24 Repealed. Laws 1989, LB 319, § 82.

44-127.25 Repealed. Laws 1989, LB 319, § 82.

44-127.26 Repealed. Laws 1989, LB 319, § 82.

44-127.27 Repealed. Laws 1989, LB 319, § 82.

44-127.28 Repealed. Laws 1989, LB 319, § 82.

44-127.29 Repealed. Laws 1989, LB 319, § 82.

44-127.30 Repealed. Laws 1989, LB 319, § 82.

44-127.31 Repealed. Laws 1989, LB 319, § 82.

44-128 Repealed. Laws 1989, LB 319, § 82.

44-129 Repealed. Laws 1989, LB 319, § 82.

44-130 Repealed. Laws 1989, LB 319, § 82.

44-131 Repealed. Laws 1989, LB 319, § 82.

44-132 Repealed. Laws 1989, LB 319, § 82.

44-133 Domestic company; certificate of authority; suspension or revocation; appeal.

Whenever any of the grounds mentioned in section 44-4809, 44-4812, or 44-4817 are shown to exist as to a domestic company after a hearing upon notice to the company, the Department of Insurance may suspend or revoke the certificate of authority of such company to do business, instead of applying to the court, which order of suspension or revocation shall be subject to appeal, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1913, c. 154, § 12, p. 403; R.S.1913, § 3148; Laws 1919, c. 190, tit. V, art. III, § 5, p. 581; C.S.1922, § 7749; C.S.1929, § 44-205; R.S.1943, § 44-133; Laws 1969, c. 359, § 4, p. 1269; Laws 1988, LB 352, § 39; Laws 1989, LB 319, § 65.

Cross References

Administrative Procedure Act, see section 84-920.

Under this section, Department of Insurance may revoke, upon notice, authority of domestic insurance company to do business. Clark v. Lincoln Liberty Life Ins. Co., 139 Neb. 65, 296 N.W. 449 (1941).

44-133.01 Transferred to section 44-248.

44-133.02 Transferred to section 44-249.

44-133.03 Transferred to section 44-250.

44-133.04 Transferred to section 44-251.

44-133.05 Transferred to section 44-252.

44-133.06 Transferred to section 44-253.

44-133.07 Transferred to section 44-254.

44-133.08 Transferred to section 44-255.

44-134 Foreign or alien company; certificate of authority; suspension or revocation; appeal.

Whenever the authority of a foreign or alien company to do business is suspended or revoked by its state of domicile or state of entry into the United States or whenever any of the grounds mentioned in section 44-4809, 44-4812, or 44-4817 exist as to a foreign or alien company, the Department of Insurance may suspend or revoke the certificate of authority of such company to do business in this state, which order of suspension or revocation shall be subject to appeal, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1913, c. 154, § 13, p. 404; R.S.1913, § 3149; Laws 1919, c. 190, tit. V, art. III, § 6, p. 581; C.S.1922, § 7750; C.S.1929, § 44-206; R.S.1943, § 44-134; Laws 1969, c. 359, § 5, p. 1270; Laws 1988, LB 352, § 40; Laws 1989, LB 319, § 66.

Cross References

Administrative Procedure Act, see section 84-920.

44-135 Foreign company; certificate of authority; required; personal jurisdiction.

Any foreign or alien insurance company or association, before it shall do any business in this state, shall procure a certificate of authority to do business in

this state as provided by the laws of the State of Nebraska. Procuring such a certificate shall constitute sufficient contact with this state for the exercise of personal jurisdiction over the company or association in any action arising out of its activities in this state.

Source: Laws 1913, c. 154, § 14, p. 404; R.S.1913, § 3150; Laws 1919, c. 190, tit. V, art. III, § 7, p. 582; C.S.1922, § 7751; Laws 1929, c. 123, § 1, p. 468; C.S.1929, § 44-207; Laws 1935, c. 103, § 1, p. 336; Laws 1937, c. 99, § 1, p. 346; C.S.Supp.,1941, § 44-207; R.S.1943, § 44-135; Laws 1983, LB 447, § 53.

Compliance with this section constitutes a voluntary acceptance of its provisions. Pupkes v. Sailors, 183 Neb. 784, 164 N.W.2d 441 (1969).

Service under this section on foreign insurance company is proper in reviving stay bond which has become dormant. Baker Steel & Machinery Co. v. Ferguson, 137 Neb. 578, 290 N.W. 499 (1940).

The Director of the Department of Insurance is the statutory agent for the service of process on foreign insurance companies. Maixner v. Travelers Ins. Co., 133 Neb. 574, 276 N.W. 163 (1937).

Under former law, an insurance company against whom a judgment had been obtained by service of summons upon the Auditor of Public Accounts was entitled to equitable relief in a federal court against such judgment where the company had been prevented from defending the suit by the auditor's failure to send the summons to the company. National Surety Co. v. State Bank of Humboldt, 120 F. 593 (8th Cir. 1903).

44-136 Foreign company; dissolution; effect on actions.

The dissolution of any foreign insurance company or association shall not take away or impair the right of any person to commence an action in this state against such companies or associations, or their statutory successors as agents thereof, and procure service upon such companies or their statutory successors, as herein provided, for any liability previously incurred.

Source: Laws 1935, c. 103, § 1, p. 337; Laws 1937, c. 99, § 1, p. 347; C.S.Supp.,1939, § 44-207; C.S.Supp.,1941, § 44-207; R.S.1943, § 44-136.

44-137 Repealed. Laws 1983, LB 447, § 104.

44-137.01 Transferred to section 44-2010.

44-137.02 Transferred to section 44-2011.

44-137.03 Repealed. Laws 1983, LB 447, § 104.

44-137.04 Repealed. Laws 1983, LB 447, § 104.

44-137.05 Repealed. Laws 1983, LB 447, § 104.

44-137.06 Repealed. Laws 1983, LB 447, § 104.

44-137.07 Transferred to section 44-2012.

44-137.08 Transferred to section 44-2013.

44-137.09 Repealed. Laws 1989, LB 92, § 278.

44-137.10 Transferred to section 44-2009.

44-138 Repealed. Laws 1999, LB 259, § 17.

44-139 Transferred to section 44-5503.

44-140 Transferred to section 44-5504.

44-141 Transferred to section 44-5505.

44-142 Transferred to section 44-5506.

44-143 Repealed. Laws 1978, LB 836, § 13.

44-144 Repealed. Laws 1978, LB 836, § 13.

44-145 Transferred to section 44-5507.

44-146 Repealed. Laws 1978, LB 836, § 13.

44-147 Transferred to section 44-5508.

44-147.01 Transferred to section 44-5509.

44-147.02 Transferred to section 44-5510.

44-147.03 Transferred to section 44-5511.

44-147.04 Transferred to section 44-5512.

44-147.05 Transferred to section 44-5513.

44-147.06 Transferred to section 44-5514.

44-148 Repealed. Laws 1989, LB 92, § 278.

44-149 Domestic companies; right to do business in other states; reciprocity.

If any domestic insurance company or association, or domestic fraternal benefit society, having a certificate of authority from the Department of Insurance, shall make application for admission to any other state or country, and shall comply with all the statutory regulations of such state or country, and it shall be refused admission to such state or country, the director may revoke every certificate of authority granted to like companies or societies organized under the laws of the state or country so refusing admission to a domestic insurance company or association or domestic fraternal benefit society, unless and until such country or state shall grant the necessary license or certificate to such domestic insurance company or association or fraternal benefit society.

Source: Laws 1913, c. 154, § 155a, p. 472; R.S.1913, § 3293; Laws 1919, c. 190, tit. V, art. XI, § 21, p. 654; C.S.1922, § 7900; C.S.1929, § 44-1121; R.S.1943, § 44-149; Laws 1971, LB 792, § 1; Laws 1987, LB 17, § 1.

44-150 Reciprocal licenses; retaliation; penalties; taxes; domicile of alien insurer.

(1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses and other fees, in the aggregate, or any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions, are or would be imposed upon Nebraska insurers, or upon the agents or representatives of such insurers, which are in excess of such taxes, licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the agents or representatives of such insurers, of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties,

deposit requirements, or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the Director of Insurance upon the insurers, or upon the agents or representatives of such insurers, of such other state or country doing business or seeking to do business in Nebraska. Any tax, license or other fee, or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Nebraska insurers or their agents or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to personal income taxes, nor as to ad valorem taxes on real or personal property nor as to special-purpose obligations or assessments heretofore imposed by another state in connection with particular kinds of insurance, other than property insurance; except that deductions, from premium taxes or other taxes otherwise payable, allowed on account of real estate or personal property taxes paid shall be taken into consideration by the Director of Insurance in determining the propriety and extent of retaliatory action under this section.

(3) Nothing in this section shall require retaliatory action because of fees, obligations, or prohibitions imposed on Nebraska insurance producers licensed pursuant to the Insurance Producers Licensing Act.

(4) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the Director of Insurance at time of admission to this state or within twelve months after September 28, 1959, whichever date is the later, and may be any one of the following states: (a) That in which the insurer was first authorized to transact insurance; (b) that in which is located the insurer's principal place of business in the United States; or (c) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

If the insurer makes no such designation its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

In the case of an insurer formed under the laws of Canada or a province thereof, its domicile shall be deemed to be that province in which its head office is situated.

Source: Laws 1913, c. 154, § 24, p. 408; R.S.1913, § 3160; Laws 1917, c. 72, § 1, p. 176; Laws 1919, c. 190, tit. V, art. III, § 17, p. 586; C.S.1922, § 7761; C.S.1929, § 44-217; Laws 1937, c. 100, § 1, p. 348; C.S.Supp.,1941, § 44-217; R.S.1943, § 44-150; Laws 1959, c. 194, § 1, p. 700; Laws 1999, LB 260, § 1; Laws 2001, LB 51, § 23.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-151 Loan, surrender or nonforfeiture values; reciprocal interest provisions.

Whenever the laws of any other state, or the rules and regulations of the insurance department of any such state, shall require of insurance companies organized under the laws of this state the payment of loan, surrender or nonforfeiture values to policyholders of such companies with such other state or states, based upon a minimum rate of interest less than that used by such

Nebraska company, or companies, in computing the amount of such loan, surrender or nonforfeiture values to be paid to its policyholders within this state, then, as a condition precedent to a company organized under the laws of such other state being permitted to conduct or continue to conduct business in this state, the Department of Insurance may require that such company shall compute the loan, surrender or nonforfeiture values to be paid to Nebraska policyholders by such company or companies of such other state on the basis of a minimum interest rate less than the interest rate used by such company or companies as a basis for such loan, surrender or nonforfeiture values in its home state, by an amount equal to the difference between the rate used by such Nebraska company or companies in computing such values to be paid to its policyholders in this state and the minimum rate required by such other state or states, to be used by such Nebraska company or companies in computing the amount of such values to be paid by it to its policyholders in such other state or states.

Source: Laws 1917, c. 72, § 1, p. 177; Laws 1919, c. 190, tit. V, art. III, § 17, p. 586; C.S.1922, § 7761; C.S.1929, § 44-217; Laws 1937, c. 100, § 1, p. 349; C.S.Supp.,1941, § 44-217; R.S.1943, § 44-151.

44-152 Domestic company; refusal of another state or country to license; retaliatory action.

Whenever it appears to the Director of Insurance that permission to transact business within any state of the United States or within any foreign country is refused to a company organized under the laws of this state after a certificate of compliance has been issued to the company by the director and after such company has complied with all laws of such state or foreign country, then and in every such case the director may forthwith cancel the authority of every company organized under the laws of such state or foreign government licensed to do business in this state and may refuse a certificate of authority to every such company thereafter applying to him or her for authority to do business in this state until his or her certificate has been duly recognized by the government of such state or country.

Source: Laws 1937, c. 100, § 1, p. 350; C.S.Supp.,1941, § 44-217; R.S. 1943, § 44-152; Laws 1989, LB 92, § 39.

44-153 Repealed. Laws 1989, LB 92, § 278.

44-154 Director; information; disclosure; confidentiality; privilege.

(1) Unless otherwise expressly prohibited by Chapter 44, the director may:

(a) Share documents, materials, or other information, including otherwise confidential and privileged documents, materials, or information, with other state, federal, foreign, and international regulatory and law enforcement agencies, the International Association of Insurance Supervisors, the Bank for International Settlements, and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees to maintain the confidential or privileged status of the document, material, or other information;

(b) Receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or information, from other state, federal, foreign, or international regulatory and law enforcement agen-

cies, the International Association of Insurance Supervisors, the Bank for International Settlements, and the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged any document, material, or other information received pursuant to an information-sharing agreement entered into pursuant to this section with notice or the understanding that the document, material, or other information is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(c) Enter into agreements governing sharing and use of information consistent with this subsection.

(2)(a) All confidential and privileged information obtained by or disclosed to the director by other state, federal, foreign, or international regulatory and law enforcement agencies, the International Association of Insurance Supervisors, the Bank for International Settlements, or the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this section with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information shall:

(i) Be confidential and privileged;

(ii) Not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09;

(iii) Not be subject to subpoena; and

(iv) Not be subject to discovery or admissible in evidence in any private civil action.

(b) Notwithstanding the provisions of subdivision (2)(a) of this section, the director may use the documents, materials, or other information in any regulatory or legal action brought by the director.

(3) The director, and any other person while acting under the authority of the director who has received information from other state, federal, foreign, or international regulatory and law enforcement agencies, the International Association of Insurance Supervisors, the Bank for International Settlements, or the National Association of Insurance Commissioners or its affiliates and subsidiaries pursuant to this section, may not, and shall not be required to, testify in any private civil action concerning such information.

(4) Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information received from state, federal, foreign, or international regulatory and law enforcement agencies, the International Association of Insurance Supervisors, the Bank for International Settlements, or the National Association of Insurance Commissioners or its affiliates and subsidiaries pursuant to this section as a result of disclosure to the director or as a result of information sharing authorized by this section.

Source: Laws 2001, LB 52, § 26; Laws 2012, LB887, § 2.

44-155 Copies of records or documents; furnish; cost.

Whenever numerous copies of the same records or documents are furnished or certified to by the Department of Insurance, the Director of Insurance may reduce such fees for copies or certifications thereto if he deems the total fees to be excessive; and he may, when he deems it in the public interest, furnish

without charge to the various state insurance regulatory authorities and persons other than insurers, copies, certified copies, or certifications of all records, documents, or information requested.

Source: Laws 1955, c. 168, § 11, p. 482; Laws 1961, c. 210, § 2, p. 626.

44-156 Repealed. Laws 1985, LB 726, § 1.

44-156.01 Fees and charges; erroneously paid; refund; conditions.

Commencing with any fee or charge imposed for 1985 or any subsequent year, whenever it appears to the satisfaction of the Director of Insurance that, because of a mistake of fact, error in calculation, or erroneous interpretation of a statute of this or any other state, district, province, territory, or country, any fee or charge, excluding taxes, has been paid to the director pursuant to any provision of law which is not required by law or which is in excess of the amount legally chargeable, he or she shall have the authority to refund the amount of such payment or overpayment. The refund may be made by applying such amount towards the payment of other like or similar fees or charges, except taxes, already due or which may become due until such payment or overpayment has been fully refunded. No amount shall be refunded for payment or overpayment made after two years have elapsed from the end of the year for which any fee or charge was payable. This section shall not authorize or permit refunding of any taxes.

Source: Laws 1986, LB 1114, § 4.

44-157 Fees and charges; manner of payment; deposited in Department of Insurance Cash Fund.

All fees and charges required by Chapter 44 shall be paid in the manner and within the time prescribed by the Director of Insurance as approved by the Tax Commissioner. All such fees and charges, including fees and charges collected pursuant to the retaliatory statutes of such chapter, which are in excess of or in addition to the fees and charges collected pursuant to such chapter, shall be deposited by the State Treasurer to the account of and for the use of the Department of Insurance Cash Fund to be appropriated and expended for the supervision, control, and regulation of the business of insurance in Nebraska. If payment of any such fee or charge is not made within the time prescribed, as approved, the director shall report such failure or neglect to the Attorney General who shall institute an action in the name of the State of Nebraska for the purpose of recovering the money due. All fees and charges of any nature whatsoever which are paid to the Department of Insurance or to the Director of Insurance by virtue of his or her office shall be paid forthwith into the state treasury and deposited by the State Treasurer to the Department of Insurance Cash Fund.

Source: Laws 1955, c. 168, § 13, p. 483; Laws 1965, c. 251, § 2, p. 710; Laws 1989, LB 92, § 40.

44-158 Repealed. Laws 1989, LB 92, § 278.

44-159 Repealed. Laws 1994, LB 857, § 1.

44-160 Repealed. Laws 1994, LB 857, § 1.

44-161 Foreign insurer; becoming domestic insurer; requirements.

Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. If an insurer transfers its domicile to this state, any investment held by the insurer at the time of the transfer, which shall have been an authorized investment under the laws of the insurer's former state of domicile, shall be deemed an authorized investment under the Insurers Investment Act. The domestic insurer shall be entitled to like certificates and licenses to transact business in this state and shall be subject to the authority and jurisdiction of this state.

Source: Laws 1989, LB 61, § 1; Laws 2004, LB 1047, § 1.

Cross References

Insurers Investment Act, see section 44-5101.

44-162 Domestic insurer; transfer of domicile; effect.

Any domestic insurer may, upon the approval of the Director of Insurance, transfer its domicile to any other state in which it is admitted to transact the business of insurance. Upon such a transfer, the domestic insurer shall cease to be a domestic insurer and shall be admitted to this state if qualified as a foreign insurer. The Director of Insurance shall approve any such proposed transfer unless he or she determines such transfer is not in the interest of the policyholders of this state.

Source: Laws 1989, LB 61, § 2.

44-163 Insurer; transfer of domicile; effect on business; filing requirements.

The certificate of authority, agents' appointments, licenses, rates, and other items which the Director of Insurance allows, in his or her discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its domicile to this or any other state by merger, consolidation, or any other lawful method, shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the director. Every transferring insurer shall file new policy forms with the director on or before the effective date of the transfer but may use existing policy forms with appropriate endorsements if allowed by and under such conditions as approved by the director. Every such transferring insurer shall file promptly and shall notify the director of the details of the proposed transfer and resulting amendments to corporate documents filed or required to be filed with the director.

Source: Laws 1989, LB 61, § 3.

44-164 Insurer; transfer of domicile; rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations to carry out sections 44-161 to 44-163.

Source: Laws 1989, LB 61, § 4.

44-165 Financial conglomerate; supervision on consolidated basis; director; powers; duties; application fee; violation; enforcement powers; administrative penalty; unfair trade practice; criminal penalty; appeal; expenses of supervision.

(1)(a) A financial conglomerate may submit to the jurisdiction of the Director of Insurance for supervision on a consolidated basis under this section. Supervision under this section shall be in addition to all statutory and regulatory requirements imposed on domestic insurers and shall be for the purpose of determining how the operations of the financial conglomerate impact insurance operations.

(b) For purposes of this section:

(i) Control has the same meaning as in section 44-2121; and

(ii) Financial conglomerate means either an insurance company domiciled in Nebraska or a person established under the laws of the United States, any state, or the District of Columbia which directly or indirectly controls an insurance company domiciled in Nebraska. Financial conglomerate includes the person applying for supervision under this section and all entities, whether insurance companies or otherwise, to the extent the entities are controlled by such person.

(2) The director may approve any application for supervision under this section that meets the requirements of this section and the rules and regulations adopted and promulgated under this section.

(3)(a) The director may adopt and promulgate rules and regulations for supervision of a financial conglomerate, including all persons controlled by a financial conglomerate, that will permit the director to assess at the level of the financial conglomerate the financial situation of the financial conglomerate, including solvency, risk concentration, and intra-group transactions.

(b) Such rules and regulations shall require the financial conglomerate to:

(i) Have in place sufficient capital adequacy policies at the level of the financial conglomerate;

(ii) Report to the director at least annually any significant risk concentration at the level of the financial conglomerate;

(iii) Report to the director at least annually all significant intra-group transactions of regulated entities within a financial conglomerate. Such reporting shall be in addition to all reports required under any other provision of Chapter 44; and

(iv) Have in place at the level of the financial conglomerate adequate risk management processes and internal control mechanisms, including sound administrative and accounting procedures.

(c) In adopting and promulgating the rules and regulations, the director:

(i) Shall consider the rules and regulations that may be adopted by a member state of the European Union, the European Union, or any other country for the supervision of financial conglomerates;

(ii) Shall require the filing of such information as the director may determine;

(iii) Shall include standards and processes for effective qualitative group assessment, quantitative group assessment including capital adequacy, affiliate transaction, and risk concentration assessment, risks and internal capital assessments, disclosure requirements, and investigation and enforcement powers;

(iv) Shall state that supervision of financial conglomerates concerns how the operations of the financial conglomerate impact the insurance operations;

(v) Shall adopt an application fee in an amount not to exceed the amount necessary to recover the cost of review and analysis of the application; and

(vi) May verify information received under this section.

(4)(a) If it appears to the director that a financial conglomerate that submits to the jurisdiction of the director under this section, or any director, officer, employee, or agent thereof, willfully violates this section or the rules and regulations adopted and promulgated under this section, the director may order the financial conglomerate to cease and desist immediately any such activity. After notice and hearing, the director may order the financial conglomerate to void any contracts between the financial conglomerate and any of its affiliates or among affiliates of the financial conglomerate and restore the status quo if such action is in the best interest of policyholders, creditors, or the public.

(b) If it appears to the director that any financial conglomerate that submits to the jurisdiction of the director under this section, or any director, officer, employee, or agent thereof, has committed or is about to commit a violation of this section or the rules and regulations adopted and promulgated under this section, the director may apply to the district court of Lancaster County for an order enjoining such financial conglomerate, director, officer, employee, or agent from violating or continuing to violate this section or the rules and regulations adopted and promulgated under this section and for such other equitable relief as the nature of the case and the interest of the financial conglomerate's policyholders, creditors, or the public may require.

(c)(i) Any financial conglomerate that fails, without just cause, to provide information which may be required under the rules and regulations adopted and promulgated under this section may be required by the director, after notice and hearing, to pay an administrative penalty of one hundred dollars for each day's delay not to exceed an aggregate penalty of ten thousand dollars. The director may reduce the penalty if the financial conglomerate demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the financial conglomerate.

(ii) Any financial conglomerate that fails to notify the director of any action for which such notification may be required under the rules and regulations adopted and promulgated under this section may be required by the director, after notice and hearing, to pay an administrative penalty of not more than two thousand five hundred dollars per violation.

(iii) Any violation of this section or the rules and regulations adopted and promulgated under this section shall be an unfair trade practice under the Unfair Insurance Trade Practices Act in addition to any other remedies and penalties available under the laws of this state.

(d) Any director or officer of a financial conglomerate that submits to the jurisdiction of the director under this section who knowingly violates or assents to any officer or agent of the financial conglomerate to violate this section or the rules and regulations adopted and promulgated under this section may be

required by the director, after notice and hearing, to pay in his or her individual capacity an administrative penalty of not more than five thousand dollars per violation. In determining the amount of the penalty, the director shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(e) After notice and hearing, the director may terminate the supervision of any financial conglomerate under this section if it ceases to qualify as a financial conglomerate under this section or the rules and regulations adopted and promulgated under this section.

(f) If it appears to the director that any person has committed a violation of this section or the rules and regulations adopted and promulgated under this section which so impairs the financial condition of a domestic insurer that submits to the jurisdiction of the director under this section as to threaten insolvency or make the further transaction of business by such financial conglomerate hazardous to its policyholders or the public, the director may proceed as provided in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act to take possession of the property of such domestic insurer and to conduct the business thereof.

(g) If it appears to the director that any person that submits to the jurisdiction of the director under this section has committed a violation of this section or the rules and regulations adopted and promulgated under this section which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the director may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew such insurer's license or authority to do business in this state for such period as the director finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

(h)(i) Any financial conglomerate that submits to the jurisdiction of the director under this section that willfully violates this section or the rules and regulations adopted and promulgated under this section shall be guilty of a Class IV felony.

(ii) Any director, officer, employee, or agent of a financial conglomerate that submits to the jurisdiction of the director under this section who willfully violates this section or the rules and regulations adopted and promulgated under this section or who willfully and knowingly subscribes to or makes or causes to be made any false statements, false reports, or false filings with the intent to deceive the director in the performance of his or her duties under this section or the rules and regulations adopted and promulgated under this section shall be guilty of a Class IV felony.

(iii) Any person aggrieved by any act, determination, order, or other action of the director pursuant to this section or the rules and regulations adopted and promulgated under this section may appeal. The appeal shall be in accordance with the Administrative Procedure Act.

(iv) Any person aggrieved by any failure of the director to act or make a determination required by this section or the rules and regulations adopted and promulgated under this section may petition the district court of Lancaster County for a writ in the nature of a mandamus or a peremptory mandamus directing the director to act or make such determination forthwith.

(i) The powers, remedies, procedures, and penalties governing financial conglomerates under this section shall be in addition to any other provisions provided by law.

(5)(a) The director may contract with such qualified persons as the director deems necessary to allow the director to perform any duties and responsibilities under this section.

(b) The reasonable expenses of supervision of a financial conglomerate under this section shall be fixed and determined by the director who shall collect the same from the supervised financial conglomerate. The financial conglomerate shall reimburse the amount upon presentation of a statement by the director. All money collected by the director for supervision of financial conglomerates pursuant to this section shall be remitted in accordance with section 44-116.

(c) All information, documents, and copies thereof obtained by or disclosed to the director pursuant to this section shall be held by the director in accordance with sections 44-154 and 44-2138.

Source: Laws 2008, LB855, § 50; Laws 2014, LB700, § 14.

Cross References

Administrative Procedure Act, see section 84-920.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.
Unfair Insurance Trade Practices Act, see section 44-1521.

ARTICLE 2

LINES OF INSURANCE, ORGANIZATION OF COMPANIES

Section

44-201 Insurance; lines; enumerated.

An insurance corporation may be formed for the following purposes or may insure the following lines:

(1) LIFE INSURANCE. Insurance upon lives of persons, including endowments and annuities, and every insurance pertaining thereto and disability benefits, except that life insurance shall not include variable life insurance specified in subdivision (2) of this section and variable annuities specified in subdivision (3) of this section;

(2) VARIABLE LIFE INSURANCE. Insurance on the lives of individuals, the amount or duration of which varies according to the investment experience of any separate account or accounts established and maintained by the insurer as to such insurance;

(3) VARIABLE ANNUITIES. Insurance policies issued on an individual or group basis by which an insurer promises to pay a variable sum of money either in a lump sum or periodically for life or for some other specified period;

(4) SICKNESS AND ACCIDENT INSURANCE. Insurance against loss or expense resulting from the sickness of the insured, from bodily injury or death of the insured by accident, or both, and every insurance pertaining thereto;

(5) PROPERTY INSURANCE. Insurance against loss or damage, including consequential loss or damage, to real or personal property of every kind and any interest in such property from any and all hazards or causes, except that property insurance shall not include title insurance specified in subdivision (15)

of this section and marine insurance specified in subdivision (18) of this section;

(6) CREDIT PROPERTY INSURANCE. Insurance against loss or damage to personal property used as collateral for securing a loan or to personal property purchased pursuant to a credit transaction, but only insofar as it applies to property sold to or pledged by individual consumers for personal use;

(7) GLASS INSURANCE. Insurance against loss or damage to glass, including its lettering, ornamentation, and fittings;

(8) BURGLARY AND THEFT INSURANCE. Insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation or wrongful conversion, disposal, or concealment or from any attempt at any of the foregoing;

(9) BOILER AND MACHINERY INSURANCE. Insurance against any liability and loss or damage to life, person, property, or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus;

(10) LIABILITY INSURANCE. Insurance against legal liability for the death, injury, or disability of any person, for injury or damage to any person, or for damage to property, and the providing of medical, hospital, surgical, or disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance, except that liability insurance shall not include workers' compensation and employers liability insurance specified in subdivision (11) of this section;

(11) WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE. Insurance against the legal liability of any employer for the death or disablement of or injury to an employee whether imposed by common law or statute or assumed by contract, except that workers' compensation and employers liability insurance shall not include liability insurance specified in subdivision (10) of this section;

(12) VEHICLE INSURANCE. Insurance against any loss or damage to any land vehicle, other than railroad rolling stock, or any draft animal, from any hazard or cause, and against any loss, liability, or expense resulting from or incidental to ownership, maintenance, or use of any such vehicle or animal, together with insurance against accidental injury to or death of any person, irrespective of legal liability of the insured, if such insurance is issued as an incidental part of insurance on the vehicle or draft animal;

(13) FIDELITY INSURANCE. Insurance guaranteeing the fidelity of persons holding positions of public or private trust;

(14) SURETY INSURANCE. Insurance guaranteeing the performance of contracts other than insurance policies or guaranteeing and executing all bonds, undertakings, and contracts of suretyship, except that surety insurance shall not include title insurance specified in subdivision (15) of this section and financial guaranty insurance specified in subdivision (19) of this section;

(15) TITLE INSURANCE. (a) Insurance guaranteeing or indemnifying owners of real property or others interested therein against loss or damage suffered by reason of (i) liens, encumbrances upon, defects in, or the unmarketability of title to such real property, or adverse claim to title in real property with

reasonable examination of title guaranteeing, warranting, or otherwise insuring by a title insurer the correctness of searches relating to the title to real property and (ii) defects in the authorization, execution, or delivery of an encumbrance upon such real property, or any share, participation, or other interest in such encumbrance, guaranteeing, warranting, or otherwise insuring by a title insurer the validity and enforceability of evidences of indebtedness secured by an encumbrance upon or interest in such real property; or

(b) Insurance guaranteeing or indemnifying owners of personal property or secured parties or others interested therein against loss or damage pertaining to adverse claims to title, liens, encumbrances upon, or security interests in personal property or fixtures, including the existence or nonexistence of attachment, perfection, or priority of security interests in personal property or fixtures under the Uniform Commercial Code or other laws, rules, or regulations establishing procedures for the attachment, perfection, or priority of security interests in personal property or fixtures or the accuracy or completeness of the search or filing results obtained from public registries established for determining liens or security interests in personal property or fixtures or the existence or nonexistence of protected purchaser status under the Uniform Commercial Code;

(16) CREDIT INSURANCE. Insurance against loss or damage from the failure of persons indebted to or to become indebted to the insured to meet existing or contemplated liabilities, including agreements to purchase uncollectible debts, except that credit insurance shall not include mortgage guaranty insurance specified in subdivision (17) of this section and financial guaranty insurance specified in subdivision (19) of this section;

(17) MORTGAGE GUARANTY INSURANCE. Insurance against financial loss by lenders by reason of nonpayment of principal, interest, or other sums agreed to be paid under the terms of any note or bond or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate;

(18) MARINE INSURANCE. Insurance against loss or damage, including consequential loss or damage, to vessels, craft, aircraft, automobiles, and vehicles of every kind as well as goods, freights, cargoes, merchandise, effects, disbursements, profits, money, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry, and respondentia interests, and all kinds of property and interests therein in respect to, pertaining to, or in connection with any or all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas, or waters, on land or in the air, or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment or while awaiting the same, or during any delays, storage, transshipment, or reshipment incidental thereto; including marine builders' risks and war risks; and against loss or damage to persons or property in connection with or appertaining to marine, inland marine, transit, or transportation insurance, including loss or damage to either, arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of such primary insurance, but not including life insurance or surety bonds; but, except as specified in this subdivision, marine insurance shall not include insurance against loss by reason of bodily injury to the person;

(19) FINANCIAL GUARANTY INSURANCE. (1) Insurance issued in the form of a surety bond, insurance policy, or, when issued by an insurer, an indemnity contract and any guaranty similar to the foregoing types, against financial loss to an insured claimant, obligee, or indemnitee as a result of any of the following events:

(a) Failure of any obligor on any debt instrument or other monetary obligation, including common or preferred stock guaranteed under a surety bond, insurance policy, or indemnity contract, to pay when due principal, interest, premium, dividend, or purchase price of or on such instrument or obligation, when such failure is the result of a financial default or insolvency, regardless of whether such obligation is incurred directly or as guarantor by or on behalf of another obligor that has also defaulted;

(b) Changes in the levels of interest rates, whether short or long term, or the differential in interest rates between various markets or products;

(c) Changes in the rate of exchange of currency;

(d) Inconvertibility of one currency into another for any reason or inability to withdraw funds held in a foreign country resulting from restrictions imposed by a governmental authority;

(e) Changes in the value of specific assets or commodities, financial or commodity indices, or price levels in general; or

(f) Other events which the Director of Insurance determines are substantially similar to any of the events described in subdivisions (a) through (e) of this subdivision.

(2) Financial guaranty insurance shall not include:

(a) Insurance of any loss resulting from any event described in subdivisions (19)(1)(a) through (e) of this section if the loss is payable only upon the occurrence of any of the following, as specified in a surety bond, insurance policy, or indemnity contract:

(i) A fortuitous physical event;

(ii) A failure of or deficiency in the operation of equipment; or

(iii) An inability to extract or recover a natural resource;

(b) Any individual or schedule public official bond;

(c) Any contract bond, including bid, payment, or maintenance bond, or a performance bond when the bond is guarantying the execution of any contract other than a contract of indebtedness or other monetary obligation;

(d) Any court bond required in connection with judicial, probate, bankruptcy, or equity proceedings, including waiver, probate, open estate, and life tenant bond;

(e) Any bond running to the federal, state, county, or municipal government or other political subdivision as a condition precedent to granting of a license to engage in a particular business or of a permit to exercise a particular privilege;

(f) Any loss security bond or utility payment indemnity bond running to a governmental unit, railroad, or charitable organization;

(g) Any lease, purchase, and sale or concessionaire surety bond;

(h) Credit unemployment insurance, meaning insurance on a debtor, in connection with a specific loan or other credit transaction, to provide payments

to creditor in the event of unemployment of the debtor for the installments or other periodic payments becoming due while a debtor is unemployed;

(i) Credit insurance, meaning insurance indemnifying manufacturers, merchants, or educational institutions extending credit against loss or damage resulting from nonpayment of debts owed to them for goods or services provided in the normal course of their business;

(j) Guaranteed investment contracts issued by life insurance companies which provide that the life insurer itself will make specified payments in exchange for specific premiums or contributions;

(k) Funding agreements;

(l) Synthetic guaranteed investment contracts;

(m) Guaranteed interest contracts;

(n) Deposit administration contracts;

(o) Surety insurance as specified in subdivision (14) of this section and mortgage guaranty insurance as specified in subdivision (17) of this section;

(p) Indemnity contracts or similar guaranties to the extent that they are not otherwise limited or proscribed by Chapter 44 in which a life insurer:

(i) Guaranties its obligations or indebtedness or the obligations or indebtedness of a subsidiary of which it owns more than fifty percent, other than a financial guaranty insurance corporation, except that:

(A) To the extent that any such obligations or indebtedness are backed by specific assets, such assets shall at all times be owned by the insurer or the subsidiary; and

(B) In the case of the guaranty of the obligations or indebtedness of the subsidiary that is not backed by specific assets of the life insurer, such guaranty terminates once the subsidiary ceases to be a subsidiary; or

(ii) Guaranties obligations or indebtedness, including the obligation to substitute assets where appropriate, with respect to specific assets acquired by a life insurer in the course of normal investment activities and not for the purpose of resale with credit enhancement, or guaranties obligations or indebtedness acquired by its subsidiary if such assets have been:

(A) Acquired by a special purpose entity, the sole purpose of which is to acquire specific assets of the life insurer or the subsidiary and issue securities or participation certificates backed by such assets; or

(B) Sold to an independent third party; or

(iii) Guaranties obligations or indebtedness of an employee or agent of the life insurer; and

(q) Any other form of insurance covering risks which the director determines to be substantially similar to any of the risks described in subdivisions (a) through (p) of this subdivision; and

(20) MISCELLANEOUS INSURANCE. Insurance upon any risk, including but not limited to legal expense insurance and mechanical breakdown insurance, not included within subdivisions (1) through (19) of this section, and which is a proper subject for insurance, not prohibited by law or contrary to sound public policy, to be determined by the Department of Insurance.

Source: Laws 1913, c. 154, § 78, p. 426; R.S.1913, § 3215; Laws 1917, c. 77, § 1, p. 183; Laws 1919, c. 190, tit. V, art. V, § 1, p. 606;

C.S.1922, § 7814; Laws 1925, c. 124, § 1, p. 326; Laws 1927, c. 136, § 1, p. 374; C.S.1929, § 44-401; Laws 1935, c. 96, § 1, p. 319; C.S.Supp.,1941, § 44-401; R.S.1943, § 44-201; Laws 1949, c. 138, § 1, p. 358; Laws 1965, c. 253, § 1, p. 712; Laws 1967, c. 261, § 18, p. 693; Laws 1967, c. 262, § 1, p. 699; Laws 1971, LB 767, § 1; Laws 1973, LB 234, § 1; Laws 1978, LB 767, § 1; Laws 1989, LB 92, § 41; Laws 1991, LB 235, § 2; Laws 2004, LB 1047, § 2; Laws 2015, LB180, § 1.

Life insurance includes annuity contracts. Bankers Life Ins. Co. v. Laughlin, 160 Neb. 480, 70 N.W.2d 474 (1955).

Special provisions in Chapter 60 and orders of the State Railway Commission thereunder, with reference to liability insurance taxicabs are required to carry, take precedence over the general provisions of this section. State v. Mann, 129 Neb. 195, 261 N.W. 173 (1935).

Bond guaranteeing fidelity of employees is a form of insurance and subject to the rules applicable to insurance contracts generally. Luther College v. Benson, 126 Neb. 410, 253 N.W. 421 (1934).

This section authorizes the formation of insurance companies to transact fourteen distinct classes of insurance. State ex rel. Spillman v. Federated Merchants Mut. Ins. Co., 117 Neb. 98, 219 N.W. 847 (1928).

Foreign fraternal beneficiary society, failing to show compliance with its own laws as to right to do business in this state, is not entitled to admission. Grand Lodge, A. O. U. W. v. Ins. Board, 103 Neb. 99, 170 N.W. 617 (1919).

Policy extending coverage for accidental death and dismemberment and permanent total disability indemnity not a policy of life insurance. Simmons v. Continental Cas. Co., 410 F.2d 881 (8th Cir. 1969).

44-201.01 Certificate of authority; lines of insurance; director; duties.

Any insurance company which is, on August 25, 1989, the holder of a valid certificate of authority issued by the Department of Insurance in effect immediately prior to such date may, on and after such date, subject to compliance with Chapter 44 and the rules and regulations of the department, continue to transact any insurance business in this state authorized by such certificate of authority and shall thereafter be eligible to have such certificate of authority renewed pursuant to Chapter 44. The Director of Insurance shall determine what line or lines of insurance as specified in section 44-201 each renewed certificate of authority shall include. Any certificate of authority valid on August 25, 1989, shall expire on April 30, 1990, as provided in section 44-303.

Source: Laws 1989, LB 92, § 42.

44-202 Insurance companies; organization; businesses authorized.

(1) Companies may be formed upon the stock or mutual plan to transact any line or lines of insurance authorized by section 44-201, upon the assessment plan to transact any line or lines of insurance specified in subdivisions (4), (5), (7), and (18) of such section, or upon the fraternal plan to transact insurance as authorized in Chapter 44, article 10. An assessment association may, in addition to any line or lines of insurance described in subdivisions (4), (5), (7), and (18) of section 44-201, be authorized to transact any line or lines of insurance which a mutual company may transact when such association has accumulated and thereafter at all times maintains the same reserves, surplus, and contingency funds required to be maintained by a mutual company organized to transact the same line or lines of insurance.

(2) A domestic company may, notwithstanding limitations otherwise applicable and if it maintains books and records which account for such business, engage directly in any of the following businesses: (a) Rendering investment advice; (b) rendering services related to the functions involved in the operation of its insurance business, including, but not limited to, actuarial, loss prevention, marketing and sales, safety engineering, data processing, accounting, claims, appraisal, and collection services; (c) acting as trustee or fiduciary in the administration of pension, profit-sharing, and other benefit plans for em-

ployees and self-employed persons and individual retirement accounts or annuities, if, in the judgment of the company, such plans constitute qualified plans under the Internal Revenue Code; (d) acting as administrative agent for a governmental instrumentality which is performing an insurance function for a health or welfare program; and (e) any other business activity reasonably complementary or supplementary to its insurance business, either to the extent necessarily or properly incidental to the insurance business which the company is authorized to do in this state or to the extent approved by the Director of Insurance and subject to any limitations he or she may prescribe for the protection of the interests of the policyholders of the company taking into account the effect of such business on the company's existing insurance business and its surplus, the proposed allocation of the estimated cost of such business, and the risks inherent in such business as well as the relative advantages to the company and its policyholders of conducting such business directly instead of through a subsidiary.

Source: Laws 1913, c. 154, § 79, p. 427; R.S.1913, § 3216; Laws 1919, c. 190, tit. V, art. V, § 2, p. 608; C.S.1922, § 7815; Laws 1925, c. 124, § 2, p. 328; C.S.1929, § 44-402; Laws 1931, c. 89, § 1, p. 250; C.S.Supp.,1941, § 44-402; R.S.1943, § 44-202; Laws 1949, c. 139, § 1, p. 363; Laws 1951, c. 136, § 1, p. 560; Laws 1972, LB 1336, § 1; Laws 1975, LB 437, § 1; Laws 1989, LB 92, § 43; Laws 1995, LB 574, § 42.

44-202.01 Insurance companies; licensed on August 25, 1989; continuance of authority.

An insurer holding a valid certificate of authority to transact insurance in this state immediately prior to August 25, 1989, may continue to be authorized to transact the same lines of insurance permitted by such certificate of authority by maintaining thereafter the same amount of paid-in capital stock, if a stock insurer, or the same amount of surplus, if a mutual insurer, as required by the laws of this state for such authority immediately prior to such date, except that if such insurer, on or after such date, is determined by the director to be maintaining an amount which complies with the requirements as to capital and surplus as provided in sections 44-214, 44-219, and 44-243, then such insurer shall continue to comply with such requirements. On and after such date the insurer shall not be granted authority to transact any other or additional line of insurance unless it then fully complies with the requirements as to capital and surplus as provided by sections 44-214, 44-219, and 44-243 with respect to insurers applying for original certificates of authority.

Source: Laws 1965, c. 253, § 6, p. 719; Laws 1967, c. 262, § 2, p. 703; Laws 1989, LB 92, § 44.

44-203 Insurance companies; lines of insurance; authorized.

Except as provided in section 44-1984, a company may be formed or an existing company may be authorized to transact any one or more of the lines of insurance specified in section 44-201.

Source: Laws 1913, c. 154, § 80, p. 428; R.S.1913, § 3217; Laws 1919, c. 190, tit. V, art. V, § 3, p. 608; C.S.1922, § 7816; Laws 1925, c. 124, § 3, p. 329; C.S.1929, § 44-403; R.S.1943, § 44-203; Laws

1951, c. 136, § 2, p. 560; Laws 1971, LB 767, § 2; Laws 1973, LB 181, § 1; Laws 1989, LB 92, § 45; Laws 1991, LB 235, § 3; Laws 1997, LB 53, § 47.

44-203.01 Repealed. Laws 1989, LB 92, § 278.

44-204 Repealed. Laws 1951, c. 136, § 4.

44-205 Insurance companies; formation; articles of incorporation; filing.

Five or more natural persons may act as incorporators of an insurance corporation. The articles of incorporation shall be signed by each incorporator and delivered to the Department of Insurance for approval or disapproval, and if approved and found by it to be in accordance with the laws of this state, the department shall so certify. When such articles are thus approved, they shall be filed in the office of the Secretary of State and a duplicate copy bearing the date of filing in the office of the Secretary of State shall be filed in the office of the department. Upon the filing and recording of the articles of incorporation in the office of the Secretary of State as provided in this section corporate existence shall commence.

Source: Laws 1913, c. 154, § 81, p. 429; R.S.1913, § 3218; Laws 1919, c. 190, tit. V, art. V, § 4, p. 609; Laws 1921, c. 305, § 1, p. 963; C.S.1922, § 7817; C.S.1929, § 44-404; R.S.1943, § 44-205; Laws 1989, LB 92, § 46; Laws 1997, LB 52, § 1.

44-205.01 Articles of incorporation; contents.

(1) The articles of incorporation filed pursuant to section 44-205 shall state (a) the corporate name, which shall not so nearly resemble the name of an existing corporation as, in the opinion of the Director of Insurance, will mislead the public or cause confusion, (b) the place in Nebraska where the registered office and principal office will be located, (c) the purposes, which shall be restricted to the kind or kinds of insurance to be undertaken, such other kinds of business which it shall be empowered to undertake, and the powers necessary and incidental to carrying out such purposes, and (d) such other particulars as are required by the Nebraska Model Business Corporation Act and Chapter 44.

(2) The articles of incorporation may state such other particulars as are permitted by the Nebraska Model Business Corporation Act and Chapter 44, including provisions relating to the management of the business and regulation of the affairs of the corporation and defining, limiting, and regulating the powers of the corporation, its board of directors, and the shareholders of a stock corporation or the members of a mutual or assessment corporation.

Source: Laws 1957, c. 178, § 1, p. 611; Laws 1972, LB 1336, § 2; Laws 1989, LB 92, § 47; Laws 1995, LB 109, § 215; Laws 2014, LB749, § 280.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-206 Insurance companies; formation; notice; publication.

Within the earlier of thirty days after receiving the certificate of authority to transact business or four months after filing its articles of incorporation, such

corporation shall publish a notice in some legal newspaper, which notice shall contain the same information, as far as practicable, as that required under the Nebraska Model Business Corporation Act.

Source: Laws 1913, c. 154, § 81, p. 429; R.S.1913, § 3218; Laws 1919, c. 190, tit. V, art. V, § 4, p. 609; Laws 1921, c. 305, § 1, p. 963; C.S.1922, § 7817; C.S.1929, § 44-404; R.S.1943, § 44-206; Laws 1989, LB 92, § 48; Laws 1995, LB 109, § 216; Laws 2014, LB749, § 281.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-207 Insurance companies; formation; executive officers; qualifications.

Insurance companies hereafter organizing under the laws of this state are required to have as their executive officers persons who are known to be capable of running the affairs of an insurance company. The requirements shall consist of good character and known business ability, the latter requirement including a practical knowledge of the executive duties of conducting an insurance business.

Source: Laws 1921, c. 305, § 1, p. 963; C.S.1922, § 7817; C.S.1929, § 44-404; R.S.1943, § 44-207.

44-208 Insurance companies; stock distribution and sale; compensation; limitation; statement.

No domestic insurance company shall issue, cause, or allow to be issued any stock or stock subscriptions at any time upon which all expenses of distribution and sale, including promotion, commissions, and underwriting fees, exceed ten percent of the amount paid in money upon such stock or stock subscriptions. All persons incorporating a stock insurance company shall sign a statement before a notary public stating that no one person or group of persons shall receive directly or indirectly any money or securities whatsoever for promoting and organizing any such company in excess of that amount provided for in the insurance laws of this state pertaining to the promotion and organization of insurance companies, and such statement shall be filed in the office of the Department of Insurance.

Source: Laws 1921, c. 305, § 1, p. 963; C.S.1922, § 7817; C.S.1929, § 44-404; R.S.1943, § 44-208; Laws 1989, LB 92, § 49.

44-208.01 Insurance companies; organization; filings required.

(1) In addition to the statement required by section 44-208 of persons incorporating stock companies, the incorporators of all domestic stock, mutual, and assessment insurers shall file with the Department of Insurance (a) copies of the proposed bylaws, (b) forms of subscriptions for capital stock or forms of application for membership or for insurance, and (c) a bond payable to the Director of Insurance and his or her successors, as trustees, in the penal sum to be determined by the Director of Insurance and in no event to be less than ten thousand dollars, with corporate surety, and conditioned upon the faithful accounting to the corporation on completion of its organization and the receipt of its certificate of authority from the Department of Insurance, to the shareholders, applicants for membership or for policies, or creditors, or to the

trustee, receiver, or assignee of the corporation, duly appointed in any court of competent jurisdiction in this state, in accordance with their respective rights in the event the organization of the corporation is not completed and a certificate of authority to do business is not procured.

(2) In addition to the requirements of subsection (1) of this section, the incorporators of stock insurers shall file an application to solicit subscriptions for stock which shall include (a) the correct names and addresses of the incorporators and promoters, (b) a detailed statement of the plan upon which the corporation will operate, (c) the names, the addresses, and a brief description of the business experience of the proposed executive officers, including supervisory and administrative personnel, (d) the par value of the stock, (e) the subscription price of the stock, (f) the amount to be expended for organization and promotion expenses, expressed in a percentage of the subscription price of the stock, (g) the proposed plan of soliciting subscriptions for stock, (h) the place and manner in which the proceeds from full and partial subscriptions for stock will be held pending the corporation's organization, (i) an outline of the manner in which the corporation proposes to maintain its books and records, including the records pertaining to the solicitation of subscriptions for stock, (j) duplicate copies of all advertising matter which is to be used in connection with the sale of stock, (k) duplicate copies of all contracts to be entered into with persons employed to solicit subscriptions, and (l) such other information as may be required by the Department of Insurance.

Source: Laws 1957, c. 178, § 2, p. 612; Laws 1989, LB 92, § 50.

44-208.02 Insurance companies; organization; subscriptions to stock; permit.

If the Director of Insurance approves the forms of subscriptions for capital stock or the forms of application for membership or for insurance, the corporate surety on the bond required by section 44-208.01, and, in the case of stock insurers, the application to solicit subscriptions for stock, he or she shall deliver to the promoter or incorporators a permit in the name of the corporation authorizing it to complete its organization. Upon receiving such permit, the corporation shall have authority to solicit subscriptions and payments for capital stock if a stock insurer and applications and premiums or advance assessments for insurance if other than a stock insurer and to exercise such powers, subject to the limitations imposed by the Nebraska Model Business Corporation Act and Chapter 44, as may be necessary and proper in completing its organization and qualifying for a license to transact the kind or kinds of insurance proposed in its articles of incorporation. No corporation shall issue policies or enter into contracts of insurance until it receives a certificate of authority permitting it to do so.

Source: Laws 1957, c. 178, § 3, p. 613; Laws 1989, LB 92, § 51; Laws 1995, LB 109, § 217; Laws 2014, LB749, § 282.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-208.03 Insurance companies; organization; solicitors; written contract required; filing.

No person shall solicit subscriptions for the capital stock of, or applications for membership or for insurance in any corporation in the process of organization, unless he has entered into a written contract with the corporation and a

certificate of his authority, signed by at least three incorporators, has been filed with the Department of Insurance.

Source: Laws 1957, c. 178, § 4, p. 613.

44-208.04 Insurance companies; organization; promotion expense; subscription, required stipulations.

Every subscription to the capital stock of a corporation in the process of organization shall contain a stipulation that no sum shall be used for promotion or organization expense in excess of a stated percent of the amount paid upon the subscription. Such sum shall in no event exceed the percentage permitted by law. All sums paid by subscribers shall be held or invested in the manner described in the corporation's application for approval to solicit subscriptions required by section 44-208.01, and no sums may be disbursed by the corporation except for commissions or other promotion or organization expenses until the corporation has procured a certificate of authority from the Department of Insurance. Every subscription for stock, and every application for membership or for insurance made prior to the date the corporation is authorized to write insurance, shall contain a stipulation that the consideration paid by the subscriber or applicant shall be returned to him without any deduction except for organization and promotion expenses actually incurred, in no event to exceed the maximum permitted by law, in case the corporation fails to complete its organization and procure its certificate of authority, or issue the policy applied for.

Source: Laws 1957, c. 178, § 5, p. 613.

44-208.05 Insurance companies; organization; failure to complete; proceedings authorized.

(1) If a corporation does not qualify for a certificate of authority within one year from the date it receives its permit to complete its organization or if an agent of the corporation employed to solicit subscriptions or applications has violated the insurance laws of the state, the Director of Insurance may revoke such permit and order the assets of the corporation to be distributed to the persons or legal entities entitled thereto or proceed against the corporation as an insolvent insurance company in the manner authorized and directed by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

(2) If any corporation does not qualify to receive its certificate of authority within two years from the date it receives its permit to complete organization, the Director of Insurance shall order the assets of the corporation to be distributed to the persons or legal entities entitled thereto or proceed against the corporation as an insolvent insurance company in the manner authorized and directed by the act.

Source: Laws 1957, c. 178, § 6, p. 614; Laws 1989, LB 92, § 52; Laws 1989, LB 319, § 67.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-208.06 Insurance companies; shares of stock; sale in excess of subscription price, limitation.

Until a certificate of authority is issued to a corporation to transact business on the stock plan and for three years thereafter, no shares of stock shall be issued by the corporation or sold or transferred by the promoters, incorporators, or other persons engaged in soliciting subscriptions or in organizing or promoting the corporation, without approval of the Department of Insurance, for an amount in excess of the original subscription price as stated in the application required by section 44-208.01. Except to the extent provided in this section, sales and transfers of shares of stock by the record owner or owners shall not be subject to sections 44-208.01 to 44-208.08.

Source: Laws 1957, c. 178, § 7, p. 615; Laws 1989, LB 92, § 53.

44-208.07 Insurance companies; organization; rules and regulations.

The Director of Insurance shall have authority to adopt and promulgate rules and regulations to regulate all other matters in connection with the organization of domestic insurers for the purpose of protecting the public or preventing fraud.

Source: Laws 1957, c. 178, § 8, p. 615; Laws 1989, LB 92, § 54.

44-208.08 Insurance companies; organization; violation of law; personal liability of solicitors.

Any person, firm, association, partnership, limited liability company, or corporation which solicits any subscriptions for stock or any application for membership or for a policy or sells any surplus note for any insurer in process of organization in violation of law shall be personally liable to any person from whom he or she may have solicited such subscription for stock or application or to whom he or she may have sold such surplus note in an amount equal to that paid by the purchaser or applicant. Suit to recover the same may be brought by such purchasers or applicants, jointly or severally, in any court of competent jurisdiction in this state.

Source: Laws 1957, c. 178, § 9, p. 615; Laws 1989, LB 92, § 55; Laws 1993, LB 121, § 219.

44-209 Repealed. Laws 1989, LB 92, § 278.

44-210 Annual meeting; special meeting; voting rights; proxies; preferred stock; limitation on right to vote; quorum requirements; when.

Every domestic stock and mutual company and assessment association shall hold an annual meeting of its shareholders, if a stock company, or of its members, if a mutual company or an assessment association, on or before the 30th day of June in each and every calendar year, for the purpose of receiving the report of its officers and directors, to elect directors whose terms expire, and to transact such other business as may be lawful for it to do. Special meetings of the shareholders or members may be held as may be provided in the articles of incorporation or the bylaws and as otherwise provided by law. Each outstanding share of stock in a stock company and each member in a mutual company or assessment association shall be entitled to one vote on each matter submitted to a vote at an annual or special meeting of the shareholders or members, except as otherwise provided by law and except that any such stock company in its articles of incorporation may provide that the holders of preferred shares of stock shall have no right to vote and, in such event, such

shares of stock shall not be entitled to vote. A shareholder or member may vote either in person or by proxy executed in writing by the shareholder or member or by his or her duly authorized attorney in fact appointing any director, officer, shareholder, or member for such purpose. In the case of a mutual company or an assessment association, such proxy may be incorporated into a member's application for insurance or policy. All such proxies shall be filed or on file with the stock or mutual company or assessment association at least five days prior to the day of the meeting, and they shall expire eleven months from their effective date, unless otherwise provided in such proxy, application, or policy. Nothing in this section shall be construed to prohibit or limit the right of a shareholder or member to vote in person or otherwise revoke any such proxy at any time prior to any exercise thereof. In the case of a mutual company or an assessment association, there shall be no quorum requirements for any meeting of members except as set forth in the articles of incorporation or the bylaws of such mutual company or assessment association.

Source: Laws 1913, c. 154, § 63, p. 422; R.S.1913, § 3199; Laws 1919, c. 190, tit. V, art. IV, § 33, p. 602; C.S.1922, § 7798; C.S.1929, § 44-333; R.S.1943, § 44-210; Laws 1963, c. 265, § 1, p. 794; Laws 1965, c. 254, § 1, p. 720; Laws 1989, LB 92, § 56; Laws 1994, LB 1222, § 47.

44-211 Incorporators; manage business until first meeting of shareholders; board of directors; election; number; qualifications; powers.

The business and affairs of an insurance corporation shall be managed by the incorporators until the first meeting of shareholders or members and then and thereafter by a board of directors elected by the shareholders or members and as otherwise provided by law. The board of directors shall consist of not less than five persons, and one of them shall be a resident of the State of Nebraska. At least one-fifth of the directors of an insurance company, which is not subject to section 44-2135, shall be persons who are not officers or employees of such company. A person convicted of a felony may not be a director, and all directors shall be of good moral character and known professional, administrative, or business ability, such business ability to include a practical knowledge of insurance, finance, or investment. No person shall hold the office of director unless he or she is a policyholder, if the company is a mutual company or assessment association. Unless otherwise provided in the articles of incorporation, the board of directors shall make all bylaws. A director shall discharge his or her duties as a director in accordance with section 21-2,102.

Source: Laws 1913, c. 154, § 82, p. 429; R.S.1913, § 3219; Laws 1919, c. 190, tit. V, art. V, § 5, p. 609; C.S.1922, § 7818; C.S.1929, § 44-405; R.S.1943, § 44-211; Laws 1953, c. 145, § 1, p. 469; Laws 1959, c. 195, § 1, p. 702; Laws 1961, c. 212, § 1, p. 630; Laws 1965, c. 255, § 1, p. 722; Laws 1967, c. 263, § 1, p. 706; Laws 1989, LB 92, § 57; Laws 1991, LB 236, § 35; Laws 1999, LB 259, § 2; Laws 2007, LB191, § 2; Laws 2014, LB749, § 283.

44-211.01 Repealed. Laws 1963, c. 340, § 1.

44-212 Insurance companies; officers; elections; terms; salaries.

The directors of every stock company and the board of directors or members of every mutual company or assessment association may elect such officers as

are necessary to conduct the business of the company, including a president, secretary, and treasurer, and employ such other officers and employees as may be required to carry on the business of the company and may fix their terms of office or employment and their salaries and compensation, but such action shall not be in conflict with the provisions of law relating thereto.

Source: Laws 1913, c. 154, § 29, p. 411; R.S.1913, § 3165; Laws 1919, c. 190, tit. V, art. III, § 21, p. 590; C.S.1922, § 7765; C.S.1929, § 44-221; R.S.1943, § 44-212; Laws 1989, LB 92, § 58.

Basic authority for fixing salaries of employees was vested in board of directors. Ledwith v. Bankers Life Ins. Co., 156 Neb. 107, 54 N.W.2d 409 (1952).

44-213 Employee, officer, trustee, or director of domestic company; salaries; length of contract; limitations; deferred payment of compensation; employee benefit plans.

No domestic insurance company shall pay any salary, compensation, or emolument to any salaried employee or to any officer, trustee, or director thereof in excess of a reasonable return for the services performed or to be performed by such person. The shareholders of stock companies and the members of other companies shall retain the power at any meeting to alter or discontinue any employment agreement. No such company shall make an agreement with any salaried employee or with any officer, trustee, or director whereby it agrees that, for any services to be rendered, he or she shall receive any salary, compensation, or emolument that will extend beyond a period of five years from the date of such agreement, but any such company may make a conditional or unconditional agreement with any such person whereby it agrees that, in consideration of a current salary, compensation, or emolument of any amount less than a reasonable return for the services performed or to be performed by such person, he or she shall at specified future time or times, without regard to the five-year limitation set out in this section, receive, either without further condition or subject to reasonable contingencies, additional deferred salary, compensation, or emolument of any amount adequate to make the total thereof received by such person a reasonable return for the services performed by such person. Salary, compensation, and emolument as used in this section shall not include payments made pursuant to a plan for retirement, disability, sickness, accident, or death benefits.

Source: Laws 1913, c. 154, § 46, p. 418; R.S.1913, § 3182; Laws 1919, c. 190, tit. V, art. IV, § 17, p. 597; C.S.1922, § 7782; Laws 1925, c. 125, § 1, p. 331; C.S.1929, § 44-317; R.S.1943, § 44-213; Laws 1945, c. 106, § 1, p. 340; Laws 1953, c. 146, § 1, p. 470; Laws 1957, c. 176, § 1, p. 608; Laws 1961, c. 213, § 1, p. 631; Laws 1975, LB 374, § 1; Laws 1989, LB 92, § 59.

44-213.01 Repealed. Laws 2019, LB469, § 10.

44-213.02 Repealed. Laws 2019, LB469, § 10.

44-213.03 Repealed. Laws 2019, LB469, § 10.

44-213.04 Repealed. Laws 2019, LB469, § 10.

44-213.05 Repealed. Laws 2019, LB469, § 10.

44-213.06 Repealed. Laws 2019, LB469, § 10.

44-213.07 Repealed. Laws 2019, LB469, § 10.

44-214 Stock insurance company; capital stock and surplus requirements; lines of insurance authorized; additional requirements.

(1) Except as provided in section 44-202.01, no stock insurance company shall, on and after August 25, 1989, transact any line of insurance specified in section 44-201 in this state unless it maintains a capital stock, actually paid in cash or invested as provided by law, of at least one million dollars, nor shall it, on or after such date, transact the line or lines of insurance specified in subdivisions (1) and (2) of section 44-201 and in addition thereto one or more lines of insurance other than those specified in subdivisions (3) and (4) of such section in this state unless it maintains a capital stock, actually paid in cash or invested as provided by law, of at least two million dollars. No stock insurance company shall, on and after August 25, 1989, begin to transact any line of insurance as specified in section 44-201 unless it has a surplus of at least one million dollars, nor shall it, on and after such date, begin to transact the line or lines of insurance specified in subdivisions (1) and (2) of section 44-201 and in addition thereto one or more lines of insurance other than those specified in subdivisions (3) and (4) of such section in this state unless it has a surplus of at least two million dollars.

(2) The provisions of subsection (1) of this section shall be considered minimum requirements. Stock insurers holding a certificate of authority to transact business in this state shall also be subject to the requirements of the Insurers and Health Organizations Risk-Based Capital Act.

Source: Laws 1913, c. 154, § 86, p. 430; R.S.1913, § 3223; Laws 1919, c. 190, tit. V, art. V, § 9, p. 610; C.S.1922, § 7822; Laws 1925, c. 123, § 1, p. 324; C.S.1929, § 44-409; Laws 1935, c. 98, § 1, p. 326; C.S.Supp.,1941, § 44-409; R.S.1943, § 44-214; Laws 1949, c. 141, § 1, p. 365; Laws 1957, c. 177, § 1, p. 610; Laws 1965, c. 253, § 2, p. 716; Laws 1967, c. 262, § 3, p. 703; Laws 1974, LB 919, § 1; Laws 1989, LB 92, § 61; Laws 1993, LB 583, § 39; Laws 1994, LB 978, § 15; Laws 1999, LB 258, § 1.

Cross References

Insurers and Health Organizations Risk-Based Capital Act, see section 44-6001.

Under prior law, setting the subscription price of the capital stock of a former mutual company at one hundred twenty-five percent of par so as to provide the surplus required by the statute, was at most a mere irregularity. Leininger v. North Am. Nat. Life Ins. Co., 115 Neb. 801, 215 N.W. 167 (1927).

44-215 Repealed. Laws 1965, c. 253, § 7.

44-216 Mutual company; assessment association; articles of incorporation; contents.

The articles of incorporation of a mutual company or an assessment association may limit the insurance to specified kinds or classes of property, lives, individuals, or liabilities within any subdivision of section 44-201 or the territory within which insurance shall be granted and shall provide the manner in which policyholders of a mutual company shall participate in the profits of the company.

Source: Laws 1913, c. 154, § 85, p. 430; R.S.1913, § 3222; Laws 1919, c. 190, tit. V, art. V, § 8, p. 610; C.S.1922, § 7821; C.S.1929, § 44-408; R.S.1943, § 44-216; Laws 1989, LB 92, § 62.

44-217 Mutual company; assessment association; membership; voting.

Each person, corporation, association, partnership, or limited liability company owning a policy or policies of insurance issued by a mutual company or an assessment association shall be a member thereof and have one vote.

Source: Laws 1913, c. 154, § 83, p. 429; R.S.1913, § 3220; Laws 1919, c. 190, tit. V, art. V, § 6, p. 610; C.S.1922, § 7819; C.S.1929, § 44-406; R.S.1943, § 44-217; Laws 1989, LB 92, § 63; Laws 1993, LB 121, § 220.

The provision that guarantees full rights of subscription to the members of a mutual insurance company, transformed into a stock company, refers to the policyholders of the former mutual company. Leininger v. North Am. Nat. Life Ins. Co., 115 Neb. 801, 215 N.W. 167 (1927).

44-218 Mutual company; limitation of liability.

The liability of a member of a mutual company shall be limited to the premiums stated in the policy.

Source: Laws 1913, c. 154, § 79, p. 428; R.S.1913, § 3216; Laws 1919, c. 190, tit. V, art. V, § 2, p. 608; C.S.1922, § 7815; Laws 1925, c. 124, § 2, p. 328; C.S.1929, § 44-402; Laws 1931, c. 89, § 1, p. 251; C.S.Supp.,1941, § 44-402; R.S.1943, § 44-218; Laws 1957, c. 189, § 1, p. 662; Laws 1989, LB 92, § 64.

Assessments conformed to statute and could be recovered by company in action against policyholder. Nebraska Mutual Ins. Co. v. Borden, 132 Neb. 656, 272 N.W. 767 (1937).

Assessment in excess of limitation herein prescribed is at least partially invalid, and failure to pay same is no defense to action on policy. Hobza v. State Farmers Ins. Co., 125 Neb. 776, 252 N.W. 214 (1934).

44-219 Domestic mutual company; transaction of business; policies and reserve required; additional requirements.

(1)(a) No domestic mutual insurance company shall begin to transact the business of insurance until (i) it has received not less than one hundred applications for insurance unless organized to write (A) workers' compensation and employers liability insurance, in which case it shall receive applications from at least twenty employers covering in the aggregate five hundred employees, or (B) the line or lines of insurance specified in subdivisions (13) and (14) of section 44-201, in which case no application shall be required, and in addition thereto (ii) it has received in cash one annual premium for each application for insurance.

(b) Except as provided in section 44-202.01, no mutual insurance company shall, on and after August 25, 1989, transact any line of insurance specified in section 44-201 in this state unless it has and maintains a minimum surplus, in cash or invested as provided by law, of at least one million dollars, nor shall it, on and after such date, transact the line or lines of insurance specified in subdivisions (1) and (2) of section 44-201 and in addition thereto one or more lines of insurance other than those specified in subdivisions (3) and (4) of such section in this state unless it has and maintains a minimum surplus, in cash or invested as provided by law, of at least two million dollars.

(2) The provisions of subsection (1) of this section shall be considered minimum requirements. Mutual insurers holding a certificate of authority to transact business in this state shall also be subject to the requirements of the Insurers and Health Organizations Risk-Based Capital Act.

Source: Laws 1913, c. 154, § 87, p. 431; R.S.1913, § 3224; Laws 1919, c. 190, tit. V, art. V, § 10, p. 611; C.S.1922, § 7823; C.S.1929,

§ 44-410; Laws 1941, c. 84, § 1, p. 332; C.S.Supp.,1941, § 44-410; R.S.1943, § 44-219; Laws 1949, c. 142, § 1(1), p. 366; Laws 1957, c. 178, § 11, p. 616; Laws 1965, c. 253, § 3, p. 717; Laws 1967, c. 262, § 4, p. 703; Laws 1974, LB 919, § 2; Laws 1986, LB 811, § 15; Laws 1989, LB 92, § 65; Laws 1993, LB 583, § 40; Laws 1994, LB 978, § 16; Laws 1999, LB 258, § 2.

Cross References

Insurers and Health Organizations Risk-Based Capital Act, see section 44-6001.

Contracts, providing for distribution of a percentage of the premiums collected annually as dividends to charter members, made in an effort to secure the number of applications required by statute before business may be commenced, are ultra vires in the absence of authority therefore in the statute or charter. Durland v. Elkhorn Life & Acc. Ins. Co., 112 Neb. 105, 198 N.W. 564 (1924).

44-219.01 Repealed. Laws 1967, c. 262, § 6.

44-219.02 Repealed. Laws 1965, c. 253, § 7.

44-219.03 Repealed. Laws 1965, c. 253, § 7.

44-219.04 Repealed. Laws 1989, LB 92, § 278.

44-219.05 Repealed. Laws 1989, LB 92, § 278.

44-219.06 Repealed. Laws 1989, LB 92, § 278.

44-219.07 Repealed. Laws 1989, LB 92, § 278.

44-219.08 Repealed. Laws 1989, LB 92, § 278.

44-219.09 Repealed. Laws 1989, LB 92, § 278.

44-220 Domestic company; power to borrow; purposes; conditions; issuance of surplus notes.

In addition to the general power and authority to borrow money for its regular business purposes, any domestic insurance company may borrow money: (1) To defray the reasonable expenses of its organization; (2) to provide special contingency loss funds; (3) to provide additional surplus funds; (4) to make good any deficiency; and (5) to provide the amount of minimum surplus required by Chapter 44 and may issue its notes therefor, to be known as surplus notes, which shall fully recite the purpose for which the money was borrowed, if application has been made to the Department of Insurance and approval in writing is obtained from the Director of Insurance for the issuance of such surplus notes in a stated maximum amount. The amount thereof outstanding with the unpaid interest shall be stated in each annual report.

Source: Laws 1913, c. 154, § 84, p. 429; R.S.1913, § 3221; Laws 1919, c. 190, tit. V, art. V, § 7, p. 610; C.S.1922, § 7820; C.S.1929, § 44-407; Laws 1941, c. 83, § 1, p. 330; C.S.Supp.,1941, § 44-407; R.S.1943, § 44-220; Laws 1949, c. 143, § 1, p. 368; Laws 1965, c. 256, § 1, p. 723; Laws 1989, LB 92, § 66; Laws 1994, LB 1222, § 48.

44-221 Domestic company; surplus notes; repayment; interest rate.

(1) Except as provided in this subsection, surplus notes issued prior to September 9, 1995, and the indebtedness which they represent shall not be a

liability or claim against any of the assets of the company. The principal of such notes may be paid from time to time, either in full or in part, from available surplus funds of the company only when the amount of the surplus of the company over all liabilities is double that of the principal amount then being paid. The company shall have the right to make such repayments whenever it is able to do so, except that the company shall first receive the prior approval of the Director of Insurance for any such repayments. The director shall use the standards set forth in section 44-2136 relating to adequacy of surplus in determining whether or not to approve such repayments. The interest on such notes shall only be payable from the surplus and shall not exceed such sum as may be fixed. Upon a dissolution of the company, the principal and accrued and unpaid interest shall be payable from the surplus.

(2) Except as provided in this subsection, the principal of surplus notes issued on or after September 9, 1995, and the indebtedness which such notes represent shall not be a liability or claim against any of the assets of the company. The principal of and interest on such notes may be paid from time to time, either in full or in part, from available surplus funds of the company only when the amount of the surplus of the company over all liabilities is double that of the amount of principal and interest then being paid. The company shall have the right to make such payments whenever it is able to do so, except that the company shall first receive the prior approval of the Director of Insurance for any such payments. The director shall use the standards set forth in section 44-2136 relating to adequacy of surplus in determining whether or not to approve such payments. Upon a dissolution of the company, the principal and accrued and unpaid interest shall be payable from the surplus.

Source: Laws 1913, c. 154, § 84, p. 430; R.S.1913, § 3221; Laws 1919, c. 190, tit. V, art. V, § 7, p. 610; C.S.1922, § 7820; C.S.1929, § 44-407; Laws 1941, c. 83, § 1, p. 330; R.S.Supp.,1941, § 44-407; R.S.1943, § 44-221; Laws 1973, LB 405, § 1; Laws 1989, LB 92, § 67; Laws 1991, LB 236, § 36; Laws 1994, LB 1222, § 49; Laws 1995, LB 162, § 1.

44-222 Insurance; maximum risks; exceptions.

Except as otherwise provided by law, no insurance company shall expose itself to any loss on any one risk in an amount exceeding ten percent of its surplus to policyholders as reflected by the last annual statement of the company, except that domestic assessment associations organized for the primary purpose of writing insurance coverage on farm properties and which write such insurance in less than thirty-one counties in Nebraska shall not write any policy for an amount in excess of one-eighth of one percent of its insurance in force. The term loss shall mean the incremental decrease in surplus resulting from payment of a claim equal to the maximum liability of the insurer on any one risk. The term any one risk shall mean, in the case of property insurance, all properties insured by the same insurance company which are customarily considered by underwriters to be subject to loss or destruction from the same hazard or occurrence except hazards or occurrences of a catastrophic nature. The term surplus to policyholders shall mean the amount obtained by subtracting, from the admitted assets, actual liabilities, including any reserves which by law must be maintained. In the case of a stock company, surplus to policyholders shall also include the paid-up and outstanding capital stock. Any reinsurance taking effect simultaneously with the policy or bond shall be deducted in

determining whether any one risk or policy exceeds the limitation of risk or policy prescribed in this section. This section shall not be applicable to workers' compensation or employers liability insurance or to any policy or type of coverage as to which the maximum possible loss to the insurance company is not ascertainable on issuance of the policy.

Source: Laws 1913, c. 154, § 88, p. 431; R.S.1913, § 3225; Laws 1919, c. 190, tit. V, art. V, § 11, p. 611; C.S.1922, § 7824; C.S.1929, § 44-411; Laws 1935, c. 98, § 2, p. 326; C.S.Supp.,1941, § 44-411; R.S.1943, § 44-222; Laws 1957, c. 179, § 1, p. 618; Laws 1959, c. 197, § 1, p. 704; Laws 1986, LB 811, § 16; Laws 1987, LB 416, § 18; Laws 1989, LB 92, § 68; Laws 1994, LB 978, § 17.

44-222.01 Insurance; maximum risk; reinsurance; filing information with director.

For the purpose of determining whether any one risk exceeds the limitation imposed by section 44-222, reinsurance shall be in a company acceptable to the Director of Insurance. If requested by the director, the original company writing the risk or policy shall file with the Director of Insurance evidence of such reinsurance listing the name of the reinsurer and such other information pertaining thereto as may be required by the director.

Source: Laws 1959, c. 197, § 2, p. 705; Laws 1989, LB 92, § 69.

44-222.02 Violations; report to Attorney General; suspension of authority to do business; appeal.

The Director of Insurance may, if he or she finds that any person or insurer has violated any of the provisions of sections 44-222 and 44-222.01, report the facts to the Attorney General for prosecution in accordance with the provisions of section 44-395. In lieu of the criminal prosecution provided herein or in addition thereto the Director of Insurance may suspend such insurer's authority to do business in Nebraska for such length of time as the director may prescribe. An appeal may be taken from the decision of the director, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1959, c. 197, § 3, p. 705; Laws 1969, c. 359, § 9, p. 1271; Laws 1988, LB 352, § 41; Laws 1989, LB 92, § 70.

Cross References

Administrative Procedure Act, see section 84-920.

44-223 Insurance companies; incorporators and directors; liability.

The original incorporators, until the election of directors, and thereafter the directors shall be jointly and severally liable for any losses incurred during the following time or times: (1) For the excess of any policy above the maximum single risks prescribed by section 44-222 during the time that such policy exceeds such maximum single risks; (2) for any losses occurring upon any new risk taken after the expiration of the period designated by the Department of Insurance in accordance with sections 44-120 to 44-124 in which to make good

any deficiency; and (3) for all debts and liabilities contracted prior to the time the company received its certificate of authority.

Source: Laws 1913, c. 154, § 89, p. 432; R.S.1913, § 3226; Laws 1919, c. 190, tit. V, art. V, § 12, p. 612; C.S.1922, § 7825; C.S.1929, § 44-412; R.S.1943, § 44-223; Laws 1959, c. 198, § 1, p. 706; Laws 1989, LB 92, § 71.

44-224 Repealed. Laws 1957, c. 180, § 11.

44-224.01 Reinsurance, merger, consolidation; terms, defined.

For purposes of sections 44-224.01 to 44-224.10, unless the context otherwise requires:

(1) Director shall mean the Director of Insurance or his or her authorized representative;

(2) Policyholders shall mean the members of mutual insurance companies, the members of assessment associations, and the subscribers to reciprocal insurance exchanges;

(3) Merger or contract of merger shall mean a merger or consolidation agreement between stock insurance companies as authorized by the Nebraska Model Business Corporation Act;

(4) Consolidation or contract of consolidation shall mean a merger or consolidation agreement between companies operating on other than the stock plan of insurance; and

(5) Bulk reinsurance or contract of bulk reinsurance shall mean an agreement whereby one company cedes by an assumption reinsurance agreement fifty percent or more of its risks and business to another company.

Source: Laws 1957, c. 180, § 1, p. 620; Laws 1969, c. 359, § 10, p. 1271; Laws 1989, LB 92, § 72; Laws 1995, LB 109, § 218; Laws 2014, LB749, § 284.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-224.02 Reinsurance; authorization.

(1) Any domestic insurance company may, in the course of its business, accept reinsurance or bulk reinsurance for the same kinds of insurance and within the same limits as it is authorized to transact directly.

(2) Any domestic insurance company may, in the usual course of business, reinsure any of its risks.

Source: Laws 1957, c. 180, § 2, p. 620.

44-224.03 Domestic stock company; bulk reinsurance; contract; approval.

(1) Any domestic stock insurance company may cede its business to another licensed insurer by a contract of bulk reinsurance, but such contract shall not become effective unless first filed with and approved by the director and thereafter approved by a majority vote of the shareholders of the ceding company present in person or by proxy and voting at an annual meeting or at a special meeting called for that purpose.

(2) The director shall approve such contract within a reasonable time after such filing unless he or she finds it is inequitable to the shareholders or policyholders of both insurers. If the director does not approve the contract, he or she shall so notify the respective insurers in writing specifying his or her reasons therefor. If approved by the director, the contract shall then be submitted to the shareholders of the ceding company for their approval as provided in subsection (1) of this section. If approved by the required vote of the shareholders, the contract shall then become effective.

Source: Laws 1957, c. 180, § 3, p. 620; Laws 1989, LB 92, § 73.

44-224.04 Domestic stock company merger; contract; approval.

Any domestic stock insurance company may merge with another stock insurer after the contract of merger is approved by the director. The director shall not approve any such contract of merger unless the interests of the policyholders or shareholders of both parties thereto are properly protected. If the director does not approve the contract of merger, he or she shall issue a written order of disapproval setting forth his or her findings. After having obtained the approval of the director, the contract of merger shall be consummated in the manner set forth in the Nebraska Model Business Corporation Act for the merger or consolidation of stock corporations.

Source: Laws 1957, c. 180, § 4, p. 621; Laws 1969, c. 362, § 1, p. 1286; Laws 1976, LB 916, § 1; Laws 1989, LB 92, § 74; Laws 1995, LB 109, § 219; Laws 2014, LB749, § 285.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-224.05 Domestic nonstock company; bulk reinsurance; contract; approval.

(1) Any domestic insurance company operating on other than the stock plan may cede its business to another licensed insurer, whether stock, mutual, assessment, or reciprocal exchange, by a contract of bulk reinsurance upon compliance with this section.

(2) Such contract of bulk reinsurance shall not become effective unless first filed with and approved by the director and thereafter approved by a majority vote of the members of the ceding company present in person or by proxy and voting at an annual meeting or at a special meeting called for that purpose. The director shall not approve such contract unless he or she finds it to be fair and equitable to the policyholders of each insurer involved. If the director does not so approve, he or she shall notify each insurer involved in writing specifying his or her reasons therefor.

(3) Contracts of bulk reinsurance whereby an insurer operating on other than the stock plan of insurance cedes its business to a stock insurer shall provide for distribution to each policyholder of the ceding company of his or her equity in the surplus funds, if any, of such ceding company as determined under a fair and equitable formula approved by the director.

Source: Laws 1957, c. 180, § 5, p. 621; Laws 1989, LB 92, § 75.

This section does not abrogate the common law duties of corporate directors to policyholders of a mutual insurance company and the approval of a contract of bulk reinsurance by the Director of Insurance does not insulate the directors of the company from liability for violation of their fiduciary duties. Doyle v. Union Ins. Co., 202 Neb. 599, 277 N.W.2d 36 (1979).

44-224.06 Domestic assessment association; bulk reinsurance; contract.

Any domestic assessment association, which has accumulated and maintains the same reserve for liabilities that is required of a mutual company transacting the same kind or kinds of business, and which has a surplus or contingency funds equal to, or in excess of the surplus required of a mutual company transacting the same kind or kinds of business, may in any contract of reinsurance or bulk reinsurance, agree to limit its assessments to the premium stated in the policies issued by the ceding company.

Source: Laws 1957, c. 180, § 6, p. 622.

44-224.07 Domestic company; consolidation; contract; approval.

(1) A contract of consolidation involving a domestic insurance company shall be approved by a majority vote of the board of directors or other governing body of each of the respective parties thereto as well as by a majority vote of the members present in person or by proxy at an annual meeting or at a special meeting called for that purpose. Such contract of consolidation shall be approved by the director prior to submission to the members for approval. After approval by the members, the officers of the respective parties thereto may enter into and consummate such contract of consolidation and do and perform all acts necessary to the final and complete consummation thereof. Such contract of consolidation shall designate the corporation which is to continue or survive and which shall thereafter retain a certificate of authority issued by the department. The surviving company may assume, in whole or in part, the name of the retiring company. Such contract of consolidation upon becoming effective shall have the effect of transferring the assets, rights, franchises, and interests of the companies so consolidated to the continuing or surviving company, and simultaneously therewith, such surviving or continuing company shall be deemed to have assumed all the liabilities of the consolidated companies. A contract of consolidation need not require a disposition or other distribution of the surplus assets of either party thereto to their respective policyholders. No action or proceeding pending at the time of such consolidation to which either of the consolidating parties may be a party shall be abated or discontinued by reason of such consolidation, but the same may be prosecuted to final judgment in the same manner as if the consolidation had not taken place or the continuing or surviving company may be substituted in place of any such company so consolidated, as the case may be, by order of the court in which the action or proceeding is pending.

(2) Any assessment association which has accumulated and maintains the same reserve for liabilities that is required of a mutual company transacting the same kind or kinds of business and which has a surplus or contingency funds equal to or in excess of that required of a mutual company transacting the same kind or kinds of business may, in any consolidation agreement in which it is to continue or survive as an assessment association, agree to limit its assessments to the premium stated in the policies issued by the retiring company.

Source: Laws 1957, c. 180, § 7, p. 622; Laws 1989, LB 92, § 76.

44-224.08 Reinsurance; special meetings of shareholders; notice.

All special meetings of shareholders or members called pursuant to sections 44-224.03, 44-224.05, and 44-224.07 shall be called upon a printed notice

which shall contain (1) the time, place, and purpose of the meeting, (2) a brief statement of the substance of the contract and, in the case of the type of a bulk reinsurance contract contemplated by subsection (3) of section 44-224.05, a brief statement of the plan for distributing or otherwise disposing of the surplus assets, if any, of the ceding company, and (3) a copy of the order of the director approving the contract. Such notice shall be mailed at least ten days prior to the date the special meeting is called and shall be directed to the shareholder or member at his or her last post office address appearing on the records of the company.

Source: Laws 1957, c. 180, § 8, p. 623; Laws 1989, LB 92, § 77.

44-224.09 Merger, consolidation, reinsurance; appeal.

Any party aggrieved by any order of the director approving or disapproving any contract of merger, consolidation, or bulk reinsurance may appeal, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1957, c. 180, § 9, p. 624; Laws 1969, c. 359, § 11, p. 1272; Laws 1988, LB 352, § 42.

Cross References

Administrative Procedure Act, see section 84-920.

44-224.10 Reinsurance; consolidation; forfeiture of charter; when.

Whenever any company operating on other than the stock plan reinsures all of its risk and business in bulk its charter shall be deemed forfeited to the State of Nebraska. Whenever any company enters into a contract of consolidation and thereby loses its separate identity, its charter shall be deemed forfeited to the State of Nebraska.

Source: Laws 1957, c. 180, § 10, p. 624.

44-224.11 Domestic company; reinsurance; acceptance; conditions.

(1) In addition to any other reinsurance authority granted by Chapter 44, any domestic insurance company authorized to transact business in this state pursuant to Chapter 44, article 2, may accept reinsurance for any insurance transacted by any affiliate or affiliates of such company which such company is not authorized to transact directly. The term affiliate shall have the same meaning as that stated for such term in section 44-2121.

(2) Before an insurance company may transact a business of accepting reinsurance pursuant to this section, it shall obtain the approval of the Department of Insurance. No such approval shall be granted or continued in effect unless the company has and maintains a minimum surplus, in cash or invested as provided by law, of at least two million dollars and has and maintains admitted assets of at least ten million dollars. No such approval shall be granted or continued in effect if the Director of Insurance finds that such approval would not be in the best interests of the policyholders, shareholders, or public because of the competence, experience, or integrity of the management personnel of such business, the terms of reinsurance accepted in connection with such business, or the effect of the operation of such business on the other operations of the company.

(3) No insurance company shall accept reinsurance pursuant to the authority granted by this section on any one risk in an amount exceeding five percent of

its surplus to policyholders as reflected by the last annual statement of the company. The term any one risk and the term surplus to policyholders shall have the same meaning as that stated for such terms in section 44-222.

(4) Nothing in this section shall be construed to require any insurance company otherwise authorized by law to transact the business of reinsurance to exercise the authority granted by this section.

(5) The Department of Insurance shall adopt and promulgate such reasonable rules and regulations as may be necessary or appropriate to carry out the provisions of this section in accordance with the provisions of the Administrative Procedure Act. Such rules and regulations may include rules and regulations pertaining to the form of application for transaction of business authorized by this section, the plan of operation of such business, the qualifications of personnel engaged in such business, and the accounting and reporting procedures applicable to such business.

Source: Laws 1978, LB 464, § 1; Laws 1991, LB 236, § 37.

Cross References

Administrative Procedure Act, see section 84-920.

44-225 Repealed. Laws 1957, c. 180, § 11.

44-226 Repealed. Laws 1957, c. 180, § 11.

44-227 Repealed. Laws 1957, c. 180, § 11.

44-228 Repealed. Laws 1957, c. 180, § 11.

44-229 Repealed. Laws 1957, c. 180, § 11.

44-230 Repealed. Laws 1957, c. 180, § 11.

44-231 Domestic company; articles of incorporation; amendment; procedure; exception.

Except as otherwise provided in the Insurers Demutualization Act, any domestic insurance company, association, or society, hereinafter called company, may amend its articles of incorporation from time to time without limitation so long as the articles as amended contain only such provisions as are authorized in original articles of incorporation under Chapter 44. Proposed amendments to the articles shall be made in the following manner:

(1) The board of directors of such company shall adopt, by a two-thirds vote of all of the directors thereof, the proposed amendments to the articles of incorporation;

(2) Prior to the meeting of the shareholders or members at which the proposed amendments are to be considered, the proposed amendments, with all matters relating thereto, shall be submitted to the Department of Insurance for examination. If satisfied that the interests of the policyholders of such company and all concerned are properly protected and that no reasonable objections exist to the proposed amendments to the articles, the department may approve the same or it may require change or modification prior to any approval, as it may deem best for the interest of those affected; and

(3) If the Department of Insurance requires any changes or modifications of the proposed amendments to the articles of incorporation, such amendments shall be in turn submitted to and be adopted by a two-thirds vote of all the

directors of such company. The proposed amendments to the articles of incorporation as originally adopted or readopted, as the case may be, shall then be submitted to the shareholders or members of the company entitled to vote for adoption at a regular meeting or a special meeting thereof.

Except as hereinafter provided, notice of such a special meeting together with a description of the proposed amendment to the articles of incorporation shall be given to each shareholder or member entitled to vote in the manner authorized or approved by the department at least thirty days prior thereto.

If the proposed amendments to the articles of incorporation are to be considered at a regular annual meeting of the members or shareholders, the Director of Insurance may, in his or her discretion, require the giving of the same notice as is required for a special meeting.

If the proposed amendments to the articles of incorporation are to be considered at a special meeting of the members of a mutual or assessment company or at a regular annual meeting thereof, notice of which has been required, the Director of Insurance may, upon application of the board of directors of such company, permit the company to exclude from the members entitled to notice those who in the opinion of the director are not reasonably ascertainable.

If the proposed amendments to the articles of incorporation are adopted by a two-thirds vote of all the stock, if a stock company, by a vote of two-thirds of the members voting at such meeting in person or by proxy, if a mutual or assessment company, or pursuant to the Insurers Demutualization Act, then they shall be filed in the same offices as original articles of incorporation as provided in section 44-205, and the same notice shall be published.

Source: Laws 1913, c. 154, § 92, p. 434; R.S.1913, § 3229; Laws 1919, c. 190, tit. V, art. V, § 15, p. 614; C.S.1922, § 7828; C.S.1929, § 44-415; Laws 1935, c. 102, § 1, p. 332; C.S.Supp.,1941, § 44-415; R.S.1943, § 44-231; Laws 1961, c. 214, § 1, p. 632; Laws 1989, LB 92, § 78; Laws 1993, LB 583, § 61; Laws 1997, LB 52, § 2.

Cross References

Insurers Demutualization Act, see section 44-6101.

Fraternal benefit society may change into a mutual legal reserve life insurance company, but obligations of its existing contracts remain unimpaired. Royal Highlanders v. Wiseman, 140 Neb. 28, 299 N.W. 459 (1941).

This section and the proceedings thereunder to transform a mutual insurance company into a stock company were constitutional and regular. Leininger v. North Am. Nat. Life Ins. Co., 115 Neb. 801, 215 N.W. 167 (1927).

Section is constitutional and applies only to companies existing at the time the statute was adopted. State ex rel. Martin v. Howard, 96 Neb. 278, 147 N.W. 689 (1914).

44-232 Repealed. Laws 1993, LB 583, § 116.

44-233 Domestic stock company; change to mutual company; requirements.

If any domestic insurance company, operating upon a stock basis, hereafter desires to amend its articles of incorporation and change its methods of doing business to those of a mutual company, it shall, in addition to the requirements of section 44-231, comply with the provisions of sections 44-233 to 44-241.

Source: Laws 1953, c. 152, § 1, p. 480.

44-234 Domestic stock company; change to mutual company; plan; requirements.

The board of directors shall submit to the Director of Insurance:

(1) Two copies of the proposed amendments to its articles of incorporation as provided for in section 44-231, duly certified by the secretary of the company, for filing in the office of the director and as many additional copies thereof as there are shareholders of the company;

(2) Two copies of a comprehensive plan for the mutualization of the company as approved by the board of directors, duly certified by the secretary of the company, for filing in the office of the director and as many additional copies thereof or copies of an adequate summary of the plan as there are shareholders of the company; and

(3) A complete list of the shareholders of the company showing the name of, number of shares owned by, and the latest address of each shareholder as shown by the company's records.

Source: Laws 1953, c. 152, § 2, p. 480; Laws 1989, LB 92, § 80.

44-235 Domestic stock company; change to mutual company; plan; contents.

The plan for the mutualization of the company shall among other things include:

(1) A statement of the value of the interest of the shareholders in the company as ascertained by the company, which value shall not exceed the fair value thereof, and the amount proposed to be paid to each shareholder upon retirement of his or her shares of stock;

(2) A statement of the method of ascertaining the value of the interest of the shareholders;

(3) A statement of the procedure proposed for paying the shareholders for their stock, which may be done over a period of time and performed with due regard for the interest of the policyholders, and for retiring and canceling the stock;

(4) A statement of the method to be followed in continuing the management of the company during any period intervening between the inception of the plan and the retirement of the stock and in instituting management by the policyholders; and

(5) A provision for approval of the plan for mutualization by at least two-thirds of the policyholders voting in person or by proxy at a meeting of policyholders called by the company upon at least thirty days' written notice mailed to the policyholders at their latest addresses as shown by the company's records and containing an adequate summary of the essential provisions of the plan.

Source: Laws 1953, c. 152, § 3, p. 481; Laws 1989, LB 92, § 81.

44-236 Domestic stock company; change to mutual company; plan; director; duties; notice.

Upon receipt of the documents described in section 44-234, the Director of Insurance shall promptly forward by mail to each shareholder of the company a copy of the proposed amendments to the articles of incorporation, a copy of the plan for mutualization or a summary thereof, and a written notice of hearing. The notice of hearing shall contain:

(1) A notification of the time, which shall be at least thirty days from the time of mailing the notice, and place for the hearing of objections to the plan for mutualization; and

(2) A statement that, upon the hearing and due consideration of the proposed plan and amendments to the articles of incorporation, the director may either disapprove the plan, approve the plan as submitted, including the value of the interest of the shareholders in the company as ascertained and stated in the plan, or approve the plan only subject to such modifications as he or she may propose, in which event it shall be returned to the company for approval by the board of directors, and that upon final approval in either event the plan shall, subject to approval by the owners of at least two-thirds of the stock of the company at a regular or special meeting called for the purpose, be placed in effect and the stock of the company retired and canceled and the value ascertained by the director paid to the shareholders all as provided in the plan.

Source: Laws 1953, c. 152, § 4, p. 481; Laws 1989, LB 92, § 82.

44-237 Domestic stock company; change to mutual company; hearing; objections; evidence.

The Director of Insurance shall hold the hearing on objections as provided by sections 44-233 to 44-241 and shall receive written objections to the plan and amendments from any policyholder or shareholder and any evidence offered in support thereof. He or she may employ such actuaries, appraisers, and other experts and make such examinations of the company and its books, records, and property as he or she deems necessary. The Director of Insurance shall cause a full and complete written record of the hearing to be made. Any interested party having objections to the plan or any part thereof shall fully state such objections in written form and file them with the director prior to the hearing. Upon the hearing any objector may offer such evidence as may be determined by the Director of Insurance to be relevant and proper. Upon appeal from the order of the director, the value of each shareholder's interest in the company and the amount to be paid therefor shall not be increased or decreased by reason of any change of circumstances occurring after the filing of such order.

Source: Laws 1953, c. 152, § 5, p. 482; Laws 1989, LB 92, § 83.

44-238 Domestic stock company; change to mutual company; hearing; order; appeal.

If, upon the hearing, the Director of Insurance disapproves the plan, he or she shall enter a written order fully stating the reason therefor. If he or she approves the proposed plan and amendments, he or she shall (1) make and enter an appropriate order approving them, (2) make a finding that the provisions of the plan are in conformity with the requirements of sections 44-231 and 44-235, (3) make a specific finding as to the fair value of the shareholders' interest in the company as of the date of the order, (4) find the value of each shareholder's interest as represented by his or her shares therein and the amount to be paid therefor, and (5) order that, conditioned upon the approval and adoption of the plan and amendments to the articles of incorporation by the shareholders at a regular or special meeting duly called for the purpose as provided in section 44-231, (a) the plan shall be placed in effect, (b) all shareholders of the company shall surrender their stock for cancellation

pursuant to the plan and receive payment therefor in accordance therewith, and (c) upon any shareholder's failing or neglecting to so surrender his or her stock, all of his or her rights, powers, and privileges as such shareholder shall nevertheless terminate and be extinguished, excepting only his or her right to receive payment for his or her stock. The order shall recite that appeal may be had and that the appeal shall be in accordance with the Administrative Procedure Act. A copy of the order, duly certified by the director, shall be promptly forwarded by mail to each of the shareholders of the company at his or her latest address as shown on the records of the company.

Source: Laws 1953, c. 152, § 6, p. 483; Laws 1969, c. 359, § 12, p. 1272; Laws 1988, LB 352, § 43; Laws 1989, LB 92, § 84.

Cross References

Administrative Procedure Act, see section 84-920.

44-239 Domestic stock company; change to mutual company; plan; modification by director.

If the Director of Insurance proposes modifications in the proposed plan for mutualization or amendments to the articles of incorporation, he or she shall make such proposals in the form of a written order approving the plan only upon the condition that such modifications be promptly made thereto and approved by a two-thirds vote of the board of directors and adopted by the owners of at least two-thirds of the stock of the company. The order shall in all other respects follow the form and contain the provisions of an order approving such plan as set out in section 44-238 and shall be similarly forwarded to the shareholders of the company.

Source: Laws 1953, c. 152, § 7, p. 484; Laws 1989, LB 92, § 85.

44-240 Domestic stock company; change to mutual company; plan; approval by policyholders.

Any plan for mutualization approved by the Director of Insurance shall be submitted to the policyholders of the company at a meeting held pursuant to the plan and shall be adopted only upon the affirmative vote of two-thirds of the policyholders present and voting in person or by proxy at the meeting as provided in the plan. The plan and amendments to the articles of incorporation shall also be submitted to the shareholders of the company as provided in section 44-231, and upon affirmative vote of at least two-thirds of the shareholders, the plan shall be placed in full effect and operation and the amendments to the articles shall be deemed adopted to become fully effective upon filing at the time specified in the plan and as provided for in section 44-205, and upon such filing being made, the company shall forthwith become and be a mutual insurance company for all purposes. The company shall publish notice of the amendments to its articles of incorporation as provided in section 44-206.

Source: Laws 1953, c. 152, § 8, p. 484; Laws 1989, LB 92, § 86.

44-241 Domestic stock company; change to mutual company; expenses of department; payment by company.

All reasonable expenses incurred by the Department of Insurance shall be certified to by the director and paid by the company.

Source: Laws 1953, c. 152, § 9, p. 484.

44-242 All-lines insurer; terms, defined.

For purposes of sections 44-242 to 44-247, unless the context otherwise requires:

(1) An all-lines insurer shall mean an insurer authorized to write more than one line of insurance included in a life insurance class of insurance and one or more lines of insurance included in a property and liability class of insurance;

(2) Life insurance class of insurance shall mean the lines of insurance specified in subdivisions (1) through (4) of section 44-201; and

(3) Property and liability class of insurance shall mean the lines of insurance specified in subdivisions (4) through (14) and (16) through (20) of section 44-201, except that, with respect to any particular all-lines insurer, the line of insurance specified in subdivision (4) of section 44-201 may be included in either the life insurance class of insurance or property and liability class of insurance but shall not be included in both classes or, without the approval of the department, transferred from one class to another.

Source: Laws 1979, LB 332, § 1; Laws 1989, LB 92, § 87.

44-243 All-lines insurer; minimum surplus; maintain; failure; effect.

Except as provided in section 44-202.01, an all-lines insurer shall maintain a minimum surplus to policyholders, as defined in section 44-222, of at least two million dollars in the form of capital, if a stock insurance company, or in the form of surplus, if a mutual insurance company, in accordance with sections 44-214 and 44-219, respectively. Such an insurer shall not be subject to section 44-245 so long as its surplus to policyholders exceeds such minimum. Whenever the surplus to policyholders of such an insurer falls below such minimum, it shall be deemed to be an impaired insurer and shall automatically be subject to section 44-245.

Source: Laws 1979, LB 332, § 2; Laws 1989, LB 92, § 88.

44-244 All-lines insurer; class of insurance; annual statement; premiums; how accounted for.

Each line of insurance written by an all-lines insurer which is included in the life insurance class of insurance or the property and liability class of insurance shall be accounted for separately in life and accident and health annual statement blanks and fire and casualty annual statement blanks, respectively. Nothing in this section shall prohibit the writing of combination policy forms by an all-lines insurer combining any line or lines of insurance included in the life insurance class of insurance with any line or lines of insurance included in the property and liability class of insurance, but the allocable and separately stated premiums for each line of insurance shall be accounted for separately according to its classification.

Source: Laws 1979, LB 332, § 3; Laws 1989, LB 92, § 89.

44-245 All-lines insurer; impairment or insolvency; liabilities; how charged.

In the event of impairment or insolvency of an all-lines insurer, the excess of the liabilities of one class of insurance over the accumulated assets attributable to that class of insurance may be charged as necessary against the assets of the other class only to the extent that assets attributable to such other class exceed the amount of reserves and other liabilities of such other class.

Source: Laws 1979, LB 332, § 4.

44-246 Insurance statutes, applicability; sections, how construed.

All requirements, limitations, and restrictions of Chapter 44 which apply to specific lines of insurance or to companies identified by the specific lines of insurance transacted by them shall apply to such companies and to all persons or agents thereof with respect to such specific line of insurance only to the extent transacted or conducted by such companies notwithstanding the fact that companies authorized under this section are formed or authorized to transact lines of insurance included in both the life insurance and property and casualty classes of insurance. If any provisions of sections 44-242 to 44-247 conflict with any other provisions of Chapter 44, the provisions of sections 44-242 to 44-247 shall prevail.

Source: Laws 1979, LB 332, § 5; Laws 1989, LB 92, § 90.

44-247 Department; rules and regulations.

The department shall adopt and promulgate rules and regulations necessary to carry out sections 44-242 to 44-247.

Source: Laws 1979, LB 332, § 6; Laws 1989, LB 92, § 91.

44-248 Plan of exchange; act, how cited.

Sections 44-248 to 44-255 shall be known and may be cited as the Insurance Company Plan of Exchange Act.

Source: Laws 1973, LB 296, § 1; R.S.1943, (1988), § 44-133.01; Laws 1989, LB 92, § 23.

44-249 Plan of exchange; adoption.

Any domestic stock insurance company may adopt a plan providing for the exchange of its outstanding shares for the consideration designated in this section to be paid or provided by a corporation which is to acquire such shares in the manner provided in sections 44-248 to 44-255.

The plan of exchange may provide that the acquiring corporation, as consideration for the stock of the domestic corporation, (1) transfer shares of its stock, (2) transfer other securities issued by it, (3) pay cash therefor, (4) pay or provide other consideration, or (5) pay or provide any combination of the foregoing types of consideration.

Acquiring corporation, as used in sections 44-248 to 44-255, shall mean any corporation incorporated under the laws of the State of Nebraska, any foreign or alien corporation domesticated or qualified to do business in Nebraska, or any foreign or alien insurance company authorized to do business in Nebraska.

Source: Laws 1973, LB 296, § 2; R.S.1943, (1988), § 44-133.02.

44-250 Plan of exchange; approval by directors.

The board of directors of each corporation which is a party to a plan of exchange shall by resolution upon a vote of two-thirds of all of its directors approve a plan of exchange setting forth:

(1) The names of the companies proposing to adopt a plan of exchange, and the names of the states or countries under which each of the companies is incorporated or organized;

(2) The terms and conditions of the proposed plan of exchange, and the mode of carrying the same into effect;

(3) The manner and basis of exchanging the shares of stock of the acquired company or other consideration involved in the plan of exchange; and

(4) Such other provisions with respect to the plan of exchange as are deemed necessary or advisable.

Source: Laws 1973, LB 296, § 3; R.S.1943, (1988), § 44-133.03.

44-251 Plan of exchange; approval; submit to shareholders.

(1) Such plan of exchange shall then be submitted to the Director of Insurance for his or her approval after a hearing at which the shareholders of the company to be acquired shall have an opportunity to be heard upon at least ten days' notice to be given by the company to its shareholders of record at the time of mailing such notice. The director shall approve such plan within twenty days after such hearing unless he or she finds that the terms and conditions thereof for the issuance and exchange of securities or other consideration are unfair to the shareholders of the company to be acquired or if he or she finds that any of the conditions set forth in subsection (1) of section 44-2127 exist.

(2) After having obtained the approval of the Director of Insurance, the plan of exchange shall be submitted to a vote at a meeting of the shareholders of the company to be acquired. Such meeting may be either an annual or a special meeting. Notice shall be given not less than twenty days before such meeting to each shareholder of record as of the time of mailing such notice. Such notice shall be deemed to be delivered when deposited in the United States mail with postage prepaid, addressed to the shareholder at his or her address as it appears on the records of the company. A copy or summary of the plan of exchange shall be included in or enclosed with such notice. Each outstanding share of such company shall be entitled to vote on the proposed plan, whether or not such share has voting rights under the provisions of the articles of incorporation of such company. The affirmative vote of two-thirds of all of the outstanding shares, in person or by proxy, shall be necessary for the approval of any such plan by such shareholders.

Source: Laws 1973, LB 296, § 4; R.S.1943, (1988), § 44-133.04; Laws 1989, LB 92, § 24; Laws 1991, LB 236, § 38.

44-252 Plan of exchange; effective; abandon; when.

Upon such approval of the plan by the shareholders, it shall be executed by the company acquired by its president or vice president and by its secretary or an assistant secretary and shall become effective without other action upon the filing thereof with the Director of Insurance along with a certification as to the number of shares outstanding entitled to vote and the number of shares voted for and against such plan respectively. At any time prior to the filing of the

same with the director with such certification, the plan of exchange may be abandoned pursuant to the provisions therefor, if any, set forth in the plan.

Source: Laws 1973, LB 296, § 5; R.S.1943, (1988), § 44-133.05.

44-253 Plan of exchange; disapproval by shareholder; demand for payment; disagreement; action of shareholder; judgment; payment; effect.

Any shareholder of the company acquired may elect to exercise a right of dissent by filing with the company, prior to or at the meeting of shareholders at which such proposed plan is submitted to a vote, written objections to such proposed plan. If such proposed plan be approved by the required vote and such shareholder shall not have voted in favor thereof, such shareholder may, within ten days after the date on which the vote was taken, make written demand on the company for payment of the fair value of such shareholder's shares, and, if such proposed plan is effected, such company shall pay to such shareholder, upon surrender of the certificate or certificates representing such shares, the fair value thereof as of the day prior to the date on which the vote was taken approving the proposed plan, excluding any appreciation or depreciation in anticipation of such corporate action. Any shareholder failing to make demand within the ten-day period shall be bound by the terms of the proposed plan. If the proposed plan shall be abandoned or rescinded or the shareholder shall revoke the authority to effect such action, then the right of such shareholder to be paid the fair value of his shares shall cease.

Within twenty days after such plan is effected, the company so acquired shall give written notice thereof to each dissenting shareholder who has made demand as provided in this section, and shall make a written offer to each such shareholder to pay for his shares at a specified price deemed by such company to be the fair value thereof.

If within thirty days after the date on which such plan was effected the fair value of such shares is agreed upon between any such dissenting shareholder and the company, payment therefor shall be made within ninety days after the date on which such plan was effected, upon surrender of the certificate or certificates representing such shares. Upon payment of the agreed value, the dissenting shareholder shall cease to have any interest in such shares.

If within such period of thirty days the dissenting shareholder and the company do not agree, then the dissenting shareholder may, within sixty days after the expiration of the thirty-day period, file a petition in any court of competent jurisdiction in the county in which the registered office of the company is situated asking for a finding and determination of the fair value of such shares, and shall be entitled to a judgment against the company for the amount of such fair value as of the day prior to the date on which such vote was taken approving such plan, together with interest thereon at the rate of five percent per year to the date of such judgment. The action shall be prosecuted as an equitable action and the practice and procedure shall conform to the practice and procedure in equity cases. The judgment shall be payable only upon and simultaneously with the surrender to the company of the certificate or certificates representing such shares.

Upon payment of the judgment, the dissenting shareholder shall cease to have any interest in such shares. Unless the dissenting shareholder shall file such petition within the time limited by the provisions of this section, such

shareholder and all persons claiming under him shall be conclusively presumed to have approved and ratified the plan and shall be bound by the terms thereof.

Shares acquired by the company pursuant to payment of the agreed value therefor or payment of the judgment entered therefor, as provided in this section, shall stand canceled unless otherwise provided for in the plan of exchange.

Source: Laws 1973, LB 296, § 6; R.S.1943, (1988), § 44-133.06.

A proceeding by a dissenting minority shareholder for a finding and determination of the fair value of his shares under this section is in essence similar to an inverse condemnation action. Becker v. Natl. American Ins. Co., 202 Neb. 545, 276 N.W.2d 202 (1979).

In a proceeding by a dissenting shareholder seeking a finding and determination of the fair value of shares of stock under the provisions of this section the statutory provisions as to a judgment against the insurance company for the fair value of the shares together with interest, are mandatory. Becker v. Natl. American Ins. Co., 202 Neb. 545, 276 N.W.2d 202 (1979).

44-254 Plan of exchange; transfer; effect.

(1) Upon a plan of exchange becoming effective, the exchange provided for therein shall be considered to have been consummated and each shareholder of the stock insurance company acquired shall cease to be a shareholder of such company. The ownership of all shares of the issued and outstanding stock of such company shall vest in the acquiring corporation automatically without any physical transfer or deposit of certificates representing such shares. The acquiring corporation thereupon shall become the sole shareholder of such stock insurance company and have all of the rights, privileges, immunities and powers and, except as otherwise provided in sections 44-248 to 44-255, be subject to all the duties and liabilities to the extent provided by law of a shareholder of an insurance company organized under the laws of this state.

(2) Certificates representing shares of a domestic insurance company to be acquired prior to the plan of exchange becoming effective shall, after the plan of exchange becomes effective, represent (a) shares of the issued and outstanding capital stock or other securities issued by the acquiring corporation and (b) the right, if any, to receive cash or other consideration upon such terms as are specified in the plan of exchange. The plan of exchange may specify that all such certificates shall after the plan of exchange becomes effective represent only the right to receive shares of stock or other securities issued by the acquiring corporation, or cash or other consideration or any combination thereof, upon such terms as are specified in the plan of exchange.

Source: Laws 1973, LB 296, § 7; R.S.1943, (1988), § 44-133.07.

44-255 Plan of exchange; corporate status.

The stock company acquired under a plan of exchange and the acquiring corporation shall be in all respects separate and distinct corporations, with neither corporation having any liability to the creditors or policyholders, if any, or shareholders of the other for any acts or omissions of the officers, directors, or shareholders of either or both of such corporations.

Source: Laws 1973, LB 296, § 8; R.S.1943, (1988), § 44-133.08.

ARTICLE 3

GENERAL PROVISIONS RELATING TO INSURANCE

Section
44-301. Insurance companies; corporation laws apply; exceptions.

Section
44-332. Repealed. Laws 1984, LB 801, § 50.
44-333. Repealed. Laws 1984, LB 801, § 50.
44-333.01. Repealed. Laws 1984, LB 801, § 50.
44-333.02. Repealed. Laws 1984, LB 801, § 50.
44-333.03. Repealed. Laws 1984, LB 801, § 50.
44-333.04. Repealed. Laws 1984, LB 801, § 50.
44-333.05. Repealed. Laws 1984, LB 801, § 50.
44-333.06. Repealed. Laws 1984, LB 801, § 50.
44-334. Repealed. Laws 1984, LB 801, § 50.
44-334.01. Repealed. Laws 1984, LB 801, § 50.
44-335. Repealed. Laws 1984, LB 801, § 50.
44-336. Transferred to section 44-3909.
44-336.01. Transferred to section 44-3910.
44-336.02. Transferred to section 44-3911.
44-336.03. Transferred to section 44-3912.
44-336.04. Transferred to section 44-3913.
44-336.05. Transferred to section 44-3914.
44-336.06. Transferred to section 44-3915.
44-337. Repealed. Laws 1961, c. 218, § 8.
44-338. Repealed. Laws 1961, c. 218, § 8.
44-339. Repealed. Laws 1984, LB 801, § 50.
44-339.01. Repealed. Laws 1984, LB 801, § 50.
44-339.02. Repealed. Laws 1984, LB 801, § 50.
44-340. Repealed. Laws 1984, LB 801, § 50.
44-341. Repealed. Laws 1984, LB 801, § 50.
44-342. Repealed. Laws 1984, LB 801, § 50.
44-342.01. Repealed. Laws 1984, LB 801, § 50.
44-342.02. Repealed. Laws 1984, LB 801, § 50.
44-342.03. Repealed. Laws 1984, LB 801, § 50.
44-342.04. Repealed. Laws 1984, LB 801, § 50.
44-343. Repealed. Laws 1984, LB 801, § 50.
44-344. Repealed. Laws 1984, LB 801, § 50.
44-344.01. Repealed. Laws 1984, LB 801, § 50.
44-345. Repealed. Laws 1984, LB 801, § 50.
44-346. Repealed. Laws 1984, LB 801, § 50.
44-347. Repealed. Laws 1984, LB 801, § 50.
44-348. Policies, bonds, or certificates; form; approval.
44-349. Policy or contract; statement required.
44-350. Insurance companies; use of name; policies; state name of company; exceptions.
44-351. Insurance companies; similar names; use prohibited.
44-352. Insurance companies; name of other company; use; penalty; appeal.
44-353. Policies; department may inspect.
44-354. Policies; special fees prohibited.
44-355. Policies; premiums; report required.
44-356. Policies; violations; penalty.
44-357. Policies; stipulations forbidden.
44-358. Policies; misrepresentations; warranties; conditions; effect.
44-359. Policies; actions; attorney's fees.
44-360. Insurance companies; agreements affecting rates or lessening competition; prohibited; appeal.
44-361. Rebates; prohibited; activities not considered a rebate.
44-361.01. Rebates; circumventing; presumptions.
44-361.02. Rebates; circumventing; enforcement; penalty.
44-362. Repealed. Laws 1989, LB 92, § 278.
44-363. Repealed. Laws 1989, LB 92, § 278.
44-364. Repealed. Laws 1989, LB 92, § 278.
44-365. Repealed. Laws 1989, LB 92, § 278.
44-366. Repealed. Laws 1989, LB 92, § 278.
44-367. Rebates; violation; license; revocation; appeal.
44-368. Repealed. Laws 1989, LB 92, § 278.

44-301 Insurance companies; corporation laws apply; exceptions.

The Nebraska Model Business Corporation Act, except as otherwise provided in Chapter 44, shall apply to all domestic incorporated insurance companies so far as the act is applicable or pertinent to and not in conflict with other provisions of the law relating to such companies. An assessment association that has accumulated and continues to maintain (1) reserves and (2) surplus or contingency funds at least equal to those required of a mutual insurance company shall, unless otherwise provided by law, be deemed to have all the powers and privileges in transacting its business and managing its affairs as those possessed by a mutual insurance company qualified to transact the same line or lines of insurance as the assessment association.

Source: Laws 1913, c. 154, § 30, p. 412; R.S.1913, § 3166; Laws 1919, c. 190, tit. V, art. IV, § 1, p. 590; C.S.1922, § 7766; C.S.1929, § 44-301; R.S.1943, § 44-301; Laws 1955, c. 172, § 1, p. 488; Laws 1989, LB 92, § 92; Laws 1995, LB 109, § 220; Laws 2014, LB749, § 286.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-302 Insurance law; companies and persons amenable.

All domestic insurance companies, and all insurance agents, solicitors, brokers, surveyors or adjusters doing business in this state, and all insurance business transacted in whole or in part within or outside this state, the subject and matter of which is located wholly or in part in this state, shall be subject to and be governed by this chapter, and the records of such insurance company, agent, solicitor, broker, surveyor or adjuster doing business in this state shall be subject to inspection and examination of the Department of Insurance.

Source: Laws 1913, c. 154, § 35, p. 413; R.S.1913, § 3171; Laws 1919, c. 190, tit. V, art. IV, § 6, p. 591; C.S.1922, § 7771; C.S.1929, § 44-306; R.S.1943, § 44-302.

44-303 Insurance companies; certificate of authority; duration; promotion expenses; use of premiums prohibited.

No insurance company shall transact any insurance business in this state unless it has received a certificate of authority from the Department of Insurance to do so. This certificate shall expire on the last day of April in each year and shall be renewed annually if the company has continued to comply with the laws of this state and the rules and regulations of the department. Authority to do an insurance business shall be refused any company which contracts to pay

or does pay any part of the premiums arising from insurance it has written or may write as compensation, directly or indirectly, for promoting or organizing the company.

Source: Laws 1913, c. 154, § 31, p. 412; R.S.1913, § 3167; Laws 1919, c. 190, tit. V, art. IV, § 2, p. 591; C.S.1922, § 7767; C.S.1929, § 44-302; R.S.1943, § 44-303; Laws 1957, c. 178, § 12, p. 617; Laws 1965, c. 257, § 1, p. 724; Laws 1989, LB 92, § 93.

44-304 Insurance companies; authority to do business; conditions.

Every insurance company before transacting the business of insurance in this state shall file in the office of the Department of Insurance a legally authenticated copy of its charter, articles of incorporation or record of its organization, and bylaws as follows: (1) If a domestic company, a copy of its articles of incorporation together with any amendments made therein; and (2) if a foreign or alien company, a copy of its articles of incorporation or charter and bylaws, including all amendments made therein, with a certificate duly executed by the officer having the custody of such articles or charter, under his or her seal of office, that such company is duly authorized under the laws of such state or country to do business therein, and a certificate showing the amount of issued and outstanding capital stock and assets as required by section 44-305. Such company shall furnish such other information and copies of all other papers which the department may require.

Source: Laws 1913, c. 154, § 37, p. 413; R.S.1913, § 3173; Laws 1919, c. 190, tit. V, art. IV, § 8, p. 592; C.S.1922, § 7773; C.S.1929, § 44-308; R.S.1943, § 44-304; Laws 1989, LB 92, § 94.

44-305 Foreign or alien company; capital and surplus required.

No foreign or alien insurance company shall be permitted to transact any business of insurance in this state: (1) If a stock company, unless it possesses, in its own exclusive name and right, paid-up, unimpaired capital stock and surplus equal to the minimum amount required by section 44-214 to entitle any domestic stock insurance company to transact a like kind or kinds of business; and (2) if a mutual company, unless it owns, has, and possesses, in its own exclusive name and right, surplus unimpaired of the kind and equal to the minimum amount required by section 44-219 to entitle any domestic mutual insurance company to transact a like kind or kinds of business. No part of such minimum capital or surplus shall consist of the capital stock of its own or any other insurance company. No alien insurance company shall be authorized to transact any business of insurance in this state unless it shall have deposited with the insurance department of some one state in the United States not less than two hundred thousand dollars in approved securities for the benefit of all its policyholders in the United States.

Source: Laws 1913, c. 154, § 38, p. 414; R.S.1913, § 3174; Laws 1919, c. 190, tit. V, art. IV, § 9, p. 593; C.S.1922, § 7774; C.S.1929, § 44-309; R.S.1943, § 44-305; Laws 1947, c. 161, § 1, p. 442; Laws 1989, LB 92, § 95.

44-306 Repealed. Laws 1989, LB 92, § 278.

44-307 Insurance companies; business authorized.

No domestic insurance company shall transact any business other than that specified in its articles of incorporation or otherwise authorized by law, and no foreign or alien company admitted to transact business in this state shall transact any other kind of business than that which it has been authorized by the laws of the state or country of its incorporation to do.

Source: Laws 1913, c. 154, § 48, p. 419; R.S.1913, § 3184; Laws 1919, c. 190, tit. V, art. IV, § 19, p. 598; C.S.1922, § 7784; C.S.1929, § 44-319; R.S.1943, 44-307; Laws 1969, c. 356, § 20, p. 1251.

44-308 Assessment life associations; new associations prohibited.

No life insurance company or association, other than fraternal benefit society, which issues contracts, the performance of which is contingent upon the payment of assessments or calls made upon its members, shall be hereafter organized to do business within this state. All such companies or associations as are now licensed to do business within the state on such plans may continue and carry on the business of insurance on the plan under which they are organized and doing business July 17, 1913, without being required to value their assessment policies or certificates of membership as yearly renewal term contracts.

Source: Laws 1913, c. 154, § 150, p. 470; R.S.1913, § 3287; Laws 1919, c. 190, tit. V, art. XI, § 15, p. 652; C.S.1922, § 7894; C.S.1929, § 44-1115; R.S.1943, § 44-308; Laws 1987, LB 17, § 2.

44-309 Pollutant exclusion; exception for bodily injury.

An exclusion in a homeowner's or owner's, landlord's, and tenant's policy of insurance for loss arising out of the discharge, dispersal, release, or escape of pollutants shall include an exception to the exclusion for bodily injury sustained within a building and caused by smoke, fumes, vapor, or soot produced by or originating from a heating system or ventilation system. This section applies to policies issued or delivered in this state on or after January 1, 2015.

Source: Laws 2014, LB876, § 1.

44-310 Individual sickness and accident or medicare supplement policy; death of insured; refund of unearned premium.

In the event of the death of the insured of an individual sickness and accident or medicare supplement policy, the insurer, upon receipt of a request for a pro rata refund by a party legally entitled to claim such a refund, shall refund the unearned premium prorated to the month of the insured's death if the request has been made within one year after the insured's death. The refund of the premium and termination of the coverage shall be without prejudice to any claim originating prior to the date of the insured's death.

Source: Laws 2014, LB735, § 1.

44-311 Health care sharing ministry; treatment under insurance laws.

(1) A health care sharing ministry shall not be considered to be engaging in the business of insurance for purposes of the insurance laws of this state.

(2) For purposes of this section, health care sharing ministry means a faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code which:

(a) Limits its participants to those who are of a similar faith;

(b) Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;

(c) Provides for the financial or medical needs of a participant through contributions from one participant to another;

(d) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;

(e) Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution;

(f) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance:

IMPORTANT NOTICE. This organization is not an insurance company, and its product should never be considered insurance. If you join this organization instead of purchasing health insurance, you will be considered uninsured. By the terms of this agreement, whether anyone chooses to assist you with your medical bills as a participant of this organization will be totally voluntary, and neither the organization nor any participant can be compelled by law to contribute toward your medical bills. Regardless of whether you receive payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills. This organization is not regulated by the Nebraska Department of Insurance. You should review this organization's guidelines carefully to be sure you understand any limitations that may affect your personal medical and financial needs;

(g) Has participants which retain participation even after they develop a medical condition; and

(h) Conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

Source: Laws 2014, LB700, § 12.

44-312 Telehealth and telemonitoring services covered under policy, certificate, contract, or plan; insurer; duties.

(1) For purposes of this section:

(a)(i) Telehealth means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care provider in the diagnosis or treatment of a patient.

(ii) Telehealth includes (A) services originating from a patient's home or any other location where such patient is located, (B) asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care provider at another site for medical evaluation, and (C) telemonitoring.

(iii) Telehealth also includes audio-only services for the delivery of individual behavioral health services for an established patient, when appropriate, or crisis management and intervention for an established patient as allowed by federal law; and

(b) Telemonitoring means the remote monitoring of a patient's vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care provider for analysis and storage.

(2) Any insurer offering (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state, (b) any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, or (c) any self-funded employee benefit plan to the extent not preempted by federal law, shall provide upon request to a policyholder, certificate holder, or health care provider a description of the telehealth and telemonitoring services covered under the relevant policy, certificate, contract, or plan.

(3) The description shall include:

(a) A description of services included in telehealth and telemonitoring coverage, including, but not limited to, any coverage for transmission costs;

(b) Exclusions or limitations for telehealth and telemonitoring coverage, including, but not limited to, any limitation on coverage for transmission costs; and

(c) Requirements for the licensing status of health care providers providing telehealth and telemonitoring services.

Source: Laws 2015, LB257, § 1; Laws 2021, LB400, § 1.
Effective date August 28, 2021.

44-313 Insurer; contract for pharmacist professional services; authorized.

(1) For purposes of this section:

(a) Insurer means any insurer offering any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and any self-funded employee benefit plan to the extent not preempted by federal law; and

(b) Pharmacist professional services means professional services provided to patients by licensed pharmacists as allowed by law.

(2) On and after January 1, 2016, an insurer may contract with a licensed pharmacist for pharmacist professional services. Nothing in this section shall prohibit an insurer from contracting with a licensed pharmacist who is not employed or associated with a pharmacy. Nothing in this section shall require a licensed pharmacist to contract with an insurer for pharmacist professional services.

Source: Laws 2015, LB342, § 1.

44-314 City or county offering individual or family health insurance to first responders; prohibited acts.

(1) No city or county offering an individual or family health insurance policy to first responders shall cancel such individual or family health insurance for any first responder who suffers serious bodily injury from an assault that occurs while the first responder is on duty and that results in the first responder falling below the minimum number of working hours needed to maintain his or her regular individual or family health insurance.

(2) The city or county shall only be obligated to provide such health insurance while the first responder is employed with the city or county.

(3) A city or county may cancel such health insurance if the first responder does not return to employment within twelve months after the date of injury.

(4) For purposes of this section, first responder means a sheriff, deputy sheriff, police officer, paid firefighter, or paid individual licensed under a licensure classification in subdivision (1) of section 38-1217 who provides medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

Source: Laws 2017, LB444, § 1.

44-315 Electronic delivery of notices or documents; conditions; insurer; duties; applicability.

(1) For purposes of this section:

(a) Delivered by electronic means includes:

(i) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(ii) Posting on an electronic network or site accessible via the Internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting which shall be provided by electronic mail to the address at which the party has consented to receive notices or documents or by any other delivery method that has been consented to by the party; and

(b) Party means any recipient of any notice or document required as part of a first-party insurance transaction, including, but not limited to, an applicant, an insured, or a policyholder.

(2) Subject to the requirements of this section, any notice to a party or any other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means so long as it meets the requirements of the Uniform Electronic Transactions Act.

(3) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law, including delivery by first-class mail, registered mail, certified mail, certificate of mailing, or a commercial mail delivery service. In any instance in which proof of receipt is required for a mailing, the electronic delivery method used must provide for verification or acknowledgment of receipt.

(4) A notice or document may be delivered by electronic means by an insurer to a party under this section if:

(a) The party has affirmatively consented to such method of delivery and has not withdrawn the consent;

(b) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

(i) The right of the party to withdraw consent to have a notice or document delivered by electronic means at any time;

(ii) Any conditions or consequences imposed in the event consent is withdrawn;

(iii) The transactions and types of notices and documents to which the party's consent would apply;

(iv) The right of a party to have a notice or document delivered in paper form by mail and the means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means; and

(v) The procedure a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the party's electronic mail address;

(c) The party:

(i) Before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(ii) Consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent; and

(d) After consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:

(i) Provides the party with a statement that describes:

(A) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(B) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent; and

(ii) Complies with subdivision (4)(b) of this section.

(5) This section does not affect requirements related to content or timing of any notice or document required under applicable law.

(6) If any provision of Chapter 44 or any other applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(7) If verification or acknowledgment of receipt is not obtained, the notice or document shall be sent to the party by mail as prescribed by Chapter 44. If two or more electronic communications to the party are returned as undeliverable during a thirty-day period, all future communications shall be sent to the party by first-class or other mail as prescribed by law unless and until the party consents electronically, or confirms electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that

will be used for notices or documents delivered by electronic means as to which the party has given consent.

(8) A withdrawal of consent by a party does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective. A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer. Failure by an insurer to comply with subdivision (4)(d) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(9) This section does not apply to a notice or document delivered by an insurer in an electronic form before September 1, 2019, to a party who, before such date, has consented to receive notices or documents in an electronic form otherwise allowed by law.

(10) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before September 1, 2019, and pursuant to this section an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically, the insurer shall provide the party with a statement that describes:

(a) The notices or documents that will be delivered by electronic means under this section that were not previously delivered electronically; and

(b) The party's right to withdraw consent to have notices or documents delivered by electronic means without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

(11) An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if:

(a) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party; or

(b) The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

(12) A producer shall not be subject to civil liability for any harm or injury that occurs as a result of a party's election to receive any notice or document by electronic means or by the insurer's failure to deliver a notice or document by electronic means.

(13) This section shall not be construed to modify, limit, or supersede the federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. 7001 et seq., as such act existed on September 1, 2019.

(14) This section shall apply only to life insurance policies, annuity contracts, and property and casualty insurance policies.

Source: Laws 2019, LB116, § 1.

Cross References

Uniform Electronic Transactions Act, see section 86-612.

44-316 Insurer; policy and endorsement; mailing, delivery, or posting on website; conditions for posting on insurer's website.

Notwithstanding the provisions of section 44-315, life insurance policies, annuity contracts, and property and casualty insurance policies and endorse-

ments that do not contain personally identifiable financial information as defined in section 44-903 may be mailed, delivered, or posted on the insurer's website. If the insurer elects to post insurance policies and endorsements on its website in lieu of mailing or delivering them to the insured, the insurer must comply with all of the following conditions:

(1) The policy and endorsements must be accessible to the insured and producer of record and remain that way for as long as the policy is in force;

(2) After the expiration of the policy, the insurer must archive its expired policies and endorsements for a period of five years and make them available upon request;

(3) The policies and endorsements must be posted in a manner that enables the insured and producer of record to print and save the policy and endorsements using programs or applications that are widely available on the Internet and free to use;

(4) The insurer must provide the following information in, or simultaneously with, each declarations page provided at the time of issuance of the initial policy and any renewals of such policy:

(a) A description of the exact policy and endorsement forms purchased by the insured;

(b) A description of the insured's right to receive, upon request and without charge, a paper copy of the policy and endorsements by mail; and

(c) The Internet address where the policy and endorsements are posted;

(5) The insurer, upon request and without charge, must mail a paper copy of the policy and endorsements to the insured; and

(6) The insurer must provide notice, in the manner in which the insurer customarily communicates with the insured, of any changes to the forms or endorsements, the insured's right to obtain, upon request and without charge, a paper copy of such forms or endorsements, and the Internet address where such forms or endorsements are posted.

Source: Laws 2019, LB116, § 2.

44-317 Loans from insurance client; restrictions.

No insurance producer, surplus lines licensee, or insurance consultant shall obtain a loan from an insurance client that is not a financial institution and who is not related to the insurance producer, surplus lines licensee, or insurance consultant by birth, marriage, or adoption.

Source: Laws 2001, LB 51, § 25.

44-318 Authority to transact business; certificate of department; evidentiary effect.

A certificate under the seal of the department, relative to the authority of the company, insurance producer, business entity, or surplus lines licensee to transact business in this state upon any particular date, shall be received by any court in this state in lieu of the testimony of the director.

Source: Laws 2001, LB 51, § 26.

44-319 Insurance producer or surplus lines licensee; fiduciary duties.

Every person acting as an insurance producer or surplus lines licensee in this state shall be responsible in a fiduciary capacity for all funds received or collected as an insurance producer or surplus lines licensee. Nothing in this section shall be construed to require any person to maintain a separate bank deposit if the funds of each principal are clearly ascertainable from the books of accounts and records of that person.

Source: Laws 2001, LB 51, § 27.

44-319.01 Domestic companies; securities; terms, defined.

For purposes of sections 44-319.01 to 44-319.13, unless the context otherwise requires:

(1) Director shall mean the Director of Insurance or his or her authorized representative;

(2) Policyholders shall mean all persons having a legal or equitable right against a depositing insurer or assessment association arising out of or by reason of depositing insurer's or association's policies and obligees under its surety contracts;

(3) State shall mean any state of the United States, the government of Puerto Rico, and the District of Columbia;

(4) Eligible securities shall mean the investments authorized under the Insurers Investment Act other than investments authorized under sections 44-5134, 44-5143 to 44-5145, 44-5149, 44-5152, and 44-5153, and unless otherwise provided by law, the values of such investments shall, for the purpose of sections 44-319.01 to 44-319.13, be an amount not exceeding the current market values thereof; and

(5) Insurer shall mean stock and mutual insurance companies and reciprocal exchanges.

Source: Laws 1955, c. 174, § 1, p. 498; Laws 1961, c. 210, § 3, p. 627; Laws 1969, c. 359, § 13, p. 1273; Laws 1991, LB 237, § 58; Laws 1997, LB 273, § 1; Laws 1998, LB 1035, § 1.

Cross References

Insurers Investment Act, see section 44-5101.

44-319.02 Domestic companies; securities; amount required.

Every domestic insurer hereafter organized to transact the business of insurance in this state shall deposit and continually maintain with the Department of Insurance eligible securities for the benefit of all of its policyholders in the United States in the amount of one hundred thousand dollars.

Source: Laws 1955, c. 174, § 2, p. 499; Laws 1989, LB 92, § 96.

44-319.03 Domestic companies; securities; deposit; minimum required.

Every domestic assessment association hereafter organized to transact the business of insurance in this state, except (1) health and accident assessment associations and (2) assessment associations organized primarily to write insurance coverage on farm properties against the perils of fire, lightning, windstorm, and hail, shall deposit with the Department of Insurance eligible securities for the benefit of all of its policyholders in the United States equal to

one-fifth of the minimum surplus funds required of domestic mutual insurance companies licensed to write the same kind or kinds of insurance.

Source: Laws 1955, c. 174, § 3, p. 499; Laws 1993, LB 583, § 73.

44-319.04 Domestic companies; securities; transacting business in foreign state; deposit permitted.

Domestic insurers and assessment associations transacting or desiring to transact business in any other state, province, or country may deposit additional securities with the Department of Insurance in the kind and to the amount required by such other state, province, or country as a condition to transact business therein.

Source: Laws 1955, c. 174, § 4, p. 499.

44-319.05 Domestic companies; securities; deposit; aggregate required.

Every domestic insurer and assessment association required by Chapter 44 to deposit securities with the Department of Insurance shall continue to deposit all of its eligible securities until they aggregate the sum of one hundred thousand dollars.

Source: Laws 1955, c. 174, § 5, p. 499; Laws 1989, LB 92, § 97.

44-319.06 Foreign companies; securities; amount required.

No foreign insurer or assessment association now or hereafter authorized to do business in this state shall henceforth transact such business unless it shall deposit and continually maintain with the Department of Insurance or with the proper official of some one state of the United States designated by law to accept such deposit, eligible securities in the amount of not less than one hundred thousand dollars for the benefit of all of its policyholders in the United States.

Source: Laws 1955, c. 174, § 6, p. 499.

44-319.07 Securities; exchange; withdrawal; approval of director; forfeiture for failure to comply.

(1) The depositing insurer or assessment association may, from time to time, exchange for the deposited securities, or any of them, other securities eligible for deposit if the aggregate value of such deposit will not thereby be reduced below the amount required by sections 44-319.01 to 44-319.13. Upon application of the depositing insurer or assessment association, the director may approve the withdrawal of securities which are in excess of the amount required by sections 44-319.01 to 44-319.13. Insurers and assessment associations may, upon an application approved by the director, withdraw all or any part of the securities so deposited upon good cause therefor being shown. Securities so withdrawn shall, except if withdrawn as the result of a merger, consolidation, or total reinsurance, be used to pay excess losses only and shall be restored within such time and under such conditions as the director may direct by order.

(2) If the depositing insurer or assessment association fails to comply with the requirements of subsection (1) of this section or the rules and regulations adopted and promulgated pursuant to section 44-319.11, such insurer or assessment association shall forfeit five hundred dollars for each such failure.

The director shall collect and remit the forfeitures to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Source: Laws 1955, c. 174, § 7, p. 500; Laws 2007, LB117, § 2.

44-319.08 Securities; not subject to execution.

No creditor or other claimant may levy upon such a deposit or any part thereof. Upon an order of liquidation, rehabilitation, or conservation of any depositing insurer or assessment association by a court of competent jurisdiction, the funds deposited and the income therefrom shall be deemed transferred to the director as liquidator, rehabilitator, or conservator.

Source: Laws 1955, c. 174, § 8, p. 500.

44-319.09 Securities deposited under former law; treatment.

All securities now held on deposit by the director, which were made pursuant to any prior insurance law, shall be deemed to be held in compliance with the provisions of sections 44-319.01 to 44-319.13, for the purpose for which such deposits were originally made.

Source: Laws 1955, c. 174, § 9, p. 500.

44-319.10 Interest; collectible by depositing insurer; Securities Deposit Trust Fund; created; disbursement.

(1) Unless prohibited by the order of a court, all income on securities deposited with the Department of Insurance or with an authorized depository of the department shall be collectible by the depositing insurer or assessment association. In the event such income is paid to the Director of Insurance or to the department, it shall be paid by the department into the state treasury and deposited by the State Treasurer in a trust fund to be known as the Securities Deposit Trust Fund which is hereby created, to be expended as provided by this section.

(2) The Director of Administrative Services, upon presentation of a voucher properly countersigned by the director, is authorized to draw his warrants against the Securities Deposit Trust Fund only for the purpose of paying to depositing insurers or assessment associations entitled thereto, amounts equal to the total income paid to the director or to the department on securities deposited with the department, all as more fully explained in subsection (1) of this section.

Source: Laws 1955, c. 174, § 10, p. 500; Laws 1957, c. 182, § 1, p. 633; Laws 1979, LB 196, § 1.

44-319.11 Securities; designation of depository; director; duties.

The director may designate any bank or trust company domiciled in this state as the depository for the Department of Insurance to receive and hold for safekeeping purposes any securities deposited pursuant to sections 44-319.01 to 44-319.13 or any prior insurance law. The holding of any such securities shall be at the expense of the insurer or assessment association. The director is hereby relieved of all personal and official liability for securities held by or in transit to or from such authorized depository. The director shall (1) adopt and promulgate reasonable rules and regulations relative to the manner in which

securities may be deposited and withdrawn and (2) purchase such insurance as he or she may deem necessary for the protection of the State of Nebraska and its employees and agents. The premium for such insurance shall be paid from the Department of Insurance Cash Fund.

Source: Laws 1955, c. 174, § 11, p. 501; Laws 1989, LB 92, § 98.

44-319.12 Securities; liquidation; effect.

All securities heretofore or hereafter deposited with the Department of Insurance by any incorporated or unincorporated insurer or assessment association shall become the property of the State of Nebraska in the event such securities remain unclaimed for a period of not less than seven years following the effective date of a voluntary or involuntary liquidation, merger, consolidation, or total reinsurance thereof. It shall be the duty of the director to take necessary action to transfer the proceeds of such securities to the State Treasurer who shall, upon receipt thereof, deposit such proceeds to the account of the state General Fund.

Source: Laws 1955, c. 174, § 12, p. 501.

44-319.13 Sections; cumulative.

Nothing in sections 44-319.01 to 44-319.13 shall be construed to amend, repeal, or otherwise affect the provisions of sections 44-305 and 44-821 to 44-825.

Source: Laws 1955, c. 174, § 13, p. 501.

44-320 Domestic company; officers and directors; borrowing and sales to company prohibited; exception.

(1) Except as provided in subsections (2) through (6) of this section, no director or officer of any domestic insurance company shall directly or indirectly receive any money or valuable consideration for negotiating any loan for the company or for selling or aiding in the sale of any property to or by the company and no such director or officer shall directly or indirectly borrow money from, purchase any property from, or sell any property to the company.

(2)(a) Nothing in this section shall prevent any domestic insurance company from making a loan to an officer of the company for the purchase of a principal residence or acquiring the principal residence of an officer in connection with the relocation of the officer's place of employment at the request of the company either during the course of employment or upon initial employment of such officer. Any loan permitted under this subsection shall be secured by a first trust deed or first mortgage and shall not exceed seventy-five percent of the market value of the property. Any acquisition permitted under this subsection shall not exceed the market value of the property.

(b) For purposes of this subsection, market value shall mean the market value of real estate as determined by a real property appraiser credentialed by the Real Property Appraiser Board.

(c) Any loan or acquisition permitted under this subsection shall be subject to (i) the approval of the domestic insurance company's board of directors or a delegated committee of the company and (ii) prior written approval of the Director of Insurance based upon written application by the company including full and fair disclosure of the terms of the transaction. Approval of such

transaction by the Director of Insurance shall be presumed unless notice of disapproval is received by the applicant within thirty days of the filing of the application. Approval of such transaction may be denied if the director finds that it is not in the best interest of the company or that the terms of the transaction are not fair and reasonable to the company.

(3) Nothing in this section shall prevent any director or officer of any domestic insurance company from purchasing from his or her company an insurance policy or annuity contract if (a) the purchase is in the ordinary course of the company's business and subject to all of the requirements normally imposed by the company in the sale of such policies and contracts and (b) no discount granted to the director or officer in connection with the purchase is greater than discounts provided to other employees of the company in connection with the sale of similar policies and contracts.

(4) Nothing in this section shall prevent any director or officer of any domestic insurance company from purchasing from his or her company surplus personal property having a total purchase price not in excess of ten thousand dollars in any calendar year if the personal property is sold to the director or officer at not less than its fair market value.

(5) Nothing in this section shall prevent any director or officer of any domestic insurance company from selling to his or her company property of any type or nature having a total purchase price not in excess of ten thousand dollars in any calendar year if the sale is in the ordinary course of business of the director's or officer's business and if the property is sold to the company at not more than its fair market value.

(6) Except as otherwise provided in this section, if any director or officer of any domestic insurance company desires to borrow money from, purchase any property from, or sell any property to the company in excess of ten thousand dollars in any calendar year, the company shall file an application with the Director of Insurance requesting written approval to engage in such transaction. The application shall set out the names of all of the parties interested in the transaction and the respective percentage of interest of each party, a brief description of the nature of the transaction, and a full disclosure of all consideration given or received by the company in connection with such transaction. The application shall be a public record open to public inspection from the date of filing. If the transaction is not approved or disapproved by the director within thirty days from the date of filing, the transaction shall be deemed disapproved. In determining whether to approve or disapprove such transaction, the director shall consider the following factors:

(a)(i) The fact that the transaction has been disclosed or made known to the board of directors of the company or a delegated committee of the company which must authorize approval or ratify the transaction by a vote or consent sufficient for the purpose without counting the vote or consent of any interested director or officer; and

(ii) If applicable, the fact of such transaction has been disclosed or made known to the shareholders entitled to vote and they authorize approval or ratify such transaction by vote or written consent; or

(b)(i) The transaction is fair and reasonable to the company; and

(ii) The transaction is of a nature normally engaged in by the company and the consideration is fair and reasonable.

(7) The Director of Insurance may proceed in a court of competent jurisdiction against a domestic insurance company to reverse or hold invalid a transaction made in violation of subsection (6) of this section unless the transaction was approved pursuant to such subsection.

(8) In addition to other remedies and penalties available under the law of this state, each violation of this section shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 1913, c. 154, § 43, p. 417; R.S.1913, § 3179; Laws 1919, c. 190, tit. V, art. IV, § 14, p. 595; C.S.1922, § 7779; C.S.1929, § 44-314; R.S.1943, § 44-320; Laws 1953, c. 149, § 1(1), p. 477; Laws 1988, LB 713, § 1; Laws 1991, LB 234, § 1; Laws 1991, LB 237, § 59; Laws 2006, LB 778, § 4.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-320.01 Domestic company; capital stock; retirement not to constitute sale, when; reinsurance or consolidation; effect.

Retirement of the capital stock of a domestic stock insurance company and the payment to the holders of such stock of its value under a plan for the mutualization of such company shall not constitute a sale of such stock within the prohibition of section 44-320; nor shall a contract to reinsure or assume the risks and business of another insurance company through reinsurance or consolidation as provided for by sections 44-224.01 to 44-224.10, be deemed to be either a sale or purchase of property within the prohibition of section 44-320.

Source: Laws 1953, c. 149, § 1(2), p. 477; Laws 1959, c. 198, § 2, p. 706.

44-321 Health insurance policy; mental health service delivered in a school; insurer; prohibited acts.

(1) For purposes of this section:

(a) Health insurance policy means (i) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for a policy that provides coverage for a specified disease or other limited-benefit coverage, and (ii) any self-funded employee benefit plan to the extent not preempted by federal law; and

(b) School means a public, private, denominational, or parochial school which meets the requirements for accreditation or approval prescribed in Chapter 79.

(2) Notwithstanding section 44-3,131, an insurer offering a health insurance policy shall not deny coverage or payment for a mental health service solely because the service is delivered in a school.

(3) Nothing in this section shall:

(a) Require an insurer offering a health insurance policy to pay for mental health services that are otherwise excluded from such health insurance policy;

(b) Require an insurer offering a health insurance policy to pay for mental health services that are provided by an individual employed by or under

contract with a school district or an educational service unit in a regular full-time or part-time position; or

(c) Prevent application of any other provision of such health insurance policy.

(4) This section applies to health insurance policies issued or renewed on or after January 1, 2020, and to claims for reimbursement based on such policies for costs incurred on or after January 1, 2020.

Source: Laws 2019, LB619, § 1.

44-322 Insurance companies; annual financial statement; contents; time of filing; failure to file; administrative penalty; participation in information system.

(1)(a)(i) Every insurance company holding a certificate of authority to transact the business of insurance in this state shall file with the director or, if required by the director, with the National Association of Insurance Commissioners, on or before March 1 of each year, an annual financial statement for the year ending December 31 immediately preceding on forms prescribed by the director which conform substantially to the forms adopted by the National Association of Insurance Commissioners, except that fees, premium tax payments, and other payments associated with such filings shall be paid to the director.

(ii) The financial statement shall be prepared in accordance with annual statement instructions and accounting practices and procedures manuals as prescribed by the director which conform substantially to the annual statement instructions and the Accounting Practices and Procedures Manuals adopted by the National Association of Insurance Commissioners.

(iii) The salaries and compensation of the officers and any other information required by the director shall be filed with the director.

(iv) Every insurance company subject to this section shall make such other periodic financial filings as the director may reasonably require.

(b)(i) Within seven days after the failure of an insurance company to comply with the requirements of subdivision (1)(a) of this section, the director shall notify the insurance company of such failure.

(ii) Subject to subdivision (1)(b)(iii) of this section, if an insurance company fails to comply with the requirements of subdivision (1)(a) of this section and any rules and regulations adopted and promulgated under such subdivision and any orders issued under such subdivision, (A) such insurance company shall pay a fine of one hundred dollars for each day thereafter such failure continues and the insurance company continues to transact any business of insurance and (B) in addition to the fine required under subdivision (1)(b)(ii)(A) of this section, the director may suspend or refuse to renew the certificate of authority of the insurance company until it has complied with the requirements of subdivision (1)(a) of this section and any rules and regulations adopted and promulgated under such subdivision and any orders issued under such subdivision. The director shall remit all such fines to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

(iii) For good and sufficient cause shown, the director may grant a reasonable extension of time not to exceed thirty days within which the financial statement may be filed as required under subdivision (1)(a) of this section without the fine required under subdivision (1)(b)(ii)(A) of this section and without any suspen-

sion or refusal to renew authorized under subdivision (1)(b)(ii)(B) of this section.

(2) Every insurance company holding a certificate of authority to transact the business of insurance in this state shall participate in the National Association of Insurance Commissioners Insurance Regulatory Information System, including the payment of all fees and charges of such system, except as exempted by the director. Each participating insurance company shall file with the National Association of Insurance Commissioners on or before March 1 of each year a copy of its annual financial statement along with any additional filings required by the director for the immediately preceding year. The financial statement so filed shall be in the same format and scope as that required by subsection (1) of this section and shall include a signed jurat page and actuarial certification except as exempted by the director. Each participating insurance company shall file with the National Association of Insurance Commissioners any amendments and addendums to the financial statement and annual and quarterly financial statement information in computer readable format as required by the Insurance Regulatory Information System.

Source: Laws 1913, c. 154, § 45, p. 417; R.S.1913, § 3181; Laws 1917, c. 75, § 1, p. 181; Laws 1919, c. 190, tit. V, art. IV, § 16, p. 596; C.S.1922, § 7781; C.S.1929, § 44-316; R.S.1943, § 44-322; Laws 1957, c. 183, § 1, p. 635; Laws 1991, LB 237, § 60; Laws 1994, LB 978, § 18; Laws 1995, LB 162, § 2; Laws 1999, LB 326, § 1; Laws 2003, LB 216, § 3; Laws 2021, LB21, § 1.
Effective date August 28, 2021.

44-322.01 Financial analysis ratios; examination synopses; confidentiality; immunity.

(1) All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the director by the National Association of Insurance Commissioners which are determined by such association to be confidential may not be disclosed or released for public inspection by the director.

(2) In the absence of actual malice, members of the National Association of Insurance Commissioners, the association's duly authorized committees, subcommittees, task forces, delegates, and employees, and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks are acting as agents of the director and shall not be subject to civil liability for libel, slander, or any cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required of insurance companies under the insurance laws of this state or similar laws of other states.

Source: Laws 1989, LB 92, § 9.

44-323 Repealed. Laws 1989, LB 92, § 278.

44-324 Repealed. Laws 1989, LB 92, § 278.

44-325 Domestic insurer; dividends; payment; limitation.

No domestic insurer shall declare or pay a dividend from any source other than earned surplus. For purposes of this section, earned surplus means an

amount equal to the unassigned funds of an insurer as set forth in the most recent annual statement of the insurer submitted to the Director of Insurance including any surplus arising from unrealized capital gains or revaluation of assets.

Any dividend in excess of the unassigned funds of an insurer, excluding any surplus arising from unrealized capital gains or revaluation of assets, shall be deemed an extraordinary dividend and shall be subject to the requirements of section 44-2134.

Source: Laws 1913, c. 154, § 53, p. 420; R.S.1913, § 3189; Laws 1919, c. 190, tit. V, art. IV, § 24, p. 599; C.S.1922, § 7789; C.S.1929, § 44-324; R.S.1943, § 44-325; Laws 1976, LB 916, § 2; Laws 1996, LB 689, § 1.

44-326 Domestic company; disbursements; how made.

No domestic company shall make any disbursement of one hundred dollars or more other than policy proceeds or benefits unless the disbursement is evidenced by an invoice, a statement of account, or a voucher issued by or on behalf of the person, firm, or corporation receiving the money and correctly describing the consideration for the disbursement. If the invoice, statement of account, or voucher is unavailable, the disbursement shall be evidenced by an affidavit of some officer of the company identifying the disbursement and the consideration for the disbursement and stating the reason the invoice, statement of account, or voucher is unavailable.

Source: Laws 1913, c. 154, § 47, p. 418; R.S.1913, § 3183; Laws 1919, c. 190, tit. V, art. IV, § 18, p. 597; C.S.1922, § 7783; C.S.1929, § 44-318; R.S.1943, § 44-326; Laws 1989, LB 92, § 99.

44-327 Repealed. Laws 1984, LB 801, § 50.

44-328 Repealed. Laws 1984, LB 801, § 50.

44-329 Repealed. Laws 1984, LB 801, § 50.

44-330 Repealed. Laws 1984, LB 801, § 50.

44-331 Repealed. Laws 1984, LB 801, § 50.

44-332 Repealed. Laws 1984, LB 801, § 50.

44-333 Repealed. Laws 1984, LB 801, § 50.

44-333.01 Repealed. Laws 1984, LB 801, § 50.

44-333.02 Repealed. Laws 1984, LB 801, § 50.

44-333.03 Repealed. Laws 1984, LB 801, § 50.

44-333.04 Repealed. Laws 1984, LB 801, § 50.

44-333.05 Repealed. Laws 1984, LB 801, § 50.

44-333.06 Repealed. Laws 1984, LB 801, § 50.

44-334 Repealed. Laws 1984, LB 801, § 50.

44-334.01 Repealed. Laws 1984, LB 801, § 50.

44-335 Repealed. Laws 1984, LB 801, § 50.

44-336 Transferred to section 44-3909.

44-336.01 Transferred to section 44-3910.

44-336.02 Transferred to section 44-3911.

44-336.03 Transferred to section 44-3912.

44-336.04 Transferred to section 44-3913.

44-336.05 Transferred to section 44-3914.

44-336.06 Transferred to section 44-3915.

44-337 Repealed. Laws 1961, c. 218, § 8.

44-338 Repealed. Laws 1961, c. 218, § 8.

44-339 Repealed. Laws 1984, LB 801, § 50.

44-339.01 Repealed. Laws 1984, LB 801, § 50.

44-339.02 Repealed. Laws 1984, LB 801, § 50.

44-340 Repealed. Laws 1984, LB 801, § 50.

44-341 Repealed. Laws 1984, LB 801, § 50.

44-342 Repealed. Laws 1984, LB 801, § 50.

44-342.01 Repealed. Laws 1984, LB 801, § 50.

44-342.02 Repealed. Laws 1984, LB 801, § 50.

44-342.03 Repealed. Laws 1984, LB 801, § 50.

44-342.04 Repealed. Laws 1984, LB 801, § 50.

44-343 Repealed. Laws 1984, LB 801, § 50.

44-344 Repealed. Laws 1984, LB 801, § 50.

44-344.01 Repealed. Laws 1984, LB 801, § 50.

44-345 Repealed. Laws 1984, LB 801, § 50.

44-346 Repealed. Laws 1984, LB 801, § 50.

44-347 Repealed. Laws 1984, LB 801, § 50.

44-348 Policies, bonds, or certificates; form; approval.

Except as otherwise provided in Chapter 44 or by the director, no insurance policy, bond, or certificate issued under such policy or bond shall be issued or

delivered in this state unless and until a copy of the form has been filed with and approved by the director.

Source: Laws 1913, c. 154, § 138, p. 466; R.S.1913, § 3275; Laws 1919, c. 190, tit. V, art. XI, § 3, p. 648; C.S.1922, § 7882; C.S.1929, § 44-1103; R.S.1943, § 44-348; Laws 1989, LB 92, § 100; Laws 1991, LB 233, § 44.

An otherwise valid and authorized contract of insurance is not rendered void merely because it has not been approved by the Department of Insurance prior to its issuance. Equity Mut. Ins. Co. v. Allstate Ins. Co., 190 Neb. 515, 209 N.W.2d 592 (1973).

Where endorsement form approved to eliminate coverage of named person is altered by insurer to directly conflict with omnibus clause, it is not valid. Workman v. Great Plains Ins. Co., Inc., 189 Neb. 22, 200 N.W.2d 8 (1972).

Copy of policy form was filed with and approved by department. Peterson v. State Automobile Ins. Assn., 160 Neb. 420, 70 N.W.2d 489 (1955).

Department of Insurance cannot be compelled to approve form of rider which does not state in concise terms the exact coverage or liability prescribed by statute. State ex rel. Republic National Life Ins. Co., v. Smrha, 138 Neb. 484, 293 N.W. 372 (1940).

44-349 Policy or contract; statement required.

No policy or contract of insurance or renewal thereof shall be made, issued, used, or delivered by any assessment insurer in this state unless it states on its face that it is issued by an assessment insurer.

Source: Laws 1913, c. 154, § 136, p. 466; R.S.1913, § 3273; Laws 1919, c. 190, tit. V, art. XI, § 1, p. 647; C.S.1922, § 7880; C.S.1929, § 44-1101; R.S.1943, § 44-349; Laws 1959, c. 201, § 1, p. 711; Laws 2008, LB855, § 3.

44-350 Insurance companies; use of name; policies; state name of company; exceptions.

Every insurance company shall conduct its business in this state in its own name, and the policies and contracts of insurance issued by it shall be headed or entitled by such name. Two or more companies may jointly issue an underwriter's policy, upon which must appear the names of the companies guaranteeing the same, and such companies shall be jointly and severally liable thereon; *Provided*, this limitation shall not apply to any insurance company admitted to this state and issuing an underwriter's policy prior to the passage and approval of this chapter, nor, in the discretion of the Department of Insurance, to any insurance company desiring to issue an underwriter's policy after the passage and approval of this chapter.

Source: Laws 1913, c. 154, § 32, p. 412; R.S.1913, § 3168; Laws 1919, c. 190, tit. V, art. IV, § 3, p. 591; C.S.1922, § 7768; C.S.1929, § 44-303; R.S.1943, § 44-350.

44-351 Insurance companies; similar names; use prohibited.

No company, association, or society organized under sections 44-202 to 44-208.08 shall take any name in use by any other company, association, or society or so closely resembling such name as to mislead the public as to its identity.

Source: Laws 1913, c. 154, § 73, p. 424; R.S.1913, § 3209; Laws 1919, c. 190, tit. V, art. IV, § 43, p. 604; C.S.1922, § 7808; C.S.1929, § 44-343; R.S.1943, § 44-351; Laws 1989, LB 92, § 101.

Grand Lodge of one state may be enjoined from transacting insurance business in another state to injury of Grand Lodge of that state. Grand Lodge, A. O. U. W. v. Grand Lodge, A. O. U. W., 106 Neb. 12, 182 N.W. 510 (1921).

Question of similarity of names is judicial question. Grand Lodge, A. O. U. W. v. Insurance Board, 103 Neb. 99, 170 N.W. 617 (1919).

If name or title of beneficiary insurance company contains a descriptive word by which it is generally known to public, to incorporate that word as the characteristic word in the name of a proposed new company would have a tendency to mislead the public. Knights of Maccabees of the World v. Searle, 75 Neb. 285, 106 N.W. 448 (1905).

44-352 Insurance companies; name of other company; use; penalty; appeal.

It shall be unlawful for any insurance company to permit the use of its name or for any other company, person, or firm to use the name of any insurance company in such a way as to deceive or mislead the public. The violation of this section or section 44-351 by an insurance company shall be grounds for the suspension or revocation of its license, and the person, firm, or corporation so using the name of an insurance company shall be punished by a fine not exceeding one hundred dollars for each offense. An appeal of a suspension, revocation, or fine may be taken, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1913, c. 154, § 33, p. 412; R.S.1913, § 3169; Laws 1919, c. 190, tit. V, art. IV, § 4, p. 591; C.S.1922, § 7769; C.S.1929, § 44-304; R.S.1943, § 44-352; Laws 1969, c. 359, § 14, p. 1274; Laws 1988, LB 352, § 44; Laws 1989, LB 92, § 102.

Cross References

Administrative Procedure Act, see section 84-920.

44-353 Policies; department may inspect.

The Department of Insurance and its employees shall have the right at any time to inspect any policy covering any risk in this state. Every policyholder shall procure and exhibit any policy in his possession or control when required for the inspection of the department or its assistants or employees.

Source: Laws 1913, c. 154, § 68, p. 423; R.S.1913, § 3204; Laws 1919, c. 190, tit. V, art. IV, § 38, p. 603; C.S.1922, § 7803; C.S.1929, § 44-338; R.S.1943, § 44-353.

44-354 Policies; special fees prohibited.

It shall be unlawful for any insurance company, association or society, or for any officer, manager, agent, or other representative thereof, to include in the sum charged or designated in any policy as the consideration for insurance, any fee, compensation, charge, or perquisite whatsoever, not specified in the policy. When collected the same shall be reported as such.

Source: Laws 1913, c. 154, § 69, p. 423; R.S.1913, § 3205; Laws 1919, c. 190, tit. V, art. IV, § 39, p. 603; C.S.1922, § 7804; C.S.1929, § 44-339; R.S.1943, § 44-354.

Premium or consideration for insurance should be designated in policy as provided herein. Machurek v. Ohio Nat. Life Ins. Co., 125 Neb. 35, 249 N.W. 81 (1933).

44-355 Policies; premiums; report required.

Every agent or other representative of any company issuing a policy on its own behalf in this state shall report to the company the exact consideration charged and written in the policy as a premium for the risk.

Source: Laws 1913, c. 154, § 70, p. 424; R.S.1913, § 3206; Laws 1919, c. 190, tit. V, art. IV, § 40, p. 603; C.S.1922, § 7805; C.S.1929, § 44-340; R.S.1943, § 44-355.

44-356 Policies; violations; penalty.

(1) A violator of any of the provisions of section 44-353 shall be fined not more than one hundred dollars.

(2) A violation of any of the provisions of section 44-354 or 44-355 shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 1913, c. 154, § 71, p. 424; R.S.1913, § 3207; Laws 1919, c. 190, tit. V, art. IV, § 41, p. 603; C.S.1922, § 7806; C.S.1929, § 44-341; R.S.1943, § 44-356; Laws 1989, LB 92, § 103; Laws 2008, LB855, § 4.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-357 Policies; stipulations forbidden.

No insurance company shall issue in this state any policy or contract of insurance containing a provision, stipulation or agreement that such policy shall be construed according to the laws of any other state or country, or any provision limiting the time within which an action may be brought to less than the regular period of time prescribed by the statutes of limitations of this state, unless otherwise prescribed by this chapter.

Source: Laws 1913, c. 154, § 49, p. 419; R.S.1913, § 3185; Laws 1919, c. 190, tit. V, art. IV, § 20, p. 598; C.S.1922, § 7785; C.S.1929, § 44-320; R.S.1943, § 44-357.

A fire insurance policy legally issued in Nebraska containing one year limitation of action but also containing provision conforming it to state statutes is subject to limitation hereunder. Wulf v. Farm Bureau Ins. Co., 190 Neb. 34, 205 N.W.2d 640 (1973).

Where policy issued in this state provides twelve months' limitation for filing action but also contains provision amending terms to conform with conflicting statutes, limitations in state statutes are applicable. Hiram Scott College v. Insurance Co. of North America, 187 Neb. 290, 188 N.W.2d 688 (1971).

Statute of limitations on fire insurance policy was governed by provisions of New York standard form. Rhodes v. Continental Ins. Co., 180 Neb. 10, 141 N.W.2d 415 (1966).

A provision in benefit certificate that suit must be commenced within one year of death of member, if valid in state where contract is made, will be enforced in Nebraska. Avondale v. Sovereign Camp, W. O. W., 134 Neb. 717, 279 N.W. 355 (1938).

Where defendant amended its by-laws so as to avail itself of the provisions of this section, question of the amended by-law being reasonable, as to the insured and binding upon his beneficiary, was raised but not decided. Williams v. Western Travelers Accident Assn., 97 Neb. 352, 149 N.W. 822 (1914).

44-358 Policies; misrepresentations; warranties; conditions; effect.

No oral or written misrepresentation or warranty made in the negotiation for a contract or policy of insurance by the insured, or in his behalf, shall be deemed material or defeat or avoid the policy, or prevent its attaching, unless such misrepresentation or warranty deceived the company to its injury. The breach of a warranty or condition in any contract or policy of insurance shall not avoid the policy nor avail the insurer to avoid liability, unless such breach shall exist at the time of the loss and contribute to the loss, anything in the policy or contract of insurance to the contrary notwithstanding.

Source: Laws 1913, c. 154, § 51, p. 419; R.S.1913, § 3187; Laws 1919, c. 190, tit. V, art. IV, § 22, p. 598; C.S.1922, § 7787; C.S.1929, § 44-322; R.S.1943, § 44-358.

1. Misrepresentation
2. Breach of condition
3. Miscellaneous

1. Misrepresentation

In Nebraska there is a common-law right to rescind or avoid insurance policies for material misrepresentations, which is recognized in and limited by this provision. This section has been interpreted to recognize the right to avoid a policy of insurance under certain circumstances in the case of material misrepresentations by the insured. An accident resulting in injury or damage to a third person does not destroy the right of an insurer to rescind an automobile liability insurance policy for fraud in the application. Glockel v. State Farm Mut. Auto. Ins. Co., 224 Neb. 598, 400 N.W.2d 250 (1987).

This section shall be read in pari materia with section 44-710.14. White v. Medico Life Ins. Co., 212 Neb. 901, 327 N.W.2d 606 (1982).

The exclusion of flight by pilot without medical certificate was not invalidated by this section. Omaha Sky Divers Parachute Club, Inc. v. Ranger Ins. Co., 189 Neb. 610, 204 N.W.2d 162 (1973).

Policy avoided where insured knowingly misrepresented condition of health with intent to deceive insurer to its injury. Vackiner v. Mutual of Omaha, 182 Neb. 611, 156 N.W.2d 163 (1968).

This section does not deprive an insurance company of the defense of fraud. Sorter v. Citizens Fund Mutual Fire Ins. Co., 151 Neb. 686, 39 N.W.2d 276 (1949).

Where a question in an application for insurance calls for an answer peculiarly within the knowledge of the applicant, an untrue answer relating to a matter material to the risk and relied upon by the insurer will avoid the policy. Gillan v. Equitable Life Assurance Society, 143 Neb. 647, 10 N.W.2d 693 (1943).

To defeat recovery on the ground of fraudulent representations, the insurance company must prove that the representations were untrue, were made by the insured knowingly with the fraudulent intent to deceive, and that they were material to the risk and were relied upon by the defendant. Carpenter v. Sun Indemnity Co., 138 Neb. 552, 293 N.W. 400 (1940).

The mere failure or omission to state the name of a physician and a treatment by him of some temporary indisposition or ailment will not avoid policy. McCleneghan v. London Guarantee & Accident Co., Ltd., 132 Neb. 131, 271 N.W. 276 (1937).

Untrue answers in application for disability benefit contract, attached to life insurance policy, will avoid the policy where, if truth had been told, contract would not have been issued. Scott v. New England Mutual Life Ins. Co., 126 Neb. 514, 253 N.W. 685 (1934).

Where false answer is inserted in application by agent of insurer, the applicant having made full and honest answers to agent's questions, the insurer cannot take advantage of such false statement to void the policy. Roth v. Employers Fire Ins. Co., 123 Neb. 300, 242 N.W. 612 (1932).

Defense of fraud in action to recover on policy is not precluded and right of such defense is not defeated by showing that false statement did not contribute to loss. Goodell v. Union Automobile Ins. Co., 111 Neb. 228, 196 N.W. 112 (1923); Muhlbach v. Illinois Bankers Life Assn., 108 Neb. 146, 187 N.W. 787 (1922).

Statements contained in application for insurance policy are not construed as warranties unless provisions of application and policy taken together leave no room for any other construction. Farmers Union Grain Co. v. U.S. Fidelity & Guaranty Co., 109 Neb. 142, 190 N.W. 221 (1922).

Misrepresentations made in an application for fire insurance will not bar recovery on the policy if the misrepresentations do not contribute to the loss or deceive the insurer to its injury. Central Granaries Co. v. Nebraska L. M. Ins. Assn., 106 Neb. 80, 182 N.W. 582 (1921).

Where the application for insurance did not correctly state the year in which the car was made, but did state facts from which the correct year could have been ascertained by the use of ordinary diligence, and where the car had been rebuilt, recovery on the policy is not barred as a matter of law by the insurer being deceived to its injury. Traynor v. Auto. Mut. Ins. Co., 105 Neb. 677, 181 N.W. 566 (1921).

2. Breach of condition

Maintaining proof of an insured's qualification to perform a covered activity is the type of condition subsequent that this section was intended to address. Devese v. Transguard Ins. Co., 281 Neb. 733, 798 N.W.2d 614 (2011).

The contribute-to-the-loss standard in this section applies to breaches of preloss conditions subsequent and continuing warranties that function as conditions subsequent. Regardless of an insurer's labeling, a clause in an insurance policy that requires an insured to avoid an increased hazard is a preloss condition subsequent for coverage. D & S Realty v. Markel Ins. Co., 280 Neb. 567, 789 N.W.2d 1 (2010).

This section was intended to limit an insurer's ability to avoid liability for breach of increased hazard conditions which are so broad that an insured's violation of them is not causally relevant to the loss. D & S Realty v. Markel Ins. Co., 280 Neb. 567, 789 N.W.2d 1 (2010).

This section does not relate to a breach of the terms of a policy which could arise only after the loss has occurred. This section relates to the question of a recoverable loss and not to the question of procedure to be followed in collecting for the loss. This section concerns warranties which are conditions precedent to the existence of an insurance contract, not with promissory warranties the fulfillment of which are conditions precedent to recovery. Coppi v. West Am. Ins. Co., 247 Neb. 1, 524 N.W.2d 804 (1994).

The second sentence of this section has no application to a breach which could only arise after a loss has occurred. Ach v. Farmers Mut. Ins. Co., 191 Neb. 407, 215 N.W.2d 518 (1974); Clark v. State Farmers Ins. Co., 142 Neb. 483, 7 N.W.2d 71 (1974).

Failure to give notice of replacement automobile is not a breach of contract under this section; rule regarding coverage under automatic insurance provisions for replacement automobiles stated. Christiansen v. Moore, 184 Neb. 818, 172 N.W.2d 620 (1969).

Taking out of additional insurance, in violation of terms of policy, does not avoid the policy or permit the insurer to avoid liability where the breach did not contribute to the loss. Slafter v. New Brunswick Fire Ins. Co., 142 Neb. 209, 5 N.W.2d 217 (1942).

Statutory provision that insured's breach of contract will not avail insurer to avoid liability unless it contributes to the loss, is by construction part of the insurance contract. Ware v. Home Mutual Ins. Assn., 135 Neb. 329, 281 N.W. 617 (1938).

Breach of promissory warranty in policy of insurance against loss by theft to the effect that in case of damage to property the insured would use due care to protect the property from loss by theft, will prevent recovery on such policy for loss by theft, when such breach existed at time of such loss and contributed to the loss. Sanks v. St. Paul Fire & Marine Ins. Co., 131 Neb. 266, 267 N.W. 454 (1936).

Where a breach of condition was not properly pleaded, the court refused to consider plaintiff's contention that the claimed breach did not contribute to the loss. Lehnherr v. Nat. Accident Ins. Co., 126 Neb. 199, 252 N.W. 823 (1934).

Where insured horse was moved to a location not covered by policy and there killed by lightning, such unauthorized removal was breach of the policy contributing to the loss and defeating recovery thereon. Johnson v. Caledonian Ins. Co., 125 Neb. 759, 251 N.W. 821 (1933).

Breach of conditions in fire policy as to procurement of insurer's consent to other insurance and failure of notice of foreclosure proceedings under junior mortgage, does not preclude recovery in absence of evidence that breach contributed to loss. Newman v. Nat. Union Fire Ins. Co., 122 Neb. 94, 239 N.W. 464 (1931).

Violation of condition of insurance policy by removal of insured stock from place listed in policy does not invalidate insurance contract unless such removal contributed to the loss. Mayfield v. North River Ins. Co., 122 Neb. 63, 239 N.W. 197 (1931).

Breach of condition in any insurance policy does not allow insurer to avoid liability unless such breach contributes to the loss. George v. Aetna Casualty & Surety Co., 121 Neb. 647, 238 N.W. 36 (1931).

Violation of condition in fire insurance policy by mortgaging of property insured does not invalidate insurance unless breach of contract contributes to loss. Calnon v. Fidelity-Phenix Fire Ins. Co., 114 Neb. 194, 206 N.W. 765 (1925).

In policy of insurance on livestock, removal of insured chattels from premises of owner does not invalidate insurance unless such breach of contract shall exist at time of and contribute to loss. Hannah v. American Live Stock Ins. Co., 111 Neb. 660, 197 N.W. 404 (1924).

Breach of a condition in a fire insurance policy by mortgaging the insured chattels is no defense where such breach did not contribute to the loss. Security State Bank of Eddyville v. Aetna Ins. Co., 106 Neb. 126, 183 N.W. 92 (1921).

Evidence raised a jury question as to whether the insured had used due diligence to maintain a sprinkler system in proper working order, as required by the policy, and, if not, whether such breach contributed to the loss. Liverpool & London & Globe Ins. Co. v. Nebraska Storage Warehouses, 96 F.2d 30 (8th Cir. 1938).

Provision as to breach not invalidating policy unless existing at time of loss and contributing thereto, does not preclude defense that notice of loss on fidelity bond was not given in time. American Surety Co. v. Bankers' Savings & Loan Assn., 59 F.2d 577 (8th Cir. 1932).

Where the only effect of a foreclosure suit had been to change the record title, the mortgagee's interest and lien remaining the same as before, breach of condition in fire policy requiring insured to notify the company of any change in title was no defense where breach did not contribute to the loss. Westchester Fire Ins. Co. v. Norfolk Bldg. & Loan Assn., 14 F.2d 524 (8th Cir. 1926).

Statute providing that breach of condition shall not avoid policy, unless it existed at time of loss and contributed to loss, does not apply in the absence of contract relationship between the parties. St. Paul F. & M. Ins. Co. v. Ruddy, 299 F. 189 (8th Cir. 1924).

3. Miscellaneous

The provisions of this section have no application to insurance policy provisions requiring the giving of notice of loss. First Security Bank v. New Hampshire Ins. Co., 232 Neb. 493, 441 N.W.2d 188 (1989).

An insurer may unilaterally rescind an automobile liability policy contemplated by sections 44-514 to 44-521 under this provision. Lowry v. State Farm Mut. Auto. Ins. Co., 228 Neb. 171, 421 N.W.2d 775 (1988).

This section relates to recission and sections 44-514 to 44-521 relate to termination or cancellation and are therefore not in conflict. As such, the right to recission as limited by this section is still available to an insurer regarding policies of the type defined in section 44-514. Glockel v. State Farm Mut. Auto. Ins. Co., 224 Neb. 598, 400 N.W.2d 250 (1987).

Evidence failed to show that insurer relied on incomplete statement in application. MFA Mut. Ins. Co. v. Meisinger, 183 Neb. 285, 159 N.W.2d 829 (1968).

Insurance company must be deceived to its injury to avoid loss under policy. Zimmerman v. Continental Cas. Co., 181 Neb. 654, 150 N.W.2d 268 (1967).

This section does not apply to an excepted risk never assumed by the insurer. Krause v. Pacific Mutual Life Ins. Co., 141 Neb. 844, 5 N.W.2d 229 (1942).

Where fire insurance policy provided as a condition of the insurance that the total insurance on the property should not exceed a sum named, and at the time, unknown to insurer, there existed other valid insurance in an amount greater than the sum so named, the latter policy does not take effect as a policy of insurance. Quisenberry v. National Fire Ins. Co., 132 Neb. 793, 273 N.W. 197 (1937).

Where insured property was transferred to plaintiff without knowledge or consent of insurance company, plaintiff could not avail itself of provisions of above statute. Krug Park Amusement Co. v. New York Underwriters Ins. Co., 129 Neb. 239, 261 N.W. 364 (1935).

Statute is part of every fire insurance contract in Nebraska. Weiner v. Aetna Ins. Co., 128 Neb. 575, 259 N.W. 507 (1935).

Section does not apply to case where insurance company has never entered into contractual relations with person claiming under policy. Stephenson v. Germania Fire Ins. Co., 100 Neb. 456, 160 N.W. 962 (1916).

This section does not invalidate a record warranty clause. Coppi v. West Am. Ins. Co., 2 Neb. App. 834, 516 N.W.2d 264 (1994).

Statutory provisions are read into and constitute part of insurance contracts. Ohio Casualty Co. v. Swan, 89 F.2d 719 (8th Cir. 1937).

Provision of fidelity bond by which company insures against losses discovered within duration of policy or two years thereafter was valid, notwithstanding above statute. American Employers' Ins. Co. v. Roundup Coal Mining Co., 73 F.2d 592 (8th Cir. 1934).

Statute limiting effect of conditions in insurance policy is part of contract under fidelity bond. American Surety Co. v. Bankers' Savings & Loan Assn., 67 F.2d 803 (8th Cir. 1933).

Section is part of fire insurance contract. Westchester Fire Ins. Co. v. Norfolk Bldg. & Loan Assn., 14 F.2d 524 (8th Cir. 1926).

44-359 Policies; actions; attorney's fees.

In all cases when the beneficiary or other person entitled thereto brings an action upon any type of insurance policy, except workers' compensation insurance, or upon any certificate issued by a fraternal benefit society, against any company, person, or association doing business in this state, the court, upon rendering judgment against such company, person, or association, shall allow the plaintiff a reasonable sum as an attorney's fee in addition to the amount of his or her recovery, to be taxed as part of the costs. If such cause is appealed, the appellate court shall likewise allow a reasonable sum as an attorney's fee for the appellate proceedings, except that if the plaintiff fails to obtain judgment for more than may have been offered by such company, person, or association

in accordance with section 25-901, then the plaintiff shall not recover the attorney's fee provided by this section.

Source: Laws 1913, c. 234, § 1, p. 738; R.S.1913, § 3212; Laws 1919, c. 190, tit. V, art. IV, § 46, p. 604; C.S.1922, § 7811; C.S.1929, § 44-346; R.S.1943, § 44-359; Laws 1971, LB 958, § 1; Laws 1986, LB 811, § 17; Laws 1987, LB 17, § 4.

1. Allowance proper
2. Allowance not proper
3. Amount of allowance
4. Allowance in federal courts
5. Miscellaneous

1. Allowance proper

A plaintiff in an action on an insurance policy is entitled to recover under this section when he or she obtains a judgment against any company doing business in this state, whether or not the company is an insurance company. Webb v. American Employers Group, 268 Neb. 473, 684 N.W.2d 33 (2004).

An insurance policy beneficiary who successfully sues his or her insurance company is entitled to a reasonable attorney fee at the trial level and on appeal. Rod Rehm, P.C. v. Tamarack Amer., 261 Neb. 520, 623 N.W.2d 690 (2001).

Cost of expert witnesses and for photocopying may not be distinguished from other expenses necessary to a client's representation and are recoverable under this section. National Am. Ins. Co. v. Continental Western Ins. Co., 243 Neb. 766, 502 N.W.2d 817 (1993).

In a successful action to enforce a policy of insurance by the insured, the court shall tax attorney fees against the insurance carrier. Control Specialists v. State Farm Mut. Auto. Ins. Co., 228 Neb. 642, 423 N.W.2d 775 (1988).

Named insured and permissive driver are ''beneficiaries'' under policy and thus entitled to attorney fees in declaratory judgment action to enforce liability policy, but insurer of driver seeking adjustment of liability priorities is not entitled to fees under this section. Dairyland Ins. Co. v. Kammerer, 213 Neb. 108, 327 N.W.2d 618 (1982).

Under the mandatory language of this section, a successful litigant is entitled to receive a reasonable attorney's fee for in-house counsel actually engaged in preparation and trial to the same extent as outside counsel. Dale Electronics, Inc. v. Federal Ins. Co., 205 Neb. 115, 286 N.W.2d 437 (1979).

Under this section, reasonable attorney's fees may properly be awarded in actions upon insurance policies. Herrera v. American Standard Ins. Co., 203 Neb. 477, 279 N.W.2d 140 (1979).

Where plaintiff recovers against an insurance company, court shall allow a reasonable attorney's fee in addition. Omaha Paper Stock Co. v. California Union Ins. Co., 200 Neb. 31, 262 N.W.2d 175 (1978).

In action on performance bond where surety admits execution of bond but does not admit defective performance by contractor, the plaintiff may recover attorney's fee. Omaha Home for Boys v. Stitt Constr. Co., Inc., 195 Neb. 422, 238 N.W.2d 470 (1976).

Attorney's fee was allowed against insurance company in garnishment action. Townley v. Whetstone, 190 Neb. 541, 209 N.W.2d 350 (1973).

An insured and his judgment creditor under a policy of liability insurance are entitled to an award of attorney's fee where the insurer brings action for declaratory judgment to determine coverage and they prevail. State Farm Fire & Cas. Co. v. Muth, 190 Neb. 248, 272, 207 N.W.2d 364 (1973).

Where insurer brings action for declaratory judgment to have coverage determined and insured prevails, the latter is entitled to an attorney's fee hereunder. State Farm Mut. Auto. Ins. Co. v. Selders, 189 Neb. 334, 202 N.W.2d 625 (1972).

A claim for attorneys' fee after judgment for plaintiff in action on fidelity policy or bond may be presented by motion at subsequent term of court. Beshaler v. Helberg, 187 Neb. 584, 193 N.W.2d 261 (1971).

Insurer liable for attorney's fees only when judgment is rendered upon a policy of insurance of insurer. Lundt v. Insurance Co. of North America, 184 Neb. 208, 166 N.W.2d 404 (1969).

Attorney's fees properly allowed in a garnishment action to reach insurer under omnibus clause in a fleet automobile insurance policy. Arndt v. Davis, 183 Neb. 726, 163 N.W.2d 886 (1969).

Attorney's fee allowed for services in Supreme Court in suit on accidental death insurance policy. Mustard v. St. Paul Fire & Marine Ins. Co., 183 Neb. 15, 157 N.W.2d 865 (1968).

Guaranty by insurer was insurance contract. Abel v. Southwest Cas. Ins. Co., 182 Neb. 605, 156 N.W.2d 166 (1968).

Recovery under uninsured motorist coverage in an insurance policy permits allowance of attorney's fees. Stephens v. Allied Mut. Ins. Co., 182 Neb. 562, 156 N.W.2d 133 (1968).

An attorney's fee was properly allowed for services in Supreme Court in suit on builder's bond. School Dist. No. 65R v. Universal Surety Co., 178 Neb. 746, 135 N.W.2d 232 (1965).

In suit on bond of contractor to build church, allowance of attorney's fee was proper. Reorganized Church of Jesus Christ v. Universal Surety Co., 177 Neb. 60, 128 N.W.2d 361 (1964).

The allowance of a reasonable attorney's fee is unaffected by the fact that attorney has a contingent fee contract. Metcalf v. Hartford Acc. & Ind. Co., 176 Neb. 468, 126 N.W.2d 471 (1964).

Attorney's fee was properly allowed in suit upon an errors and omissions policy. Otteman v. Interstate Fire & Cas. Co., Inc., 172 Neb. 574, 111 N.W.2d 97 (1961).

Attorney's fee could be allowed upon recovery on statutory motor vehicle dealer's bond. Sun Ins. Co. v. Aetna Ins. Co., 169 Neb. 94, 98 N.W.2d 692 (1959).

Attorney's fee was allowable in action on group life insurance policy. Exstrum v. Union Cas. & Life Ins. Co., 165 Neb. 554, 86 N.W.2d 568 (1957).

Where recovery upon bond is allowed, allowance of attorney's fee is mandatory. State ex rel. School Dist. v. Ellis, 160 Neb. 400, 70 N.W.2d 320 (1955).

In absence of showing that law of another state in which policy was issued differs, allowance of attorney's fees upon recovery on policy is proper. Banks v. Metropolitan Life Ins. Co., 142 Neb. 823, 8 N.W.2d 185 (1943).

Where judgment is properly rendered against a surety company on official bond, a reasonable attorney's fee may be taxed as costs. Ericsson v. Streitz, 132 Neb. 692, 273 N.W. 17 (1937).

Where plaintiff recovers judgment in action against an executive officer of state bank on his fidelity bond, statute permits allowance of reasonable attorney's fee to be taxed as costs. Luikart v. Flannigan, 130 Neb. 901, 267 N.W. 165 (1936).

Commission merchant's bond is within operation of statute. Swisher v. Fidelity & Casualty Co., 113 Neb. 592, 204 N.W. 383 (1925).

Attorney's fees taxed as costs relate to remedy, and are to be so taxed without regard to whether contract sued upon was

entered into before or after enactment of this section. Central Nebraska Millwork Co. v. Olson & Johnson Co., 111 Neb. 396, 196 N.W. 707 (1923); O'Shea v. N. A. Hotel Co., 109 Neb. 317, 191 N.W. 321 (1922); Sharpe v. Grand Lodge, A. O. U. W., 108 Neb. 193, 188 N.W. 100 (1922), 189 N.W. 176 (1922); Security State Bank of Eddyville v. Aetna Ins. Co., 106 Neb. 126, 183 N.W. 92 (1921); Reed v. American Bonding Co., 102 Neb. 113, 166 N.W. 196 (1918); Ward v. Bankers Life Co., 99 Neb. 812, 157 N.W. 1017 (1916); Nye-Schneider-Fowler Co. v. Bridges, Hoye & Co., 98 Neb. 863, 155 N.W. 235 (1915).

Attorney's fees are allowable in suit on fire insurance contract. Johnson v. St. Paul Fire & Marine Ins. Co., 104 Neb. 831, 178 N.W. 926 (1920).

Attorney's fee may be taxed in judgments upon insurance policies in all classes of indemnity insurance not expressly exempted by law. Belk v. Capital Fire Ins. Co., 102 Neb. 702, 169 N.W. 262 (1918).

2. Allowance not proper

When read in conjunction with section 25-901, this section prohibits an award of attorney fees to a plaintiff, in a suit against the plaintiff's insurer, who rejects an offer of judgment and later fails to recover more than the amount offered. Dutton-Lainson Co. v. Continental Ins. Co., 279 Neb. 365, 778 N.W.2d 433 (2010).

A successful pro se litigant in an action on an insurance policy is not entitled to recover an attorney fee, even if the pro se litigant is a licensed attorney. Young v. Midwest Fam. Mut. Ins. Co., 276 Neb. 206, 753 N.W.2d 778 (2008).

Expert witness fees are not taxable as court costs and are not recoverable under this section. Young v. Midwest Fam. Mut. Ins. Co., 276 Neb. 206, 753 N.W.2d 778 (2008).

Read together, this section and section 25-901 prohibit an award of attorney fees to a plaintiff, in a suit against the plaintiff's insurer, who rejects an offer to allow judgment and later fails to recover more than the amount offered. Young v. Midwest Fam. Mut. Ins. Co., 272 Neb. 385, 722 N.W.2d 13 (2006).

If a party is not successful on appeal in obtaining an amount of recovery, the party is not entitled to attorney fees on appeal under this section. Kirwan v. Chicago Title Ins. Co., 261 Neb. 609, 624 N.W.2d 644 (2001).

A contractor who brings an action under a repair contract may not collect attorney fees under this section. Union Ins. Co. v. Bailey, 234 Neb. 257, 450 N.W.2d 661 (1990).

An action to determine whether the policy is still in effect is not an action upon the policy and, therefore, in such a case, an attorney fee is not recoverable under this section. Jelsma v. Colonial Penn Ins. Co., 232 Neb. 49, 439 N.W.2d 479 (1989).

A pension or long-term disability plan provided to employees by an employer which is not offered primarily for profit nor which coverage is limited to employees and not resulting from advertisement or solicitation of insurance business from the public, and which does not cause the employer to hold itself out as doing business as a commercial insurer, is neither ''any type of insurance policy'' nor ''a certificate issued by a fraternal beneficiary association'', and an employee is not entitled to attorney fees under this section in a suit on such a plan. Blue v. Champion International Corp., 211 Neb. 480, 319 N.W.2d 83 (1982).

Attorney's fees not allowed where insurer confessed judgment in full on the pleadings. Wendt v. Cavalier Ins. Corp., 197 Neb. 622, 250 N.W.2d 243 (1977).

Attorney's fee allowance, based on contingency percentage, rejected in determining amount of ''reasonable'' fee. Ruby Coop. Co. v. Farmers Elevator Mut. Ins. Co., 197 Neb. 605, 250 N.W.2d 239 (1977).

Plaintiff's failure to allege and prove cause of action against contractor or its insurance carrier precluded recovery of attorney's fee. Woodmen of the World Life Ins. Soc. v. Peter Kiewit Sons' Co., 196 Neb. 158, 241 N.W.2d 674 (1976).

In action on performance bond where surety admits execution of bond but does not admit defective performance by contractor, the plaintiff may recover attorney's fee. Omaha Home for Boys v. Stitt Constr. Co., Inc., 195 Neb. 422, 238 N.W.2d 470 (1976).

The amount of attorney's fees allowed generally rests in the sound discretion of the court. Schmer v. Hawkeye-Security Ins. Co., 194 Neb. 94, 230 N.W.2d 216 (1975).

In suit against principal and bonding company as surety where issue of liability of surety was not presented to jury and judgment was against principal, attorney's fee was not recoverable. Ritzau v. Wiebe Constr. Co., 191 Neb. 92, 214 N.W.2d 244 (1974).

Conduct of attorney justified disallowance of fee. Iowa Mut. Ins. Co. v. Meckna, 180 Neb. 516, 144 N.W.2d 73 (1966).

Attorney's fee is not recoverable in action on automobile insurance policy for damages resulting from a collision. Riley v. National Auto Ins. Co., 162 Neb. 658, 77 N.W.2d 241 (1956).

Attorney's fee is not authorized in suits for loss of personal property by fire. Borden v. General Ins. Co., 157 Neb. 98, 59 N.W.2d 141 (1953).

Attorney's fee should not be allowed to party who is not at the time entitled to maintain action at law on policy. Hawkeye Casualty Co. v. Stoker, 154 Neb. 466, 48 N.W.2d 623 (1951).

In action to obtain decree that policy of insurance had not lapsed, allowance of attorney's fee was not authorized. Cunningham v. Northwestern Mutual Life Ins. Co., 148 Neb. 250, 27 N.W.2d 221 (1947).

Where insured recovers on an accident insurance policy, a reasonable fee for insured's attorneys may be taxed as costs on appeal to Supreme Court where judgment is affirmed. McCleneghan v. London Guarantee & Accident Co., 132 Neb. 131, 271 N.W. 276 (1937).

Attorney's fees should not be allowed where it appears that there was no reasonable necessity to resort to law to secure one's rights. Gipson v. Metropolitan Life Ins. Co., 112 Neb. 302, 199 N.W. 541 (1924).

Under prior law, attorney's fee for services on appeal was not authorized. O'Shea v. N. A. Hotel Co., 111 Neb. 582, 197 N.W. 385 (1924); Kaneft v. Mutual Benefit Health & Accident Assn., 102 Neb. 87, 166 N.W. 121 (1918).

Attorney's fee is not taxable in workmen's compensation cases under this section. Abel Constr. Co. v. Goodman, 105 Neb. 700, 181 N.W. 713 (1921).

In action under Workmen's Compensation Act, court cannot tax attorney's fee as part of costs under this section. United States Fidelity & Guaranty Co. v. Wickline, 103 Neb. 21, 170 N.W. 193 (1918).

When determining whether the plaintiff has obtained a judgment for more than was offered prior to trial, the term ''judgment'' shall include the amount recovered under the insurance policy and the costs of the action allowed under section 25-901, excluding attorney fees. Eledge v. Farmers Mut. Home Ins. Co. of Hooper, 6 Neb. App. 140, 571 N.W.2d 105 (1997).

Excess judgment suit against insurer is not a suit on insurance policy, and attorney's fee is not allowable hereunder. Lienemann v. State Farm Mut. Auto Fire & Cas. Co., 540 F.2d 333 (8th Cir. 1976).

Beneficiary, who sued for double indemnity but recovered only face of policy, which had been tendered by insurer, was not entitled to attorney's fees under Nebraska statute. McCrary v. New York Life Ins. Co., 84 F.2d 790 (8th Cir. 1936).

3. Amount of allowance

An attorney fee awarded under the provisions of this section must be solely and only for services actually rendered in the preparation and trial of the litigation on the policy in question. Young v. Midwest Fam. Mut. Ins. Co., 276 Neb. 206, 753 N.W.2d 778 (2008).

To determine proper and reasonable attorney fees, it is necessary for the court to consider the nature of the litigation, the time and labor required, the novelty and difficulty of the ques-

tions raised, the skill required to properly conduct the case, the responsibility assumed, the care and diligence exhibited, the result of the suit, the character and standing of the attorney, and the customary charges of the bar for similar services. Young v. Midwest Fam. Mut. Ins. Co., 276 Neb. 206, 753 N.W.2d 778 (2008).

There is no presumption of reasonableness placed on the amount of attorney fees offered by the party requesting fees. Koehler v. Farmers Alliance Mut. Ins. Co., 252 Neb. 712, 566 N.W.2d 750 (1997).

To determine the proper amount of attorney fees, it is necessary to consider many factors, including, but not limited to, the nature of the litigation, the skill required, and the customary charge of the bar for similar services. Koehler v. Farmers Alliance Mut. Ins. Co., 252 Neb. 712, 566 N.W.2d 750 (1997).

In determining the value of legal services rendered by an attorney, it is proper to consider the amount involved, the nature of the litigation, the time and labor required, the novelty and difficulty of the questions raised, the skill required to properly conduct the case, the responsibility assumed, the care and diligence exhibited, the result of the suit, the character and standing of the attorney, and the customary charges of the bar for similar services. Muller v. Tri-State Ins. Co., 252 Neb. 1, 560 N.W.2d 130 (1997).

The amount of an attorney fee awarded under this section is addressed to the discretion of the trial court, whose ruling will not be disturbed on appeal in the absence of an abuse of discretion. Muller v. Tri-State Ins. Co., 252 Neb. 1, 560 N.W.2d 130 (1997).

The amount of the allowance for attorney fees under this section rests in the sound discretion of the trial court. Smith v. Union Ins. Co., 218 Neb. 797, 359 N.W.2d 113 (1984).

The action contemplated herein need not be brought in any particular form. The fee awarded under this section must be based solely and only on the services actually rendered in the preparation and trial of the litigation on the policy in question. Evidence as to the amount of the potential ultimate recovery is not indispensable to the court's determination of the amount thereof. Hemenway v. MFA Life Ins. Co., 211 Neb. 193, 318 N.W.2d 70 (1982).

The amount of attorney fees to be allowed under this section rests in the sound discretion of the court. Rieschick Drilling Co. v. American Cas. Co., 208 Neb. 142, 303 N.W.2d 264 (1981).

Attorney's fee allowance, based on contingency percentage, rejected in determining amount of ''reasonable'' fee. Ruby Coop. Co. v. Farmers Elevator Mut. Ins. Co., 197 Neb. 605, 250 N.W.2d 239 (1977).

The amount of attorney's fees allowed generally rests in the sound discretion of the court. Schmer v. Hawkeye-Security Ins. Co., 194 Neb. 94, 230 N.W.2d 216 (1975).

Court may base allowance of attorney's fees upon observance of course of proceedings, amount involved, questions of law raised, time and labor necessary, and professional diligence and skill required. McNaught v. New York Life Ins. Co., 145 Neb. 694, 18 N.W.2d 56 (1945).

Allowance of five hundred dollars attorney's fees for recovery of one hundred dollars disability benefits was not excessive when loss of greater amount was involved. Gillan v. Equitable Life Assur. Soc., 142 Neb. 497, 6 N.W.2d 782 (1942).

In allowing attorney's fee in action on automobile liability insurance policy, court may consider the amount involved, responsibility assumed, questions of law raised, time and labor required, results obtained, and professional diligence and skill. Andrews v. Commercial Casualty Ins. Co., 128 Neb. 496, 259 N.W. 653 (1935).

In fixing attorney's fee, court will consider nature of litigation, amount involved, result, time spent, attorney's standing, subject to exceptions and review. Allen v. Tallon, 120 Neb. 611, 234 N.W. 411 (1931).

Reasonableness of attorney's fee is question of fact. First Nat. Bank of Lincoln v. Lincoln Grain Co., 116 Neb. 809, 219 N.W. 192 (1928).

4. Allowance in federal courts

Attorney's fee may be recovered in federal court under Nebraska statute, but it is not costs in the ordinary sense, and not within the field of costs legislation covered by federal statutes. Henkel v. Chicago, St. P. M. & O. Ry. Co., 284 U.S. 444 (1932).

In suit on insurance policy in federal court in Nebraska, attorney's fees may be properly allowed as part of costs and included in judgment. People of Sioux County v. National Surety Co., 276 U.S. 238 (1928).

Attorney's fee was properly allowed on fidelity bond. Hartford Acc. & Ind. Co. v. Baldwin, 262 F.2d 202 (8th Cir. 1958).

Where district court allowed substantial attorney's fees, further allowance on appeal in federal court was not justified where reasonable ground for contesting liability existed. Travelers Mut. Cas. Co. v. Rector, 138 F.2d 396 (8th Cir. 1943).

Attorney's fee may be fixed by court without evidence. Globe Indemnity Co. v. Sulpho-Saline Bath Co., 299 F. 219 (8th Cir. 1924).

Machinery floater policies are not within the class of policies contemplated by this section. Babcock & Wilcox Co. v. Parsons Corp., 298 F.Supp. 898 (D. Neb. 1969).

Attorney's fee was allowance even though action was brought in federal court rather than state court. Baldwin v. Hartford Acc. & Ind. Co., 168 F.Supp. 86 (D. Neb. 1958).

5. Miscellaneous

Attorney fees are costs awarded to prevailing parties; attorney fees are not damages, either compensatory or punitive in nature. Brodersen v. Traders Ins. Co., 246 Neb. 688, 523 N.W.2d 24 (1994).

This section does not violate the equal protection clause. Farm Bureau Life Ins. Co. v. Luebbe, 218 Neb. 694, 358 N.W.2d 754 (1984).

Attorney's fees taxed as costs are considered no part of the judgment recovered, and should not be included in computing amount due attorney under contingent fee agreement. Solomon v. Farney, Inc., 136 Neb. 338, 286 N.W. 254 (1939).

Allowance of attorney's fees is subject to revisory action of Supreme Court in consideration of all of the facts disclosed by the record. Hemmer v. Metropolitan Life Ins. Co., 133 Neb. 470, 276 N.W. 153 (1937).

Allowance of proper attorney's fee for counsel engaged in addition to regular salaried city attorney was proper. City of Scottsbluff v. Southern Surety Co., 124 Neb. 260, 246 N.W. 346 (1933).

Attorney's fee taxed as costs is no part of judgment and is subject to exceptions and review in like manner as taxation of other costs. Wirtele v. Grand Lodge, A. O. U. W., 111 Neb. 302, 196 N.W. 510 (1923).

This section is procedural rather than substantive and will apply even if another state's law governs the contract. City of Carter Lake v. Aetna Cas. & Sur. Co., 604 F.2d 1052 (8th Cir. 1979).

Claim for attorney's fees, in suit on policy, if made in good faith, may be included as part of amount in controversy in determining jurisdiction of federal court. Mutual Ben. Health & Accident Assn. v. Bowman, 96 F.2d 7 (8th Cir. 1938).

44-360 Insurance companies; agreements affecting rates or lessening competition; prohibited; appeal.

If any insurance company authorized to transact business in this state or any agent or representative thereof shall, either within or outside this state, directly

or indirectly, enter into any contract, understanding, or combination with any other insurance company, agent, or representative thereof or with any association of such companies or agents, for the purpose of controlling the rates to be charged for insuring any risk or class or classes of risks in this state or for the purpose of, or that may have the tendency or effect of, preventing or lessening lawful competition in the transaction of the business of insurance in this state, the Department of Insurance shall forthwith revoke its license and the licenses of its agents, and no renewal of the license shall be granted until after the expiration of one year from the date of final revocation. An appeal may be taken from the decision of the department, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1913, c. 154, § 50, p. 419; R.S.1913, § 3186; Laws 1919, c. 190, tit. V, art. IV, § 21, p. 598; C.S.1922, § 7786; C.S.1929, § 44-321; Laws 1935, c. 100, § 1, p. 329; C.S.Supp.,1941, § 44-321; R.S.1943, § 44-360; Laws 1969, c. 359, § 15, p. 1274; Laws 1988, LB 352, § 45.

Cross References

Administrative Procedure Act, see section 84-920.

44-361 Rebates; prohibited; activities not considered a rebate.

No insurance company, by itself or any other party, and no insurance agent or broker, personally or by any other party, shall offer, promise, allow, give, set off, or pay, directly or indirectly, any rebate of, or part of, the premium payable on the policy, or of any policy, or agent's commission thereon, or earnings, profits, dividends, or other benefits founded, arising, accruing or to accrue thereon or therefrom, or any paid employment or contract for service, or for advice of any kind, or any other valuable consideration or inducement to, or for insurance, on any risk authorized to be taken under section 44-201 now or hereafter to be written, which is not specified in the policy contract of insurance; nor shall any such company, agent, or broker, personally or otherwise, offer, promise, give, sell or purchase any stock, bonds, securities or property, or any dividends or profits accruing or to accrue thereon, or other things of value whatsoever, as inducement to insurance or in connection therewith, which is not specified in the policy. No insured person or party shall receive or accept, directly or indirectly, any rebate of premium, or part thereof, or agent's or broker's commission thereon, payable on the policy, or on any policy of insurance, or any favor or advantage or share in the dividends or other benefits to accrue on, or any valuable consideration or inducement not specified in the policy contract of insurance. Extending of interest-free credit on life and liability insurance premiums or interest-free credit on crop hail insurance premiums shall not be a rebate of the premium. Payments made pursuant to the Nebraska Right to Shop Act shall not be considered a rebate of the premium for purposes of this section.

Source: Laws 1913, c. 154, § 140, p. 466; R.S.1913, § 3277; Laws 1919, c. 190, tit. V, art. XI, § 5, p. 648; C.S.1922, § 7884; C.S.1929, § 44-1105; R.S.1943, § 44-361; Laws 1961, c. 220, § 1, p. 653; Laws 1971, LB 137, § 1; Laws 1972, LB 1354, § 2; Laws 2018, LB1119, § 25.

Cross References

Nebraska Right to Shop Act, see section 44-1401.

Agreement to rebate is expressly forbidden, and insured could not recover from agent thereon nor could insured compel rescission of contract of insurance or the policy on that ground. Kortright v. Mutual Life Ins. Co., 123 Neb. 746, 243 N.W. 904 (1932).

44-361.01 Rebates; circumventing; presumptions.

(1) A licensed agent whose total commissions and underwriting fees on business written upon the property, life, health, or liability of himself or herself, his or her relatives by consanguinity or affinity, and his or her employer or employees exceed ten percent of the total commissions or underwriting fees received during any one license year shall be presumed to have obtained a license or renewal thereof primarily to circumvent the enforcement of section 44-361, except that for a licensed agent soliciting crop insurance, the percentage shall be thirty percent for commissions and underwriting fees on crop insurance business.

(2) A licensed agent whose total commissions and underwriting fees on business written upon the property, life, health, or liability of himself or herself, his or her relatives by consanguinity or affinity, and his or her employer or employees exceed thirty percent of the total commissions and underwriting fees received during any one license year shall be conclusively presumed to have obtained a license or renewal thereof primarily to circumvent the enforcement of section 44-361, except that for a licensed agent soliciting crop insurance, the percentage shall be fifty percent for commissions and underwriting fees on crop insurance business.

Source: Laws 1955, c. 175, § 3, p. 503; Laws 2013, LB59, § 1.

44-361.02 Rebates; circumventing; enforcement; penalty.

Any agent who is found to have obtained a license or renewal primarily to circumvent enforcement of section 44-361 shall, in addition to any other penalty imposed by law, be guilty of a Class V misdemeanor.

Source: Laws 1955, c. 175, § 4, p. 504; Laws 1977, LB 40, § 232.

44-362 Repealed. Laws 1989, LB 92, § 278.

44-363 Repealed. Laws 1989, LB 92, § 278.

44-364 Repealed. Laws 1989, LB 92, § 278.

44-365 Repealed. Laws 1989, LB 92, § 278.

44-366 Repealed. Laws 1989, LB 92, § 278.

44-367 Rebates; violation; license; revocation; appeal.

The license of any insurance company, agent, or broker found by the Department of Insurance, after hearing, to have violated section 44-361 may be revoked or suspended. Appeal may be taken from the decision of the Director of Insurance, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1913, c. 154, § 144, p. 469; R.S.1913, § 3281; Laws 1919, c. 190, tit. V, art. XI, § 9, p. 650; C.S.1922, § 7888; C.S.1929, § 44-1109; Laws 1935, c. 97, § 2, p. 325; C.S.Supp.,1941, § 44-1109; R.S.1943, § 44-367; Laws 1969, c. 359, § 16, p. 1274; Laws 1988, LB 352, § 46; Laws 1989, LB 92, § 104.

Cross References

Administrative Procedure Act, see section 84-920.

44-368 Repealed. Laws 1989, LB 92, § 278.

44-369 Premium notes; sale or pledge before delivery of policy; prohibited.

It shall be unlawful for any company or agent thereof to hypothecate, sell or dispose of a promissory note, received in payment for any part of a premium on a policy of insurance applied for under the provisions of this chapter, prior to the delivery of the policy to the applicant.

Source: Laws 1913, c. 154, § 154, p. 471; R.S.1913, § 3291; Laws 1919, c. 190, tit. V, art. XI, § 19, p. 653; C.S.1922, § 7898; C.S.1929, § 44-1119; R.S.1943, § 44-369.

Sale or pledge of note given for insurance premium is unlawful prior to delivery of policy. Standard Investment Co. v. Fisher, 126 Neb. 394, 253 N.W. 427 (1934).

Evidence was insufficient to show good faith in the purchase of note which was bought before insurance policy delivered. State Bank v. House, 114 Neb. 681, 209 N.W. 246 (1926).

A bank purchasing with full knowledge that the note was given to pay insurance prior to delivery of policy is not a bona fide holder and cannot recover thereon. Stockmen's State Bank v. Fisher, 106 Neb. 525, 184 N.W. 55 (1921).

44-370 Life insurance policy; proceeds; payments; sale; surrender; pledge; change of beneficiary.

A life insurance company may provide that the amount to become due under a policy shall be paid in installments to a beneficiary therein named. If such beneficiary shall die before all said installments are paid, said policy may provide to whom the remaining ones shall be paid. Any person holding a policy in any such company may, without the consent of the beneficiary, unless the appointment of such beneficiary be irrevocable, either sell and surrender the same to the company, or pledge or assign the same as security for a debt, which, if due the company, shall be secured by said policy, whether it is in the possession of the company or not; or, with the consent of the company, he may change his beneficiary unless the appointment of such beneficiary be irrevocable.

Source: Laws 1913, c. 154, § 153, p. 471; R.S.1913, § 3290; Laws 1919, c. 190, tit. V, art. XI, § 18, p. 653; C.S.1922, § 7897; C.S.1929, § 44-1118; R.S.1943, § 44-370; Laws 1969, c. 366, § 1, p. 1302.

The phrase ''person holding a policy,'' used in this section, describes the owner of the policy. The owner of a life insurance policy need not be the insured, that is, the person whose death obligates the insurer to pay under the policy. Universal Assurors Life Ins. Co. v. Hohnstein, 243 Neb. 359, 500 N.W.2d 811 (1993).

Where insured was unable to obtain possession of policy of insurance from divorced wife, notice of change of beneficiary was effective, even though change was not endorsed on policy. Marley v. New York Life Ins. Co., 147 Neb. 646, 24 N.W.2d 652 (1946).

Statute does not preclude a husband from legally transferring the beneficial interest in a life insurance policy to a person other than his wife. Smith v. Pacific Mutual Life Ins. Co., 130 Neb. 501, 265 N.W. 534 (1936).

Change in beneficiary was effected even though details of consent were not complied with by insurer before death of insured. Goodrich v. Equitable Life Assurance Society, 111 Neb. 616, 197 N.W. 380 (1924).

44-371 Annuity contract; insurance proceeds and benefits; exempt from claims of creditors; exceptions.

(1)(a) Except as provided in subdivision (1)(b) of this section and in section 68-919, all proceeds, cash values, and benefits accruing under any annuity contract, under any policy or certificate of life insurance payable upon the death of the insured to a beneficiary other than the estate of the insured, or under any accident or health insurance policy shall be exempt from attachment, garnishment, or other legal or equitable process and from all claims of

creditors of the insured and of the beneficiary if related to the insured by blood or marriage, unless a written assignment to the contrary has been obtained by the claimant.

(b) Subdivision (1)(a) of this section shall not apply to:

(i) An individual's aggregate interests greater than one hundred thousand dollars in all loan values or cash values of all matured or unmatured life insurance contracts and in all proceeds, cash values, or benefits accruing under all annuity contracts owned by such individual; and

(ii) An individual's interest in all loan values or cash values of all matured or unmatured life insurance contracts and in all proceeds, cash values, or benefits accruing under all annuity contracts owned by such individual, to the extent that the loan values or cash values of any matured or unmatured life insurance contract or the proceeds, cash values, or benefits accruing under any annuity contract were established or increased through contributions, premiums, or any other payments made within three years prior to bankruptcy or within three years prior to entry against the individual of a money judgment which thereafter becomes final.

(c) An insurance company shall not be liable or responsible to any person to determine or ascertain the existence or identity of any such creditors prior to payment of any such loan values, cash values, proceeds, or benefits.

(2) Notwithstanding subsection (1) of this section, proceeds, cash values, and benefits accruing under any annuity contract or under any policy or certificate of life insurance payable upon the death of the insured to a beneficiary other than the estate of the insured shall not be exempt from attachment, garnishment, or other legal or equitable process by a judgment creditor of the beneficiary if the judgment against the beneficiary was based on, arose from, or was related to an act, transaction, or course of conduct for which the beneficiary has been convicted by any court of a crime punishable only by life imprisonment or death. No insurance company shall be liable or responsible to any person to determine or ascertain the existence or identity of any such judgment creditor prior to payment of any such proceeds, cash values, or benefits. This subsection shall apply to any judgment rendered on or after January 1, 1995, irrespective of when the criminal conviction is or was rendered and irrespective of whether proceedings for attachment, garnishment, or other legal or equitable process were pending on March 14, 1997.

Source: Laws 1933, c. 73, § 1, p. 315; C.S.Supp.,1941, § 44-1130; R.S. 1943, § 44-371; Laws 1980, LB 940, § 4; Laws 1981, LB 327, § 1; Laws 1987, LB 335, § 1; Laws 1997, LB 47, § 1; Laws 2005, LB 465, § 3; Laws 2017, LB268, § 8.

Where this section is not applicable, an oral assignment or pledge of a life insurance policy by the named beneficiary, after the death of the insured, to secure a debt or obligation of the beneficiary, accompanied by delivery of the policy, constitutes a pledge entitling the pledgee to an equitable lien upon the proceeds of the policy. Albracht v. Prudential Ins. Co., 201 Neb. 249, 267 N.W.2d 511 (1978).

Exemption is not applicable to proceeds of policy where premiums are paid by funds wrongfully misappropriated. Mullikin v. Pedersen, 161 Neb. 22, 71 N.W.2d 485 (1955).

Money received by insured upon surrender of the insurance contract wherein such amount is payable to the insured personally is not exempt. Bank of Brule v. Harper, 141 Neb. 616, 4 N.W.2d 609 (1942).

44-372 Life insurance; annuity; nonpayment of premium; effect.

Any policy containing a provision for a deferred annuity on the life of the insured only, unless paid for by a single premium, shall provide that in the event of the nonpayment of any premium after three full years' premium shall

have been paid, the annuity shall automatically become converted into a paid-up annuity for such proportion of the original annuity as the number of completed years' premiums paid bears to the total number of premiums required under the contract.

Source: Laws 1913, c. 154, § 146, p. 469; R.S.1913, § 3283; Laws 1919, c. 190, tit. V, art. XI, § 11, p. 651; C.S.1922, § 7890; C.S.1929, § 44-1111; R.S.1943, § 44-372.

Legislature has used the word premiums as descriptive of the payment on annuity contracts. Bankers Life Ins. Co. v. Laughlin, 160 Neb. 480, 70 N.W.2d 474 (1955).

44-373 Corporate directors, officers, and employees; insurance upon lives; requirements.

Whenever a corporation, organized under the laws of this state, has heretofore caused or shall hereafter cause the life of any director, officer, agent or employee to be insured, or whenever such corporation is named as a beneficiary in, or assignee of, any policy of life insurance, due authority to assign, release, relinquish, convert, surrender, change the beneficiary, or to take any other or different action with reference to such insurance, shall be sufficiently evidenced to the insurance company by a written statement that the same has been approved by a majority of the board of directors, which statement shall be signed by the president and the secretary, or other corresponding officer, of such corporation, under its corporate seal. Such statement shall be binding upon such corporation, and shall protect the insurance company concerned in any act done or suffered by it upon the faith thereof without further inquiry into the validity of the corporate authority or the regularity of the corporate proceedings. No person shall be disqualified, by reason of interest in the subject matter, from acting as a director or as a member of the executive committee of such corporation on any corporate act touching such insurance.

Source: Laws 1927, c. 137, § 1, p. 378; C.S.1929, § 44-1123; R.S.1943, § 44-373.

44-374 Property insurance; insurable interest required.

No policy of insurance shall be issued upon any property except in the name of some party having an interest in the property.

Source: Laws 1913, c. 154, § 34, p. 413; R.S.1913, § 3170; Laws 1919, c. 190, tit. V, art. IV, § 5, p. 591; C.S.1922, § 7770; C.S.1929, § 44-305; R.S.1943, § 44-374.

Policy of insurance, issued in name of two joint owners of automobile, could not be canceled by one owner without consent of the other owner. Kent v. Dairyland Mut. Ins. Co., 177 Neb. 709, 131 N.W.2d 146 (1964).

44-375 Insurance; applicable only to insured's interest.

When the name of the party intended to be insured is specified in a policy, such insurance can be applied only to his own proper interest.

Source: Laws 1913, c. 154, § 64, p. 423; R.S.1913, § 3200; Laws 1919, c. 190, tit. V, art. IV, § 34, p. 602; C.S.1922, § 7799; C.S.1929, § 44-334; R.S.1943, § 44-375.

A claimant under an insurance contract must show an interest in the contract that would be recognized and protected by the courts. Sayah v. Metropolitan Prop. & Cas. Ins. Co., 273 Neb. 744, 733 N.W.2d 192 (2007).

Neither family use of property nor the family relationship alone gives automatic rise to an insurable property interest. Sayah v. Metropolitan Prop. & Cas. Ins. Co., 273 Neb. 744, 733 N.W.2d 192 (2007).

To have an insurable interest, the claimant must have some legally enforceable right that would be recognized and enforced in the property at issue. Sayah v. Metropolitan Prop. & Cas. Ins. Co., 273 Neb. 744, 733 N.W.2d 192 (2007).

When no legally enforceable interest exists, no insurable interest exists. Sayah v. Metropolitan Prop. & Cas. Ins. Co., 273 Neb. 744, 733 N.W.2d 192 (2007).

44-376 Insurance; policy issued to agent or trustee.

When insurance is issued to an agent or trustee, the fact that his principal or beneficiary is the person really insured is sufficiently indicated by describing him as agent or trustee or by other general words in the policy.

Source: Laws 1913, c. 154, § 65, p. 423; R.S.1913, § 3201; Laws 1919, c. 190, tit. V, art. IV, § 35, p. 603; C.S.1922, § 7800; C.S.1929, § 44-335; R.S.1943, § 44-376.

44-377 Insurance; joint, partnership, or limited liability company interest; policy terms.

To render an insurance policy effective by one partner, member, or part owner applicable to the interest of another partner, member, or owner, it is necessary that the terms of the policy should be such as are applicable to the joint, partnership, or limited liability company interest.

Source: Laws 1913, c. 154, § 66, p. 423; R.S.1913, § 3202; Laws 1919, c. 190, tit. V, art. IV, § 36, p. 603; C.S.1922, § 7801; C.S.1929, § 44-336; R.S.1943, § 44-377; Laws 1993, LB 121, § 221.

44-378 Insurance; insured described generally; who may claim.

When the description of the insured in the policy is so general that it may comprehend any person or class of persons, he only can claim the benefit of the policy who can show that it was intended to include him.

Source: Laws 1913, c. 154, § 67, p. 423; R.S.1913, § 3203; Laws 1919, c. 190, tit. V, art. IV, § 37, p. 603; C.S.1922, § 7802; C.S.1929, § 44-337; R.S.1943, § 44-378.

44-379 Transferred to section 44-522.

44-379.01 Transferred to section 44-523.

44-380 Transferred to section 44-501.02.

44-381 Repealed. Laws 1971, LB 958, § 2.

44-382 Repealed. Laws 1989, LB 92, § 278.

44-383 Repealed. Laws 1989, LB 92, § 278.

44-384 Repealed. Laws 1989, LB 92, § 278.

44-385 Repealed. Laws 1989, LB 92, § 278.

44-386 Unincorporated mutual associations; business authorized; contributions; restrictions; exceptions.

Nothing in Chapter 44 shall be construed to prevent any number of persons, not to exceed two thousand five hundred, who are residents of this state from making mutual pledges and giving valid obligations to each other for their own

insurance from loss by fire, lightning, tornado, cyclone, windstorms, hail, death, or other cause for which insurance may be obtained under any of the laws of this state. Such association of persons shall in no case insure any property not owned by one of their number and no life except that of their number, nor shall the provisions of Chapter 44, article 3, or the Insurers Investment Act be applicable to such associations of persons except that the Department of Insurance may require such reports as it deems advisable. Such associations of persons shall receive no premiums, shall make no dividends, and shall not hire or compensate any agent, solicitors, adjusters, or appraisers. Officers and employees of such association shall be hired by the board of directors. All salaries of such officers and employees shall be approved by the board, but in no case shall such salaries exceed ten dollars per day. No such association of persons shall ever make any levies or collect any money from its members or prospective members except to pay for losses on property or lives insured and such expenses as are necessary and incidental to the operation of such association, except that one membership fee of not more than five dollars per person may be charged at the time of entrance for the purpose of providing a fund, which shall not be in excess of one hundred fifty percent of the average monthly disbursement during such calendar year at the end of each calendar year unless specifically approved by the director each year, out of which benefits may be paid pending assessment receipts and for the purpose of paying initial expenses. All fees and receipts shall be debited to the assets of the association and shall be expended as allowable for expenses, salaries, and benefits or distributed as provided in this section. No money shall be paid or donated to any organization or to any person except as a benefit or as an allowable salary or expense. All expenses including salaries shall not exceed twenty percent of all assessments, levies, and fees received. No surplus except that in the fund described in this section shall be maintained or allowed. Advance payments of assessments shall not be considered as surplus money for purposes of this section. All surplus money except that maintained in the fund and that allowed for expenses and salaries must be distributed to the members, except that if membership in such association is limited to the employees or former employees of a particular employer and such employer has contributed funds to such association to be used to pay benefits to the members in the period during which any such surplus fund was accumulated, then upon any distribution of such surplus, other than in payment of expenses, salaries, and benefits, whether upon the order of the Director of Insurance or otherwise, such distribution shall be equitably divided among the members in good standing on the date of such distribution and such employer in proportion to their respective contributions made in the period during which such surplus was accumulated. No such distribution shall be made until approved by the director.

Source: Laws 1913, c. 154, § 77, p. 425; R.S.1913, § 3214; Laws 1919, c. 190, tit. V, art. IV, § 48, p. 605; C.S.1922, § 7813; C.S.1929, § 44-348; R.S.1943, § 44-386; Laws 1963, c. 268, § 1, p. 801; Laws 1971, LB 510, § 1; Laws 1979, LB 417, § 1; Laws 1991, LB 237, § 61.

Cross References

Insurers Investment Act, see section 44-5101.

44-386.01 Unincorporated mutual associations; contract of association; approval of director required; changes or additions, filing.

No association described in section 44-386 as may hereafter be formed shall provide any insurance coverage until it has filed with and received the approval of the Department of Insurance on such association's contract of association containing the name of the association, the place in Nebraska where its principal office will be located, the method of electing its officers and directors, and the method and procedure of doing business and copies of all contracts of association for insurance, applications, policies, certificates, and other evidence of insurance coverage to be used by such association in connection with its operation. No such association shall receive approval to operate if it has not filed its contract of association prior to August 25, 1989. All changes of or any additions to such information shall first be filed with and approved by the department before such changes or additions are used or become effective.

Source: Laws 1963, c. 268, § 2, p. 802; Laws 1989, LB 92, § 105.

44-386.02 Unincorporated mutual associations; existing associations, continuance in operation; approval required.

No such association now existing shall continue to operate after June 30, 1964, unless it shall have met the requirements of section 44-386.01.

Source: Laws 1963, c. 268, § 3, p. 802.

44-386.03 Unincorporated mutual associations; annual meetings; election of officers and directors; vote required; notice of meeting.

Every such association shall hold annual meetings of its members at regular intervals which shall not be, in any case, more than fourteen nor less than ten months apart. At such annual meeting there shall be transacted such business of the association as may come before it, which business shall include but not be limited to the election of officers or directors from among the members. All of said officers or directors shall be elected annually and shall not be less than five in number; *Provided,* that the Director of Insurance may approve a different number of directors and officers, or a different method of choosing the directors or officers, or both, or both a different number and a different method of choosing such directors and officers, if, in the opinion of the director, the interests of the members of the association are adequately protected thereby. Passage of all matters and business of such association shall require at least a majority vote of the members present in person or by proxy at any annual meeting or at any special meeting called. Notice of such annual meeting or special meeting shall be mailed to each member at his last-known address or otherwise distributed to him not less than ten nor more than thirty days prior to such meeting; *Provided,* that all references to members in this section shall be construed to mean a parent or the legal guardian of every member who is under twenty years of age. The minutes of every annual and special meeting must be taken and made available to any member upon request.

Source: Laws 1963, c. 268, § 4, p. 802; Laws 1969, c. 367, § 2, p. 1304; Laws 1972, LB 1059, § 1.

44-386.04 Unincorporated mutual associations; books and records; open to inspection by department.

The books and records of every such association and every officer, director, or employee thereof shall be subject to the inspection and examination of the Department of Insurance. Upon at least ten days' written notice to the president or secretary of the association, the Director of Insurance may require that the books and records be brought to the Department of Insurance for inspection and examination.

Source: Laws 1963, c. 268, § 5, p. 803; Laws 1969, c. 367, § 3, p. 1305.

44-386.05 Unincorporated mutual associations; hearing on business affairs; notice; expenses.

Whenever, from an inspection of the books and records or a review of the annual report, the Director of Insurance deems it prudent for the protection of the members of any association, he or she may conduct a hearing on the business affairs of the association. Notice shall be given as provided in the Administrative Procedure Act. Actual expenses of the Department of Insurance shall be paid by the association.

Source: Laws 1969, c. 367, § 4, p. 1305; Laws 1989, LB 6, § 4; Laws 1989, LB 92, § 106.

Cross References

Administrative Procedure Act, see section 84-920.

44-386.06 Unincorporated mutual associations; cease and desist orders; misappropriation of funds; director; duties.

If, after the hearing provided for in section 44-386.05, the Director of Insurance finds that any rule or regulation adopted and promulgated pursuant to section 44-386.08 or any statute is being violated, he or she may issue an order to cease and desist all business of the association or any activity connected therewith until such time as corrective measures have been taken. If the director determines that any officer or member has misappropriated any funds or wrongfully converted any funds to his or her own use, he or she shall refer the matter to the county attorney of the county in which the books of the association are kept for prosecution by the county attorney under the applicable criminal statutes.

Source: Laws 1969, c. 367, § 5, p. 1306; Laws 1989, LB 92, § 107.

44-386.07 Unauthorized mutual associations; cease and desist order; appeal.

If the Director of Insurance orders any person to cease and desist all business of the association or any activity connected therewith, such order may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1969, c. 367, § 6, p. 1306; Laws 1988, LB 352, § 48.

Cross References

Administrative Procedure Act, see section 84-920.

44-386.08 Unincorporated mutual associations; rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations for the administration and enforcement of the provisions of sections 44-386.01 to 44-386.07, for the procedures for examination of books and records, for the

requirements of reports, and for procedures for approval of changes or additions of evidence of insurance coverage to be used by the associations.

Source: Laws 1969, c. 367, § 7, p. 1306; Laws 1989, LB 92, § 108.

44-387 Transferred to section 44-1499.

44-388 Transferred to section 44-14,100.

44-389 Transferred to section 44-14,101.

44-390 Transferred to section 44-14,102.

44-391 Repealed. Laws 1995, LB 385, § 14.

44-392 Insurance; solicitation and sale; when authorized.

Any bank, trust company, investment company, bank affiliate, corporation, partnership, limited liability company, or association, owned or controlled by any bank located in this state, may sell or solicit any kind or form of insurance, either directly or indirectly, through any officer, agent, employee, or representative thereof. The sale and solicitation of insurance pursuant to this section shall be subject to compliance with the insurance laws of this state and rules and regulations adopted and promulgated thereunder.

Source: Laws 1933, c. 74, § 1, p. 316; C.S.Supp.,1941, § 44-349; R.S. 1943, § 44-392; Laws 1959, c. 202, § 1, p. 711; Laws 1977, LB 40, § 236; Laws 1993, LB 121, § 222; Laws 1999, LB 191, § 1.

44-393 Insurance laws; violations; reports confidential.

Every insurance company, agent, solicitor, or broker, and every person or party having knowledge of violation of any of the provisions of this chapter, is required to promptly report the facts and circumstances pertaining thereto to the Department of Insurance, which report and the name of the informant may be held confidential by the department, its officers, assistants and employees, and not be made public.

Source: Laws 1913, c. 154, § 62, p. 422; R.S.1913, § 3198; Laws 1919, c. 190, tit. V, art. IV, § 32, p. 602; C.S.1922, § 7797; C.S.1929, § 44-332; R.S.1943, § 44-393.

44-394 Insurance companies; violations; general penalty.

Any company or person who knowingly violates any provision of this chapter for which no penalty is provided, shall be guilty of a Class III misdemeanor.

Source: Laws 1913, c. 154, § 155, p. 472; R.S.1913, § 3292; Laws 1919, c. 190, tit. V, art. XI, § 20, p. 653; C.S.1922, § 7899; C.S.1929, § 44-1120; R.S.1943, § 44-394; Laws 1977, LB 40, § 237.

An otherwise valid and authorized contract of insurance is not rendered void merely because it has not been approved by the Department of Insurance prior to its issuance. Equity Mut. Ins. Co. v. Allstate Ins. Co., 190 Neb. 515, 209 N.W.2d 592 (1973).

Rebating is a misdemeanor punishable by fine or imprisonment. Kortright v. Mutual Life Ins. Co., 123 Neb. 746, 243 N.W. 904 (1932).

Both the insurer and the agent may be punished under criminal law for the transfer of a premium note before the policy has been delivered. State Bank v. House, 114 Neb. 681, 209 N.W. 246 (1926).

44-395 Actions; prosecution and defense; duties of Attorney General and county attorneys.

In all proceedings instituted in any court, or otherwise, under the provisions of this chapter, it shall be and hereby is made the duty of the Attorney General, and of the several county attorneys throughout the state, to prosecute or defend all such proceedings, when requested by the Department of Insurance.

Source: Laws 1913, c. 154, § 145, p. 469; R.S.1913, § 3282; Laws 1919, c. 190, tit. V, art. XI, § 10, p. 650; C.S.1922, § 7889; C.S.1929, § 44-1110; R.S.1943, § 44-395.

44-396 Insurance companies or officers; actions against; witnesses; immunity.

No person shall be excused from testifying, or from producing any books, papers, contracts, agreements or documents at the trial or hearing of any person or company charged with violating any provisions of this chapter, on the ground that such testimony or evidence may tend to incriminate himself, but no person shall be prosecuted for any act concerning which he shall be compelled so as to testify or produce evidence, documentary or otherwise, except for perjury committed in so testifying.

Source: Laws 1913, c. 154, § 152, p. 471; R.S.1913, § 3289; Laws 1919, c. 190, tit. V, art. XI, § 17, p. 653; C.S.1922, § 7896; C.S.1929, § 44-1117; R.S.1943, § 44-396.

44-397 Repealed. Laws 1991, LB 237, § 72.

44-398 Repealed. Laws 1991, LB 237, § 72.

44-399 Repealed. Laws 1991, LB 237, § 72.

44-3,100 Repealed. Laws 1989, LB 92, § 278.

44-3,101 Repealed. Laws 1989, LB 92, § 278.

44-3,102 Repealed. Laws 1981, LB 273, § 33.

44-3,103 Repealed. Laws 1981, LB 273, § 33.

44-3,104 Repealed. Laws 1989, LB 92, § 278.

44-3,105 Repealed. Laws 1989, LB 92, § 278.

44-3,106 Repealed. Laws 1989, LB 92, § 278.

44-3,107 Equity securities insider trading; statement of certain owners; form; required; filing.

Every domestic stock insurer shall file with the Director of Insurance, on such forms as the director may require, a separate statement for each person who is directly or indirectly the beneficial owner of more than ten percent of any class of any equity security of such insurer, and for each person who is a director or an officer of such insurer. The statement of the amount of all equity securities of such insurer, directly or indirectly owned by the individuals enumerated above, shall be filed with the director on or before January 1, 1970; within ten days after a person becomes an officer, director, or such beneficial

owner; and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership.

Source: Laws 1965, c. 248, § 1, p. 702; Laws 1969, c. 368, § 1, p. 1307.

44-3,107.01 Equity securities insider trading; terms, defined.

As used in sections 44-3,107 to 44-3,114, unless the context otherwise requires:

(1) Person shall mean any individual, corporation, partnership, limited liability company, association, joint-stock company, business trust, unincorporated organization, or holding company whose primary purpose is owning or controlling insurance companies. A holding company shall be presumed to have as its primary purpose the owning or controlling of insurance companies if fifty-one percent or more of the assets of the holding company consist of the equity securities of one or more stock insurers, one of which is a domestic stock insurer; and

(2) Officer shall mean president, vice president, treasurer, actuary, secretary, controller, or any other person who performs the company functions corresponding to those performed by any of the foregoing officers.

Source: Laws 1969, c. 368, § 2, p. 1307; Laws 1993, LB 121, § 223.

44-3,107.02 Equity securities insider trading; holder or owner of stock; report; filing; violation; effect.

Any person who is the beneficial owner of more than ten percent of the equity securities of any class of a domestic stock insurer and any officer or director of a domestic stock insurer who shall purchase or hold the stock of such insurer shall report such purchase or holding to such domestic stock insurer. Such report shall be filed with such insurer within five days after a person becomes an officer, director or such beneficial owner and not later than the close of the calendar month in which there has been a change in such ownership. Failure of any individual to report such ownership or purchase shall relieve the insurer of the duties prescribed in section 44-3,107 unless the insurer knows or should have known that the purchase was made by an officer, director, or beneficial owner of more than ten percent of the equity securities of the insurer.

Source: Laws 1969, c. 368, § 3, p. 1308.

44-3,107.03 Equity securities insider trading; owner; reports; filing.

A person, instead of the insurer, shall file the reports required by section 44-3,107 if:

(1) He fails to make the reports required by section 44-3,107.02; or

(2) His indirect beneficial ownership in the equity securities of a domestic stock insurer through a holding company, together with the amount of such equity securities of which he is otherwise directly or indirectly the beneficial owner, aggregate more than ten percent of the outstanding equity securities of a domestic stock insurer.

Source: Laws 1969, c. 368, § 4, p. 1308.

44-3,107.04 Equity securities insider trading; failure to file report; penalty.

Any domestic insurer which fails to comply with section 44-3,107 and any person who fails to comply with section 44-3,107.03 shall forfeit to the State of Nebraska the sum of one hundred dollars for each and every day such failure to comply shall continue. Such forfeiture, which shall be in lieu of any criminal penalty for such failure to comply which might be deemed to arise under sections 44-3,107 to 44-3,107.04 and 44-3,111 to 44-3,114, shall be payable into the treasury of the State of Nebraska and shall be recoverable in a civil suit in the name of the State of Nebraska.

Source: Laws 1969, c. 368, § 5, p. 1308.

44-3,108 Equity securities insider trading; unfair transactions; action for damages; limitation.

For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. This section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the Director of Insurance by rules and regulations may exempt as not comprehended within the purpose of this section.

Source: Laws 1965, c. 248, § 2, p. 703; Laws 1972, LB 1059, § 3.

44-3,109 Equity securities insider trading; unlawful acts.

It shall be unlawful for any such beneficial owner, director or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or his principal (1) does not own the security sold, or (2) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

Source: Laws 1965, c. 248, § 3, p. 703.

44-3,110 Equity securities insider trading; exemptions.

The provisions of section 44-3,108 shall not apply to any purchase and sale, or sale and purchase, and the provisions of section 44-3,109 shall not apply to any sale, of an equity security of a domestic stock insurance company not then

or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market, otherwise than on an exchange as defined in the Securities Exchange Act of 1934, for such security. The Director of Insurance may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

Source: Laws 1965, c. 248, § 4, p. 704.

44-3,111 Equity securities insider trading; arbitrage transactions; exceptions.

The provisions of sections 44-3,107 to 44-3,109 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the Director of Insurance may adopt and promulgate in order to carry out the purposes of sections 44-3,107 to 44-3,114.

Source: Laws 1965, c. 248, § 5, p. 704; Laws 1969, c. 368, § 6, p. 1309; Laws 1989, LB 92, § 109.

44-3,112 Equity security, defined.

Equity security when used in sections 44-3,107 to 44-3,114 shall mean (1) any stock or similar security, (2) any security convertible, with or without consideration, into such a security or carrying any warrant or right to subscribe to or purchase such a security, (3) any such warrant or right, or (4) any other security which the Director of Insurance deems to be of similar nature and considers necessary or appropriate, by such rules and regulations as he or she may adopt and promulgate in the public interest or for the protection of investors, to treat as an equity security.

Source: Laws 1965, c. 248, § 6, p. 704; Laws 1969, c. 368, § 7, p. 1309; Laws 1989, LB 92, § 110.

44-3,113 Equity securities insider trading; applicability of sections.

The provisions of sections 44-3,107 to 44-3,109 shall not apply to equity securities of a domestic stock insurance company if such securities shall be registered, or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, as amended, and a copy of such registration has been filed with the director, if so requested.

Source: Laws 1965, c. 248, § 7, p. 705; Laws 1969, c. 368, § 8, p. 1309.

44-3,114 Equity securities insider trading; rules and regulations.

The Director of Insurance shall have the power to adopt and promulgate such rules and regulations as may be necessary for the execution of the functions vested in him or her by the provisions of sections 44-3,107 to 44-3,113 and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his or her jurisdiction. No provision of sections 44-3,107 to 44-3,109 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Director of Insurance, notwithstanding that such rule or regulation may, after

such act or omission, be amended, rescinded, or determined by judicial or other authority to be invalid for any reason.

Source: Laws 1965, c. 248, § 8, p. 705; Laws 1969, c. 368, § 9, p. 1309; Laws 1989, LB 92, § 111.

44-3,115 Shareholders information; applicability of sections; insurer, file documents with director.

Sections 44-3,115 to 44-3,118 shall apply to all domestic stock insurers having one hundred or more shareholders, except that such sections shall not apply to any insurer if ninety-five percent or more of its stock is owned or controlled by a parent or an affiliated insurer and the remaining shares are held by less than five hundred shareholders. A domestic stock insurer which files with the Securities and Exchange Commission forms of proxies, consents, and authorizations complying with the requirements of the Securities Exchange Act of 1934, the Securities Exchange Act amendments of 1964, and the rules and regulations of the Securities and Exchange Commission promulgated thereunder shall file copies of all such documents with the Director of Insurance on the same date such documents are filed with the Securities and Exchange Commission.

Source: Laws 1965, c. 249, § 1, p. 706; Laws 1969, c. 369, § 1, p. 1310; Laws 1989, LB 92, § 112.

44-3,116 Shareholders information; file documents with director.

To insure that shareholders are provided with adequate information and to prevent fraud, deception, or dissemination of misleading information, a copy of every form of proxy, consent, or authorization for use at any meeting of shareholders and a copy of every solicitation, announcement, or other communication to shareholders under circumstances reasonably calculated to result in the procurement, withholding, or revocation of a proxy, consent, or authorization shall be filed with the director by the person intending to use, issue, publish, or circulate such document.

Source: Laws 1965, c. 249, § 2, p. 706; Laws 1969, c. 369, § 2, p. 1311; Laws 1989, LB 92, § 113.

44-3,116.01 Shareholders information; director; disapproval; effect.

The documents required to be filed with the Director of Insurance by sections 44-3,116 and 44-3,117 shall not be used, issued, published or circulated before a period of ten days following the date of such filing, or any such shorter period as may be authorized by the director, has elapsed. Within such ten-day or shorter period, the director may disapprove of any document filed with him, stating his reasons therefor in writing, in which case such documents shall not be used, issued, published, or circulated.

Source: Laws 1969, c. 369, § 3, p. 1311.

44-3,116.02 Shareholders information; failure to file; disapproved; effect; penalty.

Any domestic stock insurer or any person who uses any proxy, consent or authorization obtained in violation of sections 44-3,115 to 44-3,118, or who fails to make the filing required by sections 44-3,115 to 44-3,118 and who

thereafter uses any document required to be filed, or who uses any document before it has been filed with the director for the required period of time, or who uses any such document after receiving written notice that the document has been disapproved by the Director of Insurance, or who uses any document which is false or misleading with respect to any material fact or omits to state any material fact shall forfeit to the State of Nebraska the sum of one thousand dollars. Such forfeiture, which shall be in lieu of any criminal penalties for such act or failure to act which might be deemed to arise under the provisions of sections 44-3,115 to 44-3,118, shall be payable to the State Treasurer and shall be recoverable in a civil suit in the name of the State of Nebraska.

Source: Laws 1969, c. 369, § 4, p. 1311.

44-3,117 Shareholders information; filing requirements.

Unless proxies, consents, or authorizations in respect of a stock of a domestic insurer subject to the provisions of section 44-3,115 are solicited by or on behalf of the management of such insurer from the holders of record of stock of such insurer in accordance with the rules and regulations adopted and promulgated by the Director of Insurance pursuant to sections 44-3,115 to 44-3,118 prior to any annual or other meeting, such insurer shall, in accordance with such rules and regulations, file with the director and transmit to all shareholders of record information substantially equivalent to the information which would be required to be transmitted if such a solicitation were made.

Source: Laws 1965, c. 249, § 3, p. 707; Laws 1969, c. 369, § 5, p. 1312; Laws 1989, LB 92, § 114.

44-3,118 Shareholders information; rules and regulations.

In accordance with the provisions of sections 44-3,115 to 44-3,118, the Director of Insurance shall adopt and promulgate such rules and regulations as are reasonable, necessary, or appropriate in the public interest or for the protection of investors (1) to define the provisions and applicability of sections 44-3,115 to 44-3,118, (2) to require that information including proxy statements be transmitted to shareholders and to prescribe the kind, content, and form of such information and the circumstances, time, and manner in which such information shall be transmitted, (3) to prescribe the content, form, and requirements of proxies, consents, and authorizations and the circumstances, time, and manner in which such proxies, consents, and authorizations may be solicited, and (4) to require that information, including forms of proxy statements, proxies, consents, and authorizations, be filed with the director and to prescribe the kind, content, and form of such information and the circumstances, time, and manner in which such information shall be filed.

Source: Laws 1965, c. 249, § 4, p. 707; Laws 1969, c. 369, § 6, p. 1312; Laws 1989, LB 92, § 115.

44-3,119 Borrowing or rental of securities; insurance company; member, officer, director, attorney in fact; unlawful.

Any member, officer, director, or attorney in fact of any company or association licensed to do an insurance business in this state, who on behalf of such company or association borrows, rents, hires, leases, or otherwise engages the use of stocks, bonds, debentures, notes, investment certificates, securities, or other obligations or evidences of indebtedness owned or issued by any other

corporation, company, association, or individual, or of any government political subdivision or agency thereof, with intent to injure or defraud any other company, body politic or corporation, or person, or to deceive the Director of Insurance or any other person legally authorized to examine the affairs of any such company or association shall be guilty of a felony.

Source: Laws 1969, c. 352, § 1, p. 1231.

44-3,120 Borrowing or rental of securities; aiding and abetting; unlawful.

Any corporation organized under any laws of this state, or the laws of any other state, or which has an office or is transacting business in this state, which is engaged in, organizing or receiving subscriptions for or disposing of stocks of, or in any manner aiding or taking part in the formation or in the business of an insurance company or association, either as agent or otherwise, or which is holding capital stock of one or more insurance companies for the purpose of controlling the management thereof as voting trustees or otherwise, or any employee, agent, or attorney thereof, who aids and abets such insurance company or association in borrowing, renting, hiring, leasing, or engaging the use of such stocks, bonds, debentures, notes, investment certificates, securities, or other obligations or evidences of indebtedness, shall be guilty of a felony.

Source: Laws 1969, c. 352, § 2, p. 1232.

44-3,121 Violations; penalty.

Any person convicted for violation of section 44-3,119 or 44-3,120 shall be guilty of a Class IV felony.

Source: Laws 1969, c. 352, § 3, p. 1232; Laws 1977, LB 40, § 240.

44-3,122 Violations by corporation; penalty.

Any corporation convicted for violation of section 44-3,120 shall be punished by a fine of not more than ten thousand dollars.

Source: Laws 1969, c. 352, § 4, p. 1232.

44-3,123 Possession of borrowed or rented securities; proceedings authorized.

If any insurance company or association is found in possession of stocks, bonds, debentures, notes, investment certificates, securities, or other obligations or evidences of indebtedness acquired in violation of section 44-3,119 or if any of its officers, directors, members, or attorneys in fact have been convicted under section 44-3,119, such company or association may be subject to suspension of its certificate of authority by the Director of Insurance. Nothing in this section shall be construed to prevent the Director of Insurance from proceeding against such insurance company or association in the manner authorized and directed by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1969, c. 352, § 5, p. 1232; Laws 1989, LB 319, § 68.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-3,124 Repealed. Laws 1989, LB 214, § 10.

44-3,125 Repealed. Laws 1989, LB 214, § 10.

44-3,126 Repealed. Laws 1989, LB 214, § 10.

44-3,127 Fine or penalty; collected by department; distribution.

The Department of Insurance shall remit all money collected as a fine or penalty to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Source: Laws 1979, LB 196, § 2; Laws 2021, LB21, § 2.
Effective date August 28, 2021.

44-3,128 Automobile liability policy; insurance carrier; surcharge prohibited.

When any person insured under an automobile liability policy is involved in an accident in which the license of the operator of another motor vehicle is suspended pursuant to section 60-507 because the operator failed to provide proof of financial responsibility and there is a reasonable possibility of judgment being rendered against such operator, the insurance carrier covering the insured person shall not surcharge any of the automobile coverages in the insured party's current policy or any subsequent renewal policy for any loss which was sustained in such accident by the insured person and covered under such person's automobile liability policy.

Source: Laws 1985, LB 404, § 4.

44-3,128.01 Automobile liability policy or endorsement; right of subrogation of medical payments; limitation.

A provision in an automobile liability policy or endorsement which is effective in this state and which grants the insurer the right of subrogation for payment of benefits under the medical payments coverage portion of the policy shall be valid and enforceable, except that if the claimant receives less than actual economic loss from all parties liable for the bodily injuries, subrogation of medical payments shall be allowed in the same proportion that the medical expenses bear to the total economic loss. For purposes of this section, it shall be conclusively presumed that any settlement or judgment which is less than the policy limits of any applicable liability insurance coverage constitutes complete recovery of actual economic loss.

Source: Laws 1991, LB 224, § 1.

The conclusive presumption found in this section does not violate due process because it does not impair a constitutionally protected right and it meets the standard of legislative reasonableness. Ploen v. Union Ins. Co., 253 Neb. 867, 573 N.W.2d 436 (1998).

44-3,129 Health care coverages or services; legislative intent.

The Legislature recognizes the increasing number of proposals to mandate or require the offering of health care coverages or services by insurance or otherwise, health care service contractors, and health maintenance organizations as a component of insurance policies or employee welfare benefit plans. Improved access to health care services by segments of the population which desire such services can provide beneficial social and health consequences which may be in the public interest.

The cost ramifications of expanding health care coverages and services are a growing concern. The structures of such coverages or services and the steps taken to create incentives to provide cost-effective services or to take advantage

of cost-offsetting features of services can significantly influence the cost impact of mandating particular coverages and services.

Source: Laws 1986, LB 895, § 1.

44-3,130 Health care coverages or services; defined.

For purposes of sections 44-3,129 to 44-3,131, health care coverages or services shall mean any services rendered for a fee which are included in the furnishing to any individual of medical care, or other services incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

Source: Laws 1986, LB 895, § 2.

44-3,131 Health care coverages or services; applicability of provisions.

No legislative proposal to mandate or require the offering of health care coverages or services shall apply to any insurer unless the proposal applies equally to employee welfare benefit plans described in 29 U.S.C. 1001 et seq.

Source: Laws 1986, LB 895, § 3.

44-3,132 Repealed. Laws 1995, LB 385, § 14.

44-3,133 Furnishing information; exemption from liability.

(1) Any person acting without malice, fraudulent intent, or bad faith shall be immune from any civil liability by virtue of filing reports or furnishing other information required by Chapter 44 or required by the Director of Insurance under the authority granted in Chapter 44.

(2) The Director of Insurance or any employee of the Department of Insurance acting without malice, fraudulent intent, or bad faith shall be immune from any civil liability by virtue of the publication of any report or bulletin related to the official activities of the Department of Insurance.

(3) This section shall not abrogate or modify in any way any common-law or statutory privilege or immunity.

Source: Laws 1987, LB 399, § 2; Laws 1995, LB 385, § 12.

44-3,134 Motor vehicle theft or fraud; terms, defined.

As used in sections 44-3,134 to 44-3,142, unless the context otherwise requires:

(1) Authorized agency shall mean the Nebraska State Patrol, a local governmental police department, a county sheriff's office, a county attorney, a municipal attorney, a United States district attorney, a duly constituted criminal investigative agency of the United States Government, and the office of the Nebraska Attorney General;

(2) Insurer shall mean any insurance company, adjustor, or agent; and

(3) Relevant shall mean having a tendency to make the existence of any information that is of consequence to an investigation of motor vehicle theft or motor vehicle insurance fraud or a determination of such issue more probable or less probable than it would be without such information.

Source: Laws 1987, LB 78, § 1.

44-3,135 Motor vehicle theft or fraud; relevant information; release to authorized agency.

Upon written request to an insurer by an authorized agency, an insurer or person acting on behalf of the insurer shall release to a requesting authorized agency any or all relevant information relating to any specific motor vehicle theft or motor vehicle insurance fraud which the insurer may possess. Relevant information may include, but shall not be limited to:

(1) Insurance policy information relevant to the motor vehicle theft or motor vehicle insurance fraud under investigation, including any application for such a policy;

(2) Policy premium records;

(3) History of previous claims made by the insured;

(4) Information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including statements of any person, proof of loss, and notice of loss; and

(5) Any other relevant evidence or information which the authorized agency reasonably believes is important.

Source: Laws 1987, LB 78, § 2.

44-3,136 Motor vehicle theft or fraud; notification by insurer.

When an insurer knows the identity of a person whom the insurer has probable cause to believe committed a criminal or fraudulent act relating to a motor vehicle theft or a motor vehicle insurance claim or has knowledge of such a criminal or fraudulent act which the insurer reasonably believes has not been reported to an authorized agency and the suspected person is insured by the insurer, then for the purpose of notification and investigation the insurer or person acting on behalf of the insurer may notify, in writing, an authorized agency of such knowledge or reasonable belief and provide any additional relevant information in accordance with section 44-3,135.

Source: Laws 1987, LB 78, § 3.

44-3,137 Motor vehicle theft or fraud; notice; effect.

For purposes of sections 44-3,134 to 44-3,142, when an insurer provides any authorized agency with notice pursuant to section 44-3,136, such notice shall be deemed sufficient for all authorized agencies.

Source: Laws 1987, LB 78, § 4.

44-3,138 Motor vehicle theft or fraud; information; release.

The authorized agency which receives information pursuant to sections 44-3,134 to 44-3,142 may release or provide such information to any other authorized agency.

Source: Laws 1987, LB 78, § 5.

44-3,139 Motor vehicle theft or fraud; relevant information; release to insurer; when.

Any insurer which provides information to an authorized agency pursuant to sections 44-3,134 to 44-3,142 shall have the right to request and receive relevant information from such authorized agency. The authorized agency shall

provide the requested relevant information to the insurer or agent authorized by the insurer not more than thirty days after the completion of the agency's investigation.

Source: Laws 1987, LB 78, § 6.

44-3,140 Motor vehicle theft or fraud; relevant information; disclosure prohibited.

It shall be unlawful for any insurer, any person acting on behalf of the insurer, or an authorized agency to make any relevant information received or released under sections 44-3,134 to 44-3,142 a public record except in a criminal or civil proceeding.

Source: Laws 1987, LB 78, § 7.

44-3,141 Motor vehicle theft or fraud; release of relevant information; immunity.

Any insurer, any person acting on behalf of the insurer, an authorized agency, or any of their respective employees, who releases relevant information under sections 44-3,134 to 44-3,142 with reasonable cause to believe the truth of such information, shall be immune from any civil or criminal liability for releasing such information.

Source: Laws 1987, LB 78, § 8.

44-3,142 Motor vehicle theft or fraud; violation; penalty.

Any person violating any provision of sections 44-3,134 to 44-3,142 shall be guilty of a Class IV misdemeanor.

Source: Laws 1987, LB 78, § 9.

44-3,143 Life insurance policy proceeds; payment of interest; when.

(1) Any insurance company authorized to do business in this state shall pay interest on any proceeds due on a life insurance policy if:

(a) The insured was a resident of this state on the date of death;

(b) The date of death was on or after June 6, 1991;

(c) The beneficiary elects in writing to receive the proceeds in a lump-sum payment; and

(d) The proceeds are not paid to the beneficiary within thirty days of receipt of proof of death of the insured by the insurance company.

(2) Interest shall accrue from the date of receipt of proof of death to the date of payment at the rate calculated pursuant to section 45-103 in effect on January 1 of the calendar year in which occurs the date of receipt of proof of death. For purposes of this section, date of payment shall include the date of the postmark stamped on an envelope, properly addressed and postage prepaid, containing the payment.

(3) If an action is commenced to recover the proceeds, this section shall not require the payment of interest for any period of time for which interest is awarded pursuant to sections 45-103 to 45-103.04.

(4) A violation of this section shall be an unfair claims settlement practice subject to the Unfair Insurance Claims Settlement Practices Act.

Source: Laws 1991, LB 419, § 40; Laws 2011, LB72, § 1.

Cross References

Unfair Insurance Claims Settlement Practices Act, see section 44-1536.

44-3,144 Health care coverage of children; terms, defined.

For purposes of sections 44-3,144 to 44-3,150:

(1) Authorized attorney has the same meaning as in section 43-512;

(2) Child means an individual to whom or on whose behalf a legal duty of support is owed by an obligor;

(3) Department means the Department of Health and Human Services;

(4) Employer means an individual, a firm, a partnership, a corporation, an association, a union, a political subdivision, a state agency, or any agent thereof who pays income to an obligor on a periodic basis and has or provides health care coverage to the obligor-employee;

(5) Health care coverage means a health benefit plan or combination of plans, including fee for service, health maintenance organization, preferred provider organization, and other types of coverage available to either party, under which medical services could be provided to dependent children, that provide medical care or benefits;

(6) Insurer means an insurer as defined in section 44-103 offering a group health plan as defined in 29 U.S.C. 1167, as such section existed on January 1, 2002;

(7) Medical support means the provision of health care coverage, contribution to the cost of health care coverage, contribution to expenses associated with the birth of a child, other uninsured medical expenses of a child, or any combination thereof;

(8) Medical assistance program means the program established pursuant to the Medical Assistance Act;

(9) National medical support notice means a uniform administrative notice issued by the county attorney, authorized attorney, or department to enforce the medical support provisions of a support order;

(10) Obligee has the same meaning as in section 43-3341;

(11) Obligor has the same meaning as in section 43-3341;

(12) Plan administrator means the person or entity that administers health care coverage for an employer;

(13) Qualified medical child support order means an order that meets the requirements of 29 U.S.C. 1169, as such section existed on January 1, 2002; and

(14) Uninsured medical expenses means the reasonable and necessary health-related expenses that are not paid by health care coverage.

Source: Laws 1994, LB 1224, § 72; Laws 1996, LB 1044, § 234; Laws 1997, LB 307, § 103; Laws 2002, LB 1062, § 6; Laws 2006, LB 1248, § 56; Laws 2009, LB288, § 14; Laws 2018, LB702, § 4.

Cross References

Medical Assistance Act, see section 68-901.

44-3,145 Health care coverage of children; insurer; prohibited acts.

An insurer shall not deny enrollment of a child under the health care coverage of the obligor on the ground that:

(1) The child was born out of wedlock;

(2) The child is not claimed as a dependent on the obligor's federal income tax return; or

(3) The child does not reside with the obligor or in the insurer's service area.

Source: Laws 1994, LB 1224, § 73; Laws 2002, LB 1062, § 7.

44-3,146 Health care coverage of children; insurer; court or administrative order; duties; national medical support notice; effect.

(1) An insurer shall, in any case in which an obligor is required by a court or administrative order to provide health care coverage for a child and the obligor is eligible for family health care coverage through the insurer:

(a) Permit an obligor to enroll under such health care coverage any such child who is otherwise eligible for such coverage without regard to any enrollment season restriction;

(b) If an obligor is covered but fails to make application to obtain coverage for such child, enroll such child under such health care coverage upon application by (i) the obligee without regard to any enrollment season restriction, (ii) in any case in which services are provided under Title IV-D of the federal Social Security Act, as such act existed on January 1, 2002, the county attorney or authorized attorney without regard to any enrollment season restriction, or (iii) in any case in which services are not provided under Title IV-D of the federal Social Security Act, as such act existed on January 1, 2002, the department without regard to any enrollment season restriction; and

(c) Not cancel or eliminate health care coverage for any such child unless the insurer is provided satisfactory written evidence that (i) such court or administrative order is no longer in effect or (ii) the child is or will be enrolled in comparable health care coverage through another insurer which will take effect not later than the effective date of such cancellation or elimination.

(2) An employer doing business in this state shall, in any case in which an obligor is required by a court or administrative order to provide health care coverage for a child and the obligor is eligible for family health care coverage through the employer:

(a) Permit an obligor to enroll under such health care coverage any such child who is otherwise eligible for such coverage without regard to any enrollment season restriction;

(b) If an obligor is covered but fails to make application to obtain coverage for such child, enroll such child under such health care coverage upon application by (i) the obligee without regard to any enrollment season restriction, (ii) in any case in which services are provided under Title IV-D of the federal Social Security Act, as such act existed on January 1, 2002, the county attorney or authorized attorney without regard to any enrollment season restriction, or (iii) in any case in which services are not provided under Title

IV-D of the federal Social Security Act, as such act existed on January 1, 2002, the department without regard to any enrollment season restriction; and

(c) Not cancel or eliminate health care coverage for any such child unless (i) the employer is provided satisfactory written evidence that (A) such court or administrative order is no longer in effect or (B) the child is or will be enrolled in comparable health care coverage which will take effect not later than the effective date of such cancellation or elimination or (ii) the employer has eliminated family health care coverage for all of its employees.

Upon enrollment pursuant to this subsection, premiums shall be deducted from the obligor's compensation and remitted directly to the insurer. The amount withheld shall not exceed the maximum amount permitted to be withheld under section 303(b) of the federal Consumer Credit Protection Act, as such act existed on January 1, 2002. Amounts withheld pursuant to the Income Withholding for Child Support Act shall have priority over amounts withheld pursuant to this subsection. An employer receiving a national medical support notice shall transmit the notice to the plan administrator within twenty business days after receipt of the notice from the county attorney, authorized attorney, or department.

(3) If an obligor is ordered to provide health care coverage for a child in any case in which services are provided under Title IV-D of the federal Social Security Act, as such act existed on January 1, 2002, the county attorney, authorized attorney, or department shall send a national medical support notice to any employer of the obligor within two business days after receipt of information regarding employment under the New Hire Reporting Act. A national medical support notice sent by the county attorney, authorized attorney, or department to an employer pursuant to this section shall have the same effect as an enrollment application signed by the obligor. The county attorney, authorized attorney, or department shall send a copy of the national medical support notice to the obligor by mail at his or her last-known address stating:

(a) The court or administrative order upon which the enforcement action is being taken;

(b) That if the county attorney, authorized attorney, or department sends a national medical support notice to an employer, the county attorney, authorized attorney, or department will also direct the employer to withhold from the employee's compensation the employee's share of the premium for health care coverage; and

(c) That within fifteen days after receiving the notice the obligor may request a hearing to contest the enforcement action based upon evidence that (i) there is an error in the identity of the obligor, (ii) he or she has enrolled the child in an insurance plan providing coverage required by the order, (iii) the parties have stipulated to, and the court or administrative order specifically provides for, an alternative to employer-based health care coverage, or (iv) evidence that the premium cost to the obligor exceeds the amount stated in subsection (2) of this section or is otherwise unreasonable.

If a hearing is requested, the department shall hold the hearing within fifteen days after the request, and the department shall notify the obligor of its decision within fifteen days after the date the hearing is held. A national medical support notice sent by the county attorney, authorized attorney, or department to the obligor's employer shall not be held in abeyance pending the outcome of the hearing.

(4) The remedy provided in this section shall be in addition to and not in substitution for any other remedy and shall apply without regard to when the order was issued.

(5) An insurer or employer shall, upon request by the county attorney, authorized attorney, or department, provide the county attorney, authorized attorney, or department with the following information regarding an obligor required by a court or administrative order to provide health care coverage for a child: (a) The social security number; (b) the address; (c) whether the obligor has health care coverage and, if so, the policy name and number and the names of the persons covered; and (d) the cost to the obligor of enrolling.

(6) Upon receipt of a copy of a court or administrative order requiring an obligor to provide health care coverage for a child, an insurer or employer shall provide the obligee upon written request the information necessary to file an application pursuant to this section.

(7) A completed national medical support notice issued by the county attorney, authorized attorney, or department that complies with this section is a qualified medical child support order for the purposes of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. 1169(a), as such section existed on January 1, 2002.

(8) Upon the termination of employment of an obligor subject to this section, the employer shall promptly notify the county attorney, authorized attorney, or department of the termination of employment in the same manner as required for income withholding cases in accordance with subdivision (6) of section 43-1723.

(9) When there is no longer a current child support order in effect for an obligor subject to this section, the county attorney, authorized attorney, or department shall promptly notify the employer that the order is no longer in effect.

Source: Laws 1994, LB 1224, § 74; Laws 2002, LB 1062, § 8.

Cross References

Income Withholding for Child Support Act, see section 43-1701.
New Hire Reporting Act, see section 48-2301.

44-3,147 Health care coverage of children; rules and regulations.

The department shall adopt and promulgate rules and regulations to carry out section 44-3,146.

Source: Laws 1994, LB 1224, § 75.

44-3,148 Health care coverage of children; insurer; discrimination against Department of Health and Human Services prohibited.

An insurer may not impose requirements on the department when the department has been assigned the rights of an individual who is eligible for medical assistance pursuant to the medical assistance program and who is covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

Source: Laws 1994, LB 1224, § 76.

44-3,149 Health care coverage of children; insurer of obligor; duties.

An insurer shall, in any case in which a child has health care coverage through the insurer of the obligor:

(1) Provide such information to the obligor as may be necessary for the child to obtain benefits through such coverage;

(2) Permit the obligor or the provider, with the obligor's approval, to submit claims for covered services without the approval of the obligor; and

(3) Make payment on claims submitted in accordance with subdivision (2) of this section directly to such obligor, the provider, or the department pursuant to section 68-916.

Source: Laws 1994, LB 1224, § 77; Laws 2002, LB 1062, § 9; Laws 2006, LB 1248, § 57.

44-3,150 Health care coverage of children; eligibility for medical assistance; effect.

When enrolling an individual or making any payment for benefits to an individual or on an individual's behalf, an insurer shall not take into account that the individual is eligible for or is provided medical assistance pursuant to the medical assistance program or a medical assistance plan of another state.

Source: Laws 1994, LB 1224, § 78.

44-3,151 Workers' compensation insurance; association authorized to obtain for members.

An association which has a constitution and bylaws and has been organized in this state for not less than two years and is maintained in good faith for purposes other than that of obtaining insurance may obtain individual workers' compensation insurance policies through an insurance producer licensed under the Insurance Producers Licensing Act for any or all of the voting members of the association covering the liability to which each individual employer may be subject under the Nebraska Workers' Compensation Act from an insurer authorized to transact the business of workers' compensation insurance in this state.

Source: Laws 1996, LB 515, § 1; Laws 2001, LB 51, § 24.

Cross References

Insurance Producers Licensing Act, see section 44-4047.
Nebraska Workers' Compensation Act, see section 48-1,110.

44-3,152 Workers' compensation insurance; association; how treated.

An association which obtains insurance policies in compliance with sections 44-3,151 to 44-3,155 is not an insurer and is not transacting the business of insurance under the laws of this state.

Source: Laws 1996, LB 515, § 2.

44-3,153 Workers' compensation insurance; association; powers.

Under insurance policies obtained pursuant to section 44-3,151, an association is entitled to negotiate with the insurer regarding policy terms, including premiums, discounts, dividends, commissions, fees, and costs. If any policy provides for any deductible for any benefits payable under the Nebraska Workers' Compensation Act, it shall be in conformance with section 48-146.03.

The insurer shall only enter into arrangements which allow it to report data compatible with the uniform classification system and with experience rating as required by subsections (1) and (2) of section 44-7524.

Source: Laws 1996, LB 515, § 3; Laws 2000, LB 1119, § 36.

Cross References

Nebraska Workers' Compensation Act, see section 48-1,110.

44-3,154 Workers' compensation insurance; discount or dividend; how apportioned.

An association may apportion any discount or dividend received on insurance policies obtained pursuant to section 44-3,151 among the covered members according to a formula adopted in the plan of operation of the association.

Source: Laws 1996, LB 515, § 4.

44-3,155 Workers' compensation insurance; plan of operation.

An association shall adopt and maintain a plan of operation that includes the methods for administering insurance policies obtained pursuant to section 44-3,151, including the payment of premiums, the distribution of discounts, and the methods for providing risk management.

Source: Laws 1996, LB 515, § 5.

44-3,156 Workers' compensation insurance; violation; penalty.

Any person who violates sections 44-3,151 to 44-3,155 is guilty of a Class II misdemeanor.

Source: Laws 1996, LB 515, § 6.

44-3,157 Mandated coverages or services; applicability.

If the laws of any other state specify that a policy issued for delivery in that state need not provide the coverages or services mandated by that state to certificate holders who are not residents or not employed in that state, and if such a policy issued for delivery in that state does not provide the coverages or services mandated by that state to certificate holders who are not residents or not employed in that state, then the coverages or services mandated by sections 44-769 to 44-7,101 shall apply to a certificate issued to certificate holders who are residents of or employed in this state.

Source: Laws 2005, LB 119, § 38; Laws 2006, LB 875, § 1.

44-3,158 Workers' compensation insurance; assigned risk system; director; powers; certain actions of employer; effect.

(1) For purposes of this section:

(a) Assigned risk employer means a Nebraska employer that is in good faith entitled to, but is unable to obtain, workers' compensation insurance through ordinary methods; and

(b) Director means the Director of Insurance.

(2)(a) The director shall enter into an agreement with one or more workers' compensation insurers to provide workers' compensation insurance to assigned risk employers. In selecting an insurer to become an assigned risk insurer, the

director shall consider the cost of coverage to assigned risk employers, the loss control and claims handling services available from the workers' compensation insurer, the financial condition of the workers' compensation insurer, and any other relevant factors. An agreement entered into under this subsection may not exceed five years.

(b) If the director determines that the cost of workers' compensation insurance premiums for an insurer to provide assigned risk coverage pursuant to such an agreement would be unreasonably high, the director may enter into an agreement in which the assigned risk insurer covers a portion of the losses incurred by the assigned risk employer. Any agreement that involves an average rate level of less than two and one-half times the prospective loss costs approved for an advisory organization pursuant to section 44-7511 shall not be considered unreasonably high for the purposes of this section. Pursuant to any such agreement, remaining losses shall be assessed against all workers' compensation insurers writing workers' compensation insurance in this state and risk management pools created under the Intergovernmental Risk Management Act based on their workers' compensation premiums written in this state or contributions made to risk management pools. Assigned risk premiums shall be excluded from the basis for such assessments.

(c) If the assigned risk system described in subdivisions (2)(a) and (b) of this section ceases to be viable because no qualified insurer is willing to provide workers' compensation coverage at an average rate level of two and one-half times the prospective loss costs approved for an advisory organization pursuant to section 44-7511 without also requiring substantial sharing of losses with all other workers' compensation insurers writing workers' compensation insurance in this state and risk management pools created under the Intergovernmental Risk Management Act, then the director may, after consultation with insurers authorized to issue workers' compensation insurance policies in this state, create a reasonable alternative assigned risk system involving the sharing of premiums and losses for assigned risk employers among all such workers' compensation insurers writing workers' compensation insurance in this state and such risk management pools. If established, such alternative assigned risk system shall not utilize an average rate level of less than two and one-half times the prospective loss costs approved for an advisory organization pursuant to section 44-7511.

(3) The director may adopt and promulgate rules and regulations to carry out this section.

(4) An employer shall not be considered to be in good faith entitled to be covered by workers' compensation insurance under this section if:

(a) The employer is required to establish a safety committee pursuant to sections 48-443 to 48-445 and is not in compliance with such sections;

(b) The employer is in default on workers' compensation premiums;

(c) The employer has failed to reimburse an insurer for amounts to be repaid pursuant to workers' compensation insurance written on a policy with a deductible;

(d) The employer has failed to provide an insurer reasonable access to books and records necessary for a premium audit;

(e) The employer has defrauded or attempted to defraud an insurer; or

(f) The employer is found to have been owned or controlled by persons who owned or controlled a prior employer that is or would be ineligible for coverage pursuant to subdivisions (4)(b) through (e) of this section.

Source: Laws 1971, LB 572, § 15; Laws 1986, LB 811, § 72; Laws 1993, LB 757, § 14; Laws 2000, LB 1119, § 39; Laws 2005, LB 119, § 42; R.S.Supp.,2006, § 48-146.01; Laws 2007, LB117, § 3.

Cross References

Intergovernmental Risk Management Act, see section 44-4301.

44-3,159 Health plan; self-funded employee benefit plan; assertion of contractual rights to proceeds; prohibited acts; section; applicability.

(1) No health plan and no self-funded employee benefit plan to the extent not preempted by federal law shall assert any contractual rights to the proceeds of any resources purchased by or on behalf of the policyholder, subscriber, certificate holder, or enrollee, including medical payments coverage under a motor vehicle insurance policy, uninsured or underinsured motorist coverage, accident or disability income coverage, specific disease or illness coverage, or hospital indemnity or other fixed indemnity coverage.

(2) This section shall not (a) affect the coordination of benefits between health plans or self-funded employee benefit plans, (b) prevent the coordination of benefits between a health plan or self-funded employee benefit plan and medical payments coverage under a motor vehicle insurance policy if such coordination of benefits applies medical payments coverage to deductible, copayment, and coinsurance amounts after discounts provided through the health plan or self-funded employee benefit plan, or (c) prevent the application of the medical payments coverage under a motor vehicle insurance policy to items not covered by a health plan or self-funded employee benefit plan.

(3) For purposes of this section, health plan means an individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state except for (a) policies that provide coverage for specified disease or other limited-benefit coverage or hospital indemnity or other fixed indemnity coverage or (b) self-funded employee benefit plans to the extent preempted by federal law.

Source: Laws 2013, LB479, § 1.

ARTICLE 4

INSURANCE RESERVES; POLICY PROVISIONS

Section

Section

Section
44-416.08. Qualified United States financial institution, defined.
44-416.09. Rules and regulations.
44-416.10. Applicability of sections.
44-417. Credit for reinsurance; conditions.
44-418. Repealed. Laws 1985, LB 299, § 10.
44-419. Repealed. Laws 1990, LB 984, § 10.
44-420. Actuarial opinions; terms, defined.
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44-422. Actuarial opinions; life insurance company; additional requirements.
44-423. Actuarial opinions; transition period authorized.
44-424. Actuarial opinions; requirements.
44-425. Actuarial opinions; supporting memorandum; confidentiality.
44-426. Actuarial opinions; valuation of sickness and accident policies.
44-427. Actuarial opinions; rules and regulations.

44-401 Domestic property and casualty insurance companies; valuation; reserves.

In ascertaining the condition of a domestic stock property or casualty insurance company, there shall be allowed as assets only such investments, cash, and accounts as are authorized by the laws of this state at the date of the examination. In ascertaining its liabilities, there shall be charged in addition to the capital stock, all outstanding claims, and a sum equal to one hundred percent of the unearned premiums on the policies in force, after deducting credit for reinsurance authorized by sections 44-416.05 to 44-416.10, calculated on the gross sum without any deductions on any account, charged to the policyholder on each respective risk from the date of the issuance of the policy. In ascertaining the condition of a domestic mutual property or casualty insurance company, other than a company licensed solely to write the line of insurance specified in subdivision (4) of section 44-201, there shall be allowed as assets only such investments, cash, and accounts as are authorized by the laws of this state at the date of examination. In ascertaining its liabilities, there shall be charged all outstanding claims and a reserve in an amount equal to one hundred percent of the total unearned premium on all their policies in force. If the department finds this section to be impractical in ascertaining the condition of certain kinds of insurance companies, the department shall adopt and promulgate such rules and regulations as it deems proper, efficient, and consistent with law. Such rules and regulations shall give due regard to the statutes, rules, regulations, and established industry practices which may be used in other states or which are approved by the National Association of Insurance Commissioners.

Source: Laws 1913, c. 154, § 93, p. 437; R.S.1913, § 3230; Laws 1919, c. 190, tit. V, art. VI, § 1, p. 618; Laws 1921, c. 303, § 1, p. 960; C.S.1922, § 7829; Laws 1927, c. 141, § 1, p. 383; C.S.1929, § 44-501; R.S.1943, § 44-401; Laws 1949, c. 148, § 1, p. 374; Laws 1951, c. 138, § 1, p. 570; Laws 1959, c. 204, § 1, p. 713; Laws 1981, LB 330, § 1; Laws 1985, LB 299, § 7; Laws 1989, LB 92, § 116; Laws 2000, LB 930, § 2; Laws 2005, LB 119, § 5.

44-401.01 Domestic property and casualty insurance companies; loss reserves.

Loss reserves for domestic property and casualty insurance companies shall be set at the present value of estimated future payments if (1) a complete

settlement between the claimant and the insured or insurer has been agreed upon, (2) all payments due the claimant have not yet been made, and (3) the payments are structured as an annuity.

Source: Laws 1989, LB 92, § 118.

44-402 Repealed. Laws 2014, LB 755, § 19.

44-402.01 Life insurance; reserves; separate accounts; establish; procedure.

Any domestic life insurance company, including, for the purposes of sections 44-402.01 to 44-402.05, all domestic fraternal benefit societies which operate on a legal reserve basis, may, after adoption of a resolution by its board of directors and upon approval of the Director of Insurance, establish one or more separate accounts and may allocate thereto amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance and benefits incidental thereto, payable in fixed or variable amounts or both, and may, upon approval of the director, guarantee the value of the assets allocated to a separate account.

Source: Laws 1972, LB 771, § 1; Laws 1987, LB 17, § 9; Laws 2005, LB 119, § 6; Laws 2011, LB72, § 2.

44-402.02 Life insurance; reserves; separate accounts; gains and losses.

The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against such account, without regard to other income, gains or losses of such company.

Source: Laws 1972, LB 771, § 2.

44-402.03 Life insurance; reserves; separate accounts; investment; transfer.

(1) Except as may be provided with respect to reserves for guaranteed benefits, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies and the investments in such separate account or accounts shall not be taken into account in applying investment limitations otherwise applicable to investments of such company.

(2) No investment in such separate accounts or in the domestic life insurance company's general investment account shall be transferred by sale, exchange, substitution, or otherwise from one account to another unless the director approves such transfer or unless the director has not disapproved the application for transfer within thirty days from filing. The application to transfer investments shall be on a form provided by the director.

Source: Laws 1972, LB 771, § 3; Laws 1991, LB 237, § 62.

44-402.04 Life insurance; reserves; separate accounts; ownership by company.

Amounts allocated to a separate account in the exercise of the power granted by sections 44-402.01 to 44-402.05 shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and

other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

Source: Laws 1972, LB 771, § 4.

44-402.05 Variable life contracts; rules and regulations.

Notwithstanding any other provision of law, the Director of Insurance shall have the authority to adopt such reasonable rules and regulations as are appropriate and necessary to regulate the issuance and sale of variable life contracts. Such rules and regulations may relate to, but shall not be limited to, qualifications of foreign and domestic insurance companies and agents, required and prohibited policy provisions, the inapplicability of certain sections of Chapter 44, to variable life contracts, establishment and maintenance of separate accounts, filing of contracts and required reports, and examination of records. Any provision in a variable life contract relating to grace period, loans, reinstatement, and nonforfeiture shall be appropriate to such contract, and reserve liability for variable life contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

Source: Laws 1972, LB 771, § 5.

44-403 Life insurance; standard of valuation; policies issued prior to operative date of law.

This section shall apply to only those policies and contracts issued prior to the operative date defined in section 44-407.07 (the Standard Nonforfeiture Law for Life Insurance). All such valuations made by the Department of Insurance, or by its authority, shall be according to the standard of valuation adopted by the company, which standard shall be stated in its annual report to the department. Such standard of valuation, whether on the net level premium, preliminary term, any modified preliminary term, or select and ultimate reserve basis, for all such policies issued after July 17, 1913, shall be according to the American Experience or Actuaries' Table of Mortality, with not less than three and not more than four percent compound interest. When the preliminary term basis is used it shall not exceed one year. Insurance against total and permanent mental or physical disability resulting from accident or disease, or against accidental death, combined with a policy of life insurance, shall be valued on the basis of the mean reserve, being one-half of the additional annual premium charged therefor. Except as otherwise provided in subsection (3) of section 44-8907 for all annuities and pure endowments purchased on or after the operative date of such subsection under group annuity and pure endowment contracts, the legal minimum standard for the valuation of annuities shall be McClintock's Table of Mortality Among Annuitants, or the American Experience Table of Mortality, with compound interest at three and one-half percent per annum for individual annuities and five percent per annum for group annuities, but annuities deferred ten or more years, and written in connection with life or term insurance, shall be valued on the same mortality table from which the consideration or premiums were computed, with compound interest not higher than three and one-half percent per annum. The legal standard for the valuation of industrial policies shall be the American Experience Table of Mortality, with compound interest at not less than three nor more than three and one-half percent per annum, except that any life insurance company may voluntarily

value its industrial policies written on the weekly payment plan according to the Standard Industrial Mortality Table or the Substandard Industrial Mortality Table. Reserves for all such policies and contracts may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by this section.

Source: Laws 1913, c. 154, § 94, p. 437; R.S.1913, § 3231; Laws 1919, c. 190, tit. V, art. VI, § 2, p. 618; C.S.1922, § 7830; C.S.1929, § 44-502; Laws 1943, c. 106, § 1(2), p. 355; R.S.1943, § 44-403; Laws 1973, LB 309, § 1; Laws 1979, LB 354, § 1; Laws 2014, LB755, § 13.

44-404 Transferred to section 44-8907.

44-405 Life insurance; loan values.

(1) In the case of those policies issued prior to the operative date defined in section 44-407.07 (the Standard Nonforfeiture Law), the loan value referred to in provision (8) of section 44-502 shall be the reserve at the end of the current policy year on the policy and on any dividend additions thereto, less a sum not more than two and one-half percent of the amount insured by the policy and of any undivided additions thereto. The policy shall specify the mortality table and the rate of interest adopted for computing such reserve and may provide that such loan may be deferred for not exceeding six months after the application therefor is made.

(2) In the case of policies issued on or after the operative date defined in section 44-407.07 (the Standard Nonforfeiture Law), the loan value referred to in provision (8) of section 44-502 shall be the cash surrender value at the end of the current policy year as required by sections 44-407 to 44-407.09. The company shall reserve the right to defer such loan, except when made to pay premiums, for six months after application therefor is made.

(3) This section shall not apply to term insurances.

Source: Laws 1943, c. 106, § 6, p. 367; R.S.1943, § 44-405; Laws 1965, c. 262, § 2, p. 735.

44-406 Life insurance; nonforfeiture benefits.

This section shall apply only to policies of life insurance issued prior to the operative date defined in section 44-407.07 (the Standard Nonforfeiture Law). The nonforfeiture benefit referred to in provision (9) of section 44-502 shall be available to the owner of the policy, in event of default in premium payments after premiums shall have been paid for three years, and shall be a stipulated form of insurance, the net value of which shall be at least equal to the reserve, at the date of default on the policy, and on any dividend additions thereto, less a sum not more than two and one-half percent of the amount insured by the policy, and of any existing dividend additions thereto, and less any existing indebtedness to the company on the policy. The policy shall specify the mortality table and rate of interest adopted for computing such reserves and shall stipulate that it may be surrendered to the company at its home office within one month from date of default, for a specified cash value at least equal to the sum which would otherwise be available for the purchase of insurance as

aforesaid, and may provide that the company may defer payment for not more than six months after the application therefor is made.

Source: Laws 1943, c. 106, § 4, p. 362; R.S.1943, § 44-406.

44-407 Standard Nonforfeiture Law for Life Insurance; how cited.

Sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26 shall be known as the Standard Nonforfeiture Law for Life Insurance.

Source: Laws 1943, c. 106, § 5, p. 363; R.S.1943, § 44-407; Laws 1965, c. 262, § 3, p. 736; Laws 1979, LB 354, § 3; Laws 1981, LB 355, § 2.

44-407.01 Policies issued on or after operative date of law; provisions required.

In the case of policies issued on or after the operative date of this section, as defined in section 44-407.07, no policy of life insurance, except as stated in section 44-407.06, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the Department of Insurance are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section and are essentially in compliance with section 44-407.26: (a) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits. (b) That, upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified. (c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default. (d) That, if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance, or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified. (e) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate

used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy. (f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy. Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy. The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

Source: Laws 1943, c. 106, § 5(1), p. 363; R.S.1943, § 44-407.01; Laws 1961, c. 222, § 1, p. 659; Laws 1981, LB 355, § 3.

44-407.02 Policies issued on or after operative date of law; default in premium payment on policy anniversary; cash surrender value.

Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by section 44-407.01, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of (a) the then present value of the adjusted premiums as defined in sections 44-407.04, 44-407.08, 44-407.09, and 44-407.24, corresponding to premiums which would have fallen due on and after such anniversary, and (b) the amount of any indebtedness to the company on the policy. For any policy issued on or after the operative date of section 44-407.24 as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in the first paragraph of this section shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

For any family policy issued on or after the operative date of section 44-407.24 as defined therein, which defines a primary insured and provides

term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value referred to in the first paragraph of this section shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

Any cash surrender value available within thirty days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by section 44-407.01, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

Source: Laws 1943, c. 106, § 5(2), p. 364; R.S.1943, § 44-407.02; Laws 1959, c. 206, § 1, p. 719; Laws 1965, c. 262, § 4, p. 736; Laws 1981, LB 355, § 4.

44-407.03 Policies issued on or after operative date of law; default in premium payment on policy anniversary; paid-up nonforfeiture benefit.

Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26 in the absence of the condition that premiums shall have been paid for at least a specified period.

Source: Laws 1943, c. 106, § 5(3), p. 364; R.S.1943, § 44-407.03; Laws 1965, c. 262, § 5, p. 737; Laws 1981, LB 355, § 5.

44-407.04 Policies issued on or after operative date of law; adjusted premiums; basis of calculation; exception.

(a) Except as provided in subsection (c) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of the policy, of all such adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy, (ii) two percent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy, (iii) forty percent of the adjusted premium for the first policy year, and (iv) twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less; *Provided,* that in applying the percentages specified in (iii) and (iv) above, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or uniform amount equivalent thereto. The date of a

policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(b) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this section shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; *Provided*, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten were the amount provided by such policy at age ten.

(c) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (1) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (2) the adjusted premiums for such term insurance, the foregoing items (1) and (2) being calculated separately and as specified in subsections (a) and (b) of this section except that, for the purposes of (ii), (iii), and (iv) of subsection (a), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (2) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in subdivision (1) of this subsection.

(d) Except as provided in sections 44-407.08 and 44-407.09, all adjusted premiums and present values referred to in sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26, shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table; *Provided*, that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; *Provided*, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred and thirty percent of the rates of mortality according to such applicable table; *and provided further*, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Department of Insurance.

This section shall not apply to policies issued on or after the operative date of section 44-407.24 as defined therein.

Source: Laws 1943, c. 106, § 5(4), p. 365; R.S.1943, § 44-407.04; Laws 1959, c. 206, § 2, p. 719; Laws 1961, c. 222, § 2, p. 661; Laws 1965, c. 262, § 6, p. 737; Laws 1981, LB 355, § 6.

Cross References

Mortality tables, see Appendix, Nebraska Revised Statutes, Volume 2A.

44-407.05 Policies issued on or after operative date of law; default in premium payment other than on policy anniversary; cash surrender value; paid-up nonforfeiture benefit.

Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in sections 44-407.02 to 44-407.04, 44-407.08, 44-407.09, and 44-407.24, may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding the provisions of section 44-407.02, additional benefits payable (a) in the event of death or dismemberment by accident or accidental means, (b) in the event of total and permanent disability, (c) as reversionary annuity or deferred reversionary annuity benefits, (d) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26 would not apply, (e) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child, and (f) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by said sections, and no such additional benefits shall be included in any paid-up nonforfeiture benefits unless specifically included by the terms of the policy.

Source: Laws 1943, c. 106, § 5(5), p. 366; R.S.1943, § 44-407.05; Laws 1959, c. 206, § 4, p. 722; Laws 1961, c. 222, § 3, p. 663; Laws 1965, c. 262, § 7, p. 739; Laws 1981, LB 355, § 7.

44-407.06 Law; policies to which applicable.

Sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26 shall not apply to any (1) reinsurance, (2) group insurance, (3) pure endowment, (4) annuity or reversionary annuity contract, (5) term policy of uniform amount which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, (6) term policy of decreasing amount which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in sections 44-407.04, 44-407.08, 44-407.09, and 44-407.24, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance, and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy, (7) policy which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture

benefit, at the beginning of any policy year, calculated as specified in sections 44-407.02 to 44-407.04, 44-407.08, 44-407.09, and 44-407.24, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year, or (8) policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26, the age of expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

Source: Laws 1943, c. 106, § 5(6), p. 367; R.S.1943, § 44-407.06; Laws 1959, c. 206, § 5, p. 722; Laws 1965, c. 262, § 8, p. 740; Laws 1981, LB 355, § 8.

44-407.07 Law; operative date, defined.

After August 27, 1943, any company may file with the Department of Insurance a written notice of its election to comply with the provisions of sections 44-407 to 44-407.07 after a specified date before January 1, 1950. After the filing of such notice, then upon such specified date (which shall be the operative date for such company) said sections shall become operative with respect to the policies thereafter issued by such company. If a company makes no such election, the operative date of said sections for such company shall be January 1, 1950.

Source: Laws 1943, c. 106, § 5(7), p. 367; R.S.1943, § 44-407.07; Laws 1947, c. 163, § 1, p. 451.

44-407.08 Policies issued on or after operative date of law; adjusted premiums; present values; how determined; filing of election; exception.

This section shall not apply to ordinary policies issued on or after the operative date of section 44-407.24 as defined therein.

In the case of ordinary policies issued on or after the operative date of this section as defined herein, all adjusted premiums and present values referred to in sections 44-407 to 44-407.09, shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; such rate of interest shall not exceed three and one-half percent per annum except that a rate of interest not exceeding four percent per annum may be used for policies issued on or after September 2, 1973, and prior to August 24, 1979, and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after August 24, 1979; *Provided,* that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured; *provided further,* that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table; *and provided further,* that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Department of Insurance.

After September 28, 1959, any company may file with the Department of Insurance a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1966.

Source: Laws 1959, c. 206, § 3, p. 721; Laws 1965, c. 262, § 9, p. 740; Laws 1973, LB 309, § 3; Laws 1979, LB 354, § 4; Laws 1981, LB 355, § 9.

Cross References

Mortality tables, see Appendix, Nebraska Revised Statutes, Volume 2A.

44-407.09 Industrial policies issued on or after operative date of law; premiums and values; how calculated; tables used; written notice filed with department; election; exception.

This section shall not apply to industrial policies issued on or after the operative date of section 44-407.24 as defined therein.

In the case of industrial policies issued on or after the operative date of this section, all adjusted premiums and present values referred to in sections 44-407 to 44-407.09 and 44-407.24 to 44-407.26, shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits; such rate of interest shall not exceed three and one-half percent per annum except that a rate of interest not exceeding four percent per annum may be used for policies issued on or after September 2, 1973, and prior to August 24, 1979, and a rate of interest not exceeding five and one-half percent per annum may be used for policies issued on or after August 24, 1979; *Provided,* that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table; *and provided further,* that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the Department of Insurance. After September 18, 1965, any company may file with the Department of Insurance a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1968.

Source: Laws 1965, c. 262, § 10, p. 741; Laws 1973, LB 309, § 4; Laws 1979, LB 354, § 5; Laws 1981, LB 355, § 10.

Cross References

For determination of operative date, see section 44-407.23.

44-407.10 Standard Nonforfeiture Law for Individual Deferred Annuities; how cited; applicability.

(1) Sections 44-407.10 to 44-407.23 shall be known as the Standard Nonforfeiture Law for Individual Deferred Annuities.

(2) Such sections shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership, limited liability company, or sole proprietorship, by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

Source: Laws 1979, LB 354, § 6; Laws 1993, LB 121, § 225; Laws 1995, LB 574, § 44.

44-407.11 Contracts issued on or after operative date of law; provisions required.

In the case of contracts issued on or after the operative date of this act, no contract of annuity, except as stated in subsection (2) of section 44-407.10, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the Department of Insurance are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(1) That, upon cessation of payment of considerations under a contract or upon the written request of the contract owner, the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in sections 44-407.16 to 44-407.19 and 44-407.21;

(2) If a contract provides for a lump-sum settlement at maturity, or at any other time, that, upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in sections 44-407.16, 44-407.17, 44-407.19, and 44-407.21. The company shall reserve the right to defer the payment of such cash surrender benefit for a period not to exceed six months after demand therefor with surrender of the contract after making written request and receiving written approval of the director. The request shall address the necessity and equitability to all policyholders of the deferral;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits; and

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract,

any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

Source: Laws 1979, LB 354, § 7; Laws 2004, LB 1047, § 3.

Cross References

For determination of operative date, see section 44-407.23.

44-407.12 Deferred annuity contract; company; terminate; cash payment.

Notwithstanding the requirements of section 44-407.11, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to such period would be less than twenty dollars monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

Source: Laws 1979, LB 354, § 8.

44-407.13 Minimum values; basis.

The minimum values as specified in sections 44-407.16 to 44-407.19 and 44-407.21 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in section 44-407.14.

Source: Laws 1979, LB 354, § 9; Laws 2004, LB 1047, § 4.

44-407.14 Minimum nonforfeiture amount; how computed.

(1)(a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to such time at rates of interest as set forth in subsection (2) of this section of the net considerations paid prior to such time, decreased by the sum of subdivisions (1)(a)(i) through (iv) of this section:

(i) Any prior withdrawals from or partial surrenders of the contract, accumulated at rates of interest as set forth in subsection (2) of this section;

(ii) An annual contract charge of fifty dollars, accumulated at rates of interest as set forth in subsection (2) of this section;

(iii) Any premium tax paid by the company for the contract, accumulated at rates of interest as set forth in subsection (2) of this section; and

(iv) The amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract.

(b) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent of the gross consideration credited to the contract during that contract year.

(2) The interest rate used in determining the minimum nonforfeiture amount shall be an annual rate of interest determined as the lesser of three percent per

annum and the following, which shall be specified in the contract if the interest rate will be reset:

(a) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent, specified in the contract no longer than fifteen months prior to the contract issue date or redetermination date under subdivision (2)(d) of this section;

(b) Reduced by one hundred twenty-five basis points;

(c) The resulting interest rate shall not be less than fifteen basis points; and

(d) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(3) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subdivision (2)(b) of this section by up to an additional one hundred basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The director may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the director, the director may disallow or limit the additional reduction.

(4) The director may adopt rules to implement the provisions of subsection (3) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the director determines adjustments are justified.

Source: Laws 1979, LB 354, § 10; Laws 2003, LB 216, § 4; Laws 2004, LB 1047, § 5; Laws 2021, LB373, § 1.
Effective date August 28, 2021.

44-407.15 Repealed. Laws 2004, LB 1047, § 25.

44-407.16 Paid-up annuity benefit; present value; how computed.

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

Source: Laws 1979, LB 354, § 12; Laws 2004, LB 1047, § 6.

44-407.17 Cash surrender benefits; present value; determination.

For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising

from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than one percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

Source: Laws 1979, LB 354, § 13.

44-407.18 Contracts without cash surrender benefits; certain death benefit contracts; present value; determination.

For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. In no event shall the present value of paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

Source: Laws 1979, LB 354, § 14.

44-407.19 Contracts; maturity date; determination.

For the purpose of determining the benefits calculated under sections 44-407.17 and 44-407.18, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

Source: Laws 1979, LB 354, § 15.

44-407.20 Benefits not equal to minimum nonforfeiture amount; statement; when.

Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

Source: Laws 1979, LB 354, § 16.

44-407.21 Benefits; available other than on contract anniversary; how calculated.

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

Source: Laws 1979, LB 354, § 17.

44-407.22 Contract which provides excess benefits; additional benefits; how treated.

For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of sections 44-407.16 to 44-407.19 and 44-407.21, additional benefits payable (1) in the event of total and permanent disability, (2) as reversionary annuity or deferred reversionary annuity benefits, or (3) as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by sections 44-407.10 to 44-407.22. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

Source: Laws 1979, LB 354, § 18.

44-407.23 Company; when subject to law.

(1) After August 24, 1979, any company may file with the Department of Insurance a written notice of its election to comply with the provisions of sections 44-403, 44-407.08 to 44-407.23, and 44-8907 after a specified date before the second anniversary of August 24, 1979. After the filing of such notice, such specified date shall be the operative date of this act for such company. Annuity contracts thereafter issued by such company shall comply with such sections. If a company makes no such election, the operative date of this act for such company shall be the second anniversary of August 24, 1979.

(2) After July 16, 2004, a company may elect to apply sections 44-407.08 to 44-407.23 to annuity contracts on a contract-form-by-contract-form basis before the second anniversary of July 16, 2004. In all other instances, sections 44-407.08 to 44-407.23 shall become operative with respect to annuity contracts issued by the company after the second anniversary of July 16, 2004.

(3) The director may adopt and promulgate rules and regulations to carry out sections 44-407.10 to 44-407.23.

Source: Laws 1979, LB 354, § 19; Laws 2004, LB 1047, § 7; Laws 2014, LB755, § 14.

44-407.24 Policies issued on or after operative date of law; adjusted premiums; present values; how calculated; filing of election.

(1) This section shall apply to all policies issued on or after the operative date of this section as defined herein. Except as provided in subsection (7) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (a) the then present value of the future guaranteed benefits provided for by the policy; (b) one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (c) one hundred twenty-five percent of the nonforfeiture net level premium as defined in this section. In applying the percentage specified in (c) above no nonforfeiture net level premium shall be deemed to exceed four percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one percent per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premium, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in subsection (7) of this section, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (a) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense

allowance, if any, over (b) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (a) one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (b) one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (a) by (b), where (a) equals the sum of (i) the nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and (ii) the present value of the increase in future guaranteed benefits provided for by the policy; and (b) equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in sections 44-407 to 44-409 shall for all policies of ordinary insurance be calculated on the basis of (a) the Commissioners 1980 Standard Ordinary Mortality Table or (b) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year.

At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available whether or not required by section 44-407.01, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any. A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculat-

ing cash surrender values. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of such tables. For policies issued prior to the operative date of the valuation manual designated in subsection (2) of section 44-8908, any Commissioners Standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Department of Insurance for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual designated in subsection (2) of section 44-8908, the valuation manual shall provide the Commissioners Standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the Department of Insurance approves by rule and regulation any commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual designated in subsection (2) of section 44-8908, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual. For policies issued prior to the operative date of the valuation manual designated in subsection (2) of section 44-8908, any commissioners standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Department of Insurance for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual designated in subsection (2) of section 44-8908, the valuation manual shall provide the commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the Department of Insurance approves by rule and regulation any commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual designated in subsection (2) of section 44-8908, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(9) For policies issued before the operative date of the valuation manual designated in subsection (2) of section 44-8908, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred and twenty-five percent of the calendar year statutory valuation

interest rate for such policy as defined in section 44-8907, rounded to the nearer one-quarter of one percent, except that the nonforfeiture interest rate shall not be less than four percent. For policies issued on and after the operative date of the valuation manual designated in subsection (2) of section 44-8908, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(10) Notwithstanding any other provision in sections 44-407 to 44-407.06, 44-407.08, 44-407.09, 44-407.24 to 44-407.26, and 44-8907 to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After the effective date of this section any company may file with the Department of Insurance a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which shall be the operative date of this section for such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1989, except that the Director of Insurance may advance the operative date of this section for such a company after investigating and finding that (a) it is in the best interests of the policyholders of such company to do so, and (b) a majority of states in which such company is doing business have adopted legislation similar to sections 44-407 to 44-407.06, 44-407.08, 44-407.09, 44-407.24 to 44-407.26, and 44-8907.

Source: Laws 1981, LB 355, § 11; Laws 2014, LB755, § 15.

Cross References

Mortality tables, see Appendix, Nebraska Revised Statutes, Volume 2A.

44-407.25 Life insurance; future premiums; benefits; approval of plan by department.

In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in sections 44-407.01 to 44-407.04, 44-407.08, 44-407.09, and 44-407.24, then:

(a) The Department of Insurance must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by sections 44-407.01 to 44-407.04, 44-407.08, 44-407.09, and 44-407.24;

(b) The Department of Insurance must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(c) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of the Standard Nonforfeiture Law for Life Insurance, as determined by regulations promulgated by the Department of Insurance;

(d) Notwithstanding any other provision in the laws of this state, any policy, contract, or certificate providing life insurance under any such plan must be

affirmatively approved by the Department of Insurance before it can be marketed, issued, delivered, or used in this state.

Source: Laws 1981, LB 355, § 12.

44-407.26 Policies issued on or after January 1, 1985; cash surrender value; nonforfeiture benefits; determination.

This section, in addition to all other applicable provisions of sections 44-407 to 44-407.06, 44-407.08, 44-407.09, 44-407.24 to 44-407.26, and 44-8907, shall apply to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (a) the greater of zero and the basic cash value specified in this section and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary; *Provided, however,* that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in section 44-407.02 or 44-407.04, whichever is applicable, shall be the same as are the effects specified in section 44-407.02 or 44-407.04, whichever is applicable, on the cash surrender values defined in that section.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in section 44-407.04 or 44-407.24, whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage (a) must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, and (b) must be such that no percentage after the later of the two policy anniversaries specified in the preceding item (a) may apply to fewer than five consecutive policy years. No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in section 44-407.04 or 44-407.24, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of this Standard Nonforfeiture Law for Life Insurance. The cash surrender values

referred to in this section shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in sections 44-407.01 to 44-407.03, 44-407.05, and 44-407.24. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in section 44-407.05 shall conform with the principles of this section.

Source: Laws 1981, LB 355, § 13; Laws 2014, LB755, § 16.

44-408 Life insurance companies; ascertainment of condition; assets and liabilities; what considered.

In ascertaining the condition of any life insurance company, it shall be allowed as assets only such investments, cash, and accounts as are authorized by the laws of this state or of the state or country in which it is organized at the date of examination. There shall be charged against it as liabilities in addition to the capital stock, all outstanding indebtedness of the company, and the premium reserve on policies and additions thereto in force, computed according to the tables of mortality and rate of interest prescribed in sections 44-402.01 to 44-407.09.

Source: Laws 1913, c. 154, § 95, p. 439; R.S.1913, § 3232; Laws 1919, c. 190, tit. V, art. VI, § 3, p. 619; C.S.1922, § 7831; C.S.1929, § 44-503; R.S.1943, § 44-408; Laws 1965, c. 262, § 11, p. 742; Laws 2014, LB755, § 17.

44-409 Domestic sickness and accident insurance companies; assets and liabilities.

In ascertaining the condition of a domestic sickness and accident insurance company, it shall be allowed as assets only such investments, cash, and accounts as are authorized by the laws of this state at the date of the examination. In ascertaining its liabilities, there shall be charged, in addition to the capital stock and all outstanding claims, a sum equal to the total unearned premium on the policies in force, after deducting credit for reinsurance authorized by sections 44-416.05 to 44-416.10, calculated on the gross sum without any deductions on any account, charged to the policyholder on each respective risk from the date of the issuance of the policy.

Source: Laws 1913, c. 154, § 96, p. 439; R.S.1913, § 3233; Laws 1919, c. 190, tit. V, art. VI, § 4, p. 619; C.S.1922, § 7832; C.S.1929, § 44-504; R.S.1943, § 44-409; Laws 1949, c. 149, § 1, p. 375; Laws 1965, c. 263, § 1, p. 747; Laws 1981, LB 330, § 2; Laws 1985, LB 299, § 8; Laws 2000, LB 930, § 3; Laws 2005, LB 119, § 7.

A mutual insurance company is required to provide reserve fund. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-410 Repealed. Laws 1989, LB 92, § 278.

44-411 Repealed. Laws 1989, LB 92, § 278.

44-412 Repealed. Laws 1989, LB 92, § 278.

44-413 Repealed. Laws 1989, LB 92, § 278.

44-413.01 Transferred to section 44-1949.

44-414 All other insurance companies; assets and liabilities.

In ascertaining the assets, liabilities and financial condition of all other insurance companies, not otherwise provided for in sections 44-401 to 44-415, the Department of Insurance shall allow as assets only such investments, cash and accounts, as are authorized by the existing laws of this state, or under the existing laws of the state or country under which such company is organized, and which investments it may approve or reject at the date of the investigation. In estimating the liabilities there shall be added, in addition to the capital stock, all outstanding claims, and a sum equal to the unearned premiums on the policies in force, calculated on the gross sum without any deductions on any account, charged to the policyholder on each respective risk from the date of the issuance of the policy. If the department finds this rule to be impracticable in ascertaining the condition of the certain kinds of insurance companies, it shall formulate such rules as it shall deem proper and efficient and consistent with law, having due regard to such rules as may be used in other states or approved by the National Association of Insurance Commissioners; *Provided,* in relation to the affairs of any foreign company, it may, in lieu of such examination and investigation, accept a certificate of the insurance commissioner or superintendent of such state or district as to its condition.

Source: Laws 1913, c. 154, § 98, p. 443; R.S.1913, § 3235; Laws 1919, c. 190, tit. V, art. VI, § 6, p. 624; C.S.1922, § 7834; C.S.1929, § 44-506; R.S.1943, § 44-414; Laws 1981, LB 330, § 3.

A mutual insurance company is required to provide reserve fund. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-415 Life insurance company; actual premium less than net premium; separate liability of company.

When the actual premium hereafter charged for an insurance by any life insurance company doing business in this state is less than the net premium for such insurance, computed according to the table of mortality and rate of interest prescribed in section 44-403, such company shall be charged as a separate liability with the value of an annuity, the amount of which shall equal the difference between such premium and the term of which, in years, shall equal the number of future annual payments due on such insurance at the date of the valuation. This section shall apply to policies and contracts issued prior to the operative date defined in section 44-407.07.

Source: Laws 1913, c. 154, § 99, p. 444; R.S.1913, § 3236; Laws 1919, c. 190, tit. V, art. VI, § 7, p. 625; C.S.1922, § 7835; C.S.1929, § 44-507; Laws 1943, c. 106, § 2, p. 358; R.S.1943, § 44-415.

44-416 Repealed. Laws 2005, LB 119, § 44.

44-416.01 Repealed. Laws 2005, LB 119, § 44.

44-416.02 Repealed. Laws 1991, LB 236, § 89.

44-416.03 Repealed. Laws 2005, LB 119, § 44.

44-416.04 Repealed. Laws 2005, LB 119, § 44.

44-416.05 Reinsurance agreements; purpose of sections.

The purpose of sections 44-416.05 to 44-416.10 is to protect the interest of insureds, claimants, ceding insurers, assuming insurers, and the public generally. The Legislature hereby declares its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislature hereby provides a mandate that upon the insolvency of a non-United-States insurer or reinsurer that provides security to fund its United States obligations in accordance with such sections, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed, in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurance companies. The Legislature declares that the matters contained in such sections are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

Source: Laws 2005, LB 119, § 30.

44-416.06 Credit for reinsurance; when allowed; suspension or revocation of accreditation or certification; director; powers; duties; notice; hearing; insurer duties.

(1) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), (6), (7), or (8) of this section and any additional requirements contained in rules and regulations adopted and promulgated by the Director of Insurance pursuant to subsection (2) of section 44-416.09 relating to or setting forth (a) the valuation of assets or reserve credits, (b) the amount and form of security supporting reinsurance arrangements, or (c) the circumstances pursuant to which credit will be reduced or eliminated. Except as otherwise provided in section 44-224.11, credit shall be allowed under subsection (2), (3), or (4) of this section only for cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under subsection (4) or (5) of this section only if the applicable requirements of subsection (9) of this section have been satisfied.

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance in this state.

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the Director of Insurance as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:

(a) File with the director evidence of its submission to this state's jurisdiction;

(b) Submit to this state's authority to examine its books and records;

(c) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(d) File annually with the director a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(e) Demonstrate to the satisfaction of the director that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars and its accreditation has not been denied by the director within ninety days after submission of its application.

(4)(a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is domiciled in, or in the case of a United States branch of an alien assuming insurer is entered through, a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this section and the assuming insurer or United States branch of an alien assuming insurer:

(i) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars; and

(ii) Submits to the authority of this state to examine its books and records.

(b) The requirement of subdivision (4)(a)(i) of this section does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5)(a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the director to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the director information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the director and bear the expense of examination.

(b)(i) Credit for reinsurance shall not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

(A) The commissioner of the state where the trust is domiciled; or

(B) The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(ii) The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the director.

(iii) The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year the trustee of the trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(c) The following requirements apply to the following categories of assuming insurer:

(i) The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars except as provided in subdivision (5)(c)(ii) of this section;

(ii) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust; and

(iii)(A) In the case of a group including incorporated and individual unincorporated underwriters:

(I) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;

(II) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of sections 44-416.05 to 44-416.10, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(III) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which one hundred million dollars shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account;

(B) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(C) Within ninety days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's domiciliary regulator of the solvency of each underwriter member, or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(6)(a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the director as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection.

(b) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(i) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the director pursuant to subdivision (6)(d) of this section;

(ii) The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the director pursuant to rules and regulations;

(iii) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the director pursuant to rules and regulations;

(iv) The assuming insurer must agree to submit to the jurisdiction of this state, appoint the director as its agent for service of process in this state, and agree to provide security for one hundred percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(v) The assuming insurer must agree to meet applicable information filing requirements as determined by the director, both with respect to an initial application for certification and on an ongoing basis; and

(vi) The assuming insurer must satisfy any other requirements for certification deemed relevant by the director.

(c) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of subdivision (6)(b) of this section:

(i) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the director to provide adequate protection;

(ii) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(iii) Within ninety days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the director an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(d)(i) The director shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the director as a certified reinsurer.

(ii) In order to determine whether the domiciliary jurisdiction of a non-United-States assuming insurer is eligible to be recognized as a qualified jurisdiction, the director shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United-States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the director with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the director has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the director.

(iii) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners committee process. The director shall consider this list in determining qualified jurisdictions. If the director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the director shall provide thoroughly documented justification in accordance with criteria to be developed under rules and regulations.

(iv) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program shall be recognized as qualified jurisdictions.

(v) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the director has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(e) The director shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the director pursuant to rules and regulations. The director shall publish a list of all certified reinsurers and their ratings.

(f)(i) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection at a level consistent with its rating, as specified in rules and regulations adopted and promulgated by the director.

(ii) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the director and consistent with the provisions of section 44-416.07 or in a multibeneficiary trust in accordance with subsection (5) of this section, except as otherwise provided in this subsection.

(iii) If a certified reinsurer maintains a trust to fully secure its obligations subject to subsection (5) of this section and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to subsection (5) of this section. It shall be a condition to the grant of certification under this subsection that the certified reinsurer shall have bound itself, by the language

of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(iv) The minimum trusteed surplus requirements provided in subsection (5) of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of ten million dollars.

(v) With respect to obligations incurred by a certified reinsurer under this subsection, if the security is insufficient, the director shall reduce the allowable credit by an amount proportionate to the deficiency and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(vi)(A) For purposes of this subsection, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent of its obligations.

(B) As used in subdivision (6)(f)(vi)(A) of this section, the term ''terminated'' refers to revocation, suspension, voluntary surrender, and inactive status.

(C) If the director continues to assign a higher rating as permitted by other provisions of this section, the requirement in subdivision (6)(f)(vi)(A) of this section does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(g) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners-accredited jurisdiction, the director has the discretion to defer to that jurisdiction's certification and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(h) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection, and the director shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(7)(a) Credit shall be allowed when reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below:

(i) Such assuming insurer shall have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. A reciprocal jurisdiction is a jurisdiction that meets one of the following:

(A) A jurisdiction, other than a jurisdiction of the United States, that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this subsection, a covered agreement is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. 313 and 314, as such sections existed on January 1, 2020, that is currently in effect or in a period of provisional application and that addresses the elimination, under specified conditions, of collateral requirements as a

condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(B) A jurisdiction of the United States that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program; or

(C) A qualified jurisdiction as determined by the director pursuant to subdivision (6)(d)(i) of this section that is not otherwise described in subdivision (7)(a)(i)(A) or (B) of this section and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09;

(ii) Such assuming insurer shall have and maintain, on an ongoing basis, the minimum capital and surplus or the equivalent, calculated according to the methodology of its domiciliary jurisdiction, as set forth in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09. If such assuming insurer is an association, including an incorporated or individual unincorporated underwriter, such assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities and calculated according to the methodology of its domiciliary jurisdiction, and a central fund containing a minimum balance as set forth in the rules and regulations adopted and promulgated by the director pursuant to section 44-416.09;

(iii) Such assuming insurer shall have and maintain, on an ongoing basis, the minimum solvency or capital ratio, as applicable, as set forth in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09. If such assuming insurer is an association, including incorporated and individual unincorporated underwriters, such assuming insurer shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where such assuming insurer has its head office or is domiciled, as applicable, and is also licensed;

(iv) Such assuming insurer shall agree and provide adequate assurance to the director, in a form specified pursuant to rules and regulations adopted and promulgated by the director pursuant to section 44-416.09, as follows:

(A) Such assuming insurer shall provide prompt written notice and explanation to the director if such assuming insurer falls below the minimum requirements set forth in subdivisions (7)(a)(ii) and (iii) of this section or if any regulatory action is taken against such assuming insurer for serious noncompliance with applicable law;

(B) Such assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the director as the agent for service of process. The director may require that consent for service of process be provided to the director and included in each reinsurance agreement. Nothing in this subdivision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(C) Such assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal

successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(D) Each reinsurance agreement shall include a provision requiring such assuming insurer to provide security in an amount equal to one hundred percent of such assuming insurer's liabilities attributable to reinsurance ceded pursuant to such agreement if such assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which such judgment was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(E) Such assuming insurer shall confirm that such assuming insurer is not presently participating in any solvent scheme of arrangement that involves this state's ceding insurers and agree to notify the ceding insurer and the director and to provide security in an amount equal to one hundred percent of such assuming insurer's liabilities to the ceding insurer if such assuming insurer enters into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of subsection (6) of this section and section 44-416.07 and as specified in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09;

(v) Such assuming insurer or its legal successor shall provide, if requested by the director, on behalf of itself and any legal predecessors, certain documentation to the director as specified in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09;

(vi) Such assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements pursuant to criteria set forth in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09; and

(vii) Such assuming insurer's supervisory authority shall confirm to the director on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that such assuming insurer complies with the requirements set forth in subdivisions (7)(a)(ii) and (iii) of this section.

(b) Nothing in this subsection precludes an assuming insurer from providing the director with information on a voluntary basis.

(c)(i) The director shall timely create and publish a list of reciprocal jurisdictions.

(ii) The director's list shall include any reciprocal jurisdiction as defined under subdivisions (7)(a)(i)(A) and (B) of this section, and the director shall consider including any other reciprocal jurisdiction included on the most current list published through the National Association of Insurance Commissioners' committee process. The director may approve a jurisdiction that does not appear on the National Association of Insurance Commissioners' list of reciprocal jurisdictions in accordance with criteria developed under rules and regulations adopted and promulgated by the director pursuant to section 44-416.09.

(iii) The director may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction in accordance with the process set forth in rules and regulations adopted and promulgated by the director pursu-

ant to section 44-416.09, except that the director shall not remove a reciprocal jurisdiction as defined under subdivision (7)(a)(i)(A) or (B) of this section from such list. Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer that has its home office or is domiciled in such jurisdiction shall be allowed if otherwise allowed pursuant to sections 44-416.05 to 44-416.10.

(d) The director shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this subsection. The director may add an assuming insurer to such list if a jurisdiction accredited by the National Association of Insurance Commissioners pursuant to accreditation standards has added such assuming insurer to such jurisdiction's list of assuming insurers or if, upon initial eligibility, such assuming insurer submits the information to the director as required under subdivision (7)(a)(iv) of this section and complies with any additional requirements that the director may impose by rules and regulations adopted and promulgated by the director pursuant to section 44-416.09 except to the extent that any such rules and regulations conflict with an applicable covered agreement.

(e)(i) If the director determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the director may revoke or suspend the eligibility of such assuming insurer for recognition as an assuming insurer under this subsection in accordance with procedures set forth in rules and regulations adopted and promulgated by the director pursuant to section 44-416.09.

(ii) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that such assuming insurer's obligations under the contract are secured in accordance with section 44-416.07.

(iii) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by such assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that such assuming insurer's obligations under the contract are secured in a form acceptable to the director and consistent with the provisions of section 44-416.07.

(f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that such assuming insurer post security for all outstanding ceded liabilities.

(g) Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in such reinsurance agreement except as expressly prohibited by sections 44-416.05 to 44-416.10 or other applicable law or rules and regulations.

(h) Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after November 14, 2020, and only with respect to losses incurred and reserves reported on or after the later of the date on which such assuming insurer has met all eligibility requirements

pursuant to subdivision (7)(a) of this section or the effective date of such reinsurance agreement, amendment, or renewal.

(i) This subdivision (7)(h) does not alter or impair a ceding insurer's right to take credit for reinsurance to the extent that credit is not available under this subdivision (7)(h) and the reinsurance qualifies for credit under any other applicable provision of sections 44-416.05 to 44-416.10.

(ii) Nothing in this subdivision (7)(h) shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of such agreement.

(iii) Nothing in this subdivision (7)(h) shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate such agreement.

(8) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (2), (3), (4), (5), (6), or (7) of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(9) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by subsections (4) and (5) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(a)(i) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) To designate the director or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(10) If the assuming insurer does not meet the requirements of subsection (2), (3), (4), or (7) of this section, the credit permitted by subsection (5) or (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subdivision (5)(c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the state insurance commissioner with regulatory oversight all of the assets of the trust fund;

(b) The assets shall be distributed by and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight in accordance

with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(c) If the state insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the state insurance commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

(11)(a) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the director may suspend or revoke the reinsurer's accreditation or certification.

(b) The director must give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the director's order on hearing unless:

(i) The reinsurer waives its right to hearing;

(ii) The director's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subdivision (6)(g) of this section; or

(iii) The director finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the director's action.

(c) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with section 44-416.07. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subdivision (6)(f) of this section or section 44-416.07.

(12)(a) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the director within thirty days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(b) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the director within thirty days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to

exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

Source: Laws 2005, LB 119, § 31; Laws 2015, LB298, § 1; Laws 2018, LB815, § 1; Laws 2020, LB774, § 1.

44-416.07 Asset or reduction from liability for reinsurance; limitations; security required.

An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of section 44-416.06 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer subject to any additional requirements contained in rules and regulations adopted and promulgated by the Director of Insurance pursuant to subsection (2) of section 44-416.09 relating to or setting forth the valuation of assets or reserve credits, the amount and form of security supporting reinsurance arrangements, or the circumstances pursuant to which credit will be reduced or eliminated. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution. This security may be in the form of:

(1) Cash;

(2) Securities approved by the Director of Insurance. The director may use the list of securities furnished by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(3)(a) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement; or

(b) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

(4) Any other form of security acceptable to the director.

Source: Laws 2005, LB 119, § 32; Laws 2015, LB298, § 2; Laws 2018, LB815, § 2.

44-416.08 Qualified United States financial institution, defined.

(1) For purposes of subdivision (3) of section 44-416.07, qualified United States financial institution means an institution that:

(a) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;

(b) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(c) Has been determined by either the Director of Insurance or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the director.

(2) For purposes of those provisions of sections 44-416.05 to 44-416.10 specifying those institutions that are eligible to act as a fiduciary of a trust, qualified United States financial institution means an institution that:

(a) Is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(b) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

Source: Laws 2005, LB 119, § 33.

44-416.09 Rules and regulations.

(1) The director may adopt and promulgate rules and regulations to carry out sections 44-416.05 to 44-416.10.

(2)(a) The director may also adopt and promulgate rules and regulations applicable only to reinsurance arrangements described in subdivision (b) of this subsection.

(b) Any rule or regulation adopted and promulgated pursuant to this subsection shall only apply to reinsurance relating to:

(i) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(ii) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(iii) Variable annuities with guaranteed death or living benefits;

(iv) Long-term care insurance policies; or

(v) Such other life and health insurance and annuity products as determined by the director.

(c) Any rule or regulation adopted and promulgated pursuant to subdivision (b)(i) or (b)(ii) of this subsection may apply to any treaty containing (i) policies issued prior to January 1, 2015, if risk pertaining to such policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015, or (ii) policies issued on or after January 1, 2015.

(d) Any rule or regulation adopted and promulgated pursuant to this subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held, to use the valuation manual prescribed by the director pursuant to section 44-8908.

(e) Any rule or regulation adopted and promulgated pursuant to this subsection shall not apply to a cession to an assuming insurer that:

(i) Meets the conditions set forth in subsection (7) of section 44-416.06;

(ii) Is a certified reinsurer in this state pursuant to subdivision (6)(a) of section 44-416.06; or

(iii) Maintains at least two hundred fifty million dollars in capital and surplus when determined in accordance with accounting practices and procedures manuals as prescribed by the director in substantial conformity with the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners and is determined by the director to be:

(A) Licensed to transact insurance or reinsurance in at least twenty-six states; or

(B) Licensed to transact insurance or reinsurance in at least ten states and either licensed to transact insurance or is an accredited reinsurer in a total of at least thirty-five states.

(f) The authority to adopt and promulgate rules and regulations pursuant to this subsection does not limit the director's general authority to adopt rules and regulations pursuant to subsection (1) of this section.

Source: Laws 2005, LB 119, § 34; Laws 2018, LB815, § 3; Laws 2020, LB774, § 2.

44-416.10 Applicability of sections.

Sections 44-416.05 to 44-416.10 apply to all cessions after September 4, 2005, under reinsurance agreements that have an inception, anniversary, or renewal date not less than six months after September 4, 2005.

Source: Laws 2005, LB 119, § 35.

44-417 Credit for reinsurance; conditions.

No credits specified in sections 44-416.05 to 44-416.10 shall be made or allowed as an admitted asset or deduction from liability to any ceding insurer for reinsurance unless the contract of reinsurance provides in substance that, in the event of the insolvency of the ceding insurer, the portion of any risk or obligation assumed by the reinsurer, when such portion is ascertained, shall be payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer. Such payments shall be made directly to the ceding insurer or to its domiciliary liquidator except (1) when the contract or other written agreement specifically provides another payee of such reinsurance in the event of the insolvency of the ceding insurer or (2) when the assuming insurer, with the consent of the direct insured, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees. The reinsurance agreement may provide that the domiciliary liquidator, receiver, or legal successor of an insolvent ceding insurer shall give written notice of the pendency of a claim against the insolvent ceding insurer on the policy or bond reinsured, within a reasonable time after such claim is filed in the insolvency proceeding, and that during the pendency of such claim, any assuming insurer may investigate such claim and interpose, at its own expense, in the proceeding in which such claim is to be adjudicated, any defense or defenses which it may deem available to the ceding insurer or its liquidator, receiver, or legal successor. The expense thus incurred by the assuming insurer may be filed as a claim against the insolvent ceding insurer as part of the expense of liquidation, to the extent of a proportionate share of the benefit which may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer.

When two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose a defense to such claim, the expense shall be apportioned subject to court approval, in accordance with the terms of the reinsurance agreement as though such expense had been incurred by the ceding insurer.

Source: Laws 1951, c. 131, § 2, p. 552; Laws 1985, LB 299, § 9; Laws 1991, LB 236, § 43; Laws 2001, LB 360, § 1; Laws 2005, LB 119, § 8.

44-418 Repealed. Laws 1985, LB 299, § 10.

44-419 Repealed. Laws 1990, LB 984, § 10.

44-420 Actuarial opinions; terms, defined.

For purposes of sections 44-420 to 44-427:

(1) Director shall mean the Director of Insurance; and

(2) Qualified actuary shall mean an individual who is a member in good standing of the American Academy of Actuaries and who meets all requirements as determined by the director by rule or regulation.

Source: Laws 1994, LB 978, § 7.

44-421 Actuarial opinions; life insurance company; annual submission.

Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state.

Source: Laws 1994, LB 978, § 8.

44-422 Actuarial opinions; life insurance company; additional requirements.

Every life insurance company, except as exempted by the director by rule or regulation, shall also annually include in the opinion required by section 44-421 an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the director, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under and expenses associated with the policies and contracts.

Source: Laws 1994, LB 978, § 9.

44-423 Actuarial opinions; transition period authorized.

The director may provide for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by section 44-421.

Source: Laws 1994, LB 978, § 10.

44-424 Actuarial opinions; requirements.

Every opinion required by section 44-421 shall be governed by the following provisions:

(1) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994;

(2) The opinion shall apply to all business in force including individual and group sickness and accident insurance plans, in form and substance acceptable to the director;

(3) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the director may prescribe;

(4) In the case of an opinion required to be submitted by a foreign or alien company, the director may accept the opinion filed by that company with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a domestic company; and

(5) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the director, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

Source: Laws 1994, LB 978, § 11.

44-425 Actuarial opinions; supporting memorandum; confidentiality.

Every opinion required by section 44-421 shall be governed by the following provisions in addition to the provisions of section 44-424:

(1) A memorandum, in form and substance acceptable to the director, shall be prepared to support each actuarial opinion and made available to the director upon request;

(2) If the insurance company fails to provide a supporting memorandum at the request of the director within a period specified by rule or regulation or the director determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed or is otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the director;

(3) Except as provided in subdivisions (4) and (5) of this section, any memorandum in support of the opinion, and any other material provided by the company to the director in connection with the opinion, shall be kept confidential by the director and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by rules and regulations adopted and promulgated hereunder, except that the memorandum or other material may otherwise be released by the director (a) with the written consent of the company or (b) to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the director for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is

released by the company to the news media or other governmental agency other than a state insurance department or is cited by the company in its marketing, all portions of the memorandum become public information and are no longer confidential;

(4) The director may provide the memorandum in support of the opinion, and any other material provided by the company to the director in connection with the opinion, to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the information, documents, and copies; and

(5) The director may receive memorandums in support of an opinion, and any other material provided by the company to the director in connection with an opinion, from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain information received pursuant to this subdivision as confidential or privileged if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

Source: Laws 1994, LB 978, § 12; Laws 2001, LB 52, § 45.

44-426 Actuarial opinions; valuation of sickness and accident policies.

The director may adopt and promulgate rules and regulations containing the minimum standards applicable to the valuation of sickness and accident policies.

Source: Laws 1994, LB 978, § 13.

44-427 Actuarial opinions; rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the provisions of sections 44-420 to 44-427.

Source: Laws 1994, LB 978, § 14.

ARTICLE 5
STANDARD PROVISIONS AND FORMS

Cross References

Workers' compensation insurance policies, see section 48-146.

Section
44-501. Fire insurance policies; form; contents.
44-501.01. Fire insurance policies; statement as to coverage of loss by nuclear reaction, nuclear radiation, or radioactive contamination.

Section

44-501 Fire insurance policies; form; contents.

No policy or contract of fire and lightning insurance, including a renewal thereof, shall be made, issued, used, or delivered by any insurer or by any insurance producer or representative of an insurer on property within this state other than such as shall conform as nearly as practicable to blanks, size of type, context, provisions, agreements, and conditions with the 1943 Standard Fire Insurance Policy of the State of New York, a copy of which shall be filed in the office of the Director of Insurance as standard policy for this state, and no other or different provision, agreement, condition, or clause shall in any manner be made a part of such contract or policy or be endorsed thereon or delivered therewith except as provided in subdivisions (1) through (11) of this section.

(1) The name of the company, its location and place of business, the date of its incorporation or organization, the state or country under which such company is organized, the amount of paid-up capital stock, whether it is a stock, mutual, reciprocal, or assessment company, the names of its officers, the number and date of the policy, and appropriate company emblems may be printed on policies issued on property in this state. Any insurer organized under special charter provisions may so indicate upon its policy and may add a statement of the plan under which it operates in this state.

In lieu of the facsimile signatures of the president and secretary of the insurer on such policy, there may appear the signature or signatures of such persons as are duly authorized by the insurer to execute the contract. No such policy shall be void if the facsimile signature or signatures of any officer of the company shall not correspond with the actual persons who are such officers at the inception of the contract if such policy is countersigned by a duly authorized agent of the insurer.

(2) Printed or written forms of description and specifications or schedules of the property covered by any particular policy and any other matter necessary to express clearly all the facts and conditions of insurance on any particular risk, which facts or conditions shall in no case be inconsistent with or a waiver of any of the provisions or conditions of the standard policy herein provided for, may be written upon or attached or appended to any policy issued on property in this state. Appropriate forms of supplemental contracts, contracts, or endorsements, whereby the interest in the property described in such policy shall be insured against one or more of the perils which insurer is empowered to assume, may be used in connection with the standard policy. Such forms of contracts, supplemental contracts, or endorsements attached or printed thereon may contain provisions and stipulations inconsistent with the standard policy if applicable only to such other perils. The pages of the standard policy may be renumbered and rearranged for convenience in the preparation of individual contracts and to provide space for the listing of rates and premiums for coverages insured thereunder or under endorsements attached or printed thereon and such other data as may be included for duplication on daily reports for office records.

(3) A company, corporation, or association organized or incorporated under and in pursuance of the laws of this state or elsewhere, if entitled to do business in this state, may with the approval of the Director of Insurance, if the same is not already included in the standard form as filed in the office of the Department of Insurance, print on its policies any provision which it is required by law to insert therein if the provision is not in conflict with the laws of this state or the United States or with the provisions of the standard form provided for in this section, but such provision shall be printed apart from the other provisions, agreements, or conditions of the policy and in type not smaller than the body of the policy and a separate title, as follows: Provisions required by law to be stated in this policy, and be a part of the policy.

(4) There may be endorsed on the outside of any policy provided for in this section for the name, with the words insurance producer and place of business, of any insurance producer, either by writing, printing, stamping, or otherwise. There may also be added, with the approval of the Director of Insurance, a statement of the group of companies with which the company is financially affiliated and the usual company medallion.

(5) When two or more companies, each having previously complied with the laws of this state, unite to issue a joint policy, there may be expressed in the headline of each policy the fact of the severalty of the contract and also the proportion of premiums to be paid to each company and the proportion of liability which each company agrees to assume. In the printed conditions of such policy, the necessary change may be made from the singular to plural number when reference is made to the companies issuing such policy.

(6) This section shall not apply to motor vehicle, inland marine, or ocean marine insurance, reinsurance contracts between insurance companies, or insurance that does not cover risks of a personal nature. An insurer may file with the director, pursuant to the Property and Casualty Insurance Rate and Form Act, any form of policy which includes coverage against the peril of fire and substantial coverage against other perils without complying with the provisions of this section if such policy with respect to the peril of fire includes provisions which are the substantial equivalent of the minimum provisions of the standard policy provided for in this section and if the policy is complete as to all its terms without reference to any other document.

(7) If the policy is made by a mutual assessment or other company having special regulations lawfully applicable to its organization, membership, policies, or contracts of insurance, such regulations shall apply to and form a part of the policy as the same may be written or printed upon or attached or appended thereto.

(8) Assessment associations may issue policies with such modifications as shall be filed with the director pursuant to the Property and Casualty Insurance Rate and Form Act.

(9) Any other coverage which a company is authorized to write under the laws of this state may be written in combination with a fire insurance policy.

(10) The policy shall provide that claims involving total loss situations shall be paid in accordance with section 44-501.02.

(11) Notwithstanding any other provision of this section, an insurer may file, pursuant to the Property and Casualty Insurance Rate and Form Act, any form of policy with variations in terms and conditions from the standard policy provided for in this section.

Source: Laws 1913, c. 154, § 100, p. 444; R.S.1913, § 3237; Laws 1919, c. 190, tit. V, art. VII, § 1, p. 625; C.S.1922, § 7836; C.S.1929, § 44-601; R.S.1943, § 44-501; Laws 1951, c. 139, § 1, p. 572; Laws 1959, c. 207, § 1, p. 724; Laws 1973, LB 51, § 1; Laws 1989, LB 92, § 119; Laws 2003, LB 216, § 5; Laws 2007, LB117, § 4.

Cross References

Property and Casualty Insurance Rate and Form Act, see section 44-7501.

1. New York form
2. Valued policy
3. Burden of proof
4. Miscellaneous

1. New York form

Absent legislative intent to the contrary, the subsections of this section must be read in pari materia to authorize the Director of Insurance to approve fire insurance policy forms differing from the 1943 New York Standard Fire Insurance Policy only if the provisions are the substantial equivalent of the minimum provisions of the 1943 New York Standard Fire Insurance Policy. Volquardson v. Hartford Ins. Co., 264 Neb. 337, 647 N.W.2d 599 (2002).

Under this section, an insured's recovery on a fire insurance policy is limited by the provisions of the policy as written in

conformity with the 1943 Standard Fire Insurance Policy of New York and former section 44-380, now section 44-501.02, is not applicable. Insurance Co. of North America v. County of Hall, 188 Neb. 609, 198 N.W.2d 490 (1972).

New York form of fire insurance policy is in force in this state. Rhodes v. Continental Ins. Co., 180 Neb. 10, 141 N.W.2d 415 (1966).

Fire insurance is required to be written on forms prescribed by the Department of Insurance as nearly as practicable in the form known as the New York standard form. Leisy v. Farmers Mut. Home Ins. Co., 128 Neb. 278, 258 N.W. 481 (1935).

New York form should be adopted as the basis of the insurance contract but, in construing as nearly as practicable, all provisions of New York form should be omitted which are in conflict with provisions of the code. State ex rel. Martin v. Howard, 96 Neb. 278, 147 N.W. 689 (1914).

2. Valued policy

Recovery limited to actual value of property rather than amount of insurance where policy was issued and loss occurred before section 44-501 was amended in 1973 to reinstate ''valued policy'' provisions in former section 44-380, now section 44-501.02. Zweygardt v. Farmers Mut. Ins. Co., 195 Neb. 811, 241 N.W.2d 323 (1976).

Provision in fire insurance policy limiting recovery to the cost of repair or replacement is applicable to losses not covered by Valued Policy Law, and is a limitation on what otherwise might be recovered under the policy. Voges v. Mechanics Ins. Co., 119 Neb. 553, 230 N.W. 105 (1930).

Provision that it should be optional with insurer to replace destroyed property is invalid in case of total loss, as in conflict with Valued Policy Law. Fadanelli v. National Security Fire Ins. Co., 113 Neb. 830, 205 N.W. 642 (1925).

3. Burden of proof

Once a policy holder presents evidence through the introduction of the 1943 Standard Fire Insurance Policy of the State of New York that an exclusion clause fails to comply with this section, the insurer has the burden to show that the exclusion was approved by the Director of Insurance for the State of Nebraska. Spulak v. Tower Ins. Co., 251 Neb. 784, 559 N.W.2d 197 (1997).

4. Miscellaneous

Although this section precludes evidence of the actual value of the insured premises for the purpose of voiding a fire insurance policy on the basis it was procured fraudulently or for the purpose of showing that a proof of loss statement was executed with fraudulent intent, evidence of actual value may nonetheless be admitted as bearing on the insured's motive to commit arson. Heady v. Farmers Mut. Ins. Co., 217 Neb. 172, 349 N.W.2d 366 (1984).

This statute requires an ''open policy'', providing recovery for the actual value of the loss, with the amount stated in the policy being a limitation on recovery. Clemon v. Occidental Fire & Cas. Co., 200 Neb. 469, 264 N.W.2d 192 (1978).

This section by its terms is confined to fire and lightning insurance; also policy expressly waived one year statute of limitations so as to comply with Nebraska five year statute of limitations. Wulf v. Farm Bureau Ins. Co., 190 Neb. 34, 205 N.W.2d 640 (1973).

Issue of unconstitutionality of this section was not properly raised in trial court. Rhodes v. Continental Ins. Co., 180 Neb. 794, 146 N.W.2d 66 (1966).

The description of the property insured is a matter of contract between the parties, and whether the property injured was covered by the policy is a matter of construction of the words used to describe the property insured. Norfolk Packing Co. v. American Ins. Co. of Newark, 120 Neb. 19, 231 N.W. 148 (1930).

Oral agreement to insure is enforceable, but same must be definite as to all of material terms of contract. Glatfelter v. Security Ins. Co., 102 Neb. 464, 167 N.W. 572 (1918).

This section did not require use of loss payable clause under which insured's misconduct would not preclude recovery by mortgagee. State Securities Co. v. Federated Mut. Imp. & Hard. Ins. Co., 204 F.Supp. 207 (D. Neb. 1960).

44-501.01 Fire insurance policies; statement as to coverage of loss by nuclear reaction, nuclear radiation, or radioactive contamination.

Insurers issuing the standard policy pursuant to section 44-501 are hereby authorized to affix thereto or include therein, subject to the approval of the Director of Insurance, a written statement that the policy does not cover loss or damage caused by nuclear reaction, nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy; *Provided,* that nothing herein contained shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

Source: Laws 1959, c. 208, § 1, p. 727.

44-501.02 Fire insurance; valued policies.

Whenever any policy of insurance is written to insure any real property in this state against loss by fire, tornado, windstorm, lightning, or explosion and the property insured is wholly destroyed without criminal fault on the part of the insured or his or her assignee, the amount of the insurance written in such policy shall be taken conclusively to be the true value of the property insured and the true amount of loss and measure of damages.

Source: Laws 1913, c. 154, § 74, p. 424; R.S.1913, § 3210; Laws 1919, c. 190, tit. V, art. IV, § 44, p. 604; C.S.1922, § 7809; C.S.1929, § 44-344; R.S.1943, § 44-380; Laws 1977, LB 260, § 1; R.S.1943, (1988), § 44-380; Laws 1989, LB 92, § 120.

1. Constitutionality
2. Character of property
3. Valuation
4. Stipulations in policy
5. Miscellaneous

1. Constitutionality

Valued policy law does not deprive company of property without due process of law. Dinneen v. American Ins. Co., 98 Neb. 97, 152 N.W. 307 (1915).

Valued policy law is constitutional and applies to mutual as well as stock companies. State ex rel. Martin v. Howard, 96 Neb. 278, 147 N.W. 689 (1914); Farmers Mut. Ins. Co. v. Cole, 4 Neb. Unof. 130, 93 N.W. 730 (1903).

2. Character of property

A hail insurance policy is an open one, and recovery thereon rests upon the actual value of the crops damaged. Linch v. Hartford Fire Ins. Co., 138 Neb. 110, 292 N.W. 27 (1940).

Grain elevator is real estate and within protection of statute though erected under lease, for definite term, containing stipulation for removal by tenant at termination thereof. Calnon v. Fidelity-Phenix Fire Ins. Co., 114 Neb. 194, 206 N.W. 765 (1925).

3. Valuation

If the property insured was totally destroyed, the plaintiff is entitled to the total amount of the insurance upon the property regardless of its value at the time of the fire. Malm v. State Farmers Ins. Co., 125 Neb. 594, 251 N.W. 260 (1933).

Insurer accepting insured's valuation of dwelling, without investigation, cannot thereafter plead that there was a fraudulent overvaluation. United States Fire Ins. Co. v. Sullivan, 25 F.2d 40 (8th Cir. 1928).

4. Stipulations in policy

This section has no application to a stipulation in policy that insured may apply up to ten percent of amount of policy to cover private structures appertaining to and located on premises described. Morris v. American & Foreign Ins. Co., 150 Neb. 765, 35 N.W.2d 832 (1949).

An insurer may lawfully contract in the policy that it is a condition of the policy that the total insurance shall not exceed a sum named, and where there is other valid prior insurance on the property in a greater amount than the total permitted by the policy, the latter policy does not take effect as a policy of insurance. Quisenberry v. National Fire Ins. Co., 132 Neb. 793, 273 N.W. 197 (1937).

Valued Policy Law fixes worth of property insured conclusively at valuation written in policy, and, in case of total loss, that sum is measure of recovery. Leisy v. Farmers Mut. Home Ins. Co., 128 Neb. 278, 258 N.W. 481 (1935).

As a result of two fires, measure of recovery for final loss is amount written in contract less amounts paid in settlement of previous losses. Fadanelli v. National Sec. Fire Ins. Co., 113 Neb. 830, 205 N.W. 642 (1925); Lancashire Ins. Co. v. Bush, 60 Neb. 116, 82 N.W. 313 (1900).

Where there is a total loss, measure of recovery is valuation written in contract. Fadanelli v. Nat. Sec. Fire Ins. Co., 113 Neb. 830, 205 N.W. 642 (1925); Lancashire Ins. Co. v. Bush, 60 Neb. 116, 82 N.W. 313 (1900); Aetna Ins. Co. v. Simmons, 49 Neb. 811, 69 N.W. 125 (1896).

In case of partial loss, actual damage is measure of recovery. Lancashire Ins. Co. v. Bush, 60 Neb. 116, 82 N.W. 313 (1900).

Section cannot be rendered inoperative. Home Fire Ins. Co. v. Weed, 55 Neb. 146, 75 N.W. 539 (1898); German Ins. Co. v. Eddy, 36 Neb. 461, 54 N.W. 856 (1893).

To be total loss, a building need be destroyed only as a building. Insurance Co. of N. A. v. Bachler, 44 Neb. 549, 62 N.W. 911 (1895).

5. Miscellaneous

The statute applies only to total losses in real property. Clemon v. Occidental Fire & Cas. Co., 200 Neb. 469, 264 N.W.2d 192 (1978).

Recovery limited to actual value of property rather than amount of insurance where policy was issued and loss occurred before section 44-501 was amended in 1973 to reinstate ''valued policy'' provisions in section 44-380. Zweygardt v. Farmers Mut. Ins. Co., 195 Neb. 811, 241 N.W.2d 323 (1976).

Under section 44-501, R.R.S.1943, an insured's recovery on a fire insurance policy is limited by the provisions of the policy as written in conformity with the 1943 Standard Fire Insurance Policy of New York and this section is not applicable. Insurance Co. of North America v. County of Hall, 188 Neb. 609, 198 N.W.2d 490 (1972).

Recovery of attorney's fee is restricted to loss by fire, tornado, or lightning. Morton v. Travelers Indemnity Co., 171 Neb. 433, 106 N.W.2d 710 (1960).

Recovery under Valued Policy Law cannot be had for destruction by fire of buildings situated on land not owned by insured. Sorter v. Citizens Fund Mutual Fire Ins. Co., 151 Neb. 686, 39 N.W.2d 276 (1949).

In action on fire insurance policy where, if insured was entitled to recover at all, it was for the full amount of the policy, the trial court properly refused to instruct the jury that the value of insured's house was its value on the open market and not the cost of replacement. Getty v. North River Ins. Co., 136 Neb. 369, 286 N.W. 271 (1939).

Where the insured recovered the face amount of insurance under the Valued Policy Law on a policy insuring against loss by tornado, the insured has no right to recover on a policy on the same building for the same amount insuring against fire or lightning because the claims are inconsistent and the first action is an election. Brady v. State Ins. Co., 100 Neb. 497, 160 N.W. 882 (1916).

44-502 Life or endowment policies; provisions required.

No policy of life or endowment insurance, except policies of industrial insurance, shall be issued or delivered in this state unless it contains in substance the following provisions:

(1) A provision that all premiums shall be payable in advance either at the home office of the company or to any agent of the company upon delivery of a receipt signed by one or more of the officers who shall be named in the policy.

(2) A provision that the insured is entitled to a grace of one month within which the payment of any premium, after the first year, may be made, subject, at the option of the company, to an interest charge not in excess of six percent

per annum for the number of days of grace elapsing before the payment of the premium, during which period of grace the policy shall continue in force; but in case the policy becomes a claim during the said period of grace before the overdue premium or the deferred premiums of the current policy year, if any, are paid, the amount of such premiums, with interest on any overdue premium, may be deducted from any amount payable under the policy in settlement.

(3) A provision that the policy shall constitute the entire contract between the parties; but if the company desires to make the application a part of the contract, it may do so; *Provided,* a copy of such application shall be endorsed upon or attached to the policy when issued, and in such case, the policy shall contain a provision that the policy and the application therefor shall constitute the entire contract between the parties.

(4) A provision that all statements made by the insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall avoid the policy unless it is contained in a written application, and a copy of such application shall be endorsed upon or attached to the policy when issued.

(5) A provision that the policy shall be incontestable after it shall have been in force during the lifetime of the insured for two years from its date, except for nonpayment of premiums and except with respect to limitations of liability which may be contained in the policy relating to (a) death resulting from war or acts of war, declared or undeclared, where such limitations shall have been found by the Director of Insurance to be in keeping with the interests of the policyholders of the company and to be not unfairly discriminatory, and (b) aeronautics other than as a fare-paying passenger of a commercial airline, and flying on a regularly scheduled route between definitely established airports; and in any such cases the liability of the company may be limited by the terms of the policy to a sum not less than the reserve on the face of the policy and the reserve on any paid-up additions thereto and any dividends standing to the credit of the policy, less any indebtedness to the company on the policy; and, at the option of the company, provisions relative to benefits in the event of total and permanent disability, and provisions which grant additional insurance specifically against death by accident may be excepted from the incontestable clause; *Provided,* limitations with reference to aeronautics shall not be included in any policy where an extra premium is charged to cover the aeronautic risk, nor shall any such limitations extending beyond the contestable period be included in or attached to any policy where the applicant for insurance has not elected in writing to accept a policy with such limitations, and by such election has agreed to a reduced coverage for the aviation risk.

(6) A provision that if the age of the insured has been misstated, the amount payable under the policy shall be such as the premium paid would have purchased at the correct age.

(7) A provision that the policy shall participate in the surplus of the company, and that, beginning not later than the end of the third policy year, the company shall annually ascertain and apportion the amount of divisible surplus to which all such policies, as a separate class, are entitled, which amount shall be carried as a distinct and separate liability in favor of such policies. The insured, under any annual dividend policy, shall have the right each year to have the dividend arising from such participation paid in cash, and if the policy shall provide other dividend options, it shall further provide that, if the insured shall not elect

any such other options, one of such dividend options provided shall become effective as provided in the policy; but such participation and its distribution may, by contract, be deferred to a fixed or specified time, not exceeding twenty years. Upon written request of the insured the company shall furnish him or her with a statement of the amount of the surplus provisionally ascertained or set aside on such policy and held awaiting distribution at the expiration of the deferred dividend period.

(8) A provision that after three full years' premiums have been paid, the company at any time, while the policy is in force, will advance, on proper assignment or pledge of the policy, and on the sole security thereof, at a specified rate of interest determined pursuant to section 44-502.03 a sum equal to, or, at the option of the owner of the policy, less than the amount required by section 44-405, under the conditions specified thereby, and that the company will deduct from such loan value any existing indebtedness on the policy, which has not otherwise entered into the computation of such loan value, together with any unpaid balance of the premium for the current policy year, and may collect interest in advance on the loan to the end of the current policy year. Interest if payable annually in advance shall not exceed an effective rate equivalent to the specified rate of interest determined pursuant to section 44-502.03. It shall be further stipulated in the policy that failure to repay any such advance, or to pay interest, shall not avoid the policy unless the total indebtedness thereon to the company shall equal or exceed such loan value at the time of such failure, nor until one month after notice shall have been mailed by the company to the last-known address of the insured and of the assignee, if any. No condition other than as provided herein, or in section 44-405, shall be exacted as prerequisite to any such advance.

(9) A provision for nonforfeiture benefits and cash surrender values in accordance with the requirements of sections 44-406 to 44-407.09.

(10) A table showing in figures the loan values, if any, and the options available under the policies each year upon default in premium payments, during at least the first twenty years of the policy.

(11) A provision that if, in the event of default in premium payments, the value of the policy shall be applied to the purchase of other insurance, and if such insurance shall be in force and the original policy shall not have been surrendered to the company and canceled, the policy may be reinstated within three years from such default, upon evidence of insurability satisfactory to the company and payment of arrears of premiums with interest and the payment or reinstatement of any other indebtedness to the company upon such policy.

(12) A provision that when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death, or not later than two months after receipt of such proof.

(13) In case the proceeds of a policy are payable in installments, or as an annuity, a table showing the amounts of the installments or annuity payments.

(14) A title on the face of the policy correctly describing the same. Any of the foregoing provisions or portions of this section not applicable by reason of the plan of insurance may, to the extent of inapplicability, be omitted from the policy. Any such policy may be issued or delivered in this state which in the opinion of the Department of Insurance contains provisions on any one or more

of the several foregoing requirements more favorable to the policyholder than hereinbefore required.

Source: Laws 1913, c. 154, § 101, p. 446; R.S.1913, § 3238; Laws 1919, c. 190, tit. V, art. VII, § 2, p. 626; C.S.1922, § 7837; Laws 1925, c. 121, § 1, p. 318; C.S.1929, § 44-602; Laws 1941, c. 87, § 1, p. 336; C.S.Supp.,1941, § 44-602; Laws 1943, c. 106, § 3, p. 359; R.S.1943, § 44-502; Laws 1951, c. 140, § 1, p. 575; Laws 1965, c. 262, § 12, p. 742; Laws 1969, c. 371, § 1, p. 1325; Laws 1978, LB 262, § 1; Laws 1981, LB 355, § 18.

1. Constitutionality
2. Incontestability
3. Extended insurance
4. Representations and warranties
5. Miscellaneous

1. Constitutionality

Section is constitutional. State ex rel. Martin v. Howard, 96 Neb. 278, 147 N.W. 689 (1914).

2. Incontestability

Policy may provide for contestability on the ground that death came about during military service. O'Neil v. Union Nat. Life Ins. Co., 162 Neb. 284, 75 N.W.2d 739 (1956).

Incontestable provisions are exclusive, and do not permit attachment of rider restricting insurance company's liability in event of death from operating or riding in aircraft. State ex rel. Republic National Life Ins. Co. v. Smrha, 138 Neb. 484, 293 N.W. 372 (1940).

Incontestability clause in policy was not applicable to a supplemental agreement providing for total disability under terms of the agreement and provisions of statute. Penn. Mutual Life Ins. Co. v. Lindquist, 130 Neb. 813, 266 N.W. 600 (1936).

Incontestable clause, except as to certain matters stated, operated to exclude all defenses not within exception, and limitation of one year to contest for fraud was valid. Stratton v. Service Life Ins. Co., 117 Neb. 685, 222 N.W. 332 (1928).

Where the insured had died before the contestable period of a life insurance policy had expired, the insurer could not sue for cancellation for, under the statute and terms of the policy, it could never become incontestable. Aetna Life Ins. Co. v. Kennedy, 31 F.2d 971 (8th Cir. 1929).

3. Extended insurance

The period of extended insurance from date of default in payment of premium runs from the date when the premium fell due and not from the expiration of the period of grace. Burstein v. State Mutual Life Assurance Co., 140 Neb. 624, 1 N.W.2d 115 (1941).

The amount of extended life insurance where assured dies during default in the payment of an annual premium, having made a loan upon his policy should be computed according to terms of contract. Rustin v. Aetna Life Ins. Co., 98 Neb. 426, 153 N.W. 548 (1915).

4. Representations and warranties

Untrue answers in an application for life insurance, within the knowledge of the applicant and material to the risk, will avoid the policy. George v. Guarantee Mut. Life Co., 144 Neb. 285, 13 N.W.2d 176 (1944).

Statements made by an insured in an application, in the absence of fraud, are deemed representations and not warranties. Gillan v. Equitable Life Assurance Society, 143 Neb. 647, 10 N.W.2d 693 (1943).

When untrue answers are made by the agent filling out the application without the applicant having made any statement in connection therewith, the insurer is estopped to claim such representations are false. Scott v. New England Mutual Life Ins. Co., 128 Neb. 867, 260 N.W. 377 (1935).

5. Miscellaneous

Insurer is entitled to satisfactory proof of insurability before reinstating life insurance policy. Ewoldt v. American Nat. Ins. Co., 190 Neb. 290, 207 N.W.2d 521 (1973).

Policy on which premiums were payable monthly are not subject to requirements of this section. Robbins v. National Life & Acc. Ins. Co., 182 Neb. 749, 157 N.W.2d 188 (1968).

Legislature has considered that annuities are a part of life insurance business. Bankers Life Ins. Co. v. Laughlin, 160 Neb. 480, 70 N.W.2d 474 (1955).

Where life insurance company sets up property rights and benefits out of premium which it collects, the terms and conditions of such rights and benefits must comply with this section. State ex rel. Smrha v. Cosmopolitan Old Line Life Ins. Co., 137 Neb. 742, 291 N.W. 72 (1940).

Where the insured has borrowed the entire loan value on a policy, and has not paid the interest thereon on the premium due the following year, no increase in loan value can accrue until the interest and premium due has been paid. Kelly v. Prudential Ins. Co., 130 Neb. 873, 266 N.W. 757 (1936).

Insured was entitled to grace period of one month in which to pay semiannual installment of premium on life insurance policy regardless of provisions in the policy to the contrary. Higgins v. Old Line Ins. Co., 122 Neb. 254, 240 N.W. 275 (1932).

Insured's written election was not necessary to restrict double indemnity recovery when his death resulted from flight in aircraft piloted by him. Daman v. New York Life Ins. Co., 540 F.2d 382 (8th Cir. 1976).

44-502.01 Policy loans; variable interest rates.

The purpose of sections 44-502.01 to 44-502.04 is to permit and set guidelines for life insurers to include in life insurance policies issued after August 30, 1981, a provision for periodic adjustment of policy loan interest rates.

Source: Laws 1981, LB 355, § 14.

44-502.02 Policy loans; published monthly average, defined.

For purposes of sections 44-502.01 to 44-502.04, published monthly average shall mean a monthly bond yield average which is:

(1) Published by a national financial statistical organization;

(2) Recognized by the National Association of Insurance Commissioners;

(3) In current general use in the insurance industry; and

(4) Designated by the Director of Insurance.

Source: Laws 1981, LB 355, § 15.

44-502.03 Policy loans; interest rates; maximum; adjustments; notice.

(1) Policies issued on or after August 30, 1981, shall provide for policy loan interest rates as follows:

(a) A provision permitting a maximum interest rate of not more than eight percent per annum; or

(b) A provision permitting an adjustable maximum interest rate established from time to time by the life insurers as permitted by law.

(2) The rate of interest charged on a policy loan made under subdivision (1)(b) of this section shall not exceed the higher of the following:

(a) The published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(b) The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per annum.

(3) If the maximum rate of interest is determined pursuant to subdivision (1)(b) of this section, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(4) The maximum rate for each policy must be determined at regular intervals at least once every twelve months, but not more frequently than once in any three-month period. At the intervals specified in the policy, the rate being charged (a) may be increased whenever such increase as determined under subsection (2) of this section would increase that rate by one-half of one percent or more per annum, and (b) must be reduced whenever such reduction as determined under subsection (2) of this section would decrease that rate by one-half of one percent or more per annum.

(5) The life insurer shall:

(a) Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(b) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in subdivision (5)(c) of this section;

(c) Send to policyholders with loans reasonable advance notice of any increase in the rate; and

(d) Include in the notices required by this subsection the substance of the pertinent provisions of subsections (1) and (3) of this section.

(6) The loan value of the policy shall be determined in accordance with this section, but no policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall

maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(7) The substance of the pertinent provisions of subsections (1) and (3) of this section shall be set forth in the policies to which they apply.

(8) For purposes of this section:

(a) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy;

(b) Policy loan includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due;

(c) Policyholder includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer; and

(d) Policy includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(9) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

Source: Laws 1981, LB 355, § 16.

44-502.04 Policy loans; interest rate provisions; when applicable.

The provisions of sections 44-502.01 to 44-502.04 shall not apply to any insurance contract issued before August 30, 1981, unless the policyholder agrees in writing to the applicability of such provisions. Any such agreement shall be void unless it is entered into by the policyholder voluntarily and following full disclosure of its effects pursuant to the rules and regulations of the Department of Insurance.

Source: Laws 1981, LB 355, § 17; Laws 1989, LB 92, § 121.

44-502.05 Life insurance; annuity policy; return; when.

Every individual life insurance or annuity policy, except a credit life policy, shall have printed on its face or attached to the policy a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason. If a policyholder or a purchaser pursuant to such notice returns the policy to the insurer at its home office or branch office or to the agent or agency through which it was purchased, the policy shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

Source: Laws 1989, LB 92, § 128.

44-503 Life or endowment policies; provisions prohibited.

No policy of life or endowment insurance shall be issued or delivered in this state (1) if it contains in substance a provision by which the policy shall purport to be issued, or to take effect, more than six months before the original application for the insurance was made, (2) if it contains in substance a provision which excludes or restricts liability in the event of death by suicide if such death occurs more than two years after the policy date, (3) if it contains in substance provision, except such provisions as are authorized or required by

section 44-502, by which the settlement at the maturity of any policy after the expiration of the contestable period thereof shall be of less value than the amount promised on the face of the policy plus dividend additions, if any, less any indebtedness to the company on or secured by the policy, and less any premium that may, by the terms of the policy, be deducted, or (4) if there are attached thereto or issued as a part thereof or in connection therewith any coupons or other evidence of indebtedness by whatever name called, which coupons or other evidence of indebtedness are to be used in reducing the premiums on the policies or for the purchase of additional insurance or any benefit whatever or which are to be redeemed by the company in cash under any circumstances in the nature of a rebate on the premium.

Source: Laws 1913, c. 154, § 102, p. 449; R.S.1913, § 3239; Laws 1919, c. 190, tit. V, art. VII, § 3, p. 630; C.S.1922, § 7838; C.S.1929, § 44-603; Laws 1941, c. 87, § 2, p. 340; C.S.Supp.,1941, § 44-603; Laws 1943, c. 106, § 7, p. 368; R.S.1943, § 44-503; Laws 1989, LB 92, § 122.

Agreement between insurer and beneficiary, made after the death of the insured, providing for a life annuity in lieu of a lump sum payment to the beneficiary, is valid and not in violation of this section. Greevy v. Mass. Mut. Life Ins. Co., 128 Neb. 586, 259 N.W. 656 (1935).

Effective date of policy of insurance was the point of time when the application for insurance was accepted rather than the time the policy was predated. Beister v. John Hancock Mut. Life Ins. Co., 356 F.2d 634 (8th Cir. 1966).

44-503.01 Beneficiary; trustee; named or to be named in a will.

A policy of life insurance may designate as beneficiary a trustee or trustees named or to be named by will, if the designation is made in accordance with the provisions of the policy and the requirements of the insurance company. Immediately after the proving of the will the proceeds of such insurance shall be paid to the trustee or trustees named therein to be held and disposed of under the terms of the will as they exist at the death of the testator, but if no qualified trustee makes claim to the proceeds from the insurance company within one year after the death of the insured, or if satisfactory evidence is furnished the insurance company within such one-year period showing that no trustee can qualify to receive the proceeds, payment shall be made by the insurance company to those thereafter entitled. Any payment of proceeds in accordance with the provisions of this section by an insurance company shall constitute a full discharge of such insurance company's liability for the amount so paid. The proceeds of the insurance as collected by the trustee or trustees shall not be subject to debts of the insured and inheritance tax. Enactment of this section shall not invalidate previous life insurance policy beneficiary designations naming trustees of trusts established by will.

Source: Laws 1969, c. 355, § 1, p. 1235.

44-504 Repealed. Laws 1947, c. 164, § 21.

44-505 Repealed. Laws 1947, c. 164, § 21.

44-506 Repealed. Laws 1947, c. 164, § 21.

44-507 Foreign and domestic companies; policies; contents; reciprocity.

The policies of any insurance company not organized under the laws of this state may, if filed with the director pursuant to the Property and Casualty Insurance Rate and Form Act, contain any provisions which the law of the state, territory, district, or country under which the company is organized

prescribes shall be in such policies when issued in this state, and the policies of any insurance company organized under the laws of this state may, when issued or delivered in any other state, territory, district, or country, contain any provision required by the laws of the state, territory, district, or country in which such policies are issued, the provisions of sections 44-501 to 44-510 to the contrary notwithstanding.

Source: Laws 1913, c. 154, § 106, p. 453; R.S.1913, § 3243; Laws 1919, c. 190, tit. V, art. VII, § 7, p. 634; C.S.1922, § 7842; Laws 1925, c. 124, § 4, p. 330; C.S.1929, § 44-607; R.S.1943, § 44-507; Laws 2007, LB117, § 5.

Cross References

Property and Casualty Insurance Rate and Form Act, see section 44-7501.

44-508 Liability insurance; automobiles; bankruptcy of insured; policy provisions; reciprocity.

The policies or contracts of insurance covering legal liability for injury to a person or persons caused by the ownership, operation, use, or maintenance of an automobile issued by any domestic or foreign company shall, if filed with the director pursuant to the Property and Casualty Insurance Rate and Form Act, contain a provision that the insolvency or bankruptcy of the assured shall not release the company from the payment of damages for injury sustained or loss occasioned during the life of the policy, and, in case of such insolvency or bankruptcy, an action may be maintained within the terms and limits of the policy by the injured person or his or her heirs against the insurer.

Source: Laws 1925, c. 124, § 4, p. 330; C.S.1929, § 44-607; R.S.1943, § 44-508; Laws 2007, LB117, § 6.

Cross References

Property and Casualty Insurance Rate and Form Act, see section 44-7501.

44-509 Policies; invalid provisions; construction.

A policy issued in violation of sections 44-501 to 44-508 shall be held valid, but shall be construed as provided herein, and when any provision in such a policy is in conflict with any provision hereof, the rights, duties and obligations of the company, policyholder and the beneficiary shall be governed by the provisions of such sections.

Source: Laws 1913, c. 154, § 107, p. 453; R.S.1913, § 3244; Laws 1919, c. 190, tit. V, art. VII, § 8, p. 634; C.S.1922, § 7843; C.S.1929, § 44-608; R.S.1943, § 44-509.

Insured was entitled to statutory grace period of one month in which to pay semiannual installment of life insurance policy regardless of provisions in the policy to the contrary. Higgins v. Old Line Ins. Co., 122 Neb. 254, 240 N.W. 275 (1932).

Breach of condition in policy against removal of the insured property without the consent of the insurer was no bar to recovery where such breach did not contribute to the loss. Mayfield v. North River Ins. Co., 122 Neb. 63, 239 N.W. 197 (1931).

44-510 Policies; provisions; violations; penalty.

Any company or association, or any officer, agent, or broker thereof, which or who issues or delivers in this state, or to any citizen thereof, any policy in willful violation of the provisions of sections 44-501 to 44-508 shall be punished by a fine not exceeding one hundred dollars for each offense; and the Depart-

ment of Insurance may revoke the license of any company, association, agent or broker thereof which or who violates any of the provisions of such sections.

Source: Laws 1913, c. 154, § 108, p. 453; R.S.1913, § 3245; Laws 1919, c. 190, tit. V, art. VII, § 9, p. 634; C.S.1922, § 7844; C.S.1929, § 44-609; R.S.1943, § 44-510.

44-511 Life or annuity policy; form; approval; exception; appeal.

Except as otherwise provided by the Director of Insurance, no policy of life insurance or annuity shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form has been filed with the director. No such policy, endorsement, rider, or application shall be so used until the expiration of thirty days after the form has been received unless the director shall sooner give his or her written approval thereto. Such thirty-day period may be extended by the director for an additional period not to exceed thirty days. Notice of such extension shall be mailed to the insurer involved. The director shall notify in writing the insurer which has filed any such form if such form or provision or language thereof is unjust, unfair, inequitable, misleading, or deceptive, encourages misrepresentation of the coverage, or contrary to any provision of the statutes of this state or any rule or regulation adopted and promulgated thereunder, specifying the reasons for his or her opinion, and it shall thereafter be unlawful for such insurer to use such form in this state. In such notice, the director shall state that a hearing will be granted within thirty days upon written request of the insurer. In all other cases the director shall give his or her approval. The disapproval may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1963, c. 258, § 1, p. 782; Laws 1969, c. 359, § 19, p. 1275; Laws 1988, LB 352, § 49; Laws 1989, LB 92, § 123.

Cross References

Administrative Procedure Act, see section 84-920.

44-512 Life or annuity policy; form; withdrawal of approval; procedure; appeal.

After the expiration of such thirty days from the filing of any such form or at any time after having given written approval thereof, the director may, after a hearing of which at least ten days' written notice has been given to the insurer issuing such form, withdraw approval on any of the grounds stated in section 44-511. Such disapproval shall be effected by written order of the director which shall state the grounds for disapproval and the date, not less than thirty days after such hearing, when the withdrawal of approval shall become effective. The disapproval may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1963, c. 258, § 2, p. 782; Laws 1969, c. 359, § 20, p. 1276; Laws 1988, LB 352, § 50.

Cross References

Administrative Procedure Act, see section 84-920.

44-513 Osteopathic medicine and surgery, chiropractic, optometry, psychology, dentistry, podiatry, or mental health service; policy; provisions.

Whenever any insurer provides by contract, policy, certificate, or any other means whatsoever for a service, or for the partial or total reimbursement, payment, or cost of a service, to or on behalf of any of its policyholders, group policyholders, subscribers, or group subscribers or any person or group of persons, which service may be legally performed by a person licensed in this state for the practice of osteopathic medicine and surgery, chiropractic, optometry, psychology, dentistry, podiatry, or mental health practice, the person rendering such service or such policyholder, subscriber, or other person shall be entitled to such partial or total reimbursement, payment, or cost of such service, whether the service is performed by a duly licensed medical doctor or by a duly licensed osteopathic physician, chiropractor, optometrist, psychologist, dentist, podiatrist, or mental health practitioner. This section shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113.

Source: Laws 1967, c. 258, § 1, p. 681; Laws 1969, c. 372, § 1, p. 1330; Laws 1974, LB 712, § 1; Laws 1975, LB 190, § 1; Laws 1984, LB 902, § 15; Laws 1989, LB 342, § 2; Laws 1994, LB 1222, § 50; Laws 1995, LB 473, § 1.

The plain language of this section does not require insurance policies to charge identical copayments for a covered service, regardless of the type of provider. Cookson v. Ramge, 299 Neb. 128, 907 N.W.2d 296 (2018).

44-513.01 Repealed. Laws 1994, LB 1210, § 192.

44-513.02 Reimbursement for prescription drugs and other pharmacy services; prohibited provisions.

(1) A medical benefit contract which provides reimbursement for prescription drugs, including contracts by health maintenance organizations and preferred provider organizations, shall not require a person to obtain prescription drugs from a mail-order pharmacy as a condition to obtaining reimbursement for such drugs. This subsection shall apply to contracts delivered, issued for delivery, or renewed in this state on or after July 10, 1990.

(2)(a) A medical benefit contract, including any contract by a preferred provider organization but excluding any contract by a health maintenance organization, which provides reimbursement for prescription drugs and other pharmacy services shall not impose upon any person who is a party to or beneficiary of the contract a fee or copayment not equally imposed upon any party or beneficiary utilizing a mail-order pharmacy, and no such contract shall provide differences in coverage or impose any different conditions upon any person who is a party to or beneficiary of the contract not equally imposed upon any party or beneficiary utilizing a mail-order pharmacy. This subsection shall apply to contracts delivered, issued for delivery, or renewed in this state on or after July 16, 1994.

(b) This subsection shall not apply to reimbursement for long-term maintenance drugs. Long-term maintenance drugs means medications which are dispensed pursuant to a single prescription for a period of no less than one hundred eighty days, exclusive of authorized refills, for the ongoing treatment of a chronic medical condition or disease or congenital condition or disorder.

Source: Laws 1990, LB 1136, § 122; Laws 1994, LB 718, § 1; Laws 1995, LB 531, § 1.

44-514 Automobile liability policy; terms, defined.

For purposes of sections 44-514 to 44-521, unless the context otherwise requires:

(1) Policy shall mean an automobile liability policy providing all or part of the coverage defined in subdivision (2) of this section, delivered or issued for delivery in this state, insuring a natural person as named insured or one or more related individuals resident of the same household, and under which the insured vehicles designated in the policy are of the following types only: (a) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers nor rented to others; or (b) any other four-wheel motor vehicle of the pickup, panel, or delivery type which is not used in the occupation, profession, or business of the insured, except that sections 44-514 to 44-521 shall not apply (i) to any policy issued under an automobile assigned risk plan; (ii) to any policy subject to section 44-523; (iii) to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards; or (iv) to any policy of insurance issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance, or use of a motor vehicle on the premises of such insured or on the way immediately adjoining such premises;

(2) Automobile liability coverage shall include only coverage of bodily injury and property damage liability, medical payments, uninsured motorist coverage, and underinsured motorist coverage;

(3) Renewal or to renew shall mean the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer or the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term, except that (a) any policy with a policy period or term of less than six months shall be considered as if written for a policy period or term of six months and (b) any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year, and such policy may be terminated at the expiration of any annual period upon giving twenty days' notice of cancellation prior to such anniversary date, and such cancellation shall not be subject to any other provisions of sections 44-514 to 44-521; and

(4) Nonpayment of premium shall mean failure of the named insured to discharge when due any of his or her obligations in connection with the payment of any premium on a policy or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit.

Source: Laws 1972, LB 1396, § 1; Laws 1989, LB 92, § 124; Laws 2007, LB115, § 1.

Sections 44-358 and 44-514 to 44-521 relate to different matters and are therefore not in conflict. As such, the right to rescission as limited by section 44-358 is still available to an insurer regarding policies of the type defined in this section. Glockel v. State Farm Mut. Auto. Ins. Co., 224 Neb. 598, 400 N.W.2d 250 (1987).

44-515 Automobile liability policy; notice of cancellation; requirements; exceptions.

(1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) Nonpayment of premium;

(b) Fraud or material misrepresentation affecting the policy or in the presentation of a claim thereunder, or violation of any of the terms or conditions of the policy; or

(c) The named insured or any operator, either resident in the same household or who customarily operates an automobile insured under the policy, (i) has had his or her driver's license suspended or revoked pursuant to law, (ii) has been convicted of larceny of an automobile, or theft of an automobile in violation of section 28-516, (iii) has been convicted of an offense for which such suspension or revocation is mandatory, or (iv) whose driver's license is subject to revocation or suspension pursuant to the provisions of sections 60-4,182 to 60-4,186, by reason of his or her driving record as disclosed by the files of the Director of Motor Vehicles during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding its effective date.

(2) This section shall not apply to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(3) This section shall not apply to nonrenewal.

Source: Laws 1972, LB 1396, § 2; Laws 1978, LB 748, § 29; Laws 1993, LB 370, § 43.

This section limits the grounds for cancellation of policies of the type defined in section 44-514. Glockel v. State Farm Mut. Auto. Ins. Co., 224 Neb. 598, 400 N.W.2d 250 (1987).

Unless a cancellation statute is manifestly all-inclusive, a statute specifying the instances under which a party to an insurance contract may cancel it does not make cancellation the exclusive remedy, and it is not in derogation of other remedial rights which are recognized and implemented by other provisions of law. Glockel v. State Farm Mut. Auto. Ins. Co., 224 Neb. 598, 400 N.W.2d 250 (1987).

An automobile liability policy may be cancelled for any of the reasons appearing in this section. Glockel v. State Farm Mut. Auto. Ins. Co., 219 Neb. 222, 361 N.W.2d 559 (1985).

Section 44-516 requires registered or certified mail for every cancellation notice regardless of the period the policy has been in force. Saunders v. Mittlieder, 195 Neb. 232, 237 N.W.2d 838 (1976).

44-516 Automobile liability policy; notice of cancellation; reason for cancellation.

(1) No notice of cancellation of a policy to which section 44-515 applies shall be effective unless mailed by registered mail, certified mail, or first-class mail using intelligent mail barcode or another similar tracking method used or approved by the United States Postal Service to the named insured at least thirty days prior to the effective date of cancellation, except that if cancellation is for nonpayment of premium, at least ten days' notice of cancellation accompanied by the reason therefor shall be given. The requirements of this subsection shall apply to a cancellation initiated by a premium finance company for nonpayment of premium.

(2) Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than twenty-five days prior to the effective date of cancellation, the insurer will specify the reason for such cancellation. The insurer shall, upon such written request of the named insured, mailed or delivered to the insurer not less than twenty-five days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

(3) For purposes of sections 44-514 to 44-521:

(a) An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a cancellation of a policy; and

(b) The transfer of a policyholder between insurers within the same insurance group shall be considered a cancellation only if the transfer results in policy coverage or rates substantially less favorable to the insured.

(4) Subsections (1) and (2) of this section shall not apply to nonrenewal.

Source: Laws 1972, LB 1396, § 3; Laws 1973, LB 390, § 2; Laws 1999, LB 326, § 2; Laws 2001, LB 360, § 2; Laws 2017, LB406, § 1.

Failure of an insurer to send notice of cancellation for nonpayment of premiums to other individuals with an interest in an insured vehicle does not make cancellation ineffective as to the named insured who does receive notice in conformity with subsection (1) of this section. City of Columbus v. Swanson, 270 Neb. 713, 708 N.W.2d 225 (2005).

Purpose of the statutory scheme under sections 44-514 to 44-521 was to ensure that notice is given when cancellation is the remedy utilized and to limit the circumstances under which cancellation may be had. Glockel v. State Farm Mut. Auto. Ins. Co., 224 Neb. 598, 400 N.W.2d 250 (1987).

This section does not require notice in the case of an automatic termination by expiration of the policy period. This section, by its terms, does not apply if the insurer has manifested its willingness to renew or if nonrenewal is due to nonpayment of premium. Sampson v. State Farm Mut. Ins. Co., 205 Neb. 164, 286 N.W.2d 746 (1980).

This section requires registered or certified mail for every cancellation notice regardless of the period the policy has been in force. Saunders v. Mittlieder, 195 Neb. 232, 237 N.W.2d 838 (1976).

44-517 Automobile liability policy; notice of intention not to renew; requirements.

(1) No insurer shall refuse to renew a policy unless such insurer or its agent shall mail or deliver to the named insured, at the address shown in the policy, at least twenty days' advance notice of its intention not to renew. This section shall not apply: (a) If the insurer has manifested its willingness to renew; nor (b) in case of nonpayment of premium, except that notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

(2) For purposes of sections 44-514 to 44-521:

(a) An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a refusal to renew a policy; and

(b) The transfer of a policyholder between insurers within the same insurance group shall be considered a refusal to renew a policy only if the transfer results in policy coverage or rates substantially less favorable to the insured.

(3) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation that existed before the effective date of such renewal.

Source: Laws 1972, LB 1396, § 4; Laws 2001, LB 360, § 3.

This section does not require notice in the case of an automatic termination by expiration of the policy period. This section, by its terms, does not apply if the insurer has manifested its willingness to renew or if nonrenewal is due to nonpayment of premium. Sampson v. State Farm Mut. Ins. Co., 205 Neb. 164, 286 N.W.2d 746 (1980).

44-518 Automobile liability policy; notice of intention not to renew; reason.

If an insurer shall refuse to renew a policy, as provided for in section 44-517, the insurer shall, upon written request of the named insured, mailed or delivered not less than fifteen days prior to the effective date of such notice of intention not to renew, specify in writing the reason for such refusal to renew. Such reason shall be mailed or delivered to the named insured within five days after receipt of such request.

Source: Laws 1972, LB 1396, § 5.

44-519 Automobile liability policy; notice; proof of receipt.

Evidence of mailing notice of cancellation, of intention not to renew, or of reasons for cancellation to the named insured's last mailing address known to the insurer shall be sufficient proof of receipt of notice.

Source: Laws 1972, LB 1396, § 6; Laws 1989, LB 92, § 125.

44-520 Automobile liability policy; cancellation; notice of other insurance; contents.

When automobile bodily injury and property damage liability coverage is canceled, other than for nonpayment of premium, or in the event of failure to renew automobile bodily injury and property damage liability coverage to which section 44-517 applies, the insurer shall notify the named insured of the insured's possible eligibility for automobile liability insurance through an affiliated insurer or the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

Source: Laws 1972, LB 1396, § 7; Laws 2001, LB 360, § 4.

44-521 Automobile liability policy; no liability on director or others furnishing information.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, the Director of Insurance or against any insurer, its authorized representative, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or intention not to renew, for any statement made by any of them in any written notice of cancellation or intention not to renew, or in any other communication, oral or written, specifying the reasons for cancellation or intention not to renew, or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

Source: Laws 1972, LB 1396, § 8.

44-522 Policies; cancellation requirements.

(1) No insurer may file an insurance policy with the department, as required by the Property and Casualty Insurance Rate and Form Act, which insures against loss or damage to property or against legal liability from any cause unless such policy contains appropriate provisions for cancellation thereof by either the insurer or the insured and for nonrenewal thereof by the insurer.

(2) On any policy or binder of property, marine, or liability insurance, as specified in section 44-201, the insurer shall give the insured sixty days' written notice prior to cancellation or nonrenewal of such policy or binder, except that the insurer may cancel upon ten days' written notice to the insured in the event of nonpayment of premium or if such policy or binder has a specified term of sixty days or less unless the policy or binder has previously been renewed. The requirements of this subsection shall apply to a cancellation initiated by a premium finance company for nonpayment of premium. The provisions of this subsection and subsection (4) of this section shall not apply to nonrenewal of a policy or binder which has a specified term of sixty days or less unless the

policy or binder has previously been renewed. Such notice shall state the reason for cancellation or nonrenewal.

(3) Notwithstanding subsection (2) of this section, no policy of property, marine, or liability insurance, as specified in section 44-201, which has been in effect for more than sixty days shall be canceled by the insurer except for one of the following reasons:

(a) Nonpayment of premium;

(b) The policy was obtained through a material misrepresentation;

(c) Any insured has submitted a fraudulent claim;

(d) Any insured has violated any of the terms and conditions of the policy;

(e) The risk originally accepted has substantially increased;

(f) Certification to the Director of Insurance of loss of reinsurance by the insurer which provided coverage to the insurer for all or a substantial part of the underlying risk insured; or

(g) The determination by the director that the continuation of the policy could place the insurer in violation of the insurance laws of this state.

(4) Notice of cancellation or nonrenewal shall be sent by registered mail, certified mail, first-class mail, or first-class mail using intelligent mail barcode or another similar tracking method used or approved by the United States Postal Service to the insured's last mailing address known to the insurer. If sent by first-class mail, a United States Postal Service certificate of mailing shall be sufficient proof of receipt of notice on the third calendar day after the date of the certificate.

(5) For purposes of this section:

(a) An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a cancellation of or a refusal to renew a policy; and

(b) The transfer of a policyholder between insurers within the same insurance group shall be considered a cancellation or a refusal to renew a policy only if the transfer results in policy coverage or rates substantially less favorable to the insured.

(6) The requirements of subsections (2), (3), and (4) of this section shall not apply to automobile insurance coverage, insurance coverage issued under the Nebraska Workers' Compensation Act, insurance coverage on growing crops, or insurance coverage which is for a specified season or event and which is not subject to renewal or replacement.

(7) All policy forms issued for delivery in Nebraska shall conform to this section.

Source: Laws 1913, c. 154, § 72, p. 424; R.S.1913, § 3208; Laws 1919, c. 190, tit. V, art. IV, § 42, p. 604; C.S.1922, § 7807; C.S.1929, § 44-342; R.S.1943, § 44-379; Laws 1955, c. 176, § 1, p. 505; Laws 1986, LB 1184, § 1; R.S.1943, (1988), § 44-379; Laws 1989, LB 92, § 126; Laws 1991, LB 233, § 45; Laws 1999, LB 326, § 3; Laws 2000, LB 1119, § 37; Laws 2001, LB 360, § 5; Laws 2007, LB117, § 7; Laws 2017, LB406, § 2.

Cross References

Nebraska Workers' Compensation Act, see section 48-1,110.

Property and Casualty Insurance Rate and Form Act, see section 44-7501.

Even though an insurance company is required to accept the instructions of the sole named insured to cancel the contract, the company still has the obligation to notify all known co-owners of the insured property of the cancellation. Hansen v. U.S.A.A. Casualty Ins. Co., 206 Neb. 147, 291 N.W.2d 715 (1980).

A strict compliance by the insurer with a policy provision for notice is essential to effect a cancellation by such notice, and ambiguities in the notice will be resolved in favor of the insured. Stilen v. Cavalier Ins. Corp., 194 Neb. 824, 236 N.W.2d 178 (1975).

In order to effect a cancellation of a policy by insurer, it was necessary to tender back to the insured the paid unearned premium. Sculley v. Sullivan, 171 Neb. 795, 108 N.W.2d 82 (1961).

If the insurer exercises options to terminate and cancel insurance contracts, the obligation of the insured to pay premium is reduced to the premium earned while the risk was being carried. Bleicher v. Heeter, 141 Neb. 787, 4 N.W.2d 897 (1942).

Insured's statutory right to cancel fire insurance contract becomes part thereof. Johnson v. St. Paul Fire & Marine Ins. Co., 104 Neb. 831, 178 N.W. 926 (1920).

After request for cancellation and repayment of unearned premium by insured, right to unearned premium becomes absolute and is subject to assignment and recovery thereon by assignee. State Ins. Co. v. Farmers' Mut. Ins. Co., 65 Neb. 34, 90 N.W. 997 (1902).

Request for cancellation and claim of unearned premium takes effect from time of its receipt by insurer, with tender of policy. Farmers' Mut. Ins. Co. v. Phoenix Ins. Co., 65 Neb. 14, 90 N.W. 1000 (1902), rev'd on other grounds, 65 Neb. 17, 95 N.W. 3 (1903).

Section applies only to insurance policy in force and insured has no cause of action against insurer for unearned premium where insurer rightfully ends contract for violation of its provisions. Farmers Mut. Ins. Co. v. Home Fire Ins. Co., 54 Neb. 740, 74 N.W. 1101 (1898).

44-523 Automobile liability insurance policy; cancellation; notice; exceptions.

(1)(a) Except as provided in subdivision (1)(b) of this section, a notice of cancellation, given for reasons other than for nonpayment of premium, of a policy of automobile liability insurance issued or delivered in this state shall only be effective if mailed by registered mail, certified mail, or first-class mail using intelligent mail barcode or another similar tracking method used or approved by the United States Postal Service to the named insured at the address shown in the policy at least thirty days prior to the effective date of such cancellation.

(b) A notice of cancellation, initiated by a premium finance company, of a policy of automobile liability insurance issued or delivered in this state shall only be effective if mailed by registered mail, certified mail, or first-class mail using intelligent mail barcode or another similar tracking method used or approved by the United States Postal Service to the named insured at the address shown in the policy at least ten days prior to the effective date of such cancellation.

(2) For purposes of this section:

(a) An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a cancellation of a policy; and

(b) The transfer of a policyholder between insurers within the same insurance group shall be considered a cancellation of a policy only if the transfer results in policy coverage or rates substantially less favorable to the insured.

(3) This section shall not apply (a) to any policy subject to sections 44-514 to 44-521, (b) to any policy issued under an automobile assigned risk plan or to any policy of insurance issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance, or use of a motor vehicle on the premises of the insured or on the ways adjoining such premises, and (c) to any policy or coverage which has been in effect less than sixty days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(4) Any attempted cancellation in violation of the provisions of this section shall be void.

Source: Laws 1972, LB 481, § 1; Laws 1973, LB 390, § 1; R.S.1943, (1988), § 44-379.01; Laws 1989, LB 92, § 127; Laws 1999, LB 326, § 4; Laws 2001, LB 360, § 6; Laws 2017, LB406, § 3.

This section governs cancellation of automobile liability policies which are not included in section 44-514. Glockel v. State Farm Mut. Auto. Ins. Co., 219 Neb. 222, 361 N.W.2d 559 (1985).

44-524 Health claim form; act, how cited.

Sections 44-524 to 44-530 shall be known and may be cited as the Standardized Health Claim Form Act.

Source: Laws 1994, LB 1222, § 52.

44-525 Health claim form; purposes of act.

The purposes of the Standardized Health Claim Form Act are to standardize the forms used in the billing and reimbursement of health care, reduce the number of forms utilized and increase efficiency in the reimbursement of health care through standardization, and encourage the use of electronic data interchange of health care expenses and reimbursement.

Source: Laws 1994, LB 1222, § 53.

44-526 Health claim form; terms, defined.

For purposes of the Standardized Health Claim Form Act:

(1) Ambulatory surgical facility shall mean a facility, not a part of a hospital, which provides surgical treatment to patients not requiring hospitalization and which is licensed as a health clinic as defined by section 71-416 but shall not include the offices of private physicians or dentists whether for individual or group practice;

(2) Health care shall mean any treatment, procedure, or intervention to diagnose, cure, care for, or treat the effects of disease or injury or congenital or degenerative condition;

(3) Health care practitioner shall mean an individual or group of individuals in the form of a partnership, limited liability company, or corporation licensed, certified, or otherwise authorized or permitted by law to administer health care in the course of professional practice and shall include the health care professions and occupations which are regulated in the Uniform Credentialing Act;

(4) Hospital shall mean a hospital as defined by section 71-419 except state hospitals administered by the Department of Health and Human Services;

(5) Institutional care providers shall mean all facilities licensed or otherwise authorized or permitted by law to administer health care in the ordinary course of business and shall include all health care facilities defined in the Health Care Facility Licensure Act;

(6) Issuer shall mean an insurance company, fraternal benefit society, health maintenance organization, third-party administrator, or other entity reimbursing the costs of health care expenses;

(7) Medicaid shall mean the medical assistance program pursuant to the Medical Assistance Act;

(8) Medicare shall mean Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 et seq., as amended; and

(9) Uniform claim form shall mean the claim forms and electronic transfer procedures developed pursuant to section 44-527.

Source: Laws 1994, LB 1222, § 54; Laws 1996, LB 1044, § 235; Laws 2000, LB 819, § 68; Laws 2006, LB 1248, § 58; Laws 2007, LB463, § 1134.

Cross References

Health Care Facility Licensure Act, see section 71-401.
Medical Assistance Act, see section 68-901.
Uniform Credentialing Act, see section 38-101.

44-527 Health claim form; director; duties.

The Director of Insurance shall develop uniform claim forms and uniform electronic transfer procedures for issuers, institutional care providers, and health care practitioners. The director shall consult with interested individuals and associations who have expertise in the development and maintenance of uniform claim forms and procedures. The director shall utilize forms available from state and federal sources and may modify such forms to meet the specific needs for health care in this state.

Source: Laws 1994, LB 1222, § 55.

44-528 Health claim form; acceptance and utilization required.

No issuer, institutional care provider, or health care practitioner shall contract with any person or employer, union, or other organization under which health care services or benefits are provided unless such person or organization accepts and utilizes or agrees to accept and utilize the uniform claim form for claims for health care services and benefits provided to employees or members.

Source: Laws 1994, LB 1222, § 56.

44-529 Health claim form; hospital and ambulatory surgical facility; billing invoice; duty.

Each hospital and ambulatory surgical facility shall issue and complete a billing invoice on the uniform claim form for outpatient and inpatient services provided by the hospital or ambulatory surgical facility as a condition of reimbursement by medicaid, medicare, and issuers.

Source: Laws 1994, LB 1222, § 57.

44-530 Health claim form; violation; penalty; license revocation.

Any person who knowingly violates or knowingly aids or abets in the violation of the Standardized Health Claim Form Act or who fails to perform any duty under such act shall be guilty of a Class III misdemeanor. Any issuer who violates the act shall be subject to license revocation by the Department of Insurance.

Source: Laws 1994, LB 1222, § 58.

44-531 Reduction or elimination of coverage; restrictive condition; notice required; right of parties to amend contract.

(1) If an insurer reduces or eliminates any coverage in or introduces a more restrictive condition as part of a policy in force delivered or issued for delivery in this state and subject to sections 44-514 to 44-521 or section 44-522 or 44-523 prior to renewal of the policy and other than at the request of the named insured or as required by law, the insurer shall send to the named insured a notice explaining clearly what coverage has been reduced or eliminated or what condition has been restricted. The notice may be in a printed or electronic form if the named insured requested the electronic form and there was an agreement to that effect with the insurer prior to such request. If the named insured does not receive the notice, the reduction or elimination of coverage or restrictive condition shall not become part of the policy. It shall be a rebuttable presumption that all insureds received the notice if it was sent by email or first-class mail to the named insured's last-known email address or mailing address contained in the policy.

(2) Notice of any reduction or elimination of coverage or restrictive condition as part of a policy in force delivered or issued for delivery in this state and subject to sections 44-514 to 44-521 or section 44-522 or 44-523 and other than at the request of the named insured or as required by law shall be sent to each agency that holds an agency contract with the insurer prior to the introduction into the marketplace of a policy containing the reduction or elimination of coverage or restrictive condition.

(3) Nothing in this section shall restrict the right of the parties to an insurance contract to amend the contract, during the policy term but not during the renewal process, pursuant to an endorsement attached to the policy if requested by a named insured under the policy. An endorsement attached to a policy pursuant to this subsection requires no further notice beyond such endorsement.

Source: Laws 2008, LB1045, § 1.

ARTICLE 6

GENERAL PROVISIONS COVERING FIRE INSURANCE COMPANIES

Cross References

Occupation tax, cities of the first and second classes and villages, see section 35-106.
Reports to State Fire Marshal, see section 81-521.
Tax upon fire insurance companies for maintaining office of State Fire Marshal, see section 81-523.

Section

Section
44-619. Repealed. Laws 1957, c. 186, § 1.
44-620. Repealed. Laws 1957, c. 186, § 1.
44-621. Repealed. Laws 1957, c. 186, § 1.
44-622. Repealed. Laws 1957, c. 186, § 1.
44-623. Repealed. Laws 1957, c. 186, § 1.
44-624. Repealed. Laws 1989, LB 92, § 278.
44-625. Repealed. Laws 1989, LB 92, § 278.
44-626. Repealed. Laws 1989, LB 92, § 278.
44-627. Repealed. Laws 1989, LB 92, § 278.

44-601 Over-insurance; policies for more than five years prohibited.

It shall be unlawful for any insurance company or any agent to knowingly issue any fire insurance policy upon property within this state for an amount which, with any existing insurance, exceeds the fair value of the property or of the interest of the insured therein, or for a longer time than for five years, except as provided in section 44-812.

Source: Laws 1913, c. 154, § 109, p. 454; R.S.1913, § 3246; Laws 1919, c. 190, tit. V, art. VIII, § 1, p. 634; C.S.1922, § 7845; C.S.1929, § 44-701; R.S.1943, § 44-601.

Where fire insurance policies issued by different insurers contain prohibitions against other insurance and prorating clauses, but no escape clauses, any loss is to be prorated. Kent v. Insurance Co. of North America, 189 Neb. 769, 205 N.W.2d 532 (1973).

Where fire insurance policy contained condition that total insurance on the property should not exceed a sum named, and at the time, unknown to insurer, there existed other valid insurance in an amount greater than the sum so named, the latter policy does not take effect. Quisenberry v. National Fire Ins. Co., 132 Neb. 793, 273 N.W. 197 (1937).

44-602 Over-insurance; procurement unlawful.

It shall be unlawful for any party having an insurable interest in property located in this state to knowingly procure any fire insurance policy upon his interest in such property, for an amount in excess of the fair value of his interest in the property, or for an amount which, with any existing insurance thereon, exceeds the fair value of his interest in the property.

Source: Laws 1913, c. 154, § 110, p. 454; R.S.1913, § 3247; Laws 1919, c. 190, tit. V, art. VIII, § 2, p. 635; C.S.1922, § 7846; C.S.1929, § 44-702; R.S.1943, § 44-602.

Where fire insurance policies issued by different insurers contain prohibitions against other insurance and prorating clauses, but no escape clauses, any loss is to be prorated. Kent v. Insurance Co. of North America, 189 Neb. 769, 205 N.W.2d 532 (1973).

44-603 Over-insurance; penalties.

Every insurer who makes insurance upon any building or property or interest therein against loss or damage by fire, and every agent who issues a fire insurance policy covering any building or property or interest therein, and every insured who procures a policy of fire insurance upon any building or property or interest therein owned by him, is presumed to know the insurable value of such building or property or interest therein at the time such insurance is effected. Any insurer who knowingly makes insurance on any building or property or interest therein against loss or damage by fire in excess of the insurable value thereof, shall be fined in a sum not less than fifty dollars nor more than one hundred dollars. Any agent who knowingly effects insurance on a building or property or interest therein in excess of the insurable value

thereof shall be fined in a sum not less than fifteen nor more than twenty-five dollars.

Source: Laws 1913, c. 154, § 111, p. 454; R.S.1913, § 3248; Laws 1919, c. 190, tit. V, art. VIII, § 3, p. 635; C.S.1922, § 7847; C.S.1929, § 44-703; R.S.1943, § 44-603.

44-604 Repealed. Laws 1989, LB 92, § 278.

44-605 Repealed. Laws 1951, c. 141, § 1.

44-606 Fire insurance; premium; policy must state.

Every fire insurance policy must state on its face the amount of the premium.

Source: Laws 1913, c. 154, § 113, p. 455; R.S.1913, § 3250; Laws 1919, c. 190, tit. V, art. VIII, § 5, p. 635; C.S.1922, § 7849; C.S.1929, § 44-705; R.S.1943, § 44-606.

44-607 Repealed. Laws 1957, c. 186, § 1.

44-608 Repealed. Laws 1957, c. 186, § 1.

44-609 Repealed. Laws 1957, c. 186, § 1.

44-610 Repealed. Laws 1957, c. 186, § 1.

44-611 Repealed. Laws 1957, c. 186, § 1.

44-612 Repealed. Laws 1957, c. 186, § 1.

44-613 Repealed. Laws 1957, c. 186, § 1.

44-614 Repealed. Laws 1957, c. 186, § 1.

44-615 Repealed. Laws 1957, c. 186, § 1.

44-616 Repealed. Laws 1957, c. 186, § 1.

44-617 Repealed. Laws 1957, c. 186, § 1.

44-618 Repealed. Laws 1957, c. 186, § 1.

44-619 Repealed. Laws 1957, c. 186, § 1.

44-620 Repealed. Laws 1957, c. 186, § 1.

44-621 Repealed. Laws 1957, c. 186, § 1.

44-622 Repealed. Laws 1957, c. 186, § 1.

44-623 Repealed. Laws 1957, c. 186, § 1.

44-624 Repealed. Laws 1989, LB 92, § 278.

44-625 Repealed. Laws 1989, LB 92, § 278.

44-626 Repealed. Laws 1989, LB 92, § 278.

44-627 Repealed. Laws 1989, LB 92, § 278.

ARTICLE 7

GENERAL PROVISIONS COVERING LIFE, SICKNESS, AND ACCIDENT INSURANCE

Cross References

Life insurance proceeds, when subject to inheritance tax, see section 77-2001.
Simultaneous death of insured and beneficiary, effect, see sections 30-124 and 30-126.

Section

Section

44-701 Life insurance; policies; how signed.

All life insurance policies except industrial policies delivered in this state shall be signed by the secretary or assistant secretary; in their absence, by a secretary pro tempore and by the president or vice president, or, in their absence, by two directors, of the company issuing the same.

Source: Laws 1913, c. 154, § 118, p. 460; R.S.1913, § 3255; Laws 1919, c. 190, tit. V, art. IX, § 1, p. 641; C.S.1922, § 7854; C.S.1929, § 44-801; R.S.1943, § 44-701.

44-702 Repealed. Laws 1951, c. 142, § 1.

44-703 Life insurance; claims; false statements in application; effect.

In any claim arising under a policy which has been issued in this state by any life insurance company without previous medical examination, or without the knowledge and consent of the insured, or if said insured is under ten years of age, without the consent of the parent, guardian or other person having legal custody of said minor, the statements made in the application as to age, physical condition and family history of the insured, shall be valid and binding upon the company, but the company shall not be debarred from proving as a defense to such claim that said statements were willfully false, fraudulent or misleading.

Source: Laws 1913, c. 154, § 120, p. 460; R.S.1913, § 3257; Laws 1919, c. 190, tit. V, art. IX, § 3, p. 641; C.S.1922, § 7856; C.S.1929, § 44-803; R.S.1943, § 44-703; Laws 1969, c. 373, § 1, p. 1330.

If the defendant insurance company fails to set up a condition precedent contained in the insurance policy in suit, and fails to allege its breach by the plaintiff, such defense is waived. Farmers & Bankers Life Ins. Co. v. Mathers, 135 Neb. 757, 284 N.W. 286 (1939).

44-704 Life, sickness, or accident insurance; annuities; who may apply or own; restrictions.

(1) Except as provided in subsection (2) of this section, no policy of insurance shall be issued upon the person of any individual except upon the application of the individual insured or with the written consent of the individual insured. Nothing in this section shall be deemed to prohibit the immediate transfer or assignment of a life insurance policy or annuity contract so issued.

(2) Notwithstanding the provisions of subsection (1) of this section, (a) a husband or wife may effectuate a policy of insurance upon the person of the other and (b) any person may effectuate a policy of insurance upon the person of a child.

(3) The term policy of insurance as used in this section shall include any life insurance policy, annuity contract, and contract of sickness and accident insurance but shall not include a contract of group life insurance or a contract of blanket or group sickness and accident insurance.

(4) Nothing in Chapter 44 shall prohibit an organization or entity described in section 501(c)(3) of the Internal Revenue Code or to whom a charitable contribution could be made under section 170(c) of the code or a trust all of whose beneficiaries are organizations or entities described in section 501(c)(3) of the code or to whom a charitable contribution could be made under section 170(c) of the code from procuring, effectuating, or causing to be procured or effectuated the ownership of any life insurance policy or annuity contract upon the life of an individual if such individual gives written consent to the issuance of such policy or contract when such organization, entity, or trust is the owner of such policy or contract. Nothing in Chapter 44 shall require such organization, entity, or trust to have an insurable interest as defined in section 44-103 in the life of such individual in order for a policy or contract to be procured or effectuated pursuant to this subsection. This subsection shall apply to all policies and contracts in force on or after April 16, 1992. The changes made to this subsection by Laws 2004, LB 980, shall apply to all policies and contracts in force on or after July 16, 2004.

(5) Except as provided in subsection (4) of this section, nothing in this section shall be construed to permit a person to procure, effectuate, or cause to be procured or effectuated, directly or by assignment or otherwise, any policy of insurance upon the person of a child or other individual unless the benefits under such policy are payable to the child or other individual insured, to his or her personal representative, or to a person having, at the time such policy is issued, an insurable interest in the child or other individual insured.

Source: Laws 1913, c. 154, § 121, p. 460; R.S.1913, § 3258; Laws 1919, c. 190, tit. V, art. IX, § 4, p. 641; C.S.1922, § 7857; Laws 1925, c. 118, § 1, p. 313; C.S.1929, § 44-804; Laws 1933, c. 77, § 1, p. 319; Laws 1937, c. 102, § 1, p. 358; Laws 1941, c. 85, § 1, p. 333; C.S.Supp.,1941, § 44-804; R.S.1943, § 44-704; Laws 1957, c. 187, § 1, p. 641; Laws 1992, LB 1006, § 15; Laws 1995, LB 574, § 45; Laws 2004, LB 980, § 1.

Allowing courts to compel an obligor's consent to a former spouse's ownership of a policy on the obligor's life would violate the Legislature's express policy preference in this section. Davis v. Davis, 275 Neb. 944, 750 N.W.2d 696 (2008).

Even assuming that an ex-wife had an insurable interest in the life of her ex-husband, an insurable interest did not give her the right to own a life insurance policy on his life without his consent. Davis v. Davis, 275 Neb. 944, 750 N.W.2d 696 (2008).

No limitation is made as to beneficiaries for issuance of policy upon application by insured. Guardian National Life Ins. Co. v. Eddens, 144 Neb. 339, 13 N.W.2d 418 (1944).

44-705 Life, sickness, or accident insurance; annuities; minors; competency.

A minor not less than ten years of age, as determined by nearest birthday, shall not be deemed incompetent by reason of such minority to contract for or with respect to insurance or annuities upon his life or against bodily injury or death by accident or disability from sickness, for the benefit of himself or his estate, or for the benefit of the father, mother, husband, wife, brother or sister of such minor; nor shall such minor be deemed incompetent by reason of such minority to surrender such insurance or give a valid discharge on account of any benefit accruing or for money payable under the contract; *Provided,* such

surrender or discharge shall be approved in writing by the parent of such minor or person liable for his support.

Source: Laws 1913, c. 154, § 121, p. 462; R.S.1913, § 3258; Laws 1919, c. 190, tit. V, art. IX, § 4, p. 643; C.S.1922, § 7857; Laws 1925, c. 118, § 1, p. 314; C.S.1929, § 44-804; Laws 1933, c. 77, § 1, p. 319; Laws 1937, c. 102, § 1, p. 358; Laws 1941, c. 85, § 1, p. 333; C.S.Supp.,1941, § 44-804; R.S.1943, § 44-705; Laws 1969, c. 373, § 2, p. 1331.

44-706 Life insurance; minors; policy options; applicant may exercise.

Subject to the rights of any person other than the minor whose life is insured, the applicant for a policy upon the life of a minor may during the lifetime of said minor and prior to the time such minor shall be ten years of age at nearest birthday, exercise any option contained in said policy in all respects the same as though such applicant were the person insured by or the owner of said policy, and, under like circumstances, shall be entitled to collect and receive all sums payable upon or on account of such policy.

Source: Laws 1937, c. 102, § 1, p. 359; Laws 1941, c. 85, § 1, p. 333; C.S.Supp.,1941, § 44-804; R.S.1943, § 44-706; Laws 1969, c. 373, § 3, p. 1331.

44-706.01 Life insurance; minor; payments; competency.

Any minor domiciled in this state, who shall have attained the age of eighteen years, shall be deemed competent to receive, and to give full acquittance and discharge for a single sum or for periodical payments, not exceeding three thousand dollars in any one year, payable by a life insurance company under the maturity, death or settlement agreement provisions in effect or elected by such minor under a life insurance policy or annuity contract, if such policy, contract or agreement shall provide for the payment or payments to such minor and if prior to such payment the company had not received written notice of the appointment of a duly qualified guardian of the estate of such minor; but no such minor shall be deemed competent to alienate the right to such payment or payments or to anticipate the same.

The provisions of this section shall not be construed as requiring any insurance company making such payment to determine whether any other insurance company may be effecting a similar payment to the same minor.

Source: Laws 1969, c. 373, § 4, p. 1332.

44-707 Domestic company; contingency reserve.

Any domestic life insurance company may accumulate and maintain, in addition to the net value of its policies and all accumulations held on account of existing or future dividends, policies, or groups of such policies, a contingency reserve of not more than twenty percent of said net value, or the sum of one hundred thousand dollars, whichever is the greater. For cause shown, the Department of Insurance may, at any time, and from time to time, permit any company to accumulate and maintain a larger contingency reserve, not exceed-

ing one year under any one permission, by filing in the office of the department a written request stating the reasons therefor.

Source: Laws 1913, c. 154, § 122, p. 462; R.S.1913, § 3259; Laws 1919, c. 190, tit. V, art. IX, § 5, p. 643; C.S.1922, § 7858; C.S.1929, § 44-805; R.S.1943, § 44-707; Laws 1947, c. 165, § 1, p. 472.

44-707.01 Repealed. Laws 2000, LB 930, § 12.

44-707.02 Repealed. Laws 2000, LB 930, § 12.

44-707.03 Repealed. Laws 2000, LB 930, § 12.

44-707.04 Repealed. Laws 2000, LB 930, § 12.

44-708 Life insurers; funding agreements; authorized.

(1) Insurers authorized to deliver or issue for delivery life insurance policies in this state may deliver or issue for delivery one or more funding agreements, but the delivery or issuance for delivery of funding agreements shall not be deemed the business of insurance, life insurance or an annuity or other line of business as set forth in section 44-201, a security as defined in subdivision (15) of section 8-1101, or receipt of gross premiums as set forth in section 77-908. The delivery or issuance for delivery of a funding agreement by an admitted life insurer in this state shall constitute a lawful activity of that insurer that is reasonably related to and incidental to its insurance activities as provided in this section. However, this section shall not authorize any insurer to transact, under the guise of funding agreements, any line of insurance not authorized by its certificate of authority.

(2) No amounts shall be guaranteed or credited under any funding agreement except upon reasonable assumptions as to investment income and expenses and on a basis equitable to all holders of funding agreements of a given class.

(3) Amounts paid to the insurer, and proceeds applied under optional modes of settlement, under funding agreements may be allocated by the insurer to one or more separate accounts.

(4) The Director of Insurance may adopt and promulgate rules and regulations to implement this section, including rules and regulations setting forth the terms and conditions under which an insurer may issue funding agreements.

(5) Notwithstanding any other provision of law, the director shall have sole authority to regulate the issuance and sale of funding agreements, including the persons selling funding agreements on behalf of insurers.

(6) Nothing in this section is intended to affect the order in which allowed claims shall be given preference under section 44-4842. Holders of funding agreements shall retain the priority in allowance of claims described in subdivision (2) of section 44-4842.

(7) For purposes of this section, funding agreement means an agreement that authorizes an admitted life insurer to accept funds and that provides for an accumulation of those funds for the purpose of making one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies. Funding agreement does not include any agreement in connection with the funding of one or more payments that are excludable from the

gross income of the recipient under section 104(a)(2) of the Internal Revenue Code.

Source: Laws 2004, LB 1047, § 21.

44-708.01 Life insurers; synthetic guaranteed investment contracts; authorized.

(1) Insurers authorized to deliver or issue for delivery life insurance policies in this state may deliver or issue for delivery synthetic guaranteed investment contracts if the following requirements are met:

(a) The insurer is authorized to deliver, or issue for delivery, life insurance policies in this state; and

(b) The insurer has at least one billion dollars in admitted assets or one hundred million dollars in capital and surplus, as reflected by the most recent financial statements on file with the Director of Insurance.

(2) Synthetic guaranteed investment contracts, that are not otherwise subject to filing under applicable law and regulation, shall be filed, before being marketed or issued in this state, by the insurer with the director. If the director finds that the synthetic guaranteed investment contracts contemplate practices that are unfair or unreasonable or otherwise inconsistent with the provisions of Chapter 44, the director may disapprove of the forms of synthetic guaranteed investment contracts specifying in what regard the synthetic guaranteed investment contracts are unfair or unreasonable or otherwise inconsistent with the provisions of Chapter 44.

(3) The director may adopt and promulgate rules and regulations to implement this section, including rules and regulations setting forth the terms and conditions under which an insurer may issue synthetic guaranteed investment contracts.

(4) For purposes of this section, synthetic guaranteed investment contract means a policy, contract, or agreement that establishes the insurer's obligations under the policy, contract, or agreement by reference to a portfolio of assets that is not owned or possessed by the insurer.

Source: Laws 2004, LB 1047, § 22.

44-709 Sickness and accident insurance, defined.

The term sickness and accident insurance as used in sections 44-710 to 44-767 shall mean insurance against loss or expense resulting from the sickness of the insured, from the bodily injury or death of the insured by accident, or both.

Source: Laws 1947, c. 164, § 1, p. 452; Laws 1957, c. 188, § 1, p. 642; Laws 1989, LB 92, § 129.

44-709.01 Repealed. Laws 1957, c. 188, § 22.

44-710 Sickness and accident insurance policy; form; approval; exception; premium rates and classification of risks; filing requirements.

(1) Except as otherwise provided by the Director of Insurance and subsection (2) of this section, no policy of sickness and accident insurance shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of

the form and of the premium rates and of the classification of risks pertaining thereto has been filed with the Director of Insurance. No policy, endorsement, rider, or application shall be used until the expiration of thirty days after the form has been received by the director unless the director gives his or her written approval thereto prior to the expiration of the thirty-day period. The thirty-day period may be extended by the director for an additional period not to exceed thirty days. Notice of such extension shall be sent to the insurer involved. The director shall notify in writing the insurer which has filed any such form if it contains benefits that are unreasonable in relation to the premium charged or any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state, specifying the reasons for his or her opinion, and it shall thereafter be unlawful for such insurer to use such form in this state. In such notice, the director shall state that a hearing will be granted within thirty days upon written request of the insurer. In all other cases the director shall give his or her approval. The decision of the director may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

(2) No sickness and accident insurance policy subject to the federal Patient Protection and Affordable Care Act, Public Law 111-148, shall be delivered or issued for delivery in this state, including any policy or certificate of sickness and accident insurance issued to or for associations not domiciled in this state other than a certificate issued to an employee under an employee benefit plan of an employer headquartered in another state where the policy is lawfully issued in that state, nor shall any endorsement, rider, certificate, or application which becomes a part of any such policy be used until a copy of the form and of the premium rates and of the classification of risks pertaining thereto has been filed with and approved by the Director of Insurance. No policy, endorsement, rider, or application shall be used until the expiration of thirty days after the form has been received by the director unless the director gives his or her written approval thereto prior to the expiration of the thirty-day period. The thirty-day period may be extended by the director for an additional period not to exceed thirty days. Notice of such extension shall be sent to the insurer involved. The director shall notify in writing the insurer which has filed any such form if it contains benefits that are unreasonable in relation to the premium charged or any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state, specifying the reasons for his or her opinion, and it shall thereafter be unlawful for such insurer to use such form in this state. In such notice, the director shall state that a hearing will be granted within thirty days upon written request of the insurer. In all other cases the director shall give his or her approval. The decision of the director may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1947, c. 164, § 2(1), p. 452; Laws 1951, c. 143, § 1, p. 581; Laws 1959, c. 209, § 1, p. 728; Laws 1969, c. 359, § 21, p. 1276; Laws 1989, LB 6, § 5; Laws 1989, LB 92, § 130; Laws 2013, LB336, § 1.

Cross References

Administrative Procedure Act, see section 84-920.

44-710.01 Sickness and accident insurance; standard policy provisions; requirements; enumeration.

No policy of sickness and accident insurance shall be delivered or issued for delivery to any person in this state unless (1) the entire money and other considerations therefor are expressed therein, (2) the time at which the insurance takes effect and terminates is expressed therein, (3) it purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, any children enrolled on a full-time basis in any college, university, or trade school, or any children under a specified age which shall not exceed thirty years and any other person dependent upon the policyholder; any individual policy hereinafter delivered or issued for delivery in this state which provides that coverage of a dependent child shall terminate upon the attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child during the continuance of such policy and while the child is and continues to be both (a) incapable of self-sustaining employment by reason of an intellectual disability or a physical disability and (b) chiefly dependent upon the policyholder for support and maintenance, if proof of such incapacity and dependency is furnished to the insurer by the policyholder within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age; such insurer may charge an additional premium for and with respect to any such continuation of coverage beyond the limiting age of the policy with respect to such child, which premium shall be determined by the insurer on the basis of the class of risks applicable to such child, (4) it contains a title on the face of the policy correctly describing the policy, (5) the exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections 44-710.03 and 44-710.04, are printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS; if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies, (6) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof, (7) it contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the Director of Insurance, and (8) on or after January 1, 1999, any restrictive rider contains a notice of the existence of the Comprehensive Health Insurance Pool if the policy provides health insurance as defined in section 44-4209.

Source: Laws 1957, c. 188, § 2, p. 643; Laws 1969, c. 374, § 1, p. 1333; Laws 1989, LB 92, § 131; Laws 1998, LB 1063, § 1; Laws 2009, LB551, § 1; Laws 2013, LB23, § 11.

44-710.02 Sickness and accident insurance; insurer domiciled in state; delivery in another state; approval.

If any policy of sickness and accident insurance is issued by an insurer domiciled in this state for delivery to a person residing in another state and if the official having responsibility for the administration of the insurance laws of such other state has advised the Director of Insurance that any such policy is not subject to approval or disapproval by such official, the Director of Insurance may by ruling require that such policy meet the standards set forth in sections 44-710.01 and 44-710.03 to 44-710.09.

Source: Laws 1957, c. 188, § 3, p. 644; Laws 1989, LB 92, § 132.

44-710.03 Sickness and accident insurance; standard policy form; mandatory provisions.

Except as provided in section 44-710.05, each policy of sickness and accident insurance delivered or issued for delivery to any person in this state shall contain the provisions specified in this section in the words in which the provisions appear in this section, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Director of Insurance which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Director of Insurance may approve.

(1) A provision as follows: ENTIRE CONTRACT: CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) A provision as follows: TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year period. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period nor to limit the application of subdivisions (1) through (5) of section 44-710.04 in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision, from which the clause ''as defined in the policy'' may be omitted at the insurer's option, under the caption INCONTESTABLE: After this policy has been in force for a period of two years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application. (b) No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) A provision as follows: GRACE PERIOD: A grace period of . . . . . (insert a number not less than 7 for weekly premium policies, 10 for monthly premium policies, and 31 for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. A policy which contains a cancellation provision may add, at the end of the above provision: Subject to the right of the insurer to cancel in accordance with the cancellation provision hereof. A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision: Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to his or her last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(4) A provision as follows: REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, except that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid but not to any period more than sixty days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) until at least age fifty or (b) in the case of a policy issued after age forty-four, for at least five years from its date of issue.)

(5) A provision as follows: NOTICE OF CLAIM: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at . . . . . (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision: Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he or she shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of such disability, except in the event of legal incapacity.

The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

(6) A provision as follows: CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(7) A provision as follows: PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which the policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time and if such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) A provision as follows: TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

(9) A provision as follows: PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: (a) If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed five thousand dollars), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. (b) Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests

otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) A provision as follows: PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) A provision as follows: LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) A provision as follows: CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(13) A provision as follows: CONFORMITY WITH STATE AND FEDERAL LAW: Any provision of this policy which, on its effective date, is in conflict with the law of the federal government or the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such law.

Source: Laws 1957, c. 188, § 4, p. 644; Laws 1989, LB 92, § 133; Laws 2011, LB72, § 3.

In accordance with section 44-767, a group health insurance policy may contain contractual limitations periods so long as they are not ''less favorable to the insured than would be permitted'' under this section. Brodine v. Blue Cross Blue Shield, 272 Neb. 713, 724 N.W.2d 321 (2006).

44-710.04 Sickness and accident insurance; permissive provisions; standard policy form; requirements.

Except as provided in sections 44-710.05 and 44-787, no policy of sickness and accident insurance delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the provisions appear in this section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the Director of Insurance which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Director of Insurance may approve.

(1) A provision as follows: CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed his or her occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the

limits fixed by the insurer for such more hazardous occupation. If the insured changes his or her occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change of occupation.

(2) A provision as follows: MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) Except as provided in subdivision (6) of this section, a provision as follows: OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his or her estate; or in lieu thereof: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his or her beneficiary, or his or her estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

(4) Except as provided in subdivision (6) of this section, a provision as follows: INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision-of-service basis or on an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision-of-service basis, the like amount of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage. If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase ..... EXPENSE-INCURRED BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the Director of Insurance, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by

insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and by hospital or medical service organizations and to any other coverage the inclusion of which may be approved by the Director of Insurance. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employers liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as other valid coverage.

(5) Except as provided in subdivision (6) of this section, a provision as follows: INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense-incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined. If the foregoing policy provision is included in a policy which also contains the next preceding policy provision, there shall be added to the caption of the foregoing provision the phrase ..... OTHER BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the Director of Insurance, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and to any other coverage the inclusion of which may be approved by the Director of Insurance. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employers liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as other valid coverage.

(6) In lieu of the provisions set forth in subdivisions (3) through (5) of this section but subject to section 44-3,159, the insurer may at its option include a provision entitled COORDINATION OF BENEFITS which provides for nonduplication and coordination between two or more coverages based on rules and regulations adopted and promulgated by the director.

(7) A provision as follows: RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a

weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (a) until at least age fifty or (b) in the case of a policy issued after age forty-four for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of valid loss-of-time coverage, approved as to form by the Director of Insurance, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada or to any other coverage the inclusion of which may be approved by the Director of Insurance or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employers liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(8) A provision as follows: UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(9) A provision as follows: CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured which shall be effective only if mailed by certified or registered mail to the named insured at his or her last-known address, as shown by the records of the insurer, at least thirty days prior to the effective date of cancellation, except that cancellation due to failure to pay the premium or in cases of fraud or misrepresentation shall not require that such notice be given at least thirty days prior to cancellation. Subject to any provisions in the policy or a grace period, cancellation for failure to pay a premium shall be effective as of midnight of the last day for which the premium has been paid. In cases of fraud or misrepresentation, coverage shall be canceled upon the date of the notice or any later date designated by the insurer. After the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels,

the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(10) A provision as follows: ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(11) A provision as follows: INTOXICANTS AND NARCOTICS: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

Source: Laws 1957, c. 188, § 5, p. 650; Laws 1985, LB 76, § 1; Laws 1989, LB 92, § 134; Laws 1997, LB 55, § 2; Laws 2011, LB72, § 4; Laws 2013, LB479, § 2.

44-710.05 Sickness and accident insurance; standard policy form; inapplicable; omission or modification.

If any provision of sections 44-710.03 and 44-710.04 is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy of sickness and accident insurance, the insurer, with the approval of the Director of Insurance, shall omit from such policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Source: Laws 1957, c. 188, § 6, p. 655; Laws 1989, LB 92, § 135.

44-710.06 Sickness and accident insurance; standard policy form; provisions; order of arrangement.

The provisions which are the subject of sections 44-710.03 and 44-710.04 or any corresponding provisions which are used in lieu thereof in accordance with such sections shall be printed in the consecutive order of the provisions in such sections, or at the option of the insurer, any such provision may appear as a unit in any part of the policy of sickness and accident insurance with other provisions to which it may be logically related if the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

Source: Laws 1957, c. 188, § 7, p. 656; Laws 1989, LB 92, § 136.

44-710.07 Sickness and accident insurance; term insured; construction.

The word insured, as used in sections 44-709 to 44-767, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy of sickness and accident insurance covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

Source: Laws 1957, c. 188, § 8, p. 656; Laws 1989, LB 92, § 137.

44-710.08 Sickness and accident insurance; foreign or alien insurer; provisions required by laws of domicile of insurer.

(1) Any policy of sickness and accident insurance of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may

contain any provision which is not less favorable to the insured or the beneficiary than the provisions of sections 44-709 to 44-767 and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of sickness and accident insurance of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

Source: Laws 1957, c. 188, § 9, p. 656; Laws 1989, LB 92, § 138.

44-710.09 Sickness and accident insurance; rules and regulations.

The Director of Insurance may adopt and promulgate such reasonable rules and regulations concerning the procedure for the filing or submission of policies of sickness and accident insurance subject to sections 44-709 to 44-767 as are necessary, proper, or advisable to the administration of such sections. This provision shall not abridge any other authority granted the Director of Insurance by law.

Source: Laws 1957, c. 188, § 10, p. 656; Laws 1989, LB 92, § 139.

44-710.10 Sickness and accident insurance; nonstandard provisions; requirements.

No policy provision which is not subject to sections 44-710.03 and 44-710.04 shall make a policy of sickness and accident insurance, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 44-709 to 44-767.

Source: Laws 1957, c. 188, § 11, p. 657; Laws 1989, LB 92, § 140.

44-710.11 Sickness and accident insurance; construction of policies.

A policy of sickness and accident insurance delivered or issued for delivery to any person in this state in violation of sections 44-709 to 44-767 shall be held valid but shall be construed as provided in such sections. When any provision in a policy subject to such sections is in conflict with any provision of such sections, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of such sections.

Source: Laws 1957, c. 188, § 12, p. 657; Laws 1989, LB 92, § 141.

44-710.12 Sickness and accident insurance; copy of application attached to policy; request for reinstatement or renewal; copy attached to policy.

The insured shall not be bound by any statement made in an application for a policy of sickness and accident insurance unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state is reinstated or renewed and the insured or the beneficiary or assignee of such policy makes written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy is not so delivered or mailed, the insurer shall be precluded from introducing

such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

Source: Laws 1957, c. 188, § 13, p. 657; Laws 1989, LB 92, § 142.

44-710.13 Sickness and accident insurance; alteration of application.

No alteration of any written application for any policy of sickness and accident insurance shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

Source: Laws 1957, c. 188, § 14, p. 657; Laws 1989, LB 92, § 143.

44-710.14 Sickness and accident insurance; falsity of application; effect.

The falsity of any statement in the application for any policy of sickness and accident insurance covered by sections 44-709 to 44-767 may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Source: Laws 1957, c. 188, § 15, p. 658; Laws 1989, LB 92, § 144.

This section must be read in pari materia with section 44-358. Farm Bureau Life Ins. Co. v. Luebbe, 218 Neb. 694, 358 N.W.2d 754 (1984); White v. Medico Life Ins. Co., 212 Neb. 901, 327 N.W.2d 606 (1982).

This section should be construed with section 44-358 in determining whether policy risk is avoided. Zimmerman v. Continental Cas. Co., 181 Neb. 654, 150 N.W.2d 268 (1967).

Where insured made no false statements in application, recovery was not barred by this section. Corrigan v. Fireman's Fund Ins. Co., 180 Neb. 13, 141 N.W.2d 170 (1966).

44-710.15 Sickness and accident insurance; acts of insurer; no waiver.

The acknowledgment by an insurer of the receipt of notice given under any policy of sickness and accident insurance, the furnishing of forms for filing proofs of loss, the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

Source: Laws 1957, c. 188, § 16, p. 658; Laws 1969, c. 375, § 1, p. 1335; Laws 1989, LB 92, § 145.

44-710.16 Sickness and accident insurance; age limit; acceptance of premium, effect; misstatement of age, effect.

If any policy of sickness and accident insurance contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

Source: Laws 1957, c. 188, § 17, p. 658; Laws 1989, LB 92, § 146.

44-710.17 Sickness and accident insurance; individual and franchise policies; riders and endorsements; requirements.

No restrictive rider or endorsement which is attached to or is to become a part of any individual or franchise policy of sickness and accident insurance delivered or issued for delivery to any person in this state shall be effective unless each such restrictive rider or endorsement or specific request therefor is signed by the applicant, except that the signature of the applicant shall not be required on any endorsement applied to a policy by means of printing or stamping on the policy at the time of original issuance of the policy if notice of the endorsement is affixed on the face and filing back in contrasting color, in not less than twelve-point type. The term restrictive rider or endorsement as used in this section shall mean any rider or endorsement which reduces, restricts, or eliminates coverage of the policy of which the rider or endorsement is a part.

Source: Laws 1963, c. 260, § 1, p. 785; Laws 1965, c. 264, § 1, p. 748.

44-710.18 Sickness and accident insurance; return of policy; notice; effect.

Except as provided in section 44-3608, every individual policy of sickness and accident insurance, except single-premium nonrenewable policies, shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason. If a policyholder or a purchaser pursuant to such notice returns the policy to the insurer at its home office or branch office or to the agent or agency through which it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

Source: Laws 1969, c. 374, § 2, p. 1334; Laws 1980, LB 877, § 12; Laws 1988, LB 998, § 1; Laws 1989, LB 92, § 147.

44-710.19 Individual and group sickness and accident insurance; health maintenance organization contract; newly born child; coverage; when.

(1) All individual and group policies of sickness and accident insurance providing coverage on an expense-incurred basis and health maintenance organization contracts shall provide benefits for newly born children of the insured or subscriber from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) A policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees shall be furnished to the insurer or health maintenance organization within thirty-one days after the date of birth in order to have the coverage continue beyond such thirty-one-day period.

(4) The requirements of this section shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state on or after January 1, 1995.

Source: Laws 1975, LB 28, § 1; Laws 1989, LB 92, § 148; Laws 1994, LB 978, § 20.

This section requires that any insurance policy in force as to a covered newborn child shall provide coverage in the same manner that it does for other family members. It does not transform a services-incurred policy into an occurrence policy. Howard v. Blue Cross Blue Shield, 242 Neb. 150, 494 N.W.2d 99 (1993).

44-711 Sickness and accident insurance; hearing on policy form; disapproval; appeal.

After the expiration of such thirty days from the filing of any such form, as provided in section 44-710, or at any time after having given written approval thereof, the director may, after a hearing of which at least ten days' written notice has been given to the insurer issuing such form, withdraw approval on any of the grounds stated in section 44-710. Such disapproval shall be effected by written order of the director which shall state the grounds for disapproval and the date, not less than thirty days after such hearing, when the withdrawal of approval shall become effective. An appeal from the decision of the Director of Insurance may be taken, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1947, c. 164, § 2(2), p. 453; Laws 1969, c. 359, § 22, p. 1277; Laws 1972, LB 1059, § 4; Laws 1988, LB 352, § 52.

Cross References

Administrative Procedure Act, see section 84-920.

44-712 Sickness and accident insurance; good faith estimate; requirements; effect.

(1) Any individual or group sickness and accident insurance policy or subscriber contract, any hospital, medical, or surgical expense-incurred policy, and any prepaid dental service plan that is issued for delivery, delivered, or renewed in this state, except policies that provide coverage for a specified disease or other limited-benefit coverage and health maintenance organization contracts, that provides for payment of claims based upon a specific methodology including, but not limited to, usual and customary charges, reasonable and customary charges, maximum benefit allowance, or charges based upon the prevailing rate in the community, shall provide that, upon request, a policyholder, certificate holder, covered dependent, or authorized representative shall be provided a written statement that includes a good faith estimate of the dollar amount of the allowable benefit for a service or procedure if the request includes information regarding any service or procedure to be performed by a nonpreferred provider, including any service or procedure code number or diagnosis related group provided by the health care provider and the health care provider's estimated charge.

(2) A statement requested pursuant to this section shall be sent to the policyholder, certificate holder, covered dependent, or authorized representative within ten business days after receipt of the request from the policyholder, certificate holder, covered dependent, or authorized representative.

(3) The insurer or other entity that provides a statement pursuant to and in compliance with this section shall not be bound by a good faith estimate, except that a pattern of providing estimates that vary significantly from the ultimate payment shall be an unfair claims settlement practice subject to the Unfair Insurance Claims Settlement Practices Act.

Source: Laws 1999, LB 326, § 5.

Cross References

Unfair Insurance Claims Settlement Practices Act, see section 44-1536.

44-712.01 Repealed. Laws 1957, c. 188, § 22.

44-713 Insured in temporary custody; health insurance policy; insurer; duties; powers; incarceration; notice; refusal to credential health care provider; notice; applicability of section.

(1) For purposes of this section:

(a) Notwithstanding section 44-3,131, health insurance policy means (i) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for a policy that provides coverage for a specified disease or other limited-benefit coverage, and (ii) any self-funded employee benefit plan to the extent not preempted by federal law;

(b) Jail means a city or county correctional or jail facility operated by a political subdivision of the state;

(c) Pending disposition of charges means up until the time of sentencing and shall not include any time after sentencing as may occur due to appeals; and

(d) Temporary custody means in the custody of a jail pending disposition of charges.

(2) Except as provided in subsection (4) of this section, an insurer offering a health insurance policy may not (i) cancel the coverage of an insured while the insured is in temporary custody on the basis of such custody or (ii) deny coverage for any medical services or supplies covered by the policy and received while the insured is in temporary custody if such services or supplies were provided to the insured by an employee or contractor of a jail who meets the credentialing criteria of the health insurance policy.

(3) Except as set forth under section 47-704, an insurer offering a health insurance policy shall pay claims for covered medical services or supplies provided by an out-of-network health care provider to an insured who is in temporary custody in an amount that is not less than one hundred percent of the medicare rate for such services or supplies. The political subdivision acting as an out-of-network provider shall notify the insurer of the cost incurred by the insured while in temporary custody.

(4) An insurer offering a health insurance policy may:

(a) Deny coverage for the treatment of injuries resulting from a violation of law by the insured;

(b) Exclude from any requirements for reporting quality outcomes or performance any covered medical services provided to an insured in temporary custody;

(c) Impose the same contractual provisions, including requirements for billing and medical coding, under the policy for medical services provided to insureds who are in temporary custody as imposed for medical services provided to insureds who are not in such custody;

(d) Deny coverage of diagnostic tests or health evaluations required as a matter of course for all individuals who are in temporary custody;

(e) Limit coverage of hospital and ambulatory surgical center services provided to an insured in temporary custody to medical services provided by in-network hospitals and ambulatory surgical centers;

(f) Deny coverage for costs of medical services made necessary by the negligence, recklessness, or intentional misconduct of the jail or its employees as set forth in section 47-705; and

(g) If an insured is incarcerated after the disposition of charges or is committed to the custody or supervision of the Department of Correctional Services, cancel coverage or deny coverage for any medical services or supplies covered by the plan and provided during such incarceration or while in the custody or supervision of the department.

(5) If an insured is incarcerated after the disposition of charges or is committed to the custody or supervision of the Department of Correctional Services, a jail which has sought reimbursement for medical services under this section shall notify the insurer that the insured has been subsequently incarcerated or placed in such custody.

(6)(a) An insurer may not refuse to credential a health care provider who is an employee or a contractor of a political subdivision on the basis that the employee or contractor provides medical services in a jail.

(b) If an insurer refuses to credential a health care provider who is an employee or a contractor of a political subdivision who provides medical services in a jail, the insurer must give written notice to the provider explaining the reasons for the refusal.

(7) This section shall not:

(a) Apply to coverage for an insured in custody following the disposition of charges;

(b) Impair any right of an employer to remove an employee from coverage under a health insurance plan;

(c) Release an insurer from the requirement to coordinate benefits for persons who are insured by more than one insurer; or

(d) Limit an insurer's right to rescind coverage in accordance with law.

(8) A political subdivision shall not pay health insurance policy premiums on behalf of a person who is in temporary custody.

(9) This section applies to health insurance policies issued or renewed on or after January 1, 2019, and to claims for reimbursement based on such policies for costs incurred on or after January 1, 2019.

Source: Laws 2018, LB480, § 1.

44-714 Repealed. Laws 1957, c. 188, § 22.

44-715 Repealed. Laws 1957, c. 188, § 22.

44-716 Repealed. Laws 1957, c. 188, § 22.

44-717 Repealed. Laws 1957, c. 188, § 22.

44-718 Repealed. Laws 1957, c. 188, § 22.

44-719 Repealed. Laws 1957, c. 188, § 22.

44-720 Repealed. Laws 1957, c. 188, § 22.

44-721 Repealed. Laws 1957, c. 188, § 22.

44-722 Repealed. Laws 1957, c. 188, § 22.

44-723 Repealed. Laws 1957, c. 188, § 22.

44-724 Repealed. Laws 1957, c. 188, § 22.

44-725 Repealed. Laws 1957, c. 188, § 22.

44-726 Repealed. Laws 1957, c. 188, § 22.

44-727 Repealed. Laws 1957, c. 188, § 22.

44-728 Repealed. Laws 1957, c. 188, § 22.

44-729 Repealed. Laws 1957, c. 188, § 22.

44-729.01 Repealed. Laws 1957, c. 188, § 22.

44-730 Repealed. Laws 1957, c. 188, § 22.

44-731 Repealed. Laws 1957, c. 188, § 22.

44-732 Repealed. Laws 1957, c. 188, § 22.

44-733 Repealed. Laws 1957, c. 188, § 22.

44-734 Repealed. Laws 1957, c. 188, § 22.

44-735 Repealed. Laws 1957, c. 188, § 22.

44-736 Sickness and accident insurance; extended disability benefit; how construed.

Any policy of sickness and accident insurance may contain a provision for paying an extended disability benefit upon the insured's death from any cause, which benefit shall not be construed as life insurance.

Source: Laws 1947, c. 164, § 5(3), p. 462; Laws 1957, c. 188, § 18, p. 658; Laws 1989, LB 92, § 149.

44-737 Repealed. Laws 1957, c. 188, § 22.

44-738 Repealed. Laws 1957, c. 188, § 22.

44-739 Repealed. Laws 1957, c. 188, § 22.

44-740 Repealed. Laws 1957, c. 188, § 22.

44-741 Repealed. Laws 1957, c. 188, § 22.

44-742 Repealed. Laws 1957, c. 188, § 22.

44-742.01 Repealed. Laws 1957, c. 188, § 22.

44-742.02 Repealed. Laws 1957, c. 188, § 22.

44-742.03 Repealed. Laws 1957, c. 188, § 22.

44-742.04 Repealed. Laws 1957, c. 188, § 22.

44-743 Repealed. Laws 1957, c. 188, § 22.

44-744 Repealed. Laws 1957, c. 188, § 22.

44-745 Repealed. Laws 1957, c. 188, § 22.

44-746 Repealed. Laws 1957, c. 188, § 22.

44-747 Repealed. Laws 1957, c. 188, § 22.

44-748 Repealed. Laws 1957, c. 188, § 22.

44-749 Sickness and accident insurance; discrimination prohibited; differences permitted.

No sickness and accident insurer shall make or permit any unfair discrimination between individuals of substantially the same hazard in the amount of premium rates charged for any policy or contract of such insurance or in the benefits payable thereunder. This section shall not prohibit different premium rates, different benefits, or different underwriting procedure for individuals insured under group, family expense, franchise, or blanket plans of insurance. This section shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113.

Source: Laws 1947, c. 164, § 10, p. 465; Laws 1984, LB 902, § 16; Laws 1989, LB 92, § 150; Laws 1995, LB 473, § 2.

Forbidden discrimination not present where group policy, under which husband, as member, and wife were insured, extended permanent total disability indemnity coverage only to husband; even if present wife would not be able to recover. Simmons v. Continental Cas. Co., 410 F.2d 881 (8th Cir. 1969).

44-750 Repealed. Laws 1989, LB 92, § 278.

44-751 Repealed. Laws 1989, LB 92, § 278.

44-752 Repealed. Laws 1989, LB 92, § 278.

44-753 Repealed. Laws 1957, c. 188, § 22.

44-754 Repealed. Laws 1989, LB 92, § 278.

44-755 Industrial sickness and accident insurance, defined.

The term industrial sickness and accident insurance as used herein means sickness and accident insurance under individual policies for which the premium is payable weekly, and includes any such policy which covers sickness only or accident only.

Source: Laws 1947, c. 164, § 14(1), p. 467.

44-756 Industrial sickness and accident insurance; insurers authorized to write.

Any insurer authorized to write sickness and accident insurance in this state shall have power to issue policies of industrial sickness and accident insurance.

Source: Laws 1947, c. 164, § 14(2), p. 467; Laws 1989, LB 92, § 151.

44-757 Industrial sickness and accident insurance; required statement on policy.

No policy of industrial sickness and accident insurance may be delivered or issued for delivery in this state unless it has printed thereon the words industrial policy.

Source: Laws 1947, c. 164, § 14(3), p. 467.

44-758 Industrial sickness and accident insurance; standard provisions applicable; provisions prohibited; permissive provisions.

Each policy of industrial sickness and accident insurance shall be subject to the provisions of sections 44-709 to 44-767, except that no such policy shall be required to contain any of the provisions set forth in sections 44-710.03 and 44-710.04. No such policy shall contain any provision relative to notice of proof of loss, the time for paying benefits, or the time within which suit may be brought upon the policy, which in the opinion of the Director of Insurance is less favorable to the insured than would be permitted by such standard provisions. Such policy may contain a provision that upon proper written request a named beneficiary shall be designated in or by endorsement on the policy to receive the proceeds thereof on the death of the insured, and there shall be reserved to the insured the power to change the beneficiary at any time by written notice to the insurer at its home office, accompanied by the policy for endorsement of the change thereon by the insurer. The insurer shall have the right to refuse to designate a beneficiary if evidence satisfactory to the company of such beneficiary's insurable interest in the life of the insured is not furnished on request. Any such policy may provide in substance that any payment thereunder may be made to the insured or to the insured's estate or to any relative by blood or connection by marriage of the insured or, to the extent of such portion of any payment under the policy as may reasonably appear to the insurer to be due to such person, to any other person equitably entitled thereto by reason of having incurred expense occasioned by the maintenance or illness or burial of the insured, except that if the policy is in force at the death of the insured, the proceeds thereof shall be payable to the named beneficiary if living, but upon the expiration of fifteen days after the death of the insured, unless proof of claim in the manner and form required by the policy, accompanied by the policy for surrender, has theretofore been made by such beneficiary, the insurer may pay to any other person permitted by the policy.

Source: Laws 1947, c. 164, § 14(4), p. 467; Laws 1957, c. 188, § 19, p. 659; Laws 1989, LB 92, § 152.

44-759 Sickness and accident insurance on a franchise plan, defined.

Sickness and accident insurance on a franchise plan is hereby declared to be that form of sickness and accident insurance issued to (1) five or more employees of any corporation, partnership, limited liability company, individual employer, or governmental corporation or agency or department thereof or (2) ten or more members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years where such association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance, if such persons, with or without their dependents, are issued the same form of an

individual policy varying only as to amounts and kinds of coverage applied for by such persons.

Source: Laws 1947, c. 164, § 15, p. 468; Laws 1993, LB 121, § 226.

44-760 Group sickness and accident insurance, defined.

Group sickness and accident insurance is hereby declared to be that form of sickness and accident insurance covering groups of persons, with or without their dependents, and issued upon the following basis:

(1) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least two employees of such employer, for the benefit of persons other than the employer. The term employees shall be deemed to include the officers, managers, and employees of the employer, the partners if the employer is a partnership, the members if the employer is a limited liability company, the officers, managers, and employees of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners, and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The policy may provide that the term employees shall include retired employees. The term employer may be deemed to include any municipal or governmental corporation, unit, agency, or department thereof and the proper officers, as such, of any unincorporated municipality or department thereof, as well as private individuals, partnerships, limited liability companies, and corporations;

(2) Under a policy issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five members of the association for the benefit of persons other than the association or its officers or trustees, as such;

(3) Under a policy issued to any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group sickness and accident policy or contract;

(4) Under a policy issued to any other group as authorized by Chapter 44, article 16; or

(5) Under a health benefit policy issued to an association consisting solely of Nebraska residents which has a constitution and bylaws and which insures at least twenty-five or more of the members of the association. For purposes of this subdivision, policy shall not include accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, specified disease insurance, hospital confinement indemnity insurance, or limited-benefit health insurance.

Source: Laws 1947, c. 164, § 16(1), p. 468; Laws 1951, c. 144, § 1, p. 585; Laws 1959, c. 210, § 1, p. 730; Laws 1993, LB 121, § 227; Laws 1994, LB 1222, § 51; Laws 1997, LB 862, § 19.

Group accident policy may insure eligible members of family including wife. Simmons v. Continental Cas. Co., 410 F.2d 881 (8th Cir. 1969).

44-761 Group sickness and accident insurance; required provisions.

Each group policy of sickness and accident insurance shall contain in substance the following provisions:

(1) A provision that the policy, the application of the policyholder if such application or copy thereof is attached to such policy, and the individual applications, if any, submitted in connection with such policy by the employees or members, shall constitute the entire contract between the parties, that all statements, in the absence of fraud, made by any applicant or applicants shall be deemed representations and not warranties, and that no such statement shall avoid the insurance or reduce benefits thereunder unless contained in a written application of which a copy is attached to the policy;

(2) A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy; and

(4) A provision that the insurance coverage of the employee or member may include, originally or by subsequent amendment, upon the application of the employee or member, any two or more eligible members of his or her family, including husband, wife, dependent children, any children enrolled on a full-time basis in any college, university, or trade school, or any children under a specified age which shall not exceed thirty years, and any other person dependent upon the policyholder. Any policy which provides that coverage of an unmarried dependent child shall terminate upon the attainment of the limiting age for unmarried dependent children specified in the policy shall also provide that attainment of such limiting age shall not operate to terminate the coverage of such child during the continuance of the insurance coverage of the employee or member under such policy and while such child is and continues to be (a) incapable of self-sustaining employment by reason of mental or physical handicap and (b) chiefly dependent upon the policyholder for support and maintenance, if proof of such incapacity and dependency is furnished to the insurer by the policyholder within thirty-one days of such child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following such child's attainment of the limiting age. The insurer may charge an additional premium for and with respect to any such continuation of coverage beyond the limiting age of the policy, which premium shall be determined by the insurer on the basis of the class of risks applicable to such child. The provisions of this subdivision shall be contained in all new policies of group sickness and accident insurance delivered or issued for delivery to any person in this state. No group policy of sickness and accident insurance shall contain any provisions which are in conflict with sections 44-3,144 to 44-3,150.

Source: Laws 1947, c. 164, § 16(2), p. 469; Laws 1976, LB 649, § 1; Laws 1989, LB 92, § 153; Laws 1994, LB 1224, § 79; Laws 2009, LB551, § 2.

Group accident policy may insure eligible members of family including wife. Simmons v. Continental Cas. Co., 410 F.2d 881 (8th Cir. 1969).

44-762 Blanket sickness and accident insurance, defined.

Blanket sickness and accident insurance is hereby declared to be that form of sickness and accident insurance covering special groups of persons as enumerated in one of the following subsections (1) to (5):

(1) Under a policy or contract issued to any common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on such common carrier.

(2) Under a policy or contract issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment.

(3) Under a policy or contract issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or teachers.

(4) Under a policy or contract issued in the name of any volunteer fire department, first-aid, or other such volunteer group, which shall be deemed the policyholder, covering all of the members of such department or group.

(5) Under a policy or contract issued to any other substantially similar group which, in the discretion of the Director of Insurance, may be subject to the issuance of a blanket sickness and accident policy or contract.

Source: Laws 1947, c. 164, § 17(1), p. 470.

44-763 Blanket sickness and accident insurance; individual application not required; individual certificate unnecessary.

An individual application shall not be required from a person covered under a blanket policy or contract of sickness and accident insurance nor shall it be necessary for the insurer to furnish each person a certificate.

Source: Laws 1947, c. 164, § 17(2), p. 470; Laws 1989, LB 92, § 154.

44-764 Blanket sickness and accident insurance; benefits, how payable.

All benefits under any blanket policy of sickness and accident insurance shall be payable to the person insured, to his or her designated beneficiary or beneficiaries, or to his or her estate, except that if the person insured is minor, such benefits may be made payable to his or her parent, guardian, or other person actually supporting him or her. All or a portion of any benefits payable under such a policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services, but it shall not be required that the services be rendered by a particular hospital or person.

Source: Laws 1947, c. 164, § 17(3), p. 471; Laws 1989, LB 92, § 155.

44-765 Blanket sickness and accident insurance; legal liability of policyholders not affected.

Nothing contained in sections 44-762 to 44-765 shall be deemed to affect the legal liability of policyholders for the death of or injury to, any such member of such group.

Source: Laws 1947, c. 164, § 17(4), p. 471.

44-766 Sickness and accident insurance; wrongful delivery of policy; violations; penalties; appeal.

Any person, partnership, limited liability company, or corporation who or which willfully delivers or issues for delivery in this state any policy of sickness and accident insurance on a form which has been disapproved by the Director of Insurance or willfully violates any provision of sections 44-709 to 44-767 or an order of the director made in accordance with sections 44-710 to 44-767 shall forfeit to the people of the state a sum not to exceed one hundred dollars for each such violation which may be recovered by a civil action. The director may after notice and hearing revoke the license of an insurer or agent for any such willful violation. Any person aggrieved by any action of the Director of Insurance may appeal. The appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1947, c. 164, § 18, p. 471; Laws 1957, c. 188, § 20, p. 660; Laws 1969, c. 359, § 25, p. 1278; Laws 1988, LB 352, § 55; Laws 1989, LB 92, § 156; Laws 1993, LB 121, § 228.

Cross References

Administrative Procedure Act, see section 84-920.

44-767 Sickness and accident insurance; other insurance not affected.

Nothing in sections 44-709 to 44-767 shall apply to or affect (1) any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary coverage therein, (2) any policy or contract of reinsurance, or (3) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to sickness and accident insurance as (a) provide additional benefits in case of death, dismemberment, or loss of sight by accident and (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract. Sections 44-710.03 to 44-710.09, 44-710.12, and 44-710.16 shall not apply to those forms of sickness and accident policies enumerated in section 44-758 or sections 44-760 to 44-765, except that no such policy shall contain any provision relative to notice or proof of loss, the time for paying benefits, or the time within which suit may be brought upon the policy, which in the opinion of the Director of Insurance is less favorable to the insured than would be permitted by the policy provisions set forth in sections 44-710.03 and 44-710.04.

Source: Laws 1947, c. 164, § 19, p. 471; Laws 1957, c. 188, § 21, p. 660; Laws 1969, c. 359, § 26, p. 1278; Laws 1986, LB 811, § 18; Laws 1989, LB 92, § 157.

In accordance with this section, a group health insurance policy may contain contractual limitations periods so long as they are not ''less favorable to the insured than would be permitted'' under section 44-710.03. Brodine v. Blue Cross Blue Shield, 272 Neb. 713, 724 N.W.2d 321 (2006).

44-768 Repealed. Laws 1969, c. 359, § 33.

44-769 Legislative findings; alcoholism insurance.

The Legislature hereby declares and finds that alcoholism is a disease which, if untreated, is highly disruptive of family life and employment and costs the state, its political subdivisions, insurers, employers, and taxpayers millions of dollars annually because of highway deaths and injuries, lost wages, lower productivity, welfare and unemployment compensation, greater utilization of

health insurance benefits and premature death, alcohol-related crimes, and the corresponding costs to the criminal justice and penal systems. The Legislature further finds that while most health benefit plans pay the high cost of treating the symptoms, injuries, and diseases associated with alcoholism many exclude coverage for treatment of the disease itself or limit coverage to acute portions of hospitals which do not generally treat the disease. The Legislature therefor declares that group subscribers and insureds should have information concerning the scope of alcoholism benefits being offered and access to coverage for treatment of the disease on such terms and conditions as may be agreed upon between the subscriber or insured and the insurer or health maintenance organization.

Source: Laws 1980, LB 646, § 1; Laws 1989, LB 92, § 158.

44-770 Definitions, sections found.

For purposes of sections 44-769 to 44-781, unless the context otherwise requires, the definitions found in sections 44-771 to 44-778 shall be used.

Source: Laws 1980, LB 646, § 2.

44-771 Hospital, defined.

Hospital shall mean an institution licensed as a hospital by the Department of Health and Human Services and defined in section 71-419.

Source: Laws 1980, LB 646, § 3; Laws 1996, LB 1044, § 236; Laws 2000, LB 819, § 69; Laws 2007, LB296, § 173.

44-772 Substance abuse treatment center, defined.

Substance abuse treatment center shall mean an institution licensed as a substance abuse treatment center by the Department of Health and Human Services, which provides a program for the inpatient or outpatient treatment of alcoholism pursuant to a written treatment plan approved and monitored by a physician and which is affiliated with a hospital under a contractual agreement with an established system for patient referral.

Source: Laws 1980, LB 646, § 4; Laws 1985, LB 209, § 1; Laws 1985, LB 253, § 1; Laws 1996, LB 1044, § 237; Laws 1996, LB 1155, § 17; Laws 2000, LB 819, § 70; Laws 2007, LB296, § 174; Laws 2018, LB1034, § 47.

44-773 Outpatient program, defined.

Outpatient program shall refer to a program which is licensed or certified by the Department of Health and Human Services or the Division of Behavioral Health of the Department of Health and Human Services to provide specified services to persons suffering from the disease of alcoholism.

Source: Laws 1980, LB 646, § 5; Laws 1995, LB 275, § 3; Laws 1996, LB 1044, § 238; Laws 1996, LB 1155, § 18; Laws 2004, LB 1083, § 96; Laws 2007, LB296, § 175.

44-774 Certified, defined.

Certified shall mean approved by the Division of Behavioral Health of the Department of Health and Human Services to render specific types or levels of care to the person suffering from the disease of alcoholism.

Source: Laws 1980, LB 646, § 6; Laws 1995, LB 275, § 4; Laws 1996, LB 1044, § 239; Laws 2004, LB 1083, § 97; Laws 2007, LB296, § 176.

44-775 Accredited, defined.

Accredited shall mean accredited to render specific types or levels of care according to the Accreditation Manual for Alcoholism Programs of the Joint Commission of Accreditation of Hospitals.

Source: Laws 1980, LB 646, § 7.

44-776 Primary treatment, defined.

Primary treatment shall mean inpatient treatment rendered in a structured and scheduled setting to prevent further ingestion of alcoholic beverages, to relieve the pain of the withdrawal syndrome, and to provide intensive therapy or rehabilitation, when such treatment is rendered in a hospital or a substance abuse treatment center which is certified or accredited to render such care.

Source: Laws 1980, LB 646, § 8; Laws 1996, LB 1155, § 19.

44-777 Outpatient treatment, defined.

Outpatient treatment shall mean counseling and therapy provided on a nonresidential basis when such treatment is rendered in or through a hospital, a substance abuse treatment center, or an outpatient program which is certified or accredited to render such care.

Source: Laws 1980, LB 646, § 9; Laws 1996, LB 1155, § 20.

44-778 Basic coverage for treatment of alcoholism, defined.

Basic coverage for treatment of alcoholism shall mean coverage for primary and outpatient treatment consisting of not less than (1) thirty days of inpatient coverage for the primary treatment of alcoholism in any three-hundred-sixty-five-day benefit period with at least two such inpatient treatment periods available during the lifetime of the policy, and (2) sixty outpatient treatment visits during the lifetime of the policy.

Source: Laws 1980, LB 646, § 10.

44-779 Group sickness and accident insurance; coverage for the treatment of alcoholism; requirements.

After January 1, 1981, all policies or contracts of group sickness and accident insurance written or issued by insurance companies and all group contracts or certificates written or issued by a health maintenance organization as to which there is a premium change or which are delivered or issued for delivery in this state, which do not provide at least basic coverage for the treatment of alcoholism, shall be subject to the following:

(1) The written sales and advertising literature, the descriptive brochures, and the exclusion sections of such policy, contract, or certificate shall contain a notice in all capital letters in the following language or in words of similar

effect as approved by the Director of Insurance: This agreement does not provide basic coverage for the treatment of alcoholism. Coverage for treatment of alcoholism is available if you specifically request it and then only upon such terms and conditions as you and the company agree;

(2) The written sales and advertising literature, the descriptive brochures, and such policy, contract, or subscription agreement itself shall not, in describing the plan, contract, coverage, or benefits, use the words comprehensive;

(3) The definition of a facility, program, or agency in or through which covered alcoholism services may be rendered contained in any optional coverage shall not be more restrictive than the definitions contained in sections 44-771 to 44-775 if the effect of such definitions would be to limit, deny, or withhold benefits which would be available if the definitions used in sections 44-769 to 44-781 were applied;

(4) Such policy, contract, or subscription agreement shall provide benefits to any person covered thereunder for the treatment of alcoholism under such terms and conditions as may be agreed upon between the subscriber or insured and the insurer or health maintenance organization; and

(5) In the case of policies, contracts, and subscription agreements issued before January 1, 1981, as to which there is a premium change after January 1, 1981, the notification requirements of this section may be met by written endorsement to such policy, contract, or subscription agreement.

Source: Laws 1980, LB 646, § 11; Laws 1989, LB 92, § 159.

44-780 Basic coverage for treatment of alcoholism; when considered available.

An insurance company or health maintenance organization will be considered to be providing basic coverage for treatment of alcoholism if it makes benefits available for the treatment described in section 44-778 on terms involving durational limits, dollar limits, deductibles, and coinsurance which are no less favorable than the terms on which it makes benefits available for the treatment of physical illness generally.

Source: Laws 1980, LB 646, § 12; Laws 1989, LB 92, § 160.

44-781 Coverage for treatment of alcoholism; benefits available.

An insurance company or health maintenance organization which does not provide basic coverage for treatment of alcoholism may nevertheless provide different or lesser benefits. Nothing in sections 44-769 to 44-781 is intended to limit any insurance company or health maintenance organization from providing more coverage for the treatment of alcoholism than is described in section 44-778.

Source: Laws 1980, LB 646, § 13; Laws 1989, LB 92, § 161.

44-782 Health insurance provider; coverage of mental or nervous disorders; requirements.

No insurance company, health maintenance organization, or other health insurance provider shall deny payment for treatment of mental or nervous disorders under a policy, contract, certificate, or other evidence of coverage issued or delivered in Nebraska on the basis that the hospital or state institution licensed as a hospital by the Department of Health and Human Services and

defined in section 71-419 providing such treatment is publicly funded and charges are reduced or no fee is charged depending on the patient's ability to pay.

Source: Laws 1985, LB 487, § 1; Laws 1989, LB 92, § 162; Laws 1996, LB 1044, § 240; Laws 2000, LB 819, § 71; Laws 2007, LB296, § 177.

44-783 Health insurance insurer; choice of pharmacy; limitation; when.

(1) If any insurer authorized to transact the business of health insurance in this state reasonably determines that an insured's utilization of prescription medications has been excessive and has not been medically necessary as defined by the insured's coverage, the insurer may reserve the right to limit such insured to a pharmacy of the insured's choice for obtaining prescription drug benefits. If the insured's coverage is through a preferred provider organization, the insurer or preferred provider organization may limit the insured to a preferred provider pharmacy of the insured's choice. If an insured has been so limited, the insurer or preferred provider organization shall not be required to provide benefits for prescriptions obtained from any other pharmacy. The insurer or preferred provider organization may require that the insured provide written notification to the insurer or preferred provider organization of the insured's choice of pharmacy.

(2) The action by the insurer or preferred provider organization limiting an insured to one pharmacy of the insured's choice may be effective as of the date specified in a written notice to the insured. Such written notice shall be sent to the insured at his or her last-known address as shown by the records of the insurer or preferred provider organization by certified or registered mail and shall inform the insured that he or she is required to select one pharmacy for obtaining prescription drug benefits. The terms of the written notice shall allow the insured at least seven days to notify the insurer or preferred provider organization of his or her choice of pharmacy.

Source: Laws 1993, LB 536, § 19.

44-784 Coverage for childhood immunizations; requirements.

Notwithstanding section 44-3,131, any expense-incurred group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed after January 1, 1995, or any expense-incurred individual sickness and accident insurance policy, certificate, or subscriber contract delivered or issued for delivery after such date that provides coverage for a dependent child under six years of age shall provide coverage for childhood immunizations. Benefits for childhood immunizations shall be exempt from any deductible provision contained in the applicable policy. Copayment, coinsurance, and dollar-limit provisions applicable to other medical services may be applied to the childhood immunization benefits. This section shall not apply to any individual or group policies that provide coverage for a specified disease, accident-only coverage, hospital indemnity coverage, medicare supplement coverage, long-term care coverage, or other limited-benefit coverage.

For purposes of this section, childhood immunizations shall mean the complete set of vaccinations for children from birth to six years of age for

immunization against measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and haemophilus influenzae type B.

Source: Laws 1994, LB 1222, § 46; Laws 2007, LB63, § 1.

44-785 Coverage for screening mammography; requirements.

(1) Notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law shall include coverage for screening mammography as follows:

(i) For women who are thirty-five years of age and older but younger than forty years of age, one base-line mammogram between thirty-five and forty years of age;

(ii) For women who are forty years of age and older but younger than fifty years of age, one mammogram every two years or more frequently based on the patient's physician's recommendation; and

(iii) For women who are fifty years of age or older, one mammogram every year.

(2) This section does not prevent application of deductible or copayment provisions contained in the policy or health benefit plan or require that coverage under an individual or group policy or health benefit plan be extended to any other procedures. The coverage provided by this section shall not be less favorable than for other radiological examinations. This section does not apply if the covered individuals are provided an ongoing screening mammography program which at a minimum meets the requirements of this section as a separate benefit.

(3) For purposes of this section, screening mammography shall mean radiological examination of the breast of asymptomatic women for the early detection of breast cancer, which examination shall include (a) a cranio-caudal and a medial lateral oblique view of each breast and (b) a licensed radiologist's interpretation of the results of the procedure. Screening mammography shall not include diagnostic mammography, additional projections required for lesion definition, breast ultrasound, or any breast interventional procedure. Screening mammography shall be performed by a mammogram supplier who meets the standards of the federal Mammography Quality Standards Act of 1992.

Source: Laws 1995, LB 68, § 1.

44-786 Obstetricians/gynecologists as primary care physicians; requirements.

On or after July 1, 1996, any entity which offers any individual or group sickness and accident insurance policy, subscriber contract, health maintenance organization contract, or hospital, medical, or surgical expense-incurred policy which is delivered, issued for delivery, or renewed in this state shall include obstetricians/gynecologists as primary care physicians if they otherwise qualify as a primary care physician pursuant to the credentialing or recredentialing standards of that entity and they perform all of the functions of a

primary care physician according to the terms and conditions of such entity's primary care physician contract.

Source: Laws 1996, LB 532, § 1.

44-787 Individual health insurance policies and contracts; renewal; exceptions; failure to renew; effect; certificate of creditable coverage.

(1) All individual health insurance policies and contracts issued by health carriers providing benefits consisting of medical care, which are provided directly, through insurance or reimbursement, under any hospital or medical service policy, hospital or medical service plan contract, or health maintenance organization contract shall be renewable at the option of the covered individual, except in any of the following cases:

(a) The covered individual has failed to pay premiums or contributions in accordance with the terms of the individual policy or contract or the health carrier has not received timely premium payments;

(b) The covered individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) A health carrier decides to discontinue offering a particular type of individual policy or contract in this state. A health carrier discontinuing such individual policy or contract shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all covered individuals, and to the commissioner of insurance in each state in which a covered individual is known to reside, at least ninety days prior to the nonrenewal of any individual policies or contracts by the health carrier. Notice to the director shall be provided at least three working days prior to the notice to the covered individuals;

(iii) Offer to each covered individual provided the type of individual policy or contract the option to purchase all other individual policies or contracts currently being offered by the health carrier to individuals in this state; and

(iv) In exercising the option to discontinue the particular type of individual policy or contract and in offering the option of coverage under subdivision (1)(c)(iii) of this section, act uniformly without regard to any health-status-related factor relating to any covered individual who may become eligible for such coverage;

(d) A health carrier decides to discontinue offering and nonrenews all its individual policies and contracts delivered or issued for delivery to individuals in this state. A health carrier that discontinues such individual policies and contracts shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all covered individuals, and to the commissioner of insurance in each state in which a covered individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any individual policies or contracts by the health carrier.

Notice to the director shall be provided at least three working days prior to the notice to the covered individuals; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's individual market and not renew coverage under any individual policy or contract issued to an individual; and

(e) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the covered individuals; or

(ii) Impair the health carrier's ability to meet its contractual obligations.

(2) A health carrier that elects not to renew all of its individual policies or contracts in the state under subdivision (1)(d) of this section shall be prohibited from writing new business in the individual market in this state for a period of five years after the date of notice to the director.

(3) A health carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) of this section in the case of an individual who no longer resides, lives, or works in the service area of the health carrier or in an area for which the health carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals.

(4)(a) Health carriers shall provide written certification of creditable coverage to individuals covered under an individual health insurance policy or contract at the time:

(i) An individual ceases to be covered under the health insurance policy or contract; and

(ii) A request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage.

(b) The certificate of creditable coverage shall contain:

(i) Written certification of the period of creditable coverage of the individual under the health insurance policy or contract; and

(ii) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health insurance policy or contract.

(c) The entity providing the information pursuant to subdivision (4)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

(5) For purposes of this section:

(a) Director means the Director of Insurance;

(b) Health carrier means any entity that issues a health insurance policy or contract, including an insurance company, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(c) Health-status-related factor means any of the following factors:

(i) Health status;

(ii) Medical condition, including both physical and mental illnesses;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(viii) Disability;

(d)(i) Individual policy or contract does not include one or more, or any combination, of the following:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for onsite medical clinics; and

(H) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(ii) Individual policy or contract does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the policy or contract:

(A) Limited-scope dental or vision benefits;

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(C) Such other similar, limited benefits as are specified in federal regulations.

(iii) Individual policy or contract does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance:

(A) Coverage only for a specified disease or illness; and

(B) Hospital indemnity or other fixed indemnity insurance.

(iv) Individual policy or contract does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, 42 U.S.C. 1395ss, as such section existed on January 1, 2002;

(B) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, as such chapter existed on January 1, 2002;

(C) Similar supplemental coverage provided to coverage under a group health plan; and

(D) Short-term limited duration insurance that has an expiration date specified in the contract that is within twelve months of the effective date of the contract; and

(e) Network plan means health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and

services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Source: Laws 1997, LB 55, § 1; Laws 1998, LB 1035, § 3; Laws 1999, LB 259, § 3; Laws 2002, LB 1139, § 18.

44-788 Coverage for cancer, human immunodeficiency virus, or acquired immunodeficiency syndrome treatment; requirements.

(1) Notwithstanding section 44-3,131, any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and any self-funded employee benefit plan to the extent not preempted by federal law, which provides reimbursement for prescription drugs approved by the federal Food and Drug Administration for the treatment of a specific type of cancer shall not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the federal Food and Drug Administration for the treatment of another specific type of cancer if (a) the drug or combination of drugs is recognized for treatment of the other specific type of cancer in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration or (b) the drug or combination of drugs is recognized for treatment of the other specific type of cancer in medical literature and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration.

(2) Notwithstanding section 44-3,131, any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and any self-funded employee benefit plan to the extent not preempted by federal law, which provides reimbursement for prescription drugs approved by the federal Food and Drug Administration for the treatment of human immunodeficiency virus or acquired immunodeficiency syndrome shall not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the federal Food and Drug Administration for the treatment of human immunodeficiency virus or acquired immunodeficiency syndrome if (a) the drug or combination of drugs is recognized for treatment of human immunodeficiency virus or acquired immunodeficiency syndrome in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration or (b) the drug or combination of drugs is recognized for treatment of human immunodeficiency virus or acquired immunodeficiency syndrome in medical literature and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration.

(3) Any coverage of a drug or combination of drugs required by this section shall include medically necessary services associated with the administration of the drug if such services are covered by the insurance policy, contract, or plan.

(4) Nothing in this section shall be construed to require coverage for any experimental or investigational drug not approved by the federal Food and Drug Administration.

(5) For purposes of this section, medical literature means two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the safety and effectiveness of the drug or combination of drugs for treatment of the indication for which it has been prescribed unless two articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug or combination of drugs is unsafe or ineffective or that the safety and effectiveness of the drug or combination of drugs cannot be determined for the treatment of the indication for which the drug or combination of drugs has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or shall have been published in a journal specified by the United States Department of Health and Human Services pursuant to 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

(6) This section shall apply to policies, plans, or contracts for insurance as provided in subsections (1) and (2) of this section which are delivered, issued for delivery, or renewed in this state on or after July 15, 1998.

Source: Laws 1998, LB 1162, § 81; Laws 2002, LB 93, § 3.

44-789 Coverage for bone or joint treatment; requirements.

Notwithstanding section 44-3,131, no group policy of accident or health insurance, health services plan, or health maintenance organization subscription shall be offered for sale in this state on or after January 1, 2009, unless such policy, plan, subscription, or contract which specifically provides coverage for surgical and nonsurgical treatment involving a bone or joint of the skeletal structure includes the option to provide coverage, for an additional premium and subject to the insurer's standard of insurability, for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder. The purchaser of the group policy of accident or health insurance, health services plan, or health maintenance organization subscription shall accept or reject the coverage in writing on the application or an amendment thereto for the master group policy of accident or health insurance, health services plan, or health maintenance organization subscription. Benefits may be subject to the same preexisting conditions, limitations, deductibles, copayments, and coinsurance that generally apply to any other sickness. The maximum lifetime benefits for temporomandibular joint disorder and craniomandibular disorder treatment shall be no less than two thousand five hundred dollars. Nothing in this section shall prevent an insurer from including such coverage for temporomandibular joint disorder and craniomandibular disorder as part of a policy's basic coverage instead of offering optional coverage.

Source: Laws 1998, LB 1162, § 82; Laws 2008, LB855, § 5.

44-790 Coverage for diabetes; requirements.

(1) Notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical

expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law shall include coverage for the equipment, supplies, medication, and outpatient self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by a health care professional legally authorized by law to prescribe such items.

(2) The equipment, supplies, medication, and patient management for the use of the equipment, supplies, and medication listed in this subsection shall be included in the coverage required by this section: Blood glucose monitors; blood glucose monitors for the legally blind; test strips for glucose monitors; urine testing strips; insulin; injection aids; lancet and lancet devices; syringes; insulin pumps and all supplies for the pump; insulin infusion devices; oral agents for controlling blood sugars; glucose agents and glucagon kits; insulin measurement and administration aids for the visually impaired; patient management materials that provide essential diabetes self-management information; and podiatric appliances for the prevention of complications associated with diabetes.

(3) The benefits under this section shall be provided for the patient upon the diagnosis of diabetes, when a significant change occurs in the patient's symptoms or condition that necessitates changes in a patient's self-management, or when refresher patient management is necessary. The benefits shall cover home visits when medically necessary and prescribed by a health care professional legally authorized by law to prescribe such items. Patient management may be conducted individually or in a group setting as long as there is medical necessity.

(4) Diabetes self-management training and patient management, including medical nutrition therapy, shall be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or a health care professional that is a diabetes educator certified by the National Certification Board for Diabetes Educators.

(5) Physician-prescribed diabetes self-management training and patient management shall be covered at diagnosis, when symptoms or conditions change, and when new medications or treatments are prescribed. Diabetes self-management education must be deemed to be medically necessary by a physician to be eligible for coverage and such coverage shall not exceed five hundred dollars in a two-year period.

(6) This section does not prevent application of (a) deductible or copayment provisions or network incentives contained in the policy or health benefit plan or (b) outpatient care provisions in policies or health benefit plans that extend coverage primarily in relation to hospital confinement or surgery. This section does not require that coverage under an individual or group policy or health benefit plan be extended to any other procedures. Private third-party payors may not reduce or eliminate coverage due to this section.

(7) For purposes of this section, patient management means educational and training services furnished to an individual with diabetes in an outpatient setting by an individual or entity with experience in diabetes, in consultation with the physician who is managing the patient's condition, which physician certifies that such services are needed under a comprehensive plan of care

related to the individual's condition to ensure therapy or compliance or to provide the individual with necessary skills and knowledge, including skills related to the self-administration of injectable drugs which participate in the management of the individual's condition.

(8) Reimbursement for coverage shall be in amounts reasonably negotiated by the health care professional and the private third-party payor.

Source: Laws 1999, LB 99, § 1.

44-791 Mental health conditions; legislative findings.

The Legislature finds that mental health conditions affect a significant number of Nebraskans. Mental health conditions, like severe physical injuries or illness, can be life-altering and debilitating in nature. If properly treated and managed by mental health professionals, persons with mental health conditions can and do lead full and productive lives. However, without such treatment or management, many mental health conditions will progressively deteriorate and negatively impact upon a person's livelihood, social relationships, and physical health.

The Legislature also finds that many persons with mental health conditions either do not seek treatment or do not complete or maintain such treatment programs. Treatment options are not underutilized due to the scarcity of professional resources or the lack of desire on the part of persons with mental health conditions, but rather treatment has become unaffordable as the result of the rising health care costs combined with a lack of insurance coverage for mental health conditions. The associated societal and monetary costs of providing no treatment or untimely treatment to persons with mental health conditions are great. It is the intent of sections 44-791 to 44-795 that persons with group health insurance plans providing coverage for mental health conditions be provided with a minimum level of coverage.

Source: Laws 1999, LB 355, § 1.

44-792 Mental health conditions; terms, defined.

For purposes of sections 44-791 to 44-795:

(1) Health insurance plan means (a) any group sickness and accident insurance policy, group health maintenance organization contract, or group subscriber contract delivered, issued for delivery, or renewed in this state and (b) any self-funded employee benefit plan to the extent not preempted by federal law. Health insurance plan includes any group policy, group contract, or group plan offered or administered by the state or its political subdivisions. Health insurance plan does not include group policies providing coverage for a specified disease, accident-only coverage, hospital indemnity coverage, disability income coverage, medicare supplement coverage, long-term care coverage, or other limited-benefit coverage. Health insurance plan does not include any policy, contract, or plan covering an employer group that covers fewer than fifteen employees;

(2) Mental health condition means any condition or disorder involving mental illness that falls under any of the diagnostic categories listed in the Mental Disorders Section of the International Classification of Disease;

(3) Mental health professional means (a) a practicing physician licensed to practice medicine in this state under the Medicine and Surgery Practice Act, (b)

a practicing psychologist licensed to engage in the practice of psychology in this state as provided in section 38-3111 or as provided in similar provisions of the Psychology Interjurisdictional Compact, or (c) a practicing mental health professional licensed or certified in this state as provided in the Mental Health Practice Act;

(4) Rate, term, or condition means lifetime limits, annual payment limits, and inpatient or outpatient service limits. Rate, term, or condition does not include any deductibles, copayments, or coinsurance; and

(5)(a) Serious mental illness means, prior to January 1, 2002, (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder; and

(b) Serious mental illness means, on and after January 1, 2002, any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes, but is not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder.

Source: Laws 1999, LB 355, § 2; Laws 2007, LB463, § 1135; Laws 2018, LB1034, § 48.

Cross References

Medicine and Surgery Practice Act, see section 38-2001.
Mental Health Practice Act, see section 38-2101.
Psychology Interjurisdictional Compact, see section 38-3901.

44-793 Mental health conditions; coverage; requirements.

(1) On or after January 1, 2000, notwithstanding section 44-3,131, any health insurance plan delivered, issued, or renewed in this state (a) if coverage is provided for treatment of mental health conditions other than alcohol or substance abuse, (i) shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a serious mental illness than for access to treatment for a physical health condition, (ii) shall not establish any rate, term, or condition that places a greater financial burden on an insured for accessing treatment for a mental health condition using telehealth services as defined in section 44-312, (iii) shall provide, at a minimum, a reimbursement rate for accessing treatment for a mental health condition using telehealth services that is the same as the rate for a comparable treatment provided or supervised in person, and (iv) if an out-of-pocket limit is established for physical health conditions, shall apply such out-of-pocket limit as a single comprehensive out-of-pocket limit for both physical health conditions and mental health conditions, or (b) if no coverage is to be provided for treatment of mental health conditions, shall provide clear and prominent notice of such noncoverage in the plan.

(2) If a health insurance plan provides coverage for serious mental illness, the health insurance plan shall cover health care rendered for treatment of serious mental illness (a) by a mental health professional, (b) by a person authorized by the rules and regulations of the Department of Health and Human Services to provide treatment for mental illness, (c) using telehealth services as defined in section 44-312, (d) in a mental health center as defined in section 71-423, or (e) in any other health care facility licensed under the Health Care Facility

Licensure Act that provides a program for the treatment of a mental health condition pursuant to a written plan. The issuer of a health insurance plan may require a health care provider under this subsection to enter into a contract as a condition of providing benefits.

(3) The Director of Insurance may disapprove any plan that the director determines to be inconsistent with the purposes of this section.

Source: Laws 1999, LB 355, § 3; Laws 2000, LB 819, § 72; Laws 2007, LB296, § 178; Laws 2021, LB487, § 1.
Effective date August 28, 2021.

Cross References

Health Care Facility Licensure Act, see section 71-401.

44-794 Mental health conditions; sections; how construed.

(1) Sections 44-791 to 44-795 shall not be construed to:

(a) Require a health insurance plan to provide coverage for mental health conditions or serious mental illnesses;

(b) Require a health insurance plan to provide the same rates, terms, or conditions between treatments for serious mental illnesses and preventative care;

(c) Prohibit a health insurance plan from providing separate reimbursement rates and service delivery systems, including, but not limited to, mental health carve-out programs even if the plan does not provide similar options for the treatment of physical health conditions. A health insurance plan provided in compliance with section 44-793 shall not be construed to violate the Managed Care Plan Network Adequacy Act; or

(d) Prohibit a health insurance plan from managing the provision of benefits through common methods, including, but not limited to, preadmission screening, prior authorization of services, or other mechanisms designed to limit coverage to services for mental health conditions that are deemed to be medically necessary and clinically appropriate.

(2) A health insurance plan does not violate section 44-793 if the plan applies different rates, terms, and conditions or excludes entirely from coverage the following:

(a) Marital, family, educational, developmental, or training services;

(b) Care that is substantially custodial in nature;

(c) Services and supplies that are not medically necessary or clinically appropriate; or

(d) Experimental treatments.

(3) A health insurance plan may use a case management program or managed care organization to evaluate, determine, and provide or arrange for medically necessary and clinically appropriate care and treatment of each person with a mental health condition or serious mental illness who is covered by the plan.

(4) A health insurance plan shall not be required to offer coverage for nonemergency services rendered outside its network of contracted providers.

Source: Laws 1999, LB 355, § 4.

Cross References

Managed Care Plan Network Adequacy Act, see section 44-7101.

44-795 Mental health conditions; rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations to carry out sections 44-791 to 44-795.

Source: Laws 1999, LB 355, § 5.

44-796 Coverage for certain hearing screening tests; requirements.

(1) Notwithstanding section 44-3,131:

(a) Under a health insurance plan which provides coverage for hearing screening tests for newborns and infants, such coverage shall be subject to copayment, coinsurance, deductible, and dollar-limit provisions to the extent that other medical services covered by the health insurance plan are subject to such provisions; and

(b) This section applies to health insurance plans delivered, issued for delivery, or which become effective on or after April 11, 2000, and also applies to all renewals or changes which are effective on or after April 11, 2000.

(2) For purposes of this section, health insurance plan means a plan which includes dependent coverage for children which is delivered, issued for delivery, renewed, extended, or modified in this state. A health insurance plan includes any such group or individual sickness and accident insurance policy, health maintenance organization contract, subscriber contract, employee medical, surgical, or hospital care benefit plan, or self-funded employee benefit plan to the extent not preempted by federal law. Health insurance plan includes any policy, contract, or plan offered or administered by the state or its political subdivisions. Health insurance plan does not include policies providing coverage for a specified disease, accident-only coverage, hospital indemnity coverage, disability income coverage, medicare supplement coverage, long-term care coverage, or other limited-benefit coverage.

(3) The Department of Insurance shall adopt and promulgate rules and regulations necessary to implement this section.

Source: Laws 2000, LB 950, § 13.

44-797 Coverage for breast reconstruction; requirements; exceptions.

(1)(a) Any individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract. Writ-

ten notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

(b) Each individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract shall provide notice to each policyholder and certificate holder of the coverage required by this section. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer. For group policies, such notice shall be sent to the policyholder or certificate holder by the plan or to the participant or beneficiary by the issuer. For individual policies, such notice shall be sent to the policyholder by the issuer no later than December 31, 2006.

(2) No individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract may deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section, or penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. Nothing in this section shall be construed to prohibit normal underwriting.

(3) Nothing in this section shall be construed to prevent an individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract offering health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(4) The provisions of this section shall not apply to any individual or group policy or certificate which provides:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for onsite medical clinics;

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited-scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in federal regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, as such section existed on January 1, 2005;

(o) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, as such chapter existed on January 1, 2005; and

(p) Similar supplemental coverage provided to coverage under a group health plan.

Source: Laws 2000, LB 930, § 4; Laws 2005, LB 119, § 9.

44-798 Coverage for dental care requiring hospitalization and general anesthesia; requirements.

(1) Notwithstanding section 44-3,131, (a) any employer group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any employer group hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law shall include coverage for the reasonable cost of hospitalization and general anesthesia in order for a covered person to safely receive dental care if he or she is under eight years of age or is developmentally disabled.

(2)(a) This section does not prevent application of deductible or copayment provisions contained in the group policy, contract, or benefit plan or require that coverage under a group policy, contract, or benefit plan be extended to any other procedures, including dental care.

(b) This section does not prevent application of prior authorization requirements or other requirements of a managed care plan as established by the group policy, contract, or benefit plan, including a requirement that coverage under subsection (1) of this section shall be provided only through a contracted network of providers.

(3) For purposes of this section, the reasonable determination that hospitalization and general anesthesia are necessary for safe dental care shall be made by the entity providing coverage under subsection (1) of this section. Medical necessity shall be as defined by the group policy, contract, or benefit plan.

(4) For purposes of this section, hospital and hospitalization includes ambulatory surgical center and care at an ambulatory surgical center.

Source: Laws 2000, LB 1253, § 1.

44-799 Coverage for newly adopted children; requirements.

(1)(a) Any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law shall cover newly adopted children of the insured or enrollee. The coverage for newly adopted children shall be the same as for other dependents. No policy or health benefit plan provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval may be applied to newly adopted children when they are enrolled in accordance with this section.

(2) The coverage required by this section:

(a) Is effective upon the earlier of (i) the date of placement for the purpose of adoption or (ii) the date of the entry of an order granting the adoptive parent custody of the child for purposes of adoption;

(b) Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; and

(c) Continues unless required action as described in subsection (3) of this section is not taken.

(3) If the payment of a specific premium or subscription fee is required to provide coverage for an adopted child, the policy or health benefit plan may require that notification of the adoption of the child and the payment of the required premium or fee be furnished to the insurer or health benefit plan within thirty-one days after the adoption of the child in order to have the coverage continue beyond the thirty-one-day period.

Source: Laws 2000, LB 1253, § 43.

44-7,100 Genetic testing; prohibited acts.

(1)(a) Any hospital, medical, or surgical expense-incurred policy or certificate delivered, issued for delivery, or renewed in this state and (b) any self-funded employee benefit plan to the extent not preempted by federal law shall not require a covered person or his or her dependent or an asymptomatic applicant for coverage or his or her asymptomatic dependent to undergo any genetic test before issuing, renewing, or continuing the policy or certificate in this state.

(2) This section does not prohibit requiring an applicant for coverage to answer questions concerning family history.

(3) For purposes of this section:

(a) Clinical purposes includes:

(i) Predicting the risk of diseases;

(ii) Identifying carriers for single-gene disorders;

(iii) Establishing prenatal and clinical diagnosis or prognosis;

(iv) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families;

(v) Testing for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes; and

(vi) Other testing if the intended purpose is diagnosis of a presymptomatic genetic condition; and

(b) Genetic test means the analysis of human DNA, RNA, and chromosomes and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome in order to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including a chemical analysis, of body fluids unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

Source: Laws 2001, LB 432, § 2.

44-7,101 Prescription drug information card or other technology; requirements; use.

(1) All insurers delivering, issuing for delivery, or renewing in this state a health benefit plan which provides coverage for prescription drugs and devices and that issues, uses, or requires a card or other technology for prescription claims submission, or the insurer's agents or contractors that issue such cards or other technology, shall issue to each insured a prescription drug information card or other technology that:

(a) Conforms to the standards and format of the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide by including all of the standard information adopted by the implementation guide and required by the health benefit plan for submission and adjudication of claims for prescription drugs or devices; or

(b) Contains at a minimum the following appropriately labeled information:

(i) The card issuer name or logo on the front of the card;

(ii) The cardholder's name and identification number on the front of the card;

(iii) Complete information for electronic transaction claims routing, including:

(A) The international identification number, labeled as RxBIN;

(B) The processor control number, labeled as RxPCN, if required for proper routing of electronic claim transactions for prescription benefits; and

(C) The group number, labeled as RxGrp, if required for proper routing of electronic claim transactions for prescription benefits;

(iv) The name and address of the health benefit plan benefits administrator or the entity responsible for prescription benefits claims submission or adjudication or pharmacy provider correspondence for prescription benefits claims; and

(v) A help desk telephone number that pharmacy providers may call for prescription benefits claims assistance.

(2) All information required by subsection (1) of this section that is necessary for submission and adjudication of claims for prescription drug or device benefits, exclusive of information that can be derived from the prescription, shall be included in a clear, readable, and understandable manner on the card or other technology issued by the insurer or its agents or contractors. The content and format of all information required by such subsection shall be in the content and format required by the health benefit plan for electronic claims routing, submission, and adjudication.

(3) A prescription drug information card or technology required under subsection (1) of this section shall be issued by an insurer upon enrollment in a health benefit plan and reissued within a reasonable time upon any change in the insured's coverage that impacts data contained on the card or technology, except that the insurer or its agents or contractors shall not be required to issue a new prescription drug information card more than once in a calendar year and nothing in this section prevents the insurer or its agents or contractors from issuing stickers or other methodologies to the insureds to update the cards or other technology temporarily until the cards or other technology are reissued or from reissuing updated new cards or other technology on a more frequent basis. Cards or technology shall be updated with the latest coverage informa-

tion and shall comply with the format as approved in subsection (1) of this section.

(4) The card or other technology may be used for any and all health insurance coverage. Nothing in this section requires any person issuing, using, or requiring the card or other technology to issue, use, or require a separate card for prescription coverage if the card or other technology can accommodate the information necessary to process the claim as required by subsection (1) of this section.

(5) For purposes of this section, health benefit plan means any individual or group sickness and accident insurance policy or subscriber contract, nonprofit hospital or medical service policy or plan contract, or health maintenance organization contract and any self-funded employee benefit plan to the extent not preempted by federal law or exempted by state law. Health benefit plan does not mean one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Credit-only insurance;

(c) Coverage for specified disease or illness;

(d) Limited-scope dental or vision benefits;

(e) Coverage issued as a supplement to liability insurance;

(f) Automobile medical payment insurance or homeowners medical payment insurance;

(g) Insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability policy or equivalent self-insurance coverage; or

(h) Hospital indemnity or other fixed indemnity insurance.

(6) This section shall apply to all health benefit plans delivered or issued for delivery on or after January 1, 2004, and to all health benefit plans renewed on or after January 1, 2005.

(7) The Department of Insurance shall enforce this section. The department may adopt and promulgate rules and regulations to carry out the purposes of this section.

Source: Laws 2003, LB 73, § 10.

44-7,102 Coverage for screening for colorectal cancer.

(1) Notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for short-term major medical policies of six months or less duration and policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law shall include screening coverage for a colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person fifty years of age and older covered under such policy, certificate, contract, or plan. Such screening coverage shall include a maximum of one screening fecal occult blood test annually and a flexible sigmoidoscopy every five years, a colonoscopy every ten years, or a barium enema every five to ten years, or any combination, or the most reliable,

medically recognized screening test available. The screenings selected shall be as deemed appropriate by a health care provider and the patient.

(2) This section does not prevent application of deductible or copayment provisions contained in the policy, certificate, contract, or employee benefit plan or require that such coverage be extended to any other procedures.

Source: Laws 2007, LB247, § 86.

44-7,103 Continuing coverage for children to age thirty; requirements.

(1) For purposes of this section, health benefit plan means any expense-incurred individual or group sickness and accident insurance policy, health maintenance organization contract, subscriber contract, or self-funded employee benefit plan to the extent not preempted by federal law, except for any policy or contract that provides coverage only for excepted benefits as defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act, as such act and regulations existed on January 1, 2009, or any policy or contract that provides coverage for a specified disease or other limited-benefit coverage.

(2) Notwithstanding section 44-3,131, any health benefit plan that provides coverage for children shall provide for continuing coverage for such children as follows:

(a) If coverage under the health benefit plan would otherwise terminate because a covered child ceases to be a dependent, ceases to be a full-time student, or attains an age which exceeds the specified age at which coverage ceases pursuant to the plan, the health benefit plan shall provide the option to the insured to continue coverage for such child through the end of the month in which the child (i) marries, (ii) ceases to be a resident of the state, unless the child is under nineteen years of age or is enrolled on a full-time basis in any college, university, or trade school, (iii) receives coverage under another health benefit plan or a self-funded employee benefit plan that is not included in the definition of a health benefit plan under subsection (1) of this section but provides similar coverage, or (iv) attains thirty years of age; and

(b) The health benefit plan may require:

(i) A written election from the insured; and

(ii) An additional premium for the child. Such premium shall not vary based upon the health status of the child and shall not exceed the amount the health benefit plan would receive for an identical individual for a single adult insured. No employer shall be required to contribute to any additional premium under this subdivision.

Source: Laws 2009, LB551, § 3.

44-7,104 Coverage for orally administered anticancer medication; requirements; applicability.

(1) Notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law that provides coverage for cancer treatment shall provide coverage for a prescribed, orally

administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected anticancer medications that are covered as medical benefits by the policy, certificate, contract, or plan.

(2) This section does not prohibit such policy, certificate, contract, or plan from requiring prior authorization for a prescribed, orally administered anticancer medication. If such medication is authorized, the cost to the covered individual shall not exceed the coinsurance or copayment that would be applied to any other cancer treatment involving intravenously administered or injected anticancer medications.

(3) A policy, certificate, contract, or plan provider shall not reclassify any anticancer medication or increase a coinsurance, copayment, deductible, or other out-of-pocket expense imposed on any anticancer medication to achieve compliance with this section. Any change that otherwise increases an out-of-pocket expense applied to any anticancer medication shall also be applied to the majority of comparable medical or pharmaceutical benefits under the policy, certificate, contract, or plan.

(4) This section does not prohibit a policy, certificate, contract, or plan provider from increasing cost-sharing for all benefits, including cancer treatments.

(5) This section shall apply to any policy, certificate, contract, or plan that is delivered, issued for delivery, or renewed in this state on or after October 1, 2012.

Source: Laws 2012, LB882, § 1; Laws 2014, LB254, § 1.

44-7,105 Fees charged for dental services; prohibited acts.

Notwithstanding section 44-3,131, (1) an individual or group sickness or accident policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state and a hospital, medical, or surgical expense-incurred policy, (2) a self-funded employee benefit plan to the extent not preempted by federal law, and (3) a certificate, agreement, or contract to provide limited health services issued by a prepaid limited health service organization as defined in section 44-4702 shall not include a provision, stipulation, or agreement establishing or limiting any fees charged for dental services that are not covered by the policy, certificate, contract, agreement, or plan.

Source: Laws 2012, LB810, § 1.

44-7,106 Coverage for screening, diagnosis, and treatment of autism spectrum disorder; requirements.

(1) For purposes of this section:

(a) Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

(b) Autism spectrum disorder means any of the pervasive developmental disorders or autism spectrum disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, as the most recent edition of such manual existed on July 18, 2014;

(c) Behavioral health treatment means counseling and treatment programs, including applied behavior analysis, that are: (i) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and (ii) provided or supervised, either in person or by telehealth, by a behavior analyst certified by a national certifying organization or a licensed psychologist if the services performed are within the boundaries of the psychologist's competency;

(d) Diagnosis means a medically necessary assessment, evaluation, or test to diagnose if an individual has an autism spectrum disorder;

(e) Pharmacy care means a medication that is prescribed by a licensed physician and any health-related service deemed medically necessary to determine the need or effectiveness of the medication;

(f) Psychiatric care means a direct or consultative service provided by a psychiatrist licensed in the state in which he or she practices;

(g) Psychological care means a direct or consultative service provided by a psychologist licensed in the state in which he or she practices;

(h) Therapeutic care means a service provided by a licensed speech-language pathologist, occupational therapist, or physical therapist; and

(i) Treatment means evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist, including:

(i) Behavioral health treatment;

(ii) Pharmacy care;

(iii) Psychiatric care;

(iv) Psychological care; and

(v) Therapeutic care.

(2) Notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law, including any such plan provided for employees of the State of Nebraska, shall provide coverage for the screening, diagnosis, and treatment of an autism spectrum disorder in an individual under twenty-one years of age. To the extent that the screening, diagnosis, and treatment of autism spectrum disorder are not already covered by such policy or contract, coverage under this section shall be included in such policies or contracts that are delivered, issued for delivery, amended, or renewed in this state or outside this state if the policy or contract insures a resident of Nebraska on or after January 1, 2015. No insurer shall terminate coverage or refuse to deliver, issue for delivery, amend, or renew coverage of the insured as a result of an autism spectrum disorder diagnosis or treatment. Nothing in this subsection applies to non-grandfathered plans in the individual and small group markets that are required to include essential health benefits under the federal Patient Protection and Affordable Care Act or to medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care, or other limited benefit hospital insurance policies.

(3) Except as provided in subsection (4) of this section, coverage for an autism spectrum disorder shall not be subject to any limits on the number of visits an individual may make for treatment of an autism spectrum disorder, nor shall such coverage be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to an insured than the equivalent provisions that apply to a general physical illness under the policy.

(4) Coverage for behavioral health treatment, including applied behavior analysis, shall be subject to a maximum benefit of twenty-five hours per week until the insured reaches twenty-one years of age. Payments made by an insurer on behalf of a covered individual for treatment other than behavioral health treatment, including applied behavior analysis, shall not be applied to any maximum benefit established under this section.

(5) Except in the case of inpatient service, if an individual is receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once every six months unless the insurer and the individual's licensed physician or licensed psychologist execute an agreement that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular individual being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a licensed physician or licensed psychologist. The cost of obtaining a review under this subsection shall be borne by the insurer.

(6) This section shall not be construed as limiting any benefit that is otherwise available to an individual under a hospital, surgical, or medical expense-incurred policy or health maintenance organization contract. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, individualized education program, or individualized service plan.

Source: Laws 2014, LB254, § 2.

44-7,107 Telehealth; asynchronous review by dermatologist; coverage.

(1) For purposes of this section:

(a) Asynchronous review means the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care provider at another site for medical evaluation;

(b) Dermatologist means a board-certified physician who is trained to evaluate and treat individuals with benign and malignant disorders of the skin, hair, nails, and adjacent mucous membranes with a specialization in the diagnosis and treatment of skin cancers, melanomas, moles, and other tumors of the skin along with surgical techniques used in dermatology and interpretation of skin biopsies; and

(c) Telehealth has the same meaning as in section 44-312.

(2) Any insurer offering (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state, (b) any hospital, medical, or surgical expense-incurred policy, or (c) any self-funded employee benefit plan to the extent not preempted by federal law, shall not exclude, in any policy, certificate, contract, or plan offered or renewed on or after August 24, 2017, a service from coverage solely because the service is delivered through telehealth, including services

originating from any location where the patient is located, and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

(3)(a) Any insurer offering any policy, certificate, contract, or plan described in subsection (2) of this section for which coverage of benefits begins on or after January 1, 2021, shall not exclude from coverage telehealth services provided by a dermatologist solely because the service is delivered asynchronously.

(b) An insurer shall reimburse a health care provider for asynchronous review by a dermatologist delivered through telehealth at a rate negotiated between the provider and the insurer.

(c) It is not a violation of this subsection for an insurer to include a deductible, copayment, or coinsurance requirement for a health care service provided through telehealth if such costs do not exceed those included for the same services provided through in-person contact.

(4) Nothing in this section shall be construed to require an insurer to provide coverage for services that are not medically necessary.

(5) This section does not apply to any policy, certificate, contract, or plan that provides coverage for a specified disease or other limited-benefit coverage.

Source: Laws 2017, LB92, § 1; Laws 2020, LB760, § 1; Laws 2021, LB400, § 2.
Effective date August 28, 2021.

44-7,108 Synchronizing patient's medications; coverage.

(1) Notwithstanding section 44-3,131, (a) any individual or group sickness and accident insurance policy, certificate, or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law that provides coverage for prescription medications shall apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for a partial supply if the prescribing practitioner or pharmacist determines the fill or refill to be in the best interest of the patient and the patient requests or agrees to a partial supply for the purpose of synchronizing the patient's medications.

(2) A policy, certificate, contract, or plan provider shall not deny coverage for the dispensing of a medication that is dispensed by a network pharmacy on the basis that the dispensing is for a partial supply if the prescribing practitioner or pharmacist determines the fill or refill to be in the best interest of the patient and the patient requests or agrees to a partial supply for the purpose of synchronizing the patient's medications. The policy, certificate, contract, or plan shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon for purposes of medication synchronization.

(3) To be eligible for coverage under this section, the medication:

(a) Must be covered by the enrollee's health benefit plan or have been approved by a formulary exception process;

(b) Must meet the prior authorization or utilization management criteria specifically applicable to the medication under the health benefit plan on the date the request for synchronization is made;

(c) Must be used for treatment and management of a chronic illness;

(d) Must be a formulation that can be safely split into short-fill periods to achieve medication synchronization; and

(e) Must not be a controlled substance listed in Schedule II of section 28-405.

(4) A policy, certificate, contract, or plan provider shall not use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any prorated daily cost-sharing for the beneficiary or fee paid for alignment services.

(5) For purposes of this section, synchronizing the patient's medications means the coordination of medications for a patient who has been prescribed two or more medications for one or more chronic conditions so that the patient's medications are refilled on the same schedule for a given time period.

(6) This section shall apply to any policy, certificate, contract, or plan that is delivered, issued for delivery, or renewed in this state on or after September 7, 2019.

Source: Laws 2019, LB442, § 1.

44-7,109 Network provider; legislative findings; facility; prohibited acts; contract voidable.

(1) The Legislature finds and declares that:

(a) Nebraskans who have a plan of health insurance, health benefits, or health care services provided through a health insurer and who receive health care services from a network provider receive such health care services at rates negotiated by the health insurer;

(b) As part of such negotiations, network providers agree to accept set reimbursement from the health insurer for the health care services provided by the network provider;

(c) The person covered by the health insurer is protected by the contract between the health insurer and the network provider from receiving a bill for the balance between the negotiated rate and a billed charge;

(d) Nebraskans need to know the network status of the provider in order to understand the plan of health insurance, health benefits, or health care services applicable to the health care services being provided by the provider; and

(e) It is necessary to regulate communication by providers to avoid communication that may mislead or cause confusion for Nebraskans receiving care from providers about their network status.

(2) For purposes of this section:

(a) Facility means an institution providing health care services or a health care setting, including, but not limited to, a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a diagnostic, laboratory, or imaging center, or any rehabilitation or other therapeutic health setting. Facility does not include a physician's office;

(b) Health insurer means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service

organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health insurer does not include a self-funded employee benefit plan to the extent preempted by federal law or a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02; and

(c) Network provider means a facility providing services under a plan of health insurance, health benefits, or health care services if the plan either requires a person covered by the health insurer to use, or creates a financial incentive by providing a more favorable deductible, coinsurance, or copayment level for a person covered by the health insurer to use, a health care provider managed, owned, under contract with, or employed by the health insurer which administers the plan.

(3) A facility shall not advertise or hold itself out as a network provider, including any statement that the facility takes or accepts any health insurer, unless the facility is a network provider of the health insurer. A facility that advertises itself as a network provider of a health insurer shall provide a clarifying statement if the facility is not a network provider for all insurance products offered by the health insurer.

(4) Any contract entered into between a facility and a person covered by a health insurer is voidable at the option of the covered person if the facility violates this section.

Source: Laws 2020, LB774, § 3.

44-7,110 Dental services; provider network contracts; restrictions on method of payment, prohibited; third-party access; conditions; applicability of provisions.

(1) For the purposes of this section:

(a) Contracting entity means a person or entity that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a dental carrier or third-party administrator;

(b) Dental carrier means a dental insurance company, a prepaid limited health service organization, or any other entity authorized to offer an insurance plan that provides dental services;

(c) Dental services means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. Dental services does not include services delivered by a provider that are billed as medical services under a health insurance plan;

(d) Provider means an individual or entity that provides dental services or supplies, as defined by the health benefits plan or dental benefits plan, including a dentist or physician, but not a physician organization that leases or rents its network to a third party;

(e) Provider network contract means a contract between a contracting entity and a provider that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee; and

(f) Third party means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. Third party

does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

(2) A dental insurance plan, contract, or provider network contract with a provider shall not include any restrictions on methods of claim payment for dental services in which the only acceptable payment method is a credit card payment.

(3) A dental carrier may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract if, at the time the provider network contract is entered into or renewed, the dental carrier allows a provider who is part of a dental carrier's provider network to choose not to participate in third-party access to the provider network contract. The third-party access provision of the provider network contract shall be clearly identified. A dental carrier shall not grant a third party access to the provider network contract of any provider who does not participate in third-party access to the provider network contract.

(4) A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract, if the following requirements are met:

(a) The contracting entity identifies all third parties in existence in a list on its Internet website that is updated at least once every ninety days;

(b) The provider network contract specifically states that the contracting entity may enter into an agreement with a third party that would allow the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and when the contracting entity is a dental carrier, the provider chose to participate in third-party access at the time the provider network contract was entered into; and

(c) The third party accessing the provider network contract agrees to comply with all applicable terms of the provider network contract.

(5) A provider is not bound by and is not required to perform dental treatment or services under a provider network contract granted to a third party in violation of this section.

(6) Subsections (3), (4), and (5) of this section shall not apply if any of the following is true:

(a) The provider network contract is for dental services provided to a beneficiary of the federal medicare program pursuant to Title XVIII of the federal Social Security Act, 42 U.S.C. 1395 et seq., or the federal medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., as such sections existed on January 1, 2020; or

(b) Access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website.

(7) This section shall take effect on January 1, 2021, and shall apply to all provider network contracts that are delivered, issued for delivery, or executed in this state on or after November 14, 2020.

Source: Laws 2020, LB774, § 4.

44-7,111 Step-Therapy Reform Act, how cited.

Sections 44-7,111 to 44-7,117 shall be known and may be cited as the Step-Therapy Reform Act.

Source: Laws 2021, LB337, § 1.
Effective date August 28, 2021.

44-7,112 Terms, defined.

For purposes of the Step-Therapy Reform Act:

(1) Clinical practice guidelines means a systematically developed statement to assist decisionmaking by health care providers and decisions by covered persons about appropriate health care for specific clinical circumstances and conditions;

(2) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by a health carrier or utilization review organization to determine the medical necessity and appropriateness of health care services;

(3) Health carrier means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Director of Insurance, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a managed care organization;

(4) Pharmaceutical sample means a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug;

(5) Step-therapy override exception means that a step-therapy protocol should be overridden in favor of coverage of the prescription drug selected by a health care provider within the applicable timeframes, based on a review of the request of the health care provider or covered person for an override, along with supporting rationale and documentation;

(6) Step-therapy protocol means a protocol, policy, or program that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular covered person are covered under a pharmacy or medical benefit by a health carrier or a utilization review organization, including self-administered drugs and drugs administered by a health care provider; and

(7) Utilization review organization means an entity that conducts a utilization review other than a health carrier performing a review for its own health benefit plans.

Source: Laws 2021, LB337, § 2.
Effective date August 28, 2021.

44-7,113 Health carrier or utilization review organization; step-therapy protocol; clinical review criteria.

A health carrier or utilization review organization shall consider available recognized evidence-based and peer-reviewed clinical practice guidelines when establishing a step-therapy protocol. Upon written request of a covered person,

a health carrier or utilization review organization shall provide any clinical review criteria applicable to a specific prescription drug covered by the health carrier or utilization review organization.

Source: Laws 2021, LB337, § 3.
Effective date August 28, 2021.

44-7,114 Step-therapy override exception; process.

When coverage of a prescription drug for the treatment of any medical condition is restricted for use by a health carrier or utilization review organization through the use of a step-therapy protocol, the prescribing health care provider and the covered person shall have access to a clear, readily accessible, and convenient process to request a step-therapy override exception. A health carrier or utilization review organization may use its existing medical exceptions process to satisfy this requirement. The process used shall be easily accessible on the Internet site of the health carrier or utilization review organization.

Source: Laws 2021, LB337, § 4.
Effective date August 28, 2021.

44-7,115 Step-therapy override exception; approval; procedure; effect.

(1) A step-therapy override exception shall be approved by a health carrier or utilization review organization if any of the following circumstances apply:

(a) The prescription drug required under the step-therapy protocol is contraindicated pursuant to the drug manufacturer's prescribing information for the drug or, due to a documented adverse event with a previous use or a documented medical condition, including a comorbid condition, is likely to do any of the following:

(i) Cause an adverse reaction to the covered individual;

(ii) Decrease the ability of the covered individual to achieve or maintain reasonable functional ability in performing daily activities; or

(iii) Cause physical or mental harm to the covered individual;

(b) The prescription drug required under the step-therapy protocol is expected to be ineffective based on the known clinical characteristics of the covered person, such as the covered person's adherence to or compliance with the covered person's individual plan of care, and any of the following:

(i) The known characteristics of the prescription drug regimen as described in peer-reviewed literature or in the manufacturer's prescribing information for the drug;

(ii) The health care provider's medical judgment based on clinical practice guidelines or peer-reviewed journals; or

(iii) The covered person's documented experience with the prescription drug regimen;

(c) The covered person has had a trial of a therapeutically equivalent dose of the prescription drug under the step-therapy protocol while under the covered person's current or previous health benefit plan for a period of time to allow for a positive treatment outcome, and such prescription drug was discontinued by the covered person's health care provider due to lack of effectiveness; or

(d) The covered person is currently receiving a positive therapeutic outcome on a prescription drug selected by the covered person's health care provider for the medical condition under consideration while under the covered person's current or previous health benefit plan. Nothing in the Step-Therapy Reform Act shall prohibit the distribution of a pharmaceutical sample, except that the pharmaceutical sample may not be used to meet the requirements of this subdivision.

(2) Upon the approval of a step-therapy override exception, the health carrier or utilization review organization shall authorize coverage for the prescription drug selected by the covered person's prescribing health care provider if the prescription drug is a covered prescription drug under the covered person's health benefit plan.

(3) Except in the case of an urgent care request, a health carrier or utilization review organization shall make a determination to approve or deny a request for a step-therapy override exception within five calendar days after receipt of complete, clinically relevant written documentation supporting a step-therapy override exception under subsection (1) of this section. In the case of an urgent care request, a health carrier or utilization review organization shall approve or deny a request for a step-therapy override exception within seventy-two hours after receipt of such documentation. If a request for a step-therapy override exception is incomplete or additional clinically relevant information is required, the health carrier or utilization review organization may request such information within the applicable time period provided in this section. Once the information is submitted, the applicable time period for approval or denial shall begin again. If a health carrier or utilization review organization fails to respond to the request for a step-therapy override exception within the applicable time, the step-therapy override exception shall be deemed granted.

(4) If a request for a step-therapy override exception is denied, the health carrier or utilization review organization shall provide the covered person or the covered person's authorized representative and the covered person's prescribing health care provider with the reason for the denial and information regarding the procedure to request external review of the denial pursuant to the Health Carrier External Review Act. Any denial of a request for a step-therapy override exception that is upheld on an internal appeal shall be considered a final adverse determination for purposes of the Health Carrier External Review Act and is eligible for a request for external review by a covered person or the covered person's authorized representative pursuant to the Health Carrier External Review Act.

(5) This section shall not be construed to prevent:

(a) A health carrier or utilization review organization from requiring a pharmacist to effect substitutions of prescription drugs consistent with section 28-414.01, 38-28,111, or 71-2478;

(b) A health care provider from prescribing a prescription drug that is determined to be medically appropriate; or

(c) A health carrier or utilization review organization from requiring a covered person to try a prescription drug with the same generic name and demonstrated bioavailability or a biological product that is an interchangeable

biological product pursuant to the Nebraska Drug Product Selection Act prior to providing coverage for the equivalent branded prescription drug.

Source: Laws 2021, LB337, § 5.
Effective date August 28, 2021.

Cross References

Health Carrier External Review Act, see section 44-1301.
Nebraska Drug Product Selection Act, see section 38-28,108.

44-7,116 Rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations necessary to enforce the Step-Therapy Reform Act.

Source: Laws 2021, LB337, § 6.
Effective date August 28, 2021.

44-7,117 Act; applicability.

(1) The Step-Therapy Reform Act applies to all individual and group health insurance policies, contracts, and certificates issued by health carriers, self-funded nonfederal governmental plans, and state employee health plans offered by the State of Nebraska.

(2) The Step-Therapy Reform Act applies to any health insurance or health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2022.

Source: Laws 2021, LB337, § 7.
Effective date August 28, 2021.

ARTICLE 8

ASSESSMENT ASSOCIATIONS

Section

Section
44-824. Repealed. Laws 1991, LB 237, § 72.
44-825. Foreign health and accident associations; deposit in state of domicile.
44-826. Financial plans with other insurers to pool losses; conditions.

44-801 Domestic associations; special and additional requirements; amendments to bylaws; approval of department required.

No domestic assessment association shall begin to transact the business of insurance until (1) its bylaws, stating in detail its scheme and method of doing business, shall have been approved by the Department of Insurance; and (2) it has received one hundred or more applications for membership, and shall have received in cash the proceeds of one assessment, unless formed to insure grain elevators and contents, warehouses, coal sheds, lumber yards and flour mills, in which case there shall be not less than fifty applications for membership.

Every amendment to a bylaw, which in any manner changes the scheme or method of doing business, must be approved by the Department of Insurance before it shall take effect.

Source: Laws 1913, c. 154, § 124, p. 463; R.S.1913, § 3261; Laws 1919, c. 190, tit. V, art. X, § 1, p. 644; C.S.1922, § 7860; C.S.1929, § 44-901; R.S.1943, § 44-801; Laws 1957, c. 178, § 13, p. 617.

Assessments were made in conformity with statute and policyholder liable thereon. Nebraska Mutual Ins. Co. v. Borden, 132 Neb. 656, 272 N.W. 767 (1937).

44-802 Assessments; how determined; by whom made.

All assessments shall be determined by proper classification and rating of the risks which an assessment association may assume, so that every member may be assessed in a proper proportion to his risk. The method of estimating the pro rata amount of each member's liability for losses and his share of the expenses shall be fixed in the bylaws, which may provide for assessments for not more than one year in advance in accordance with the amount estimated by the board of directors to be necessary to meet the losses and expenses of the association for such period; *Provided,* any assessment association maintaining the same reserves, surplus, and contingency funds as are required of a stock or mutual company licensed to transact the same kind or kinds of business, may make advance assessments for periods longer than one year at the discretion of its board of directors.

Source: Laws 1913, c. 154, § 125, p. 463; R.S.1913, § 3262; Laws 1919, c. 190, tit. V, art. X, § 2, p. 644; C.S.1922, § 7861; C.S.1929, § 44-902; Laws 1935, c. 95, § 1, p. 318; Laws 1939, c. 51, § 1, p. 220; C.S.Supp.,1941, § 44-902; R.S.1943, § 44-802; Laws 1951, c. 145, § 1, p. 587.

Amendment to statute providing for assessments for future losses is not applicable to contract made before amended statute went into effect, and defendant was authorized to levy assessments only for losses which had occurred, together with necessary expenses. Ehlers v. Farmers Mutual Ins. Co., 130 Neb. 368, 264 N.W. 894 (1936).

Under prior law, assessments must be levied by board of directors subject to limitations expressed, which are to be construed as on annual basis and only for losses actually accrued at date assessment levied, and future anticipated losses or expenses may not be covered by assessments. Hobza v. State Farmers Ins. Co., 125 Neb. 776, 252 N.W. 214 (1934).

Officers and directors, members of mutual assessment association, against which compensation is claimed for employee's death, are disqualified as witnesses to transaction or conversation between them and deceased against latter's legal representative. Priest v. Business Men's Protective Assn., 117 Neb. 198, 220 N.W. 255 (1928).

Under facts herein, insurance company was not an assessment association. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-803 Assessments; limitations.

Any assessment association which has accumulated and maintains the same reserve for liabilities that is required of a stock or mutual company organized to transact the same business, and either a surplus or a contingency fund equal to the surplus required to be maintained by a stock or mutual company organized to transact the same business, may, in its bylaws or policies, limit the liability of its members for future assessments, but such limitation shall not be less than the amount of one assessment equal to the regular assessment specified in the policy. All assessments shall be made by the board of directors unless otherwise provided in the articles of association or the bylaws.

Source: Laws 1913, c. 154, § 125, p. 463; R.S.1913, § 3262; Laws 1919, c. 190, tit. V, art. X, § 2, p. 644; C.S.1922, § 7861; C.S.1929, § 44-902; Laws 1935, c. 95, § 1, p. 318; C.S.Supp.,1941, § 44-902; R.S.1943, § 44-803.

44-804 Assessments; when authorized.

No assessment shall be made on a member for liability occurring prior to his membership. A member may be excluded from all benefits during the time he is in default of payment of any assessment.

Source: Laws 1913, c. 154, § 126, p. 463; R.S.1913, § 3263; Laws 1919, c. 190, tit. V, art. X, § 3, p. 644; C.S.1922, § 7862; C.S.1929, § 44-903; R.S.1943, § 44-804.

44-805 Membership; withdrawal.

Any member may withdraw by surrendering his or her policy for cancellation at any time by giving notice in writing to the secretary of the association and paying the amount of his or her share of all claims then existing against the company in accordance with the bylaws of the company.

Source: Laws 1913, c. 154, § 127, p. 463; R.S.1913, § 3264; Laws 1919, c. 190, tit. V, art. X, § 4, p. 645; C.S.1922, § 7863; C.S.1929, § 44-904; R.S.1943, § 44-805; Laws 1989, LB 92, § 163.

Under facts herein, insurance company was not an assessment association. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-806 Losses; notice; adjustment.

Every member of such association who may sustain loss or damage shall, as soon as practicable thereafter, notify the secretary thereof, stating the amount of damage or loss claimed. The person or persons authorized by such company to adjust losses shall proceed to ascertain the amount of such loss or damage, and adjust the same.

Source: Laws 1913, c. 154, § 128, p. 464; R.S.1913, § 3265; Laws 1919, c. 190, tit. V, art. X, § 5, p. 645; C.S.1922, § 7864; C.S.1929, § 44-905; R.S.1943, § 44-806.

Statutory provisions authorizing organization of assessment hail insurance company, articles of incorporation and by-laws of company, application for membership and policy issued thereon or the application if it is in fact a policy, constitute the contract. Schnell v. United Hail Ins. Co., 145 Neb. 768, 18 N.W.2d 112 (1945).

Conversation with insurance company's employee three years after loss was not proper notice. Clark v. State Farmers Ins. Co., 142 Neb. 483, 7 N.W.2d 71 (1942).

44-807 Assessments and losses; actions to recover.

Suits at law may be brought against any member who shall neglect or refuse to pay any assessment made against him, in the same manner as for the collection of any other debt; and a member may bring an action against the company for any loss sustained.

Source: Laws 1913, c. 154, § 129, p. 464; R.S.1913, § 3266; Laws 1919, c. 190, tit. V, art. X, § 6, p. 645; C.S.1922, § 7865; C.S.1929, § 44-906; R.S.1943, § 44-807.

44-808 Losses; officers; liability.

If the officers and directors of an assessment association fail or refuse, after receiving notice of a loss, to act upon the notice of loss, they shall render themselves individually liable therefor, and an action may be maintained against them to collect such amount.

Source: Laws 1913, c. 154, § 130, p. 464; R.S.1913, § 3267; Laws 1919, c. 190, tit. V, art. X, § 7, p. 645; C.S.1922, § 7866; C.S.1929, § 44-907; R.S.1943, § 44-808; Laws 1989, LB 92, § 164.

Officers and directors have such direct interest in result of suit against company for compensation for employee's death as to disqualify them as witnesses as to transactions between them and deceased against latter's legal representative. Priest v. Business Men's Protective Assn., 117 Neb. 198, 220 N.W. 255 (1928).

44-809 Membership fees; amount; purpose.

Every such association may collect, at the time of the issuing of a policy, a membership fee not exceeding five dollars, and, if insuring property, a percentage of the amount insured not exceeding two and one-half percent, as an advance assessment, as the bylaws may provide. From the amount so collected, a contingency fund may be created, and such fund may be maintained and added to from any other funds collected by the company in the manner provided in the bylaws.

Source: Laws 1913, c. 154, § 131, p. 464; R.S.1913, § 3268; Laws 1919, c. 190, tit. V, art. X, § 8, p. 645; C.S.1922, § 7867; C.S.1929, § 44-908; Laws 1931, c. 88, § 1, p. 249; C.S.Supp.,1941, § 44-908; R.S.1943, § 44-809.

Under facts herein, insurance company is not an assessment association. Western Life & Accident Co. v. State Ins. Board, 101 Neb. 152, 162 N.W. 530 (1917).

44-810 Claims; payment; power to borrow.

Whenever the cash on hand, not including the contingency fund, shall be insufficient to pay all claims, then such deficiency may be taken from the contingency fund. If this fund is insufficient to meet all claims, then the company may borrow money for such purposes. Any diminution of the contingency fund shall be a liability to be provided for by the next assessment.

Source: Laws 1913, c. 154, § 132, p. 464; R.S.1913, § 3269; Laws 1919, c. 190, tit. V, art. X, § 9, p. 645; C.S.1922, § 7868; C.S.1929, § 44-909; R.S.1943, § 44-810.

44-811 Losses; arbitration of claims; copy of award furnished.

Any such association may provide in its bylaws for arbitrating any claim for loss or damage, where a member and the association fail to agree thereon. A

copy of any adjustment or arbitration award on any claim for loss or damage shall be furnished the policyholder by the adjuster immediately when signed by the loss claimant.

Source: Laws 1913, c. 154, § 133, p. 465; R.S.1913, § 3270; Laws 1919, c. 190, tit. V, art. X, § 10, p. 646; C.S.1922, § 7869; C.S.1929, § 44-910; R.S.1943, § 44-811; Laws 1947, c. 166, § 1, p. 474.

44-812 Policies; maximum coverage; exceptions.

No certificate or policy of an assessment association, insuring property, shall cover a longer period than five years from its date, unless such assessment association shall provide in its bylaws for readjustment or reappraisement of such property insured at least once in five years.

Source: Laws 1913, c. 154, § 134, p. 465; R.S.1913, § 3271; Laws 1919, c. 190, tit. V, art. X, § 11, p. 646; C.S.1922, § 7870; C.S.1929, § 44-911; R.S.1943, § 44-812.

44-813 Repealed. Laws 1989, LB 92, § 278.

44-813.01 Repealed. Laws 1989, LB 92, § 278.

44-814 Repealed. Laws 1989, LB 92, § 278.

44-815 Repealed. Laws 1989, LB 92, § 278.

44-816 Repealed. Laws 1989, LB 92, § 278.

44-817 Repealed. Laws 1989, LB 92, § 278.

44-818 Repealed. Laws 1989, LB 92, § 278.

44-819 Repealed. Laws 1989, LB 92, § 278.

44-820 Repealed. Laws 1989, LB 92, § 278.

44-821 Domestic health and accident associations; deposit required.

No domestic assessment association organized after August 24, 1941, shall be authorized to transact the business of health or accident insurance until it has deposited with the Department of Insurance the sum of ten thousand dollars in cash or securities as described in subdivision (4) of section 44-319.01.

Source: Laws 1941, c. 89, § 1, p. 342; C.S.Supp.,1941, § 44-807; R.S. 1943, § 44-821; Laws 1957, c. 189, § 4, p. 663; Laws 1959, c. 211, § 1, p. 731; Laws 1991, LB 237, § 63.

44-822 Domestic health and accident associations; deposit; use; restoration.

The deposit required in section 44-821 shall be used only for the payment of indemnities provided in policies issued by the depositor, and only upon a showing of necessity therefor made to the Department of Insurance, and after the approval thereof by the department. Such deposit shall be restored within such time and under such conditions as the department may direct by order.

Source: Laws 1941, c. 89, § 2, p. 342; C.S.Supp.,1941, § 44-808; R.S. 1943, § 44-822.

44-823 Domestic health and accident associations; reserves; creation.

Nothing in sections 44-821 to 44-825, or in any law enacted before August 24, 1941, shall be construed to place any limitation upon the right of any assessment association to create reserves for expenses, unearned premiums or claims, or to create a surplus or contingency fund in such amount as may in the opinion of its board of directors be deemed prudent for the future protection of its policyholders.

Source: Laws 1941, c. 89, § 3, p. 342; C.S.Supp.,1941, § 44-809; R.S. 1943, § 44-823.

44-824 Repealed. Laws 1991, LB 237, § 72.

44-825 Foreign health and accident associations; deposit in state of domicile.

After August 24, 1941, no foreign assessment association shall be authorized to transact the business of accident or health insurance in this state unless it shall have assets on deposit with the insurance department of the state of its domicile in an amount at least equal to the requirements herein made applicable to like domestic associations.

Source: Laws 1941, c. 89, § 6, p. 343; C.S.Supp.,1941, § 44-812; R.S. 1943, § 44-825.

44-826 Financial plans with other insurers to pool losses; conditions.

Any assessment association insuring property against fire, windstorm, cyclone, tornado, or other hazard which may be catastrophic, may participate with other insurers in financial plans or pools to protect the participants against excessive losses due to such catastrophes. For such purposes association funds may be deposited with or promised to trustees for the participants and loaned by such trustees to participants sustaining such excessive losses with provision for repayment over a reasonable period of years; *Provided,* that not more than twenty cents for each hundred dollars of insurance in force may be deposited or committed under such plan; *and provided further,* that participation in such plan must be approved by the Director of Insurance.

Source: Laws 1951, c. 134, § 1, p. 557.

ARTICLE 9

PRIVACY OF INSURANCE CONSUMER INFORMATION ACT

Section

Section

44-901 Act, how cited.

Sections 44-901 to 44-925 shall be known and may be cited as the Privacy of Insurance Consumer Information Act.

Source: Laws 2001, LB 52, § 1.

44-902 Act; applicability.

(1) The Privacy of Insurance Consumer Information Act governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the Department of Insurance. The act:

(a) Requires a licensee to provide notice to individuals about its privacy policies and practices;

(b) Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

(c) Provides methods for individuals to prevent a licensee from disclosing that information.

(2) The act applies to:

(a) Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family, or household purposes from licensees. The act does not apply to information about companies or about individuals who obtain products or services for business, commercial, or agricultural purposes; and

(b) All nonpublic personal health information.

(3) A licensee domiciled in this state that is in compliance with the act in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act, as the federal law existed on April 5, 2001, may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act, as such federal law existed on April 5, 2001, in such other state.

Source: Laws 2001, LB 52, § 2.

44-903 Terms, defined.

For purposes of the Privacy of Insurance Consumer Information Act:

(1) Affiliate means any company that controls, is controlled by, or is under common control with another company;

(2) Clear and conspicuous means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice;

(3) Collect means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol, or other identifying particular assigned to the individual, irrespective of the source of the underlying information;

(4) Company means any corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship, or similar organization;

(5)(a) Consumer means an individual who seeks to obtain, obtains, or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative;

(b) Consumer includes:

(i) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment, or economic advisory services relating to an insurance product or service whether or not the licensee establishes an ongoing advisory relationship;

(ii) An applicant for insurance prior to the inception of insurance coverage; and

(iii) An individual who is a beneficiary of a life insurance policy underwritten by the licensee, who is a claimant under an insurance policy issued by the licensee, who is an insured or an annuitant under an insurance policy or an annuity issued by the licensee, or who is a mortgagor of a mortgage covered under a mortgage insurance policy, if the licensee discloses nonpublic personal financial information about such individual to a nonaffiliated third party other than as permitted under sections 44-913 to 44-915;

(c) Consumer does not include an individual:

(i) Who is a consumer of another financial institution solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution;

(ii) Solely because such individual is a participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer, or fiduciary, covered under a group or blanket insurance policy or group annuity contract issued by the licensee, or a beneficiary in a workers' compensation plan if:

(A) The licensee provides the initial, annual, and revised notices under sections 44-904, 44-905, and 44-908 to the plan sponsor, group or blanket insurance policyholder, group annuity contract holder, or workers' compensation plan participant; and

(B) The licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under sections 44-913 to 44-915;

(iii) Solely because he or she is a beneficiary of a trust for which the licensee is a trustee; or

(iv) Solely because he or she has designated the licensee as a trustee for a trust;

(6) Consumer reporting agency has the same meaning as in 15 U.S.C. 1681a(f), as such section existed on April 5, 2001;

(7) Control means:

(a) Ownership, control, or power to vote twenty-five percent or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(b) Control in any manner over the election of a majority of the directors, trustees, or general partners, or individuals exercising similar functions, of the company; or

(c) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the director determines;

(8) Customer means a consumer who has a customer relationship with a licensee;

(9)(a) Customer relationship means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family, or household purposes.

(b) Customer relationship includes a continuing relationship between a consumer and a licensee if:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer obtains financial, investment, or economic advisory services relating to an insurance product or service from the licensee for a fee;

(10) Director means the Director of Insurance;

(11)(a) Financial institution means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in 12 U.S.C. 1843(k), as such section existed on April 5, 2001.

(b) Financial institution does not include:

(i) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act, 7 U.S.C. 1 et seq., as the act existed on April 5, 2001;

(ii) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971, 12 U.S.C. 2001 et seq., as the act existed on April 5, 2001; or

(iii) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales, including sales of servicing rights, or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party;

(12)(a) Financial product or service means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under 12 U.S.C. 1843(k), as such section existed on April 5, 2001.

(b) Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service;

(13) Health care means:

(a) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, services, procedures, tests, or counseling that:

(i) Relates to the physical, mental, or behavioral condition of an individual; or

(ii) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

(b) Prescribing, dispensing, or furnishing to an individual drugs, biologicals, medical devices, or health care equipment and supplies;

(14) Health care provider means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law or a health care facility;

(15) Health information means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(a) The past, present, or future physical, mental, or behavioral health or condition of an individual;

(b) The provision of health care to an individual; or

(c) Payment for the provision of health care to an individual;

(16)(a) Insurance product or service means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

(b) Insurance service includes a licensee's evaluation, brokerage, or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service;

(17)(a) Licensee means all licensed insurers, including fraternal benefit societies, producers, and other persons licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of this state.

(b) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in the Privacy of Insurance Consumer Information Act if the licensee is an employee, agent, or other representative of another licensee acting as principal and:

(i) The principal otherwise complies with, and provides the notices required by, the act; and

(ii) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by the act.

(c)(i) Subject to subdivision (17)(c)(ii) of this section, licensee also includes an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to the Surplus Lines Insurance Act.

(ii) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in the Privacy of Insurance Consumer Information Act if:

(A) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose,

including joint servicing or marketing under section 44-913, except as permitted by section 44-914 or 44-915; and

(B) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in sixteen-point type:

PRIVACY NOTICE

NEITHER THE UNITED STATES BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW;

(18)(a) Nonaffiliated third party means any person except:

(i) A licensee's affiliate; or

(ii) A person employed jointly by a licensee and any company that is not the licensee's affiliate, but nonaffiliated third party includes the other company that jointly employs the person.

(b) Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in 12 U.S.C. 1843(k)(4)(H), as such section existed on April 5, 2001, or insurance company investment activities of the type described in 12 U.S.C. 1843(k)(4)(H) and (I), as such section existed on April 5, 2001;

(19) Nonpublic personal information means nonpublic personal financial information and nonpublic personal health information;

(20)(a) Nonpublic personal financial information means:

(i) Personally identifiable financial information; and

(ii) Any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived using any personally identifiable financial information that is not publicly available.

(b) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(c) Nonpublic personal financial information does not include:

(i) Health information;

(ii) Publicly available information, except as included on a list described in subdivision (20)(a)(ii) of this section;

(iii) Any list, description, or other grouping of consumers, and publicly available information pertaining to them, that is derived without using any personally identifiable financial information that is not publicly available; or

(iv) Any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution;

(21) Nonpublic personal health information means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

(22) Personally identifiable financial information means any information:

(a) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(b) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(c) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer; and

(23)(a) Publicly available information means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(i) Federal, state, or local government records;

(ii) Widely distributed media; or

(iii) Disclosures to the general public that are required to be made by federal, state, or local law.

(b) For purposes of this definition, a licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(i) That the information is of the type that is available to the general public; and

(ii) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

Source: Laws 2001, LB 52, § 3.

Cross References

Surplus Lines Insurance Act, see section 44-5501.

44-904 Initial privacy notice to consumers; when required.

(1) A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(a) An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in subsection (5) of this section; and

(b) A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by sections 44-914 and 44-915.

(2) A licensee is not required to provide an initial notice to a consumer under subdivision (1)(b) of this section if:

(a) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by sections 44-914 and 44-915, and the licensee does not have a customer relationship with the consumer; or

(b) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

(3)(a) A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(b) A licensee establishes a customer relationship when the consumer:

(i) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer obtains insurance through that licensee; or

(ii) Agrees to obtain financial, economic, or investment advisory services relating to insurance products or services for a fee from the licensee.

(4) When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family, or household purposes, the licensee satisfies the initial notice requirements of subsection (1) of this section as follows:

(a) The licensee may provide a revised policy notice, under section 44-908, that covers the customer's new insurance product or service; or

(b) If the initial, revised, or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under subsection (1) of this section.

(5)(a) A licensee may provide the initial notice required by subdivision (1)(a) of this section within a reasonable time after the licensee establishes a customer relationship if establishing the customer relationship is not at the customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) A licensee may provide the initial notice required by subdivision (1)(a) of this section within a reasonable time after the licensee establishes a customer relationship if providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time. Providing notice not later than when a licensee establishes a customer relationship substantially delays the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service. Providing notice not later than when a licensee establishes a customer relationship does not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a website.

(6) When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to section 44-909. If the licensee uses a short form initial notice for noncustomers according to subsection (4) of section 44-906, the licensee may deliver its privacy notice according to subdivision (4)(c) of section 44-906.

Source: Laws 2001, LB 52, § 4.

44-905 Annual privacy notice to consumers; when required.

(1) A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. For purposes of this subsection, annually means at least once in any period of twelve consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(2) A licensee is not required to provide an annual notice under subsection (1) of this section if the licensee:

(a) Provides nonpublic personal information to nonaffiliated third parties only in accordance with sections 44-913 to 44-915; and

(b) Has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with section 44-904 or subsection (1) of this section.

(3)(a) A licensee is not required to provide an annual notice to a former customer.

(b) For purposes of this subsection, a former customer is an individual with whom a licensee no longer has a continuing relationship. A former customer includes:

(i) An individual who is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(ii) An individual whose policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials;

(iii) An individual whose last-known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful; and

(iv) In the case of providing real estate settlement services, the customer has completed execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

(4) When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to section 44-909.

Source: Laws 2001, LB 52, § 5; Laws 2017, LB241, § 1.

44-906 Privacy notices; requirements.

(1) The initial, annual, and revised privacy notices that a licensee provides under sections 44-904, 44-905, and 44-908 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(a) The categories of nonpublic personal financial information that the licensee collects;

(b) The categories of nonpublic personal financial information that the licensee discloses;

(c) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under sections 44-914 and 44-915;

(d) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under sections 44-914 and 44-915;

(e) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under section 44-913, and no other exception in sections 44-914 and 44-915 applies to that disclosure, a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(f) An explanation of the consumer's right under subsection (1) of section 44-910 to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(g) Any disclosures that the licensee makes under 15 U.S.C. 1681a(d)(2)(A)(iii), as such section existed on April 5, 2001;

(h) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information; and

(i) Any disclosure that the licensee makes under subsection (2) of this section.

(2) If a licensee discloses nonpublic personal financial information as authorized under sections 44-914 and 44-915, the licensee is not required to list those exceptions in the initial or annual privacy notices required by sections 44-904 and 44-905. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

(3) If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under sections 44-914 and 44-915, the licensee may simply state that fact, in addition to the information it shall provide under subdivisions (1)(a), (1)(h), and (1)(i) of this section and subsection (2) of this section.

(4)(a) A licensee may satisfy the initial notice requirements in subdivision (1)(b) of section 44-904 and subsection (3) of section 44-907 for a consumer who is not a customer by providing a short form initial notice at the same time as the licensee delivers an opt out notice as required in section 44-907.

(b) A short form initial notice shall:

(i) Be clear and conspicuous;

(ii) State that the licensee's privacy notice is available upon request; and

(iii) Explain a reasonable means by which the consumer may obtain that notice. Such reasonable means include provision of a toll-free telephone number that the consumer may call to request the notice or, for a consumer who conducts business in person at the licensee's office, maintenance of copies of the notice on hand that the licensee provides to the consumer immediately upon request.

(c) The licensee shall deliver its short form initial notice according to section 44-909. The licensee is not required to deliver its privacy notice with its short form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to section 44-909.

(5) The licensee's notice may include:

(a) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

(b) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

Source: Laws 2001, LB 52, § 6.

44-907 Opt out notice and methods.

(1) If a licensee is required to provide an opt out notice under subsection (1) of section 44-910, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(a) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(b) That the consumer has the right to opt out of that disclosure; and

(c)(i) A reasonable means by which the consumer may exercise the opt out right.

(ii) A licensee provides a reasonable means to exercise an opt out right pursuant to subdivision (1)(c) of this section if the licensee:

(A) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(B) Includes a reply form together with the opt out notice;

(C) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's website, if the consumer agrees to the electronic delivery of information; or

(D) Provides a toll-free telephone number that consumers may call to opt out.

(2) A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with section 44-904.

(3) If a licensee provides the opt out notice later than required for the initial notice in accordance with section 44-904, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

(4)(a) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer.

(b) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(i) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(ii) Permit each joint consumer to opt out separately.

(c) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(d) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(5) A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

(6) A consumer may exercise the right to opt out at any time.

(7)(a) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(b) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

(8) When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to section 44-909.

Source: Laws 2001, LB 52, § 7.

44-908 Revised privacy notice; when required.

(1) Except as otherwise authorized in the Privacy of Insurance Consumer Information Act, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under section 44-904 unless:

(a) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(b) The licensee has provided to the consumer a new opt out notice;

(c) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(d) The consumer does not opt out.

(2) When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to section 44-909.

Source: Laws 2001, LB 52, § 8.

44-909 Delivery; actual notice; when.

(1) A licensee shall provide any notices that the Privacy of Insurance Consumer Information Act requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

(2)(a) A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(i) Hand delivers a printed copy of the notice to the consumer;

(ii) Mails a printed copy of the notice to the last-known address of the consumer separately or in a policy, billing, or other written communication;

(iii) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service; and

(iv) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(b) A licensee may not reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(i) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(ii) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

(3) A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(a) The customer uses the licensee's website to access insurance products and services electronically and agrees to receive notices at the website and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the website; or

(b) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

(4) A licensee may not provide any notice required by the act solely by orally explaining the notice, either in person or over the telephone.

(5)(a) For customers only, a licensee shall provide the initial notice required by subdivision (1)(a) of section 44-904, the annual notice required by subsection (1) of section 44-905, and the revised notice required by section 44-908 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(b) A licensee shall be deemed to comply with the provisions of this subsection if the licensee:

(i) Hand delivers a printed copy of the notice to the customer;

(ii) Mails a printed copy of the notice to the last-known address of the customer; or

(iii) Makes its current privacy notice available on a website, or a link to another website, for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the website.

(6) A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

(7) If two or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual, and revised notice requirements of subsection (1) of section 44-904, subsection (1) of section 44-905, and subsection (1) of section 44-908, respectively, by providing one notice to those consumers jointly.

Source: Laws 2001, LB 52, § 9.

44-910 Disclosure of financial information to nonaffiliated third party; when.

(1)(a) Except as otherwise authorized in the Privacy of Insurance Consumer Information Act, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(i) The licensee has provided to the consumer an initial notice as required under section 44-904;

(ii) The licensee has provided to the consumer an opt out notice as required in section 44-907;

(iii) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party to opt out of the disclosure; and

(iv) The consumer does not opt out.

(b) A licensee shall be deemed to provide a consumer with a reasonable opportunity to opt out pursuant to subdivision (1)(a)(iii) of this section if:

(i) The licensee mails the notices required in subdivision (1)(a) of this section to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number, or any other reasonable means within thirty days from the date the licensee mailed the notices;

(ii) A customer opens an online account with a licensee and agrees to receive the notices required in subdivision (1)(a) of this section electronically, and the licensee allows the customer to opt out by any reasonable means within thirty days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account; or

(iii) For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in subdivision (1)(a) of this section at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

(c) For purposes of this section, opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party other than as permitted by sections 44-913 to 44-915.

(2) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship. Unless a

licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

(3) A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

Source: Laws 2001, LB 52, § 10.

44-911 Redisclosure and reuse of financial information; when.

(1) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in section 44-914 or 44-915, the licensee's disclosure and use of that information is limited as follows:

(a) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(b) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(c) The licensee may disclose and use the information pursuant to an exception in section 44-914 or 44-915 in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(2) If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in section 44-914 or 44-915, the licensee may disclose the information only:

(a) To the affiliates of the financial institution from which the licensee received the information;

(b) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(c) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(3) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in section 44-914 or 44-915, the third party may disclose and use that information only as follows:

(a) The third party may disclose the information to the licensee's affiliates;

(b) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(c) The third party may disclose and use the information pursuant to an exception in section 44-914 or 44-915 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

(4) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in section 44-914 or 44-915, the third party may disclose the information only:

(a) To the licensee's affiliates;

(b) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(c) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

Source: Laws 2001, LB 52, § 11.

44-912 Policy number; disclosure; when.

(1) A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing, or other marketing through electronic mail to the consumer.

(2) Subsection (1) of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

(a) To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(b) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(c) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

(3)(a) For purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

(b) A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, if the licensee does not provide the recipient with a means to decode the number or code.

Source: Laws 2001, LB 52, § 12.

44-913 Opt out exception for service providers and joint marketing.

(1)(a) The opt out requirements in sections 44-907 and 44-910 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(i) Provides the initial notice in accordance with section 44-904; and

(ii) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in section 44-914 or 44-915 in the ordinary course of business to carry out those purposes.

(b) If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of subdivision (1)(a)(ii) of this section if it prohibits the institution

from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in section 44-914 or 44-915 in the ordinary course of business to carry out that joint marketing.

(2) The services a nonaffiliated third party performs for a licensee under subsection (1) of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

(3) For purposes of this section, joint agreement means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse, or sponsor a financial product or service.

Source: Laws 2001, LB 52, § 13.

44-914 Notice and opt out exception for processing and servicing transactions.

(1) The requirements for initial notice in subdivision (1)(b) of section 44-904, the opt out in sections 44-907 and 44-910, and service providers and joint marketing in section 44-913 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer, or enforce a transaction that a consumer requests or authorizes, or in connection with:

(a) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(b) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(c) A proposed or actual securitization, secondary market sale, including sales of servicing rights, or similar transaction related to a transaction of the consumer; or

(d) Reinsurance or stop-loss or excess-loss insurance.

(2) For purposes of this section, necessary to effect, administer, or enforce a transaction means that the disclosure is:

(a) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(b) Required, or is an usual, appropriate, or acceptable method:

(i) To carry out the transaction or the product or service business of which the transaction is a part, and record, service, or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(ii) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(iii) To provide a confirmation, statement, or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(iv) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(v) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: Account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits, including utilization review activities, participating in research projects, or as otherwise required or specifically permitted by federal or state law; or

(vi) In connection with:

(A) The authorization, settlement, billing, processing, clearing, transferring, reconciling, or collection of amounts charged, debited, or otherwise paid using a debit, credit, or other payment card, check, or account number, or by other payment means;

(B) The transfer of receivables, accounts, or interests therein; or

(C) The audit of debit, credit, or other payment information.

Source: Laws 2001, LB 52, § 14.

44-915 Notice and opt out requirements; additional exceptions.

The requirements for initial notice to consumers in subdivision (1)(b) of section 44-904, the opt out in sections 44-907 and 44-910, and service providers and joint marketing in section 44-913 do not apply when a licensee discloses nonpublic personal financial information:

(1) With the consent or at the direction of the consumer if the consumer has not revoked the consent or direction;

(2)(a) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product, or transaction;

(b) To protect against or prevent actual or potential fraud or unauthorized transactions;

(c) For required institutional risk control or for resolving consumer disputes or inquiries;

(d) To persons holding a legal or beneficial interest relating to the consumer; or

(e) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(3) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants, and auditors;

(4) To the extent specifically permitted or required under other provisions of law and in accordance with 12 U.S.C. 3401 et seq., as such sections existed on January 1, 2019, to law enforcement agencies, including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, National Credit Union Administration, Consumer Financial Protection Bureau, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II, and 12 U.S.C. Chapter 21, as such federal laws existed on January 1, 2019, a state insurance authority, a state banking and state securities authority, and the Federal Trade Commission, to self-regulatory organizations, or for an investigation on a matter related to public safety;

(5)(a) To a consumer reporting agency in accordance with 15 U.S.C. 1681 et seq., as such sections existed on January 1, 2019; or

(b) From a consumer report reported by a consumer reporting agency;

(6) In connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

(7)(a) To comply with federal, state, or local laws, rules, and other applicable legal requirements;

(b) To comply with a properly authorized civil, criminal, or regulatory investigation, or subpoena or summons by federal, state, or local authorities;

(c) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance, or other purposes as authorized by law; or

(8) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan, or a workers' compensation plan.

Source: Laws 2001, LB 52, § 15; Laws 2019, LB258, § 14.

44-916 Disclosure of health information; authorization required; when.

(1) On and after January 1, 2003, a licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

(2) Nothing in this section shall prohibit, restrict, or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee: (a) Claims administration; (b) claims adjustment and management; (c) detection, investigation, or reporting of actual or potential fraud, misrepresentation, or criminal activity; (d) underwriting; (e) policy placement or issuance; (f) loss control; (g) ratemaking and guaranty fund functions; (h) reinsurance and excess loss insurance; (i) risk management; (j) case management; (k) disease management; (l) quality assurance; (m) quality improvement; (n) performance evaluation; (o) provider credentialing verification; (p) utilization review; (q) peer review activities; (r) actuarial, scientific, medical, or public policy research; (s) grievance procedures; (t) internal administration of compliance, managerial, and information systems; (u) policyholder service functions; (v) auditing; (w) reporting; (x) database security; (y) administration of consumer disputes and inquiries; (z) external accreditation standards; (aa) the replacement of a group benefit plan or workers' compensation policy or program; (bb) activities in connection with a sale, merger, transfer, or exchange of all or part of a business or operating unit; (cc) any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the United States Department of Health and Human Services; (dd) disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; (ee) any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process; and (ff) additional insurance functions as may be

approved by adoption and promulgation of rules and regulations of the director to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

Source: Laws 2001, LB 52, § 16.

44-917 Authorization; requirements.

(1) A valid authorization to disclose nonpublic personal health information pursuant to sections 44-916 to 44-920 shall be in written or electronic form and shall contain all of the following:

(a) The identity of the consumer or customer who is the subject of the nonpublic personal health information;

(b) A general description of the types of nonpublic personal health information to be disclosed;

(c) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure, and how the information will be used;

(d) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

(e) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

(2) An authorization for the purposes of sections 44-916 to 44-920 shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four months.

(3) A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to sections 44-916 to 44-920 at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

(4) A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

Source: Laws 2001, LB 52, § 17.

44-918 Authorization request; delivery requirements.

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt out notice pursuant to section 44-909 if the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to subsection (1) of section 44-916.

Source: Laws 2001, LB 52, § 18.

44-919 Relationship to federal rules.

Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the United States Department of Health and Human Services, if a licensee complies with

all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of sections 44-916 to 44-920.

Source: Laws 2001, LB 52, § 19.

44-920 Relationship to state laws.

Nothing in sections 44-916 to 44-920 shall preempt or supersede existing state law related to medical records or health or insurance information privacy.

Source: Laws 2001, LB 52, § 20.

44-921 Relationship to federal Fair Credit Reporting Act.

Nothing in the Privacy of Insurance Consumer Information Act shall be construed to modify, limit, or supersede the operation of 15 U.S.C. 1681 et seq., as such section existed on April 5, 2001, and no inference shall be drawn on the basis of the provisions of the act regarding whether information is transaction or experience information under 15 U.S.C. 1681a, as such section existed on April 5, 2001.

Source: Laws 2001, LB 52, § 21.

44-922 Discrimination; prohibited.

(1) A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the Privacy of Insurance Consumer Information Act.

(2) A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the act.

Source: Laws 2001, LB 52, § 22.

44-923 Unfair trade practice.

In addition to any other remedies available under the laws of this state, each violation of the Privacy of Insurance Consumer Information Act and any rules and regulations adopted and promulgated under the act shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 2001, LB 52, § 23.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-924 Rules and regulations.

(1) The director may adopt and promulgate rules and regulations to carry out the Privacy of Insurance Consumer Information Act.

(2) The director may adopt and promulgate rules and regulations to establish standards that licensees must meet in the development and implementation of administrative, technical, and physical safeguards to protect the security, confidentiality, and integrity of consumer and customer information.

Source: Laws 2001, LB 52, § 24; Laws 2003, LB 216, § 6.

44-925 Compliance with act; required; when.

(1) By July 1, 2001, a licensee shall provide an initial notice, as required by section 44-904, to consumers who are the licensee's customers on July 1, 2001, with regard to nonpublic personal financial information.

(2) Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of subdivision (1)(a)(ii) of section 44-913, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000.

Source: Laws 2001, LB 52, § 25.

ARTICLE 10

FRATERNAL INSURANCE

Cross References

Fraternal benefit societies, not subject to tax on gross premiums, see section 77-908.

Section

44-1001. Repealed. Laws 1985, LB 508, § 41.
44-1002. Repealed. Laws 1985, LB 508, § 41.
44-1003. Repealed. Laws 1985, LB 508, § 41.
44-1004. Repealed. Laws 1985, LB 508, § 41.
44-1004.01. Repealed. Laws 1985, LB 508, § 41.
44-1004.02. Repealed. Laws 1985, LB 508, § 41.
44-1005. Repealed. Laws 1985, LB 508, § 41.
44-1006. Repealed. Laws 1985, LB 508, § 41.
44-1007. Repealed. Laws 1985, LB 508, § 41.
44-1008. Repealed. Laws 1985, LB 508, § 41.
44-1009. Repealed. Laws 1985, LB 508, § 41.
44-1010. Repealed. Laws 1985, LB 508, § 41.
44-1011. Repealed. Laws 1985, LB 508, § 41.
44-1012. Repealed. Laws 1945, c. 109, § 2.
44-1013. Repealed. Laws 1985, LB 508, § 41.
44-1014. Repealed. Laws 1985, LB 508, § 41.
44-1015. Repealed. Laws 1985, LB 508, § 41.
44-1016. Repealed. Laws 1985, LB 508, § 41.
44-1017. Repealed. Laws 1985, LB 508, § 41.
44-1018. Repealed. Laws 1985, LB 508, § 41.
44-1019. Repealed. Laws 1985, LB 508, § 41.
44-1020. Repealed. Laws 1985, LB 508, § 41.
44-1021. Repealed. Laws 1985, LB 508, § 41.
44-1022. Repealed. Laws 1985, LB 508, § 41.
44-1023. Repealed. Laws 1985, LB 508, § 41.
44-1024. Repealed. Laws 1985, LB 508, § 41.
44-1025. Repealed. Laws 1985, LB 508, § 41.
44-1026. Repealed. Laws 1985, LB 508, § 41.
44-1027. Repealed. Laws 1985, LB 508, § 41.
44-1028. Repealed. Laws 1985, LB 508, § 41.
44-1029. Repealed. Laws 1985, LB 508, § 41.
44-1030. Repealed. Laws 1985, LB 508, § 41.
44-1031. Repealed. Laws 1985, LB 508, § 41.
44-1032. Repealed. Laws 1985, LB 508, § 41.
44-1033. Repealed. Laws 1985, LB 508, § 41.
44-1034. Repealed. Laws 1983, LB 447, § 104.
44-1035. Repealed. Laws 1985, LB 508, § 41.
44-1036. Repealed. Laws 1985, LB 508, § 41.
44-1037. Repealed. Laws 1985, LB 508, § 41.

Section

44-1001 Repealed. Laws 1985, LB 508, § 41.

44-1002 Repealed. Laws 1985, LB 508, § 41.

44-1003 Repealed. Laws 1985, LB 508, § 41.

44-1004 Repealed. Laws 1985, LB 508, § 41.

44-1004.01 Repealed. Laws 1985, LB 508, § 41.

44-1004.02 Repealed. Laws 1985, LB 508, § 41.

44-1005 Repealed. Laws 1985, LB 508, § 41.

44-1006 Repealed. Laws 1985, LB 508, § 41.

44-1007 Repealed. Laws 1985, LB 508, § 41.

44-1008 Repealed. Laws 1985, LB 508, § 41.

44-1009 Repealed. Laws 1985, LB 508, § 41.

44-1010 Repealed. Laws 1985, LB 508, § 41.

44-1011 Repealed. Laws 1985, LB 508, § 41.

44-1012 Repealed. Laws 1945, c. 109, § 2.

44-1013 Repealed. Laws 1985, LB 508, § 41.

44-1014 Repealed. Laws 1985, LB 508, § 41.

44-1015 Repealed. Laws 1985, LB 508, § 41.

44-1016 Repealed. Laws 1985, LB 508, § 41.

44-1017 Repealed. Laws 1985, LB 508, § 41.

44-1018 Repealed. Laws 1985, LB 508, § 41.

44-1019 Repealed. Laws 1985, LB 508, § 41.

44-1020 Repealed. Laws 1985, LB 508, § 41.

44-1021 Repealed. Laws 1985, LB 508, § 41.

44-1022 Repealed. Laws 1985, LB 508, § 41.

44-1023 Repealed. Laws 1985, LB 508, § 41.

44-1024 Repealed. Laws 1985, LB 508, § 41.

44-1025 Repealed. Laws 1985, LB 508, § 41.

44-1026 Repealed. Laws 1985, LB 508, § 41.

44-1027 Repealed. Laws 1985, LB 508, § 41.

44-1028 Repealed. Laws 1985, LB 508, § 41.

44-1029 Repealed. Laws 1985, LB 508, § 41.

44-1030 Repealed. Laws 1985, LB 508, § 41.

44-1031 Repealed. Laws 1985, LB 508, § 41.

44-1032 Repealed. Laws 1985, LB 508, § 41.

44-1033 Repealed. Laws 1985, LB 508, § 41.

44-1034 Repealed. Laws 1983, LB 447, § 104.

44-1035 Repealed. Laws 1985, LB 508, § 41.

44-1036 Repealed. Laws 1985, LB 508, § 41.

44-1037 Repealed. Laws 1985, LB 508, § 41.

44-1038 Repealed. Laws 1985, LB 508, § 41.

44-1039 Repealed. Laws 1985, LB 508, § 41.

44-1040 Repealed. Laws 1945, c. 109, § 2.

44-1041 Repealed. Laws 1985, LB 508, § 41.

44-1042 Repealed. Laws 1985, LB 508, § 41.

44-1043 Repealed. Laws 1985, LB 508, § 41.

44-1044 Repealed. Laws 1985, LB 508, § 41.

44-1045 Repealed. Laws 1985, LB 508, § 41.

44-1046 Repealed. Laws 1985, LB 508, § 41.

44-1047 Repealed. Laws 1985, LB 508, § 41.

44-1048 Repealed. Laws 1985, LB 508, § 41.

44-1049 Repealed. Laws 1985, LB 508, § 41.

44-1050 Repealed. Laws 1985, LB 508, § 41.

44-1051 Repealed. Laws 1985, LB 508, § 41.

44-1052 Repealed. Laws 1985, LB 508, § 41.

44-1053 Repealed. Laws 1985, LB 508, § 41.

44-1054 Repealed. Laws 1985, LB 508, § 41.

44-1055 Repealed. Laws 1985, LB 508, § 41.

44-1056 Repealed. Laws 1985, LB 508, § 41.

44-1057 Repealed. Laws 1985, LB 508, § 41.

44-1058 Repealed. Laws 1985, LB 508, § 41.

44-1059 Repealed. Laws 1985, LB 508, § 41.

44-1060 Repealed. Laws 1985, LB 508, § 41.

44-1061 Repealed. Laws 1985, LB 508, § 41.

44-1062 Repealed. Laws 1957, c. 175, § 10.

44-1063 Repealed. Laws 1985, LB 508, § 41.

44-1064 Repealed. Laws 1985, LB 508, § 41.

44-1065 Repealed. Laws 1985, LB 508, § 41.

44-1066 Repealed. Laws 1985, LB 508, § 41.

44-1067 Repealed. Laws 1985, LB 508, § 41.

44-1068 Repealed. Laws 1985, LB 508, § 41.

44-1069 Repealed. Laws 1985, LB 508, § 41.

44-1070 Repealed. Laws 1985, LB 508, § 41.

44-1071 Repealed. Laws 1985, LB 508, § 41.

44-1072 Fraternal benefit society.

Any incorporated society, order, or supreme lodge, without capital stock, including one exempted under subdivision (1)(b) of section 44-10,109 whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with sections 44-1072 to 44-10,109, is hereby declared to be a fraternal benefit society.

Source: Laws 1985, LB 508, § 1.

44-1073 Terms, defined.

As used in sections 44-1072 to 44-10,109, unless the context otherwise requires:

(1) Benefit contract shall mean the agreement for provision of benefits authorized by section 44-1087, as that agreement is provided in the certificate described in subsection (1) of section 44-1090;

(2) Benefit member shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract;

(3) Certificate shall mean the document issued as written evidence of the benefit contract;

(4) Laws shall mean the society's articles of incorporation, constitution, and bylaws, however designated;

(5) Lodge shall mean subordinate member units of the society, known as camps, courts, councils, or branches or by any other designation;

(6) Premiums shall mean premiums, rates, dues, or other required contributions by whatever name known, which are payable under the certificate;

(7) Rules shall mean all rules, regulations, or resolutions adopted and promulgated by the supreme governing body or board of directors which are intended to have general application to the members of the society; and

(8) Society shall mean fraternal benefit society, unless otherwise indicated.

Source: Laws 1985, LB 508, § 2.

44-1074 Lodge system; requirements.

(1) A society shall be deemed to be operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once each month to further the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children and such children shall not have a voice or vote in the management of the society.

Source: Laws 1985, LB 508, § 3.

44-1075 Representative form of government; requirements.

A society shall be deemed to have a representative form of government when:

(1) It has a supreme governing body constituted in one of the following ways:

(a) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws; or

(b) Direct election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an

elected member. The board shall meet at least quarterly to conduct the business of the society;

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors, or any intermediate assembly; and

(4) Each voting member shall have one vote and no vote may be cast by proxy.

Source: Laws 1985, LB 508, § 4.

44-1076 Purposes and powers of society.

(1) A society shall operate for the benefit of its members and their beneficiaries by:

(a) Providing benefits as specified in section 44-1087; and

(b) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

(2) Every society shall have the power to adopt and promulgate laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to, or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

Source: Laws 1985, LB 508, § 5.

44-1077 Qualification for membership.

(1) A society shall specify in its laws or rules:

(a) Eligibility standards for each and every class of membership, except that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not younger than fifteen nor older than twenty-one years of age;

(b) The process for admission to membership for each membership class; and

(c) The rights and privileges of each membership class, except that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society shall be personal to the member and shall not be assignable.

Source: Laws 1985, LB 508, § 6.

44-1078 Location of office; meetings; communications to members; grievance procedures.

(1) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory wherein such society has at least one subordinate lodge,

or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(2)(a) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member shall be deemed to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(3) A society may provide in its laws or rules for grievance or complaint procedures for members.

Source: Laws 1985, LB 508, § 7.

44-1079 Limitation on personal liability.

(1) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(2) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed (a) in relation to any matter in such action, suit, or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society or of any firm, corporation, or organization which he or she served in any capacity at the request of the society or (b) in relation to any matter in such action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in this subsection may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit, or proceeding or by a court of competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, or conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The right of indemnification and reim-

bursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors, and administrators.

(3) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

Source: Laws 1985, LB 508, § 8.

44-1080 Membership; waiver of requirements.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

Source: Laws 1985, LB 508, § 9.

44-1081 Organization of society.

A domestic society organized on or after September 6, 1985, shall be formed as follows:

(1) Seven or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge, before some officer competent to take acknowledgment of deeds, articles of incorporation in which shall be stated:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(b) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by sections 44-1072 to 44-10,109; and

(c) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority;

(2) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates and applications therefor and circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Director of Insurance, who may require such further information as he or she deems necessary. The bond with sureties approved by the director shall be in such amount, not less than three hundred thousand dollars nor more than one million five hundred thousand dollars, as the director requires. All documents filed are to be in the

English language. If the purposes of the society conform to the requirements of sections 44-1072 to 44-10,109 and all provisions of the law have been complied with, the director shall so certify, retain, and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members;

(3) No preliminary certificate of authority granted under this section shall be valid after one year from its date of issuance or after such further period, not exceeding one year, as may be authorized by the Director of Insurance upon cause shown, unless the five hundred applicants required by subdivision (4) of this section have been secured and the organization has been completed pursuant to this section. The articles of incorporation and all other proceedings thereunder shall become null and void one year from the date of issuance of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business;

(4) Upon receipt of a preliminary certificate of authority from the Director of Insurance, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, issue any certificate, or pay, allow, or offer or promise to pay or allow any benefit to any person until:

(a) Actual bona fide applications for benefits have been secured from not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(b) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted;

(c) There has been submitted to the Director of Insurance, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums therefor; and

(d) It shall have been shown to the Director of Insurance, by sworn statement of the treasurer or corresponding officer of such society that at least five hundred applicants have each paid in cash at least one regular monthly premium, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars. The advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to the applicants; and

(5) The Director of Insurance may make such examination and require such further information as he or she deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the director shall issue to the society a certificate of authority and the society shall be authorized to transact business pursuant to sections 44-1072 to 44-10,109. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The director shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

Any incorporated society authorized to transact business in this state on September 6, 1985, shall not be required to reincorporate.

Source: Laws 1985, LB 508, § 10.

44-1082 Amendments to laws of society; procedure.

(1) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods specified in this subsection.

(2) No amendment to the laws of any domestic society shall take effect unless approved by the Director of Insurance who shall approve such amendment if he or she finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society. Unless the director shall disapprove any such amendment within sixty days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the director shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the director disapproves such amendment, the reasons for such disapproval shall be stated in such written notice.

(3) Within ninety days from the approval by the Director of Insurance, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments, or a synopsis thereof, stating facts which show that such amendments or synopsis has been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis has been furnished the addressee.

(4) Every foreign or alien society authorized to do business in this state shall file with the Director of Insurance a duly certified copy of all amendments of, or additions to, its laws within ninety days after the enactment of the same.

(5) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

Source: Laws 1985, LB 508, § 11.

44-1083 Creation of not-for-profit institution; authorized.

A society may create, maintain, and operate, or may establish organizations to operate, not-for-profit institutions to further the purposes permitted by subdivision (1)(b) of section 44-1076. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement.

Source: Laws 1985, LB 508, § 12.

44-1084 Reinsurance; authorized.

(1) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the Director of Insurance, but no such society may reinsure substantially all of its insurance in force without the written permission of the director. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset to or as a deduction from liability of a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after September 6, 1985, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(2) Notwithstanding the limitation in subsection (1) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the Director of Insurance pursuant to section 44-1085.

Source: Laws 1985, LB 508, § 13.

44-1085 Consolidation or merger; authorized; procedure.

(1) A domestic society may consolidate or merge with any other society by complying with this section. It shall file with the Director of Insurance:

(a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(b) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition of the society on a date fixed by the Director of Insurance but not earlier than December 31 next preceding the date of the contract;

(c) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(d) Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(2) If the Director of Insurance finds that the contract is in conformity with this section, the financial statements are correct, and the consolidation or merger is just and equitable to the members of each society, the director shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the Director of Insurance of this state or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the head of the Department of Insurance of such state or territory

and a certificate of such approval filed with the Director of Insurance of this state.

(3) Upon the consolidation or merger becoming effective, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action belonging to such societies shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest in such real estate vested under the laws of this state in any of the societies consolidated or merged shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document stating that such notice or document has been duly addressed and mailed shall be prima facie evidence that such notice or document has been furnished the addressees.

Source: Laws 1985, LB 508, § 14.

44-1086 Conversion to mutual life insurance company.

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of law. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the Director of Insurance who may give such approval if he or she finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

Source: Laws 1985, LB 508, § 15.

44-1087 Benefits; authorized.

(1) A society may provide the following contractual benefits in any form:

(a) Death benefits;

(b) Endowment benefits;

(c) Annuity benefits;

(d) Temporary or permanent disability benefits;

(e) Hospital, medical, or nursing benefits;

(f) Monument or tombstone benefits to the memory of deceased members; and

(g) Such other benefits as authorized for life insurers and which are not inconsistent with sections 44-1072 to 44-10,109.

(2) A society shall specify in its rules persons who may be issued, or covered by, the contractual benefits listed in subsection (1) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

Source: Laws 1985, LB 508, § 16.

44-1088 Beneficiaries.

(1) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member. The portion of such benefits paid shall not exceed the sum of two thousand dollars.

(3) If at the death of any person insured under a benefit contract there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid, shall be payable to the personal representative of the deceased insured. If the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

Source: Laws 1985, LB 508, § 17.

44-1089 Benefits; exempt from claims of creditors; exceptions.

(1) No noninsurance benefit, charity, relief, or aid to be paid, provided, or rendered by any society shall be liable to attachment, garnishment, or other process, or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

(2)(a) Except as provided in subdivision (2)(b) of this section, all proceeds, cash values, and benefits accruing under any annuity contract, under any policy or certificate of life insurance payable upon the death of the insured to a beneficiary other than the estate of the insured, or under any accident or health insurance policy shall be exempt from attachment, garnishment, or other legal or equitable process and from all claims of creditors of the insured and of the beneficiary if related to the insured by blood or marriage, unless a written assignment to the contrary has been obtained by the claimant.

(b) Subdivision (2)(a) of this section shall not apply to:

(i) An individual's aggregate interests greater than one hundred thousand dollars in all loan values or cash values of all matured or unmatured life insurance contracts and in all proceeds, cash values, or benefits accruing under all annuity contracts owned by such individual; and

(ii) An individual's interest in all loan values or cash values of all matured or unmatured life insurance contracts and in all proceeds, cash values, or benefits accruing under all annuity contracts owned by such individual, to the extent that the loan values or cash values of any matured or unmatured life insurance contract or the proceeds, cash values, or benefits accruing under any annuity contract were established or increased through contributions, premiums, or any other payments made within three years prior to bankruptcy or within

three years prior to entry against the individual of a money judgment which thereafter becomes final.

(c) A fraternal benefit society shall not be liable or responsible to any person to determine or ascertain the existence or identity of any such creditors prior to payment of any such loan values, cash values, proceeds, or benefits.

(3) Notwithstanding subsection (2) of this section, proceeds, cash values, and benefits accruing under any annuity contract or under any policy or certificate of life insurance payable upon the death of the insured to a beneficiary other than the estate of the insured shall not be exempt from attachment, garnishment, or other legal or equitable process by a judgment creditor of the beneficiary if the judgment against the beneficiary was based on, arose from, or was related to an act, transaction, or course of conduct for which the beneficiary has been convicted by any court of a crime punishable only by life imprisonment or death. No fraternal benefit society shall be liable or responsible to any person to determine or ascertain the existence or identity of any such judgment creditor prior to payment of any such proceeds, cash values, or benefits. This subsection shall apply to any judgment rendered on or after January 1, 1995, irrespective of when the criminal conviction is or was rendered and irrespective of whether proceedings for attachment, garnishment, or other legal or equitable process were pending on March 14, 1997.

Source: Laws 1985, LB 508, § 18; Laws 1987, LB 335, § 2; Laws 1997, LB 47, § 2; Laws 2005, LB 465, § 4.

44-1090 Benefit contract; contents.

(1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided by the contract. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this subsection shall be void.

(2) Any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance of the contract.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of

the owner's equitable proportion of such deficiency as ascertained by its board and that if the payment is not made either (a) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates or (b) in lieu of or in combination with subdivision (a) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(5) A domestic society may assess owners as described in subsection (4) of this section only after such assessment is filed with the Director of Insurance and approved by him or her. In the case of a foreign or alien society, notice of an assessment shall be provided to the director at least thirty days before the effective date of the assessment. The director shall have the authority to prohibit any foreign or alien society that has assessed its owners from issuing any new contracts of insurance in this state.

(6) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(7) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the Director of Insurance in the manner provided for like policies issued by life insurers in this state. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after one year from September 6, 1985, shall meet the standard contract provision requirements not inconsistent with sections 44-1072 to 44-10,109 for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(8) Benefit contracts issued on the lives of persons younger than the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(9) A society may specify the terms and conditions on which benefit contracts may be assigned.

Source: Laws 1985, LB 508, § 19; Laws 2013, LB426, § 1.

44-1091 Nonforfeiture benefits; cash surrender values; certificate loans; other options.

(1) For certificates issued prior to one year after September 6, 1985, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall comply with the provisions of law applicable immediately prior to September 6, 1985.

(2) For certificates issued on or after one year from September 6, 1985, for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

Source: Laws 1985, LB 508, § 20.

Cross References

Mortality tables, see Appendix, Nebraska Revised Statutes, Volume 2A.

44-1092 Investments.

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated shall be held to meet the requirements of this section for the investment of funds.

Source: Laws 1985, LB 508, § 21.

44-1093 Establishment and disbursement of funds.

(1) All assets shall be held, invested, and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights or become entitled to any apportionment on the surrender of any part of such assets, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(3) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society (a) may adopt special procedures for the conduct of the business and affairs of a separate account, (b) may, for persons having beneficial interests therein, provide special voting and other rights including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and (c) may issue contracts on a variable basis to which subsections (2) and (4) of section 44-1090 shall not apply.

Source: Laws 1985, LB 508, § 22.

44-1094 Other insurance laws, how construed.

Societies shall be governed by sections 44-1072 to 44-10,109 and shall be exempt from all other provisions of the insurance laws of this state unless they are expressly designated therein or unless such provisions are specifically made applicable by sections 44-1072 to 44-10,109.

Source: Laws 1985, LB 508, § 23.

44-1095 Funds and property; exempt from taxation.

Every society organized or licensed under sections 44-1072 to 44-10,109 shall be a charitable and benevolent institution, and all of its funds and property shall be exempt from all and every state, county, district, municipal, and school tax.

Source: Laws 1985, LB 508, § 24; Laws 2015, LB414, § 1.

This section does not exempt a fraternal benefit society from paying sales and use taxes. Woodmen of the World v. Nebraska Dept. of Rev., 299 Neb. 43, 907 N.W.2d 1 (2018).

44-1096 Standards of valuation.

(1) Standards of valuation for certificates issued prior to one year after September 6, 1985, shall be those standards provided by the laws applicable immediately prior to September 6, 1985.

(2) The minimum standards of valuation for certificates issued on or after one year from September 6, 1985, shall be based on the following tables:

(a) For certificates of life insurance: (i) The Commissioner's 1941 Standard Ordinary Mortality Table; (ii) the Commissioner's 1941 Standard Industrial Mortality Table; (iii) the Commissioner's 1958 Standard Ordinary Mortality Table; (iv) the Commissioner's 1980 Standard Ordinary Mortality Table; or (v) any more recent table made applicable to life insurers; and

(b) For annuity and pure endowment certificates, total and permanent disability benefits, accidental death benefits, and noncancelable accident and health benefits, such tables as are authorized for use by life insurers in this state.

All of the standards of valuation listed in this subsection shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(3) The Director of Insurance may, in his or her discretion, accept other standards for valuation if he or she finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The director may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(4) Any society, with the consent of the Director of Insurance of the state of domicile of the society and under such conditions, if any, which he or she may impose, may establish and maintain reserves on its certificates in excess of the reserves required, but the contractual rights of any benefit member shall not be affected thereby.

Source: Laws 1985, LB 508, § 25.

Cross References

Mortality tables, see Appendix, Nebraska Revised Statutes, Volume 2A.

44-1097 Reports.

Reports shall be filed in the following manner:

(1) Every society transacting business in this state shall annually, on or before the first day of March, unless for cause shown such time has been extended by the Director of Insurance, file with the director a true statement of its financial condition, transactions, and affairs for the preceding calendar year and pay a filing fee in an amount determined by the director. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the director;

(2) As part of the annual statement, each society shall, on or before the first day of March, file with the Director of Insurance a valuation of its certificates in force on the preceding December 31, except that the director may, in his or her discretion for cause shown, extend the time for filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in section 44-1096. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the Department of Insurance of the state of domicile of the society; and

(3) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars for each day during which such neglect continues and, upon notice by the Director of Insurance to that effect, its authority to do business in this state shall cease while such default continues.

Source: Laws 1985, LB 508, § 26.

44-1098 Annual license; fee.

Societies which are authorized to transact business in this state immediately prior to September 6, 1985, may continue such business until April 1, 1986. The authority of such societies and all societies hereafter licensed may be renewed annually, but in all cases to terminate on the first day of the succeeding April, except that a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal, the society shall pay a fee of fifty dollars to the Director of Insurance. A duly certified copy or duplicate of such license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of sections 44-1072 to 44-10,109.

Source: Laws 1985, LB 508, § 27.

44-1099 Examination by Director of Insurance.

(1) The Director of Insurance, or any person he or she may appoint, may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign, or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Director of Insurance.

Source: Laws 1985, LB 508, § 28.

44-10,100 Foreign or alien society; admission.

No foreign or alien society shall transact business in this state without a license issued by the Director of Insurance. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of sections 44-1072 to 44-10,109 applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing with the director:

(1) A duly certified copy of its articles of incorporation;

(2) A copy of its bylaws, certified by its secretary or corresponding officer;

(3) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the director, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province, or country, satisfactory to the Director of Insurance of this state;

(4) Certification from the proper official of its home state, territory, province, or country that the society is legally incorporated and licensed to transact business therein;

(5) Copies of its certificate forms; and

(6) Such other information as the Director of Insurance may deem necessary.

The society shall also submit evidence to the director showing that its assets are invested in accordance with sections 44-1072 to 44-10,109.

Source: Laws 1985, LB 508, § 29; Laws 2001, LB 360, § 7.

44-10,101 Domestic society; violations of law; director; powers.

(1) When the Director of Insurance upon investigation finds that a domestic society (a) has exceeded its powers, (b) has failed to comply with any provision of sections 44-1072 to 44-10,109, (c) is not fulfilling its contracts in good faith, (d) has a membership of less than four hundred after an existence of one year or more, or (e) is conducting business fraudulently or in a manner hazardous to its members, its creditors, the public, or the business, the director shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The director shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the director's request for correction and if the society fails to comply, the director shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected or why an action in quo warranto should not be commenced against the society.

(2) If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the Director of Insurance may present the facts relating thereto to the Attorney

General who shall, if he or she deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(3) The court shall notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until (a) the Director of Insurance finds that the violation complained of has been corrected, (b) the costs of such action shall have been paid by the society if the court finds that the society was in default as charged, (c) the court has dissolved its injunction, and (d) the Director of Insurance has reinstated the certificate of authority.

(4) If the court orders the society liquidated, it shall be enjoined from carrying on any further business and the receiver of the society shall proceed at once to take possession of the books, papers, money, and other assets of the society and, under the direction of the court, proceed to close the affairs of the society and to distribute its funds to those entitled to such funds.

(5) No action under this section shall be recognized in any court of this state unless brought by the Attorney General upon request of the Director of Insurance. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the director as the receiver.

(6) This section shall also be applicable to a society which shall voluntarily determine to discontinue business.

Source: Laws 1985, LB 508, § 30.

44-10,102 Foreign or alien society; violations of law; director; powers.

(1) When the Director of Insurance upon investigation finds that a foreign or alien society transacting or applying to transact business in this state (a) has exceeded its powers, (b) has failed to comply with any of the provisions of sections 44-1072 to 44-10,109, (c) is not fulfilling its contracts in good faith, or (d) is conducting its business fraudulently or in a manner hazardous to its members, its creditors, or the public, the director shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. He or she shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the director's request for correction and if the society fails to comply, the director shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked, or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked, or refused, the director may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the director that such suspension or refusal should be withdrawn or the director may revoke the authority of the society to do business in this state.

(2) Nothing in this section shall be taken or construed to prevent any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business in this state.

Source: Laws 1985, LB 508, § 31.

44-10,103 Injunction; when allowed.

No application or petition for injunction against any domestic, foreign, or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the Attorney General upon request of the Director of Insurance.

Source: Laws 1985, LB 508, § 32.

44-10,104 Licensing of agents.

(1) Agents of societies shall be licensed in accordance with the laws regulating the licensing, revocation, suspension, or termination of license of resident and nonresident agents.

(2) No examination or license shall be required of any regular salaried officer, employee, or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(3) Any agent, representative, or member of a society who devotes, or intends to devote, less than fifty percent of his or her time to the solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (1) of this section. Any person who in the immediately preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of fifty thousand dollars or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than twenty-five individuals and who has received or will receive a commission or other compensation therefor shall be presumed to be devoting, or intending to devote, fifty percent of his or her time to the solicitation or procurement of insurance contracts for such society.

Source: Laws 1985, LB 508, § 33.

44-10,105 Unfair trade practices; applicability.

Every society authorized to do business in this state shall be subject to the Unfair Insurance Trade Practices Act, except that nothing in the act shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

Source: Laws 1985, LB 508, § 34; Laws 1986, LB 730, § 1; Laws 1991, LB 234, § 2.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-10,106 Service of process.

Legal process shall be served upon a society in the manner provided for service of a summons in a civil action.

Source: Laws 1985, LB 508, § 35; Laws 1987, LB 93, § 12; Laws 2001, LB 360, § 8.

44-10,107 Appeal; procedure.

All decisions and findings of the Director of Insurance made under sections 44-1072 to 44-10,109 may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1985, LB 508, § 36; Laws 1988, LB 352, § 56.

Cross References

Administrative Procedure Act, see section 84-920.

44-10,108 Violations; penalties.

(1) Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society shall be guilty of a Class I misdemeanor.

(2) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by sections 44-1072 to 44-10,109, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury as prescribed in section 28-915.

(3) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall be guilty of a Class IV misdemeanor.

(4) Any person guilty of a willful violation of or neglect or refusal to comply with sections 44-1072 to 44-10,109 for which a penalty is not otherwise prescribed shall, upon conviction, be subject to a fine not exceeding two hundred dollars.

Source: Laws 1985, LB 508, § 37.

44-10,109 Applicability of sections; exempt societies; treatment.

(1) Sections 44-1072 to 44-10,109 shall not affect or apply to:

(a) Grand or subordinate lodges of societies, orders, or associations doing business in this state immediately prior to September 6, 1985, which provide benefits exclusively through local or subordinate lodges;

(b) Orders, societies, or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families and auxiliaries to such orders, societies, or associations;

(c) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house, or corporation which provide for a death benefit of not more than four hundred dollars or disability benefits of not more than three hundred fifty dollars to any person in any one year, or both; or

(d) Domestic societies or associations of a purely religious, charitable, or benevolent description which provide for a death benefit of not more than four hundred dollars or for disability benefits of not more than three hundred fifty dollars to any one person in any one year, or both.

(2) Any such society or association described in subdivision (1)(c) or (1)(d) of this section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subdivi-

sion (1)(d) of this section which has more than one thousand members, shall not be exempted from sections 44-1072 to 44-10,109 but shall comply with all requirements thereof.

(3) No society which is exempt from the requirements of sections 44-1072 to 44-10,109 pursuant to this section, except any society described in subdivision (1)(b) of this section, shall give or allow or promise to give or allow to any person any compensation for procuring new members.

(4) Every society which provides for benefits in case of death or disability resulting solely from accident and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of sections 44-1072 to 44-10,109, except that the provisions relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society.

(5) The Director of Insurance may require from any society or association, by examination or otherwise, such information as will enable the director to determine whether such society or association is exempt from sections 44-1072 to 44-10,109.

(6) Societies exempted pursuant to this section shall also be exempt from all other provisions of the insurance laws of this state.

Source: Laws 1985, LB 508, § 38.

ARTICLE 11

VIATICAL SETTLEMENTS ACT

Section

44-1101 Act, how cited.

Sections 44-1101 to 44-1117 shall be known and may be cited as the Viatical Settlements Act.

Source: Laws 2001, LB 52, § 27; Laws 2008, LB853, § 1.

44-1102 Terms, defined.

For purposes of the Viatical Settlements Act:

(1) Advertising means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted

on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public, in this state, for the purpose of creating an interest in or inducing a person to sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy pursuant to a viatical settlement contract;

(2) Business of viatical settlements means an activity involved in, but not limited to, the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, financing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating or in any manner acquiring an interest in a life insurance policy by means of a viatical settlement contract;

(3) Chronically ill means (a) being unable to perform at least two activities of daily living, such as eating, toileting, transferring, bathing, dressing, or continence; (b) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or (c) having a level of disability similar to that described in subdivision (3)(a) of this section as determined by the Department of Health and Human Services;

(4) Department means the Department of Insurance;

(5) Director means the Director of Insurance;

(6) Financing entity means an underwriter, a placement agent, a lender, a purchaser of securities, a purchaser of a policy or certificate from a viatical settlement provider, a credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract (a) whose principal activity related to the transaction is providing funds to effect the viatical settlement or purchase of one or more viaticated policies and (b) who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. Financing entity does not include a nonaccredited investor or viatical settlement purchaser;

(7) Fraudulent viatical settlement act means:

(a) An act or omission committed by any person who, knowingly and with intent to defraud and for the purpose of depriving another of property or for pecuniary gain, commits, or permits his or her employees or agents to commit, any of the following acts:

(i) Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, viatical settlement purchaser, financing entity, insurer, insurance broker, insurance agent, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(A) An application for the issuance of a viatical settlement contract or insurance policy;

(B) The underwriting of a viatical settlement contract or insurance policy;

(C) A claim for payment or benefit pursuant to a viatical settlement contract or insurance policy;

(D) Premiums paid on an insurance policy;

(E) Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or insurance policy;

(F) The reinstatement or conversion of an insurance policy;

(G) The solicitation, offer, effectuation, or sale of a viatical settlement contract or insurance policy;

(H) The issuance of written evidence of a viatical settlement contract or insurance; or

(I) A financing transaction; or

(ii) Employing any plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies;

(b) In the furtherance of a fraud or to prevent the detection of a fraud:

(i) Removing, concealing, altering, destroying, or sequestering from the director the assets or records of a licensee or other person engaged in the business of viatical settlements;

(ii) Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

(iii) Transacting the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements; or

(iv) Filing with the director or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the director;

(c) Presenting, causing to be presented, or preparing with the knowledge or reason to believe that it will be presented, to or by a viatical settlement provider, viatical settlement broker, insurer, insurance agent, financing entity, viatical settlement purchaser, or any other person, in connection with a viatical settlement transaction or insurance transaction, an insurance policy, knowing the policy was fraudulently obtained by the insured, owner, or any agent thereof;

(d) Embezzlement, theft, misappropriation, or conversion of money, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or any other person engaged in the business of viatical settlements or insurance;

(e) Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, if the person or persons intended to defraud the policy's issuer, the viatical settlement provider, or the viator. Recklessly means engaging in the conduct in conscious and clearly unjustifiable disregard of a substantial likelihood of the existence of the relevant facts or risks and such disregard involves a gross deviation from acceptable standards of conduct;

(f) Facilitating the change of state of ownership of a policy or certificate or the state of residency of a viator to a state or jurisdiction that does not have a law similar to the Viatical Settlements Act for the express purposes of evading or avoiding the provisions of the act; or

(g) Attempting to commit, assisting, aiding, or abetting in the commission of, or conspiring to commit the acts or omissions specified in this subdivision;

(8) Life insurance producer means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to subdivision (1)(a) of section 44-4054;

(9) Person means a natural person or a legal entity, including an individual, a partnership, a limited liability company, an association, a trust, or a corporation;

(10) Policy means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state;

(11) Related provider trust means a titling trust or other trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust shall have a written agreement with the licensed viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the director as if those records and files were maintained directly by the licensed viatical settlement provider;

(12) Special purpose entity means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets:

(a) For a financing entity or licensed viatical settlement provider; or

(b)(i) In connection with a transaction in which the securities in the special purpose entity are acquired by the viator or by qualified institutional buyers as defined in Rule 144A of the federal Securities Act of 1933, as such act existed on January 1, 2008; or

(ii) The securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets;

(13) Terminally ill means having an illness or sickness that can reasonably be expected to result in death in twenty-four months or less;

(14) Viatical settlement broker means a person, including a life insurance producer as provided in subdivision (1)(b) of section 44-1103, who, working exclusively on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. Viatical settlement broker does not include an attorney, a certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser;

(15)(a) Viatical settlement contract means a written agreement between a viator and a viatical settlement provider or any affiliate of the viatical settlement provider establishing the terms under which compensation or anything of

value will be paid, which compensation or value is less than the expected death benefit of the policy, in return for the viator's present or future assignment, transfer, sale, devise, or bequest of the death benefit or ownership or any portion of the insurance policy or certificate of insurance.

(b) Viatical settlement contract includes a premium finance loan made for a life insurance policy by a lender to a viator on, before, or after the date of issuance of the policy if:

(i) The viator or the insured receives on the date of the premium finance loan a guarantee of a future viatical settlement value of the policy; or

(ii) The viator or the insured agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(c) Viatical settlement contract does not include:

(i) A policy loan or accelerated death benefit made by the insurer pursuant to the policy's terms;

(ii) A loan, the proceeds of which are used solely to pay:

(A) Premiums for the policy; or

(B) The costs of the loan, including, without limitation, interest, arrangement fees, utilization fees and similar fees, closing costs, legal fees and expenses, trustee fees and expenses, and third-party collateral provider fees and expenses, including fees payable to letter-of-credit issuers;

(iii) A loan made by a bank or other licensed financial institution in which the lender takes an interest in a life insurance policy solely to secure repayment of a loan or, if there is a default on the loan and the policy is transferred, the transfer of such a policy by the lender, if the default itself is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under the Viatical Settlements Act;

(iv) A premium finance loan not described in subdivision (15)(b) of this section;

(v) An agreement where all the parties (A) are closely related to the insured by blood or law, (B) have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured, or (C) are trusts established primarily for the benefit of such parties;

(vi) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement:

(A) Between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders;

(B) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners; or

(C) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(ix) Any other contract, transaction, or arrangement exempted from the definition of viatical settlement contract by the director based on a determination that the contract, transaction, or arrangement is not of the type intended to be regulated under the act;

(16)(a) Viatical settlement provider means a person, other than a viator, that enters into or effectuates a viatical settlement contract.

(b) Viatical settlement provider does not include:

(i) A bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy solely as collateral for a loan;

(ii) A premium finance company making premium finance loans that takes an assignment of a life insurance policy solely as collateral for a loan;

(iii) The issuer of the life insurance policy;

(iv) An authorized or eligible insurer that provides stop-loss coverage or financial guaranty insurance to a viatical settlement provider, purchaser, financing entity, special purpose entity, or related provider trust;

(v) A natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit;

(vi) A financing entity;

(vii) A special purpose entity;

(viii) A related provider trust;

(ix) A viatical settlement purchaser; or

(x) Any other person that the director exempts from the definition of viatical settlement provider;

(17)(a) Viatical settlement purchaser means a person who provides a sum of money as consideration for a life insurance policy or an interest in the death benefits of a life insurance policy, or a person who owns or acquires or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract, for the purpose of deriving an economic benefit.

(b) Viatical settlement purchaser does not include:

(i) A licensee under the Viatical Settlements Act;

(ii) An accredited investor or qualified institutional buyer as defined respectively in Rule 501(a) or Rule 144A of the federal Securities Act of 1933, as the act existed on January 1, 2008;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust;

(18) Viaticated policy means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract; and

(19)(a) Viator means the owner of a life insurance policy or a certificate holder under a group policy who resides in this state and who enters or seeks to enter into a viatical settlement contract. For purposes of the Viatical Settlements Act, a viator is not limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except as specifically addressed. If there is more than one viator on a single policy and the viators are residents of different states, the transaction shall be governed by the law of the state in which the viator having the largest percentage ownership resides or, if the viators hold equal ownership, the state of residence of one of the viators agreed upon in writing by all the viators.

(b) Viator does not include:

(i) A licensee under the act;

(ii) A qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as the act existed on January 1, 2008;

(iii) A financing entity;

(iv) A special purpose entity; or

(v) A related provider trust.

Source: Laws 2001, LB 52, § 28; Laws 2007, LB296, § 179; Laws 2008, LB853, § 2.

44-1103 License requirements; fee.

(1)(a) A person shall not operate as a viatical settlement provider or viatical settlement broker without first obtaining a license from the director or the chief insurance regulatory official of the state of residence of the viator.

(b)(i) A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a viatical settlement broker.

(ii) No later than thirty days after the first day of operating as a viatical settlement broker, the life insurance producer shall notify the director that he or she is acting as a viatical settlement broker on a form prescribed by the director and shall pay any applicable fee to be determined by the director. Notification shall include an acknowledgment by the life insurance producer that he or she will operate as a viatical settlement broker in accordance with the Viatical Settlements Act.

(iii) The insurer that issued the policy being viaticated shall not be responsible for any act or omission of a viatical settlement broker or viatical settlement provider arising out of or in connection with the viatical settlement transaction unless the insurer receives compensation for the placement of a viatical settlement contract from the viatical settlement provider or viatical settlement broker in connection with the viatical settlement contract.

(c) A licensed attorney, a certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency who is retained to

represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider may negotiate viatical settlement contracts on behalf of the viator without having to obtain a license as a viatical settlement broker.

(2) Application for a viatical settlement provider or viatical settlement broker license shall be made to the director by the applicant on a form prescribed by the director. The viatical settlement broker application shall be accompanied by a fee established by the director of not to exceed forty dollars. The viatical settlement provider application shall be accompanied by a fee established by the director of not to exceed one thousand five hundred dollars.

(3) All viatical settlement broker licenses shall expire on the last day of the month of the licensed person's birthday in the first year after issuance in which his or her age is divisible by two and may be renewed upon payment of a fee established by the director not to exceed forty dollars. All viatical settlement provider licenses shall expire on the last day of April in each year and may be renewed upon payment of a renewal fee established by the director not to exceed one hundred dollars. Failure to pay the fee by the renewal date results in expiration of the license.

(4) The applicant shall provide information on forms required by the director. The director shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members, and employees, and the director may, in the exercise of the director's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any stockholder, partner, officer, member, or employee thereof who may materially influence the applicant's conduct meets the standards of the Viatical Settlements Act.

(5) A license issued to a legal entity authorizes all partners, officers, members, and designated employees to act as viatical settlement providers and viatical settlement brokers, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

(6) Upon the filing of an application and the payment of the license fee, the director shall make an investigation of each applicant and issue a license if the director finds that the applicant:

(a) If a viatical settlement provider, provides a detailed plan of operation;

(b) Is competent and trustworthy and intends to act in good faith in the capacity for which application for a license is made;

(c) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which application for a license is made;

(d) If a viatical settlement broker or viatical settlement provider, has demonstrated evidence of financial responsibility in a format prescribed by the director through either a surety bond executed and issued by an insurer authorized to issue surety bonds in this state or a deposit of cash, certificates of deposit, or securities or any combination thereof in the amount of two hundred fifty thousand dollars;

(i) The director may ask for evidence of financial responsibility at any time the director deems necessary;

(ii) Any surety bond issued pursuant to subdivision (d) of this subsection shall be in the favor of this state and shall specifically authorize recovery by the director on behalf of any person in this state who has sustained damages as a result of an erroneous act, failure to act, conviction of fraud, or conviction of unfair practices of the viatical settlement provider or viatical settlement broker; and

(iii) Notwithstanding any provision of this section to the contrary, the director shall accept as evidence of financial responsibility proof that financial instruments in accordance with the requirements of subdivision (d) of this subsection have been filed with a state where the applicant is licensed as a viatical settlement provider or viatical settlement broker;

(e) If a legal entity, provides a certificate of good standing from the state of its domicile; and

(f) If a viatical settlement provider or viatical settlement broker, provides an antifraud plan that meets the requirements of subsection (7) of section 44-1112.

(7) A licensee shall provide to the director new or revised information about officers, ten-percent or more stockholders, partners, directors, members, or designated employees within thirty days after the change.

(8) An individual licensed as a viatical settlement broker shall complete on a biennial basis fifteen hours of training related to viatical settlements and viatical settlement transactions, except that a life insurance producer who is operating as a viatical settlement broker pursuant to subsection (1) of this section shall not be subject to the requirements of this subsection.

Source: Laws 2001, LB 52, § 29; Laws 2003, LB 216, § 7; Laws 2008, LB853, § 3.

44-1104 Disciplinary actions.

(1) The director may suspend, revoke, or refuse to issue or renew a license issued under the Viatical Settlements Act or that of a life insurance producer operating as a viatical settlement broker under subdivision (1)(b) of section 44-1103 if the director finds that:

(a) There was any material misrepresentation in the application for the license;

(b) The applicant or licensee or any officer, partner, member, or key management personnel is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(c) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(d) The applicant or licensee or any officer, partner, member, or key management personnel has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or a Class I, II, or III misdemeanor, regardless of whether a judgment of conviction has been entered by the court;

(e) The viatical settlement provider has entered into any viatical settlement contract that has not been approved pursuant to the Viatical Settlements Act;

(f) The viatical settlement broker or viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract;

(g) The licensee no longer meets the requirements for initial licensure;

(h) The viatical settlement provider has assigned, transferred, or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state, a viatical settlement purchaser, an accredited investor or qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as the act existed on January 1, 2008, a financing entity, a special purpose entity, or a related provider trust;

(i) The applicant or licensee or any officer, partner, member, or key management personnel has violated any provision of the Viatical Settlements Act or has otherwise engaged in bad faith conduct with one or more viators; or

(j) The licensee has failed to respond to the department within fifteen working days after receipt of an inquiry from the department.

(2) The director may suspend or revoke a license pursuant to subsection (1) of this section after notice and a hearing held in accordance with the Administrative Procedure Act.

(3) If the director denies a license application or refuses to renew a license pursuant to subsection (1) of this section, he or she shall notify the applicant or licensee of the reason for such denial or refusal of renewal. The applicant or licensee has thirty days after receipt of such notification to demand a hearing. The hearing shall be held within thirty days after receipt of such demand by the director and shall be held in accordance with the Administrative Procedure Act.

Source: Laws 2001, LB 52, § 30; Laws 2007, LB117, § 8; Laws 2008, LB853, § 4.

Cross References

Administrative Procedure Act, see section 84-920.

44-1105 Approval of viatical settlement contracts and disclosure statements.

A person shall not use a viatical settlement contract form or provide to a viator a disclosure statement form in this state unless first filed with and approved by the director. The director shall disapprove a viatical settlement contract form or disclosure statement form if, in the director's opinion, the contract or provisions contained therein fail to meet the requirements of sections 44-1108, 44-1109, and 44-1111 and subsection (2) of section 44-1112 or are unreasonable, contrary to the interest of the public, or otherwise misleading or unfair to the viator. At the director's discretion, the director may require the submission of advertising material.

Source: Laws 2001, LB 52, § 31; Laws 2008, LB853, § 5.

44-1106 Reporting requirements; confidentiality.

(1) Each viatical settlement provider shall file with the director on or before March 1 of each year an annual statement containing such information as the director may prescribe by rule and regulation. Such information shall be limited to only those transactions where the viator is a resident of this state. Individual transaction data regarding the business of viatical settlements or data that could compromise the privacy of personal, financial, or health information of the viator or insured shall be filed with the director on a confidential basis.

(2) Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual

knowledge of an insured's identity shall not disclose that identity as an insured or the insured's financial or medical information to any other person unless the disclosure:

(a) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(b) Is provided in response to an investigation or examination by the director or any other governmental officer or agency or pursuant to the requirements of subsection (3) of section 44-1112;

(c) Is a term of or condition to the transfer of a policy by one viatical settlement provider to another viatical settlement provider;

(d) Is necessary to permit a financing entity, related provider trust, or special purpose entity to finance the purchase of policies by a viatical settlement provider and the viator and insured have provided prior written consent to the disclosure;

(e) Is necessary to allow the viatical settlement provider or viatical settlement broker or his or her authorized representative to make contacts for the purpose of determining health status; or

(f) Is required to purchase stop-loss or financial guaranty coverage.

Source: Laws 2001, LB 52, § 32; Laws 2003, LB 216, § 8; Laws 2008, LB853, § 6.

44-1107 Examination; investigation.

(1)(a) The director may conduct an examination of a licensee under the Viatical Settlements Act as often as the director, in his or her sole discretion, deems appropriate. In scheduling and determining the nature, scope, and frequency of examination, the director shall consider such matters as consumer complaints, results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants, and other relevant criteria as determined by the director.

(b) For purposes of completing an examination of a licensee under the act, the director may examine or investigate any person or the business of any person, insofar as the examination or investigation is, in the sole discretion of the director, necessary or material to the examination of the licensee.

(c) In lieu of an examination under the act of any foreign or alien licensee licensed in this state, the director may, in his or her sole discretion, accept an examination report on the licensee as prepared by the director for the licensee's state of domicile or port-of-entry state.

(d) As far as is practical, the examination of a foreign or alien licensee shall be made in cooperation with the insurance regulatory officials of other states in which the licensee transacts business.

(2)(a) A person required to be licensed under the act shall for five years retain copies of all:

(i) Proposed, offered, or executed contracts, purchase agreements, underwriting documents, policy forms, and applications from the date of the proposal, offer, or execution of the contract, purchase agreement, underwriting document, policy form, or application, whichever is later;

(ii) Checks, drafts, or other evidence and documentation related to the payment, transfer, deposit, or release of funds from the date of the transaction; and

(iii) Other records and documents related to the requirements of the act.

(b) This section does not relieve a person of the obligation to produce documents under subdivision (a) of this subsection to the director after the retention period has expired if the person has retained the documents.

(c) Records required to be retained by this section must be legible and complete and may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces or forms a durable medium for the reproduction of a record.

(3)(a) Upon determining that an examination should be conducted, the director shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The director may also employ such other guidelines or procedures as he or she deems appropriate.

(b) Every licensee or person from whom information is sought and its officers, directors, employees, and agents shall provide to the examiner timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the director shall be grounds for the suspension, refusal, or nonrenewal of any license or authority held by the licensee to engage in the viatical settlement business or other business subject to the director's jurisdiction. Any proceedings for the suspension, revocation, or refusal of any license or authority shall be conducted pursuant to the Administrative Procedure Act.

(c) The director may issue subpoenas, administer oaths, and examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the director may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. A person who is subpoenaed shall attend as a witness at the place specified in the subpoena anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the district court, with mileage to be computed at the rate provided in section 81-1176, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized, charged against, and paid by the licensee being examined.

(d) When making an examination under the Viatical Settlements Act, the director may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the cost of which will be borne by the licensee that is the subject of the examination.

(e) Nothing contained in the act shall be construed to limit the director's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions of law made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(f) Nothing contained in the act shall be construed to limit the director's authority to use, and, if appropriate, to make public, any final or preliminary examination report, any examiner or licensee workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the director may, in his or her sole discretion, deem appropriate.

(4)(a) Examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the licensee or its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(b) No later than forty-five days following completion of the examination, the examiner in charge shall file with the director a verified written report of examination under oath. Upon receipt of the verified report, the director shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(c) Within thirty days after the end of the period allowed for the receipt of written submissions or rebuttals, the director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and shall:

(i) Adopt the examination report as submitted or with modifications or corrections. If the examination report reveals that the licensee is operating in violation of any law, rule, regulation, or prior order of the director, the director may order the licensee to take any action the director considers necessary and appropriate to cure such violation; or

(ii) Reject the examination report with directions to the examiner to reopen the examination for purposes of obtaining additional data, documentation, or information and to resubmit a report pursuant to subdivision (4)(b) of this section.

(d) Any licensee aggrieved by any action of the director pursuant to subdivision (4)(c) of this section may, within ten days after such action, make written request to the director for a hearing. Upon receipt of the licensee's request for a hearing, the director shall provide notice of the hearing no less than ten nor more than thirty days after the date of the licensee's request. The notice shall identify the subject of the hearing and the specific issues.

(e) Any hearing on an examination report shall be held in accordance with the Administrative Procedure Act.

(f) The examination report, with any modifications and corrections thereof, shall be accepted by the director and filed for public inspection immediately after the expiration of the times specified in subdivision (4)(d) of this section in the event that the licensee has not requested a hearing. Within thirty days after the filing of the examination report for public inspection, the licensee shall file

affidavits executed by each of its directors stating under oath that they have received a copy of the examination report and related orders.

(5)(a) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the director unless required by law.

(b) Except as otherwise provided in the Viatical Settlements Act, all examination reports, working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the director or any other person in the course of an examination made under the act, or in the course of analysis or investigation by the director of the financial condition or market conduct of a licensee, shall be confidential by law and privileged, shall not be subject to disclosure pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The director is authorized to use the documents, materials, communications, or other information in the furtherance of any regulatory or legal action brought as part of the director's official duties.

(c) Documents, materials, communications, or other information, including all working papers and copies thereof, in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action if they are:

(i) Created, produced, or obtained by or disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries in the course of assisting an examination made under the act or the law of another state or jurisdiction that is substantially similar to the act or assisting the director or the chief insurance regulatory official of another state in the analysis or investigation of the financial condition or market conduct of a licensee; or

(ii) Disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries under subdivision (e) of this subsection by the director or the chief insurance regulatory official of another state.

(d) Neither the director nor any person that received the documents, materials, communications, or other information while acting under the authority of the director, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials, communications, or other information subject to this subsection.

(e) In order to assist in the performance of his or her duties, the director:

(i) May share documents, materials, communications, or other information, including the confidential and privileged documents, materials, communications, or other information subject to this subsection, with other state, federal, foreign, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, foreign, and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the documents, materials, communications, or other information;

(ii) May receive documents, materials, communications, or other information, including otherwise confidential and privileged documents, materials, communications, or other information, from the National Association of Insurance

Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any documents, materials, communications, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, communications, or other information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, communications, or other information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in subdivision (e) of this subsection.

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(h) Nothing contained in the act shall prevent or be construed as prohibiting the director from disclosing the content of an examination report, preliminary report or results, or any matter relating thereto to the director or chief insurance regulatory official of any other state or country, to any law enforcement official of this state or any other state, to any agency of the federal government at any time, or to the National Association of Insurance Commissioners so long as the agency or office receiving the examination report or matters relating thereto agrees in writing to hold the examination report or matters confidential and in a manner consistent with the act.

(6)(a) An examiner may not be appointed by the director if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under the Viatical Settlements Act. This subsection shall not be construed to automatically preclude an examiner from being:

(i) A viator;

(ii) An insured in a viaticated insurance policy; or

(iii) A beneficiary in an insurance policy that is proposed to be viaticated.

(b) Notwithstanding the requirements of this subsection, the director may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under the act.

(7) The reasonable expenses of the examination of a licensee conducted under the Viatical Settlements Act shall be fixed and determined by the director who shall collect the same from the licensee examined. The licensee shall reimburse the amount thereof upon presentation of a statement by the director. Reimbursement shall be limited to a reasonable allocation for the salary of each examiner plus actual expenses. All money collected by the director for examination of licensees shall be remitted in accordance with section 44-116.

(8)(a) No cause of action shall arise nor shall any liability be imposed against the director, the director's authorized representatives, or any examiner appointed by the director for any statements made or conduct performed in good faith while carrying out the provisions of the Viatical Settlements Act.

(b) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the director or the director's authorized representative or an examiner pursuant to an examination made under the act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This subdivision does not abrogate or modify in any way common-law or statutory privilege or immunity heretofore enjoyed by any person identified in this subsection.

(c) A person identified in this subsection is entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of the Viatical Settlements Act and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(9) The director may investigate suspected fraudulent viatical settlement acts and persons engaged in the business of viatical settlements.

Source: Laws 2001, LB 52, § 33; Laws 2008, LB853, § 7.

Cross References

Administrative Procedure Act, see section 84-920.

44-1108 Disclosure; requirements; rights of viator.

(1) With each application for a viatical settlement, a viatical settlement provider or viatical settlement broker shall provide the viator with at least the disclosures required by this section no later than the time the application for the viatical settlement contract is signed by all parties. The disclosures shall be provided in a separate document that is signed by the viator and the viatical settlement provider or viatical settlement broker and shall provide the following information:

(a) Possible alternatives to viatical settlement contracts, including any accelerated death benefits or policy loans offered under the viator's life insurance policy;

(b) Some or all of the proceeds of the viatical settlement may be taxable under federal income tax laws and state franchise and income tax laws, and assistance should be sought from a professional tax advisor;

(c) Proceeds from the viatical settlement could be subject to the claims of creditors;

(d) Receipt of the proceeds from a viatical settlement may adversely effect the viator's eligibility for medicaid or other government benefits or entitlements, and advice should be obtained from the appropriate government agencies;

(e) A viatical settlement broker represents exclusively the viator, not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator, including a duty to act according to the viator's instructions and in the best interest of the viator;

(f) The viator has the right to rescind the viatical settlement contract before the earlier of sixty calendar days after the date on which the viatical settlement contract is executed by all parties or thirty calendar days after the viatical settlement proceeds have been paid to the viator as provided in subsection (3) of section 44-1109. Rescission, if exercised by the viator, is effective only if both

notice of the rescission is given and the viator repays all proceeds and any premiums, loans, and loan interest paid on account of the viatical settlement within the rescission period. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded by the viator or the viator's estate. If a viatical settlement contract is rescinded, all viatical settlement proceeds and any premiums paid by the viatical settlement provider or purchaser shall be repaid to the viatical settlement provider or purchaser within sixty days of such rescission;

(g) Funds will be sent to the viator within three business days after the viatical settlement provider has received the insurer or group administrator's written acknowledgment that the ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated;

(h) Entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits, that may exist under the policy or certificate to be forfeited by the viator, and assistance should be sought from a financial advisor;

(i) A brochure describing the process of viatical settlements. The National Association of Insurance Commissioners' form for the brochure shall be used unless one is developed by the director; and

(j) Following the execution of a viatical settlement contract, the insured may be contacted for the purpose of determining the insured's health status and to confirm the insured's residential or business street address and telephone number, or as otherwise provided under the Viatical Settlements Act. This contact is limited to once every six months if the insured has a life expectancy of more than one year, and no more than once every three months if the insured has a life expectancy of one year or less. All such contacts shall be made only by a viatical settlement provider licensed in the state in which the viator resided at the time of the viatical settlement or by the authorized representative of the viatical settlement provider.

The disclosure document shall contain the following language: All medical, financial, or personal information solicited or obtained by a viatical settlement provider or viatical settlement broker about you, the insured, including your identity or the identity of family members, a spouse, or a significant other, may be disclosed as necessary to effect the viatical settlement between the viator and the viatical settlement provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.

(2) A viatical settlement provider shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(a) The affiliation, if any, between the viatical settlement provider and the issuer of the insurance policy to be viaticated;

(b) The name, business address, and telephone number of the viatical settlement provider;

(c) Any affiliations or contractual arrangements between the viatical settlement provider and the viatical settlement purchaser;

(d) If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, there is the possibility of a loss of coverage on the other lives under the policy, and consultation with an insurance producer or the insurer issuing the policy for advice on the proposed viatical settlement is advised;

(e) The dollar amount of the current death benefit payable to the viatical settlement provider under the policy or certificate and, if known, the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate, and the extent to which the viator's interest in those benefits will be transferred as a result of the viatical settlement contract; and

(f) Whether the funds will be escrowed with an independent third party during the transfer process, and if so, provide the name, business address, and telephone number of the independent third-party escrow agent. The viator or owner may inspect or receive copies of the relevant escrow or trust agreements or documents.

(3) A viatical settlement broker shall provide the viator with at least the following disclosures no later than the date the viatical settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the viatical settlement contract or in a separate document signed by the viator and provide the following information:

(a) The name, business address, and telephone number of the viatical settlement broker;

(b) A full, complete, and accurate description of all offers, counter-offers, acceptances, and rejections relating to the proposed viatical settlement contract;

(c) A written disclosure of any affiliations or contractual arrangements between the viatical settlement broker and any person making an offer in connection with the proposed viatical settlement contracts;

(d) The amount and method of calculating the viatical settlement broker's compensation. Compensation includes anything of value paid or given to a viatical settlement broker for the placement of a policy; and

(e) If any portion of the viatical settlement broker's compensation is taken from a proposed viatical settlement offer, the viatical settlement broker shall disclose the total amount of the viatical settlement offer and the percentage of the viatical settlement offer comprised by the viatical settlement broker's compensation.

(4) If the viatical settlement provider transfers ownership or changes the beneficiary of the insurance policy, the provider shall communicate in writing the change in ownership or beneficiary to the insured within twenty days after the change.

Source: Laws 2001, LB 52, § 34; Laws 2008, LB853, § 8.

44-1108.01 Viatical settlement broker or viatical settlement provider; disclosure.

Before the initiation of a plan, transaction, or series of transactions, a viatical settlement broker or viatical settlement provider shall fully disclose to an insurer a plan, transaction, or series of transactions to which the viatical

settlement broker or viatical settlement provider is a party, to originate, renew, continue, or finance a life insurance policy with the insurer for the purpose of engaging in the business of viatical settlements at anytime prior to or during the first five years after issuance of the policy.

Source: Laws 2008, LB853, § 9.

44-1109 Viatical settlement contract requirements.

(1)(a) A viatical settlement provider entering into a viatical settlement contract shall first obtain:

(i) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind and under no constraint or undue influence to enter into a viatical settlement contract; and

(ii) A document in which the insured consents, as required in subsection (2) of section 44-1106, to the release of his or her medical records to a viatical settlement provider, a viatical settlement broker, and the insurance company that issued the life insurance policy covering the life of the insured.

(b) Within twenty days after a viator executes documents necessary to transfer any rights under an insurance policy, or within twenty days after entering any agreement, option, promise, or other form of understanding, expressed or implied, to viaticate the policy, the viatical settlement provider shall give written notice to the insurer that issued that insurance policy that the policy has or will become a viaticated policy. The notice must be accompanied by the documents required by subdivision (c) of this subsection.

(c) The viatical settlement provider shall deliver a copy of the medical release required under subdivision (a)(ii) of this subsection, a copy of the viator's application for the viatical settlement contract, the notice required under subdivision (b) of this subsection, and a request for verification of coverage to the insurer that issued the life insurance policy that is the subject of the viatical transaction. The National Association of Insurance Commissioners' form for verification of coverage shall be used unless another form is developed and approved by the director.

(d) The insurer shall respond to a request for verification of coverage submitted on an approved form by a viatical settlement provider or viatical settlement broker within thirty calendar days after the date the request is received and shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract or possible fraud. The insurer shall accept a request for verification of coverage made on a National Association of Insurance Commissioners' form or any other form approved by the director. The insurer shall accept an original, facsimile, or electronic copy of such request and any accompanying authorization signed by the viator. Failure by the insurer to meet its obligations under this subsection shall be a violation of subsection (3) of section 44-1110 and section 44-1115.

(e) Prior to or at the time of execution of the viatical settlement contract, the viatical settlement provider shall obtain a witnessed document in which the viator consents to the viatical settlement contract and represents that the viator has a full and complete understanding of the viatical settlement contract, that the viator has a full and complete understanding of the benefits of the life insurance policy, that the viator acknowledges he or she is entering into the

viatical settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, that the viator acknowledges the insured has a terminal or chronic illness and the terminal or chronic illness or condition was diagnosed after the life insurance policy was issued.

(f) If a viatical settlement broker performs any of the activities listed in this subsection on behalf of the viatical settlement provider, the provider is deemed to have fulfilled the requirements of this section.

(2) All medical information solicited or obtained by any licensee shall be subject to the applicable provisions of state law relating to confidentiality of medical information.

(3) All viatical settlement contracts entered into in this state shall provide the viator with an absolute right to rescind the contract before the earlier of sixty calendar days after the date on which the viatical settlement contract is executed by all parties or thirty calendar days after the viatical settlement proceeds have been sent to the viator as provided in subsection (5) of this section. Rescission by the viator may be conditioned on the viator both giving notice and repaying to the viatical settlement provider within the rescission period all proceeds of the settlement and any premiums, loans, and loan interest paid by or on behalf of the viatical settlement provider in connection with or as a consequence of the viatical settlement. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded. If a viatical settlement contract is rescinded, all viatical settlement proceeds and any premiums, loans, and loan interest that have been paid by the viatical settlement provider or purchaser shall be repaid to the viatical settlement provider or purchaser within sixty days of such rescission. In the event of any rescission, if the viatical settlement provider has paid commissions or other compensation to a viatical settlement broker in connection with the rescinded transaction, the viatical settlement broker shall refund all such commissions and compensation to the viatical settlement provider within five business days following receipt of a written demand from the viatical settlement provider, which demand shall be accompanied by either the viator's notice of rescission if rescinded at the election of the viator or notice of the death of the insured if rescinded by reason of death of the insured within the applicable rescission period.

(4) The viatical settlement provider shall instruct the viator to send the executed documents required to effect the change in ownership, assignment, or change in beneficiary directly to the independent escrow agent. Within three business days after the date the escrow agent receives the documents or after the date the viatical settlement provider receives the documents if the viator erroneously provides the documents directly to the provider, the provider shall pay or transfer the proceeds of the viatical settlement into an escrow or trust account maintained in a state-chartered or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation. Upon payment of the settlement proceeds into the escrow account, the escrow agent shall deliver the original change in ownership, assignment, or change in beneficiary forms to the viatical settlement provider or related provider trust or other designated representative of the viatical settlement provider. Upon the escrow agent's receipt of the acknowledgment of the properly completed transfer of ownership, assignment, or designation of beneficiary from the insurance company, the escrow agent shall pay the settlement proceeds to the viator.

(5) Failure to tender consideration to the viator for the viatical settlement contract within the time set forth in the disclosure pursuant to subdivision (1)(g) of section 44-1108 renders the viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator. Funds shall be deemed as sent by a viatical settlement provider to a viator as of the date that the escrow agent either releases funds for wire transfer to the viator or sends a check for delivery to the viator by the United States Postal Service or other nationally recognized delivery service.

(6) Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider or viatical settlement broker after the viatical settlement has occurred shall only be made by the viatical settlement provider or viatical settlement broker licensed in this state or its authorized representatives and shall be limited to once every six months for insureds with a life expectancy of more than one year and to no more than once every three months for insureds with a life expectancy of one year or less. The provider or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into. The limitations set forth in this subsection shall not apply to any contacts with an insured for reasons other than determining the insured's health status. Viatical settlement providers and viatical settlement brokers shall be responsible for the actions of their authorized representatives.

Source: Laws 2001, LB 52, § 35; Laws 2008, LB853, § 10.

44-1110 Prohibited acts.

(1) It is a violation of the Viatical Settlements Act for any person to enter into a viatical settlement contract at any time prior to the application or issuance of a policy which is the subject of a viatical settlement contract or within a five-year period commencing on the date of issuance of the insurance policy or certificate unless the viator certifies to the viatical settlement provider that one or more of the following conditions have been met within the five-year period:

(a) The policy was issued upon the viator's exercise of conversion rights arising out of a group or individual policy if the total of the time covered under the conversion policy, plus the time covered under the group or individual policy, is at least sixty months. The time covered under the group policy shall be calculated without regard to any change in insurance carriers if the coverage has been continuous and under the same group sponsorship;

(b) The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the five-year period:

(i) The viator or insured is terminally or chronically ill;

(ii) The viator's spouse died;

(iii) The viator divorced his or her spouse;

(iv) The viator retired from full-time employment;

(v) The viator became physically or mentally disabled and a physician determined that the disability prevented the viator from maintaining full-time employment; or

(vi) A final order, judgment, or decree was entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of

the viator or appointing a receiver, trustee, or liquidator for all or a substantial part of the viator's assets; and

(c) The viator enters into a viatical settlement contract more than two years after the date of issuance of a policy and, with respect to the policy, at all times prior to the date that is two years after policy issuance, the following conditions are met:

(i) Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed only to the extent of its net cash surrender value, provided by, or fully recourse liability incurred by, the insured or a person described in subdivision (15)(c)(v) of section 44-1102;

(ii) There is no agreement or understanding with any other person to guarantee any such liability or to purchase or stand ready to purchase the policy, including through an assumption or forgiveness of the loan; and

(iii) Neither the insured nor the policy has been evaluated for settlement.

(2) Copies of the independent evidence described in subdivision (1)(b) of this section and documents required by subsection (1) of section 44-1109 shall be submitted to the insurer when the viatical settlement provider or other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(3) If the viatical settlement provider submits to the insurer a copy of the owner's or insured's certification and the independent evidence described in subdivision (1)(b) of this section when the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement provider, the copy shall be deemed to conclusively establish that the viatical settlement contract satisfies the requirements of this section and the insurer shall timely respond to the request.

(4) No insurer may, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, require that the viator, insured, viatical settlement provider, or viatical settlement broker sign any forms, disclosures, consent, or waiver form that has not been expressly approved by the director for use in connection with viatical settlement contracts in this state.

(5) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within thirty calendar days with written acknowledgment confirming that the change has been effected or specifying the reasons why the requested change cannot be processed. The insurer shall not unreasonably delay effecting change of ownership or beneficiary and shall not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

Source: Laws 2001, LB 52, § 36; Laws 2008, LB853, § 11.

44-1111 Advertising for viatical settlements; guidelines and standards.

(1) The purpose of this section is to provide prospective viators with clear and unambiguous statements in the advertisement of viatical settlements and to assure the clear, truthful, and adequate disclosure of the benefits, risks, limita-

tions, and exclusions of any viatical settlement contract. This purpose is intended to be accomplished by the establishment of guidelines and standards of permissible and impermissible conduct in the advertising of viatical settlements or related products or services to assure that product descriptions are presented in a manner that prevents unfair, deceptive, or misleading advertising and is conducive to accurate presentation and description of viatical settlements or related products or services through the advertising media and material used by licensees.

(2) This section applies to any advertising of viatical settlement contracts or related products or services intended for dissemination in this state, including Internet advertising viewed by persons located in this state. If disclosure requirements are established pursuant to federal regulation, this section shall be interpreted so as to minimize or eliminate conflict with federal regulation whenever possible.

(3) Every licensee shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements of its contracts, products, and services. All advertisements, regardless of by whom written, created, designed, or presented, shall be the responsibility of the licensee or licensees, as well as the individual who created or presented the advertisement. A system of control shall include regular routine notification, at least once a year, to agents and others authorized by the licensee who disseminate advertisements of the requirements and procedures for approval prior to the use of any advertisement not furnished by the licensee.

(4) Advertisements shall be truthful and not misleading in fact or by implication. The form and content of an advertisement of a viatical settlement contract shall be sufficiently complete and clear so as to avoid deception. It shall not have the capacity or tendency to mislead or deceive. Whether an advertisement has the capacity or tendency to mislead or deceive shall be determined by the director from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed.

(5)(a) The information required to be disclosed under this section shall not be minimized, rendered obscure, or presented in an ambiguous fashion or intermingled with the text of the advertisement so as to be confusing or misleading.

(b) An advertisement shall not omit material information or use words, phrases, statements, references, or illustrations if the omission or use has the capacity, tendency, or effect of misleading or deceiving viators as to the nature or extent of any benefit, loss covered, premium payable, or state or federal tax consequence. The fact that the viatical settlement contract offered is made available for inspection prior to consummation of the sale, or an offer is made to refund the payment if the viator is not satisfied, or that the viatical settlement contract includes a free look period that satisfies or exceeds legal requirements, does not remedy misleading statements.

(c) An advertisement shall not use the name or title of a life insurance company or a life insurance policy unless the advertisement has been approved by the insurer.

(d) An advertisement shall not state or imply that interest charged on an accelerated death benefit or a policy loan is unfair, inequitable, or in any manner an incorrect or improper practice.

(e) The words free, no cost, without cost, no additional cost, or at no extra cost or words of similar import shall not be used with respect to any benefit or service unless true. An advertisement may specify the charge for a benefit or a service or may state that a charge is included in the payment or use other appropriate language.

(f)(i) Any testimonial, appraisal, analysis, or endorsement used in an advertisement must be genuine, represent the current opinion of the author, be applicable to the viatical settlement contract, product, or service advertised, and be accurately reproduced with sufficient completeness to avoid misleading or deceiving prospective viators as to the nature or scope of the testimonial, appraisal, analysis, or endorsement. In using a testimonial, an appraisal, an analysis, or an endorsement, the licensee makes as its own all the statements contained therein, and the statements are subject to all the provisions of this section.

(ii) If the individual making a testimonial, an appraisal, an analysis, or an endorsement has a financial interest in the party making use of the testimonial, appraisal, analysis, or endorsement either directly or through a related entity as a stockholder, director, officer, employee, or otherwise, or receives any benefit directly or indirectly other than required union scale wages, that fact shall be prominently disclosed in the advertisement.

(iii) An advertisement shall not state or imply that a viatical settlement contract benefit or service has been approved or endorsed by a group of individuals or any society, association, or other organization unless that is the fact and unless any relationship between an organization and the viatical settlement provider is disclosed. If the entity making the approval or endorsement is owned, controlled, or managed by the viatical settlement provider, or receives any payment or other consideration from the viatical settlement provider for making an approval or endorsement, that fact shall be disclosed in the advertisement.

(iv) When a testimonial, an appraisal, an analysis, or an endorsement refers to benefits received under a viatical settlement contract, all pertinent information shall be retained for a period of five years after its use.

(v) An advertisement shall not contain statistical information unless it accurately reflects recent and relevant facts. The source of all statistics used in an advertisement shall be identified.

(vi) An advertisement shall not disparage insurers, viatical settlement providers, viatical settlement brokers, viatical settlement investment agents, insurance producers, policies, services, or methods of marketing.

(vii) The name of the viatical settlement licensee shall be clearly identified in all advertisements about the licensee or its viatical settlement contract, products, or services, and if any specific viatical settlement contract is advertised, the viatical settlement contract shall be identified either by form number or some other appropriate description. If an application is part of the advertisement, the name of the viatical settlement provider shall be shown on the application.

(viii) An advertisement shall not use a trade name, group designation, name of the parent company of a licensee, name of a particular division of the licensee, service mark, slogan, symbol, or other device or reference without disclosing the name of the licensee if the advertisement would have the capacity or tendency to mislead or deceive as to the true identity of the licensee, or to

create the impression that a company other than the licensee would have any responsibility for the financial obligation under a viatical settlement contract.

(ix) An advertisement shall not use any combination of words, symbols, or physical materials that by their content, phraseology, shape, color, or other characteristics are so similar to a combination of words, symbols, or physical materials used by a government program or agency or otherwise appear to be of such a nature that they tend to mislead prospective viators into believing that the solicitation is in some manner connected with a government program or agency.

(x) An advertisement may state that a viatical settlement provider is licensed in the state where the advertisement appears if it does not exaggerate that fact or suggest or imply that competing viatical settlement providers may not be licensed. The advertisement may ask the audience to consult the licensee's website or contact the department to find out if the state requires licensing and, if so, whether the viatical settlement provider is licensed.

(xi) An advertisement shall not create the impression that the viatical settlement provider, its financial condition or status, the payment of its claims, or the merits, desirability, or advisability of its viatical settlement contracts are recommended or endorsed by any government entity.

(xii) The name of the licensee shall be stated in all of its advertisements. An advertisement shall not use a trade name, any group designation, the name of any affiliate or controlling entity of the licensee, a service mark, a slogan, a symbol, or any other device in a manner that would have the capacity or tendency to mislead or deceive as to the true identity of the actual licensee or create the false impression that an affiliate or controlling entity would have any responsibility for the financial obligation of the licensee.

(xiii) An advertisement shall not disclose or indirectly create the impression that any division or agency of the state or of the United States Government endorses, approves, or favors:

(A) Any licensee or its business practices or methods of operation;

(B) The merits, desirability, or advisability of any viatical settlement contract or viatical settlement program;

(C) Any viatical settlement contract or viatical settlement program; or

(D) Any life insurance policy or life insurance company.

(xiv) If the advertiser emphasizes the speed with which the viatication will occur, the advertising must disclose the average timeframe from completed application to the date of offer and from acceptance of the offer to receipt of the funds by the viator.

(xv) If the advertising emphasizes the dollar amounts available to viators, the advertising shall disclose the average purchase price as a percent of face value obtained by viators contracting with the licensee during the past six months.

Source: Laws 2001, LB 52, § 37; Laws 2008, LB853, § 13.

44-1112 Fraud prevention and control.

(1)(a) A person shall not commit a fraudulent viatical settlement act.

(b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of the Viatical Settlements Act or investigations of suspected or actual violations of the act.

(c) A person in the business of viatical settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of viatical settlements.

(2)(a) Viatical settlement contracts and applications for viatical settlements, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: Any person who knowingly presents false information in an application for insurance or viatical settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

(b) The lack of a statement as required in this subsection does not constitute a defense in any prosecution for a fraudulent viatical settlement act.

(3)(a) Any person engaged in the business of viatical settlements having knowledge or a reasonable suspicion that a fraudulent viatical settlement act is being, will be, or has been committed shall provide to the director the information required by, and in a manner prescribed by, the director.

(b) Any other person having knowledge or a reasonable belief that a fraudulent viatical settlement act is being, will be, or has been committed may provide to the director the information required by, and in a manner prescribed by, the director.

(4)(a) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent viatical settlement acts, if the information is provided to or received from:

(i) The director or the director's employees, agents, or representatives;

(ii) The Director of Banking and Finance or his or her employees, agents, or representatives;

(iii) Federal, state, or local law enforcement officials or their employees, agents, or representatives;

(iv) The National Association of Insurance Commissioners, the National Association of Securities Dealers, or the North American Securities Administrators Association, employees, agents, or representatives of any such association, or any other regulatory body overseeing life insurance, viatical settlements, securities, or investment fraud; or

(v) The life insurer that issued the life insurance policy covering the life of the insured.

(b) This subsection does not apply to statements made with actual malice, fraudulent intent, or bad faith. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent viatical settlement act, the party bringing the action shall plead specifically any allegation that this subsection does not apply because the person filing the report or furnishing the information did so with actual malice, fraudulent intent, or bad faith.

(c) A person furnishing information as identified in this subsection shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of the Viatical Settlements Act and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time it was initiated. An award granted

under this subdivision shall not apply to any person furnishing information concerning his or her own fraudulent viatical settlement acts.

(d) This section does not abrogate or modify common-law or statutory privileges or immunities enjoyed by a person described in this subsection.

(5)(a) The documents and evidence provided pursuant to subsection (4) of this section or obtained by the director in an investigation of suspected or actual fraudulent viatical settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(b) This subsection does not prohibit release by the director of documents and evidence obtained in an investigation of suspected or actual fraudulent viatical settlement acts:

(i) In administrative or judicial proceedings to enforce laws administered by the director;

(ii) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent viatical settlement acts, or to the National Association of Insurance Commissioners; or

(iii) At the discretion of the director, to a person in the business of viatical settlements that is aggrieved by a fraudulent viatical settlement act.

(c) Release of documents and evidence under this subsection does not abrogate or modify the privilege granted in this subsection.

(6) The Viatical Settlements Act shall not:

(a) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(b) Prevent or prohibit a person from disclosing voluntarily information concerning viatical settlement fraud to a law enforcement or regulatory agency other than the department; or

(c) Limit the powers granted elsewhere by the laws of this state to the director or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(7)(a) Viatical settlement providers and viatical settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts. At the discretion of the director, the director may order, or a licensee may request and the director may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section.

(b) Antifraud initiatives shall include:

(i) Fraud investigators, who may be viatical settlement provider or viatical settlement broker employees or independent contractors; and

(ii) An antifraud plan submitted to the director. The antifraud plan shall include, but not be limited to:

(A) A description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) A description of the procedures for reporting possible fraudulent viatical settlement acts to the director;

(C) A description of the plan for antifraud education and training of underwriters and other personnel; and

(D) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(c) Antifraud plans submitted to the director shall be privileged and confidential, shall not be a public record, and shall not be subject to discovery or subpoena in a civil or criminal action.

Source: Laws 2001, LB 52, § 38; Laws 2008, LB853, § 14.

44-1113 Injunctions; civil remedies; violation; penalty.

(1) In addition to the penalties and other enforcement provisions of the Viatical Settlements Act, if any person violates the act or any rule or regulation implementing the act, the director may seek an injunction in a court of competent jurisdiction and may apply for temporary and permanent orders that the director determines are necessary to restrain the person from committing the violation.

(2) Any person damaged by the acts of a person in violation of the act may bring a civil action against the person committing the violation in a court of competent jurisdiction.

(3) The director may issue, in accordance with the Administrative Procedure Act, a cease and desist order upon a person that violates any provision of the Viatical Settlements Act, any rule, regulation, or order adopted or issued by the director, or any written agreement entered into between such person and the director.

(4) When the director finds that an activity in violation of the act presents an immediate danger to the public that requires an immediate final order, the director may issue an emergency cease and desist order reciting with particularity the facts underlying the findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for ninety days. If the director begins nonemergency cease and desist proceedings, the emergency cease and desist order remains effective, absent an order by a court of competent jurisdiction pursuant to the Administrative Procedure Act.

(5) In addition to the penalties and other enforcement provisions of the Viatical Settlements Act, any person who violates the act is subject to civil penalties of up to one thousand dollars per violation. Imposition of civil penalties shall be pursuant to an order of the director issued under the Administrative Procedure Act. The director's order may require a person found to be in violation of the Viatical Settlements Act to make restitution to persons aggrieved by violations of the act.

(6) A person who is found by a court of competent jurisdiction, pursuant to an action initiated by the director, to have committed a fraudulent viatical settlement act, is subject to a civil penalty not to exceed five thousand dollars for the first violation, ten thousand dollars for the second violation, and fifteen thousand dollars for each subsequent violation.

(7) A person convicted of a violation of the act by a court of competent jurisdiction shall be guilty of a Class III misdemeanor. A person convicted of a violation of the act shall be ordered to pay restitution to persons aggrieved by the violation. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment. A prosecution under this subsection shall be in lieu of an action under subsection (6) of this section.

(8) Except for a fraudulent viatical settlement act committed by a viator, the enforcement provisions and penalties of this section shall not apply to a viator.

Source: Laws 2001, LB 52, § 39; Laws 2008, LB853, § 15.

Cross References

Administrative Procedure Act, see section 84-920.

44-1114 Director; powers.

The director shall have the authority to:

(1) Adopt and promulgate rules and regulations to carry out the Viatical Settlements Act;

(2) Establish standards for evaluating reasonableness of payments under viatical settlement contracts for persons with a terminal or chronic illness or condition. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy insuring the life of a person who is chronically ill or terminally ill;

(3) Establish appropriate licensing requirements, fees, and standards for continued licensure for viatical settlement providers and brokers;

(4) Require a bond or other mechanism for financial accountability for viatical settlement providers and brokers; and

(5) Adopt rules and regulations governing the relationship and responsibilities of insurers, viatical settlement providers, and viatical settlement brokers during the viatication of a life insurance policy or certificate.

Source: Laws 2001, LB 52, § 40; Laws 2008, LB853, § 16.

44-1115 Unfair trade practices.

A violation of the Viatical Settlements Act, including the commission of a fraudulent viatical settlement act, shall be considered an unfair trade practice under the Unfair Insurance Trade Practices Act subject to the penalties contained in the act.

Source: Laws 2001, LB 52, § 41; Laws 2008, LB853, § 17.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-1116 Compliance with act; required; when.

A viatical settlement provider and viatical settlement broker transacting business in this state on or before September 1, 2001, may continue to do so pending approval or disapproval of the provider's or broker's application for a license as long as the application is filed with the director by July 1, 2002.

Source: Laws 2001, LB 52, § 42.

44-1117 Fraudulent viatical settlement act; additional prohibited acts.

(1) With respect to any viatical settlement contract or insurance policy, no viatical settlement broker shall knowingly solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, viatical settlement purchaser, financing entity, or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker.

(2) With respect to any viatical settlement contract or insurance policy, no viatical settlement provider shall knowingly enter into a viatical settlement contract with a viator if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider or the viatical settlement purchaser, financing entity, or related provider trust that is involved in such viatical settlement contract.

(3) A violation of subsection (1) or (2) of this section shall be a fraudulent viatical settlement act.

(4) No viatical settlement provider shall enter into a viatical settlement contract unless the viatical settlement promotional, advertising, and marketing materials as may be prescribed by rule and regulation have been filed with the director. In no event shall any marketing materials expressly reference that the insurance is free for any period of time. The inclusion of any reference in the marketing materials that would cause a viator to reasonably believe that the insurance is free for any period of time shall be considered a violation of the Viatical Settlements Act.

(5) No life insurance producer, insurance company, viatical settlement broker, or viatical settlement provider shall make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

Source: Laws 2008, LB853, § 12.

ARTICLE 12

RECIPROCAL INSURANCE

Section

44-1201 Contracts, authorized.

Individuals, partnerships, limited liability companies, and corporations in this state, hereby designated as subscribers, are hereby authorized to exchange reciprocal or interinsurance contracts with each other or with individuals, partnerships, limited liability companies, and corporations of other states and countries providing indemnity among themselves from any loss which may be insured against under other provisions of the laws excepting life insurance.

Source: Laws 1917, c. 189, § 1, p. 458; Laws 1919, c. 190, tit. V, art. XV, § 1, p. 681; C.S.1922, § 7969; C.S.1929, § 44-1501; R.S.1943, § 44-1201; Laws 1993, LB 121, § 229.

Defendant was a reciprocal insurance exchange authorized under this article to write public liability automobile insurance. Davis v. Highway Motor Underwriters, 120 Neb. 734, 235 N.W. 325 (1931).

44-1202 Contracts; licensed agent or attorney may execute.

Such contracts may be executed by an attorney, agent, or other representative, herein designated attorney, duly authorized and acting for such subscribers; *Provided*, that no such interinsurance contracts covering risks located or residing in this state shall be solicited, written, or placed, or caused to be solicited, written, or placed, except by or through a duly licensed agent of the attorney, resident within this state or licensed by the Department of Insurance; except that such contracts may be executed by the attorney, or an officer of the same if the attorney is a corporation, if done at the home office of the attorney or exchange in this state. The office or offices of such attorney may be maintained at such place or places as may be designated by the subscribers in the power of attorney.

Source: Laws 1917, c. 189, § 2, p. 459; Laws 1919, c. 190, tit. V, art. XV, § 2, p. 682; C.S.1922, § 7970; C.S.1929, § 44-1502; R.S.1943, § 44-1202; Laws 1949, c. 151, § 1, p. 388.

44-1203 Declaration; filing; contents; loss fund required.

Such subscribers so contracting among themselves shall, through their attorney, file with the Department of Insurance a declaration verified by the oath of such attorney or, when such attorney is a corporation, by the oath of the chief officer thereof setting forth: (1) The name or title adopted by such subscribers proposing to exchange such indemnity contracts, which name or title shall not be so similar to any other name or title previously adopted by a similar organization or by any insurance corporation or association as in the opinion of the department is likely to result in confusion or deception; (2) the kind or kinds of insurance to be effected or exchanged; (3) a copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged, which policy contract or agreement shall state the minimum and maximum liability of subscribers for the payment of losses occurring under its contracts; (4) a copy of the form of power of attorney or other authority of such attorney under which such insurance is to be effected or exchanged; (5) the location of the office or offices from which such contracts or agreements are to be issued; (6) that applications have been made for indemnity upon at least seventy-five separate risks, aggregating not less than one and one-half million dollars, as represented by executed contracts or bona fide applications to become effective concurrently or, in the case of employers liability or workers' compensation insurance, at least seventy-five separate risks covering a total payroll of not less than one and one-half million dollars; and (7) that there is on deposit and thereafter maintained with such attorney and available for the

payment of losses a fund, in cash or invested as provided by law, of not less than one million dollars. A reciprocal doing business in this state on August 25, 1989, shall not be subject to the foregoing deposit requirement insofar as such requirement would increase the amount of deposit necessary for the issuance of contracts on those classes of insurance being issued by it on such date, except that if such reciprocal, on and after such date, is determined by the director to be maintaining an amount which complies with such deposit requirement, then such reciprocal shall continue to be subject to such requirement. On and after such date, any reciprocal desiring to write any additional line of insurance as specified in section 44-201 shall thereupon deposit and maintain funds of at least one million dollars as provided in this section. This section shall be applicable to a reciprocal exchange issuing assessable or nonassessable policy contracts or agreements.

Source: Laws 1917, c. 189, § 3, p. 459; Laws 1919, c. 190, tit. V, art. XV, § 3, p. 682; C.S.1922, § 7971; C.S.1929, § 44-1503; R.S.1943, § 44-1203; Laws 1949, c. 152, § 1, p. 389; Laws 1965, c. 253, § 5, p. 718; Laws 1967, c. 262, § 5, p. 704; Laws 1989, LB 92, § 165.

44-1204 Actions; where brought; process; judgments.

Concurrently with the filing of the declaration provided for by the terms of section 44-1203, the attorney shall file with the Department of Insurance an instrument in writing executed by him or her for said subscribers, conditioned that upon the issuance of certificate of authority provided for in section 44-1211 action may be brought in the county in which the property insured thereunder is situated and service of process may be had in the manner provided for service of a summons in a civil action in all suits in this state arising out of such policies, contracts, or agreements, which service shall be valid and binding upon all subscribers exchanging at any time reciprocal or interinsurance contracts through such attorney. Such instrument shall further provide that in all suits arising in this state on account of contracts issued by such attorney for the account of said subscribers, such action may be brought against such attorney as attorney in fact for all subscribers at such reciprocal or interinsurance exchange, and the judgment in the action shall be a judgment against and binding upon each of the subscribers, as their respective interests may appear.

Source: Laws 1917, c. 189, § 4, p. 460; Laws 1919, c. 190, tit. V, art. XV, § 4, p. 683; C.S.1922, § 7972; C.S.1929, § 44-1504; R.S.1943, § 44-1204; Laws 1983, LB 447, § 61.

44-1205 Maximum single risk; statement; filing required.

There shall be filed with the Department of Insurance, by such attorney, a statement under oath of such attorney showing the maximum amount of indemnity upon any single risk, and such attorney shall, whenever and as often as the same shall be required, file with the department a statement verified by his oath, giving such information.

Source: Laws 1917, c. 189, § 5, p. 460; Laws 1919, c. 190, tit. V, art. XV, § 5, p. 683; C.S.1922, § 7973; C.S.1929, § 44-1505; R.S.1943, § 44-1205.

44-1206 Reserve; character; amount.

In addition to the requirement that a fund, in cash or invested as provided by law, be on deposit with the attorney as provided in subdivision (7) of section 44-1203, it shall be a further requirement that such beginning deposit be continually maintained with such attorney, and in addition thereto there shall at all times be maintained with such attorney as a reserve, a sum in cash or convertible securities equal to one hundred percent of the aggregate net unearned deposits collected and credited to the accounts of participating subscribers, plus such claim and loss reserves. In computing aggregate net unearned deposits, credit will be given for reinsurance in reputable solvent companies. If at any time the assets on deposit with the attorney shall not equal the fund necessary to be maintained as provided above and in addition thereto the reserves as computed herein, the subscribers or their attorney for them shall make up any deficiency. In case of workers' compensation insurance, the Department of Insurance may require of any such attorney a bond or deposit of money with a bank or trust company of this state for the purpose of securing deferred payments or installments for compensation benefits provided for by the Nebraska Workers' Compensation Act.

Source: Laws 1917, c. 189, § 6, p. 460; Laws 1919, c. 190, tit. V, art. XV, § 6, p. 683; C.S.1922, § 7974; C.S.1929, § 44-1506; R.S.1943, § 44-1206; Laws 1949, c. 153, § 1(1), p. 391; Laws 1986, LB 811, § 19; Laws 2000, LB 930, § 5.

Cross References

Nebraska Workers' Compensation Act, see section 48-1,110.

44-1206.01 Reserve; deficiency; notice; removal.

Whenever it shall appear from any proper showing or from any examination made that the assets and resources of any domestic reciprocal insurance exchange are insufficient to meet the minimum conditions prescribed in section 44-1206, the department may promptly determine the amount of such deficiency and thereupon issue a written notice and requisition to the attorney of such reciprocal exchange requiring that such deficiency be removed within a reasonable time not to exceed one hundred eighty days from the service of such notice and requisition. If such deficiency shall not be made good within the time specified in the notice and requisition and satisfactory proof thereof filed with the department, such reciprocal exchange shall be proceeded against in the manner authorized and directed by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1949, c. 153, § 1(2), p. 392; Laws 1989, LB 319, § 69.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-1207 Annual statement; contents; examination; power of department.

Such attorney shall, within the time limited for filing the annual statement by insurance companies transacting the same kind of business, make a report to the Department of Insurance for each calendar year, showing the financial condition of affairs at the office where such contracts were issued, and shall furnish such additional information and reports as may be required; *Provided, however,* that the attorney shall not be required to file the names and addresses of any subscribers. The business affairs, records and assets of such organization

shall be subject to examination by the department at the expense of the organization examined.

Source: Laws 1917, c. 189, § 7, p. 461; Laws 1919, c. 190, tit. V, art. XV, § 7, p. 684; C.S.1922, § 7975; C.S.1929, § 44-1507; R.S.1943, § 44-1207.

44-1208 Exchange of contracts; authorized.

Any corporation organized under the laws of this state, shall, in addition to the rights, powers and franchises specified in its articles of incorporation, have full power and authority to exchange insurance contracts of the kind and character mentioned in section 44-1201. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized, and as much granted as the rights and powers expressly conferred.

Source: Laws 1917, c. 189, § 8, p. 461; Laws 1919, c. 190, tit. V, art. XV, § 8, p. 684; C.S.1922, § 7976; C.S.1929, § 44-1508; R.S.1943, § 44-1208.

44-1209 Attorney; violations; penalty.

Any attorney who shall exchange any contracts of indemnity of the kind and character specified in section 44-1201, or any attorney, agent, or any person representing him, who shall solicit or negotiate any application for same without the attorney first complying with the foregoing provisions, shall be guilty of a Class II misdemeanor.

Source: Laws 1917, c. 189, § 9, p. 462; Laws 1919, c. 190, tit. V, art. XV, § 9, p. 685; C.S.1922, § 7977; C.S.1929, § 44-1509; R.S.1943, § 44-1209; Laws 1977, LB 40, § 244.

44-1210 Solicitation for purposes of organization; license not required.

For the purposes of organization, and upon issuance of permit by the Department of Insurance, powers of attorney and applications may be solicited without license, but no attorney, agent, or other person, shall make any contracts of indemnity until he shall comply with the provisions of sections 44-1201 to 44-1214.

Source: Laws 1917, c. 189, § 9, p. 462; Laws 1919, c. 190, tit. V, art. XV, § 9, p. 685; C.S.1922, § 7977; C.S.1929, § 44-1509; R.S.1943, § 44-1210.

44-1211 Attorney's certificate of authority; issuance.

Each attorney by or through whom are issued any policies of, or contracts for, indemnity of the character referred to in section 44-1201, may procure from the Department of Insurance annually a certificate of authority, stating that all the requirements of sections 44-1201 to 44-1214 have been complied with. Upon such compliance, and the payment of the fees and taxes required by this article, the department shall issue such certificate.

Source: Laws 1917, c. 189, § 10, p. 462; Laws 1919, c. 190, tit. V, art. XV, § 10, p. 685; C.S.1922, § 7978; C.S.1929, § 44-1510; R.S.1943, § 44-1211.

44-1212 Attorney's certificate; revocation or suspension; grounds; order; appeal.

In addition to the penalties prescribed in section 44-1209 and when not otherwise provided, the penalty for failure or refusal to comply with any of the terms and provisions of sections 44-1201 to 44-1214, upon the part of the attorney, shall be the refusal, suspension, or revocation of certificate of authority or license by the Department of Insurance and publication of his or her act, after due notice and opportunity for hearing has been given such attorney so that he or she may appear and show cause why such action should not be taken. An appeal may be taken from the decision of the Director of Insurance, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1917, c. 189, § 11, p. 462; Laws 1919, c. 190, tit. V, art. XV, § 11, p. 685; C.S.1922, § 7979; C.S.1929, § 44-1511; R.S.1943, § 44-1212; Laws 1969, c. 359, § 29, p. 1280; Laws 1988, LB 352, § 57.

Cross References

Administrative Procedure Act, see section 84-920.

44-1213 Repealed. Laws 1986, LB 1114, § 23.

44-1214 Applicability of insurance laws.

Reciprocal or interinsurance contracts, the exchange thereof, the subscribers, attorneys in fact, agents, and representatives, and all matters incident to or concerned with such contracts and relationship, shall be exclusively subject to and regulated by the provisions of sections 44-1201 to 44-1214, and no other law relating to insurance heretofore or hereafter enacted, except as provided in this article, or when such other law relating to insurance specifically uses the words reciprocal or interinsurance.

Source: Laws 1917, c. 189, § 13, p. 462; Laws 1919, c. 190, tit. V, art. XV, § 13, p. 686; C.S.1922, § 7981; C.S.1929, § 44-1513; R.S.1943, § 44-1214; Laws 1949, c. 154, § 1(1), p. 393.

Fraternal benefit insurance organizations are not exempt from law confining all corporations, societies and associations to objects and purposes of existence. Folts v. Globe Life Ins. Co., 117 Neb. 723, 223 N.W. 797 (1929).

44-1215 Applicability of insurance laws; conflict; effect.

Reciprocal or interinsurance exchanges and all matters relating thereto shall be subject to and governed by Chapter 44, articles 1, 2, 3, 4, 5, 6, 7, 12, and 15, as now existing or as hereafter amended, insofar as these statutes may be reasonably applicable; and sections 44-1201 to 44-1214 shall govern in the event of conflict between the application of the articles enumerated in this section.

Source: Laws 1949, c. 154, § 1(2), p. 393; Laws 1994, LB 852, § 1.

ARTICLE 13

HEALTH CARRIER EXTERNAL REVIEW ACT

Section

Section

44-1301 Act, how cited.

Sections 44-1301 to 44-1318 shall be known and may be cited as the Health Carrier External Review Act.

Source: Laws 2013, LB147, § 1.

44-1302 Purpose of act.

The purpose of the Health Carrier External Review Act is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination.

Source: Laws 2013, LB147, § 2.

44-1303 Terms, defined.

For purposes of the Health Carrier External Review Act:

(1) Adverse determination means a determination by a health carrier or its designee utilization review organization that an admission, the availability of care, a continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefor denied, reduced, or terminated;

(2) Ambulatory review means the utilization review of health care services performed or provided in an outpatient setting;

(3) Authorized representative means:

(a) A person to whom a covered person has given express written consent to represent the covered person in an external review;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent;

(4) Benefits or covered benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(5) Best evidence means evidence based on:

(a) Randomized clinical trials;

(b) If randomized clinical trials are not available, cohort studies or case-control studies;

(c) If the criteria described in subdivisions (5)(a) and (b) of this section are not available, case-series; or

(d) If the criteria described in subdivisions (5)(a), (b), and (c) of this section are not available, expert opinions;

(6) Case-control study means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received;

(7) Case management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(8) Case-series means an evaluation of a series of patients with a particular outcome, without the use of a control group;

(9) Certification means a determination by a health carrier or its designee utilization review organization that an admission, the availability of care, a continued stay, or other health care service has been reviewed and, based upon the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(10) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services;

(11) Cohort study means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention;

(12) Concurrent review means a utilization review conducted during a patient's hospital stay or course of treatment;

(13) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(14) Director means the Director of Insurance;

(15) Discharge planning means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(16) Disclose means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information;

(17) Emergency medical condition means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention if failure to provide such medical attention would result in a serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy;

(18) Emergency services means health care items and services furnished or required to evaluate and treat an emergency medical condition;

(19) Evidence-based standard means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of an individual patient;

(20) Expert opinion means a belief or an interpretation by a specialist with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy;

(21) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(22) Final adverse determination means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of the health carrier's internal grievance process procedures as set forth in the Health Carrier Grievance Procedure Act;

(23) Health benefit plan means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(24) Health care professional means a physician or other health care practitioner licensed, accredited, or certified to perform specified health care services consistent with state law;

(25) Health care provider or provider means a health care professional or a facility;

(26) Health care services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(27) Health carrier means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services;

(28) Health information means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(a) The past, present, or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(b) The provision of health care services to an individual; or

(c) Payment for the provision of health care services to an individual;

(29) Independent review organization means an entity that conducts independent external reviews of adverse determinations and final adverse determinations;

(30) Medical or scientific evidence means evidence found in the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's United States National Library of Medicine for indexing in Index Medicus, known as Medline, and Elsevier Science Ltd. for indexing in Excerpta Medica, known as Embase;

(c) Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the federal Social Security Act;

(d) The following standard reference compendia:

(i) The AHFS Drug Information;

(ii) Drug Facts and Comparisons;

(iii) The American Dental Association Guide to Dental Therapeutics; and

(iv) The United States Pharmacopoeia Drug Information;

(e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(i) The federal Agency for Healthcare Research and Quality of the United States Department of Health and Human Services;

(ii) The National Institutes of Health;

(iii) The National Cancer Institute;

(iv) The National Academy of Sciences;

(v) The Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services;

(vi) The federal Food and Drug Administration; and

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(f) Any other medical or scientific evidence that is comparable to the sources listed in subdivisions (30)(a) through (e) of this section;

(31) Prospective review means a utilization review conducted prior to an admission or a course of treatment;

(32) Protected health information means health information:

(a) That identifies an individual who is the subject of the information; or

(b) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual;

(33) Randomized clinical trial means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of

patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time;

(34) Retrospective review means a review of medical necessity conducted after health care services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(35) Second opinion means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service;

(36) Utilization review means a set of formal techniques designed to monitor the use or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review; and

(37) Utilization review organization means an entity that conducts a utilization review, other than a health carrier performing a review for its own health benefit plans.

Source: Laws 2013, LB147, § 3.

Cross References

Health Carrier Grievance Procedure Act, see section 44-7301.

44-1304 Applicability of act.

(1) Except as provided in subsection (2) of this section, the Health Carrier External Review Act shall apply to all health carriers.

(2)(a) The act shall not apply to a policy or certificate that provides coverage for:

(i) A specified disease, specified accident, or accident-only coverage;

(ii) Credit;

(iii) Dental;

(iv) Disability income;

(v) Hospital indemnity;

(vi) Long-term care insurance as defined in section 44-4509;

(vii) Vision care; or

(viii) Any other limited supplemental benefit.

(b) The act shall not apply to:

(i) A medicare supplement policy of insurance as defined in section 44-3602;

(ii) Coverage under a plan through medicare, medicaid, or the Federal Employees Health Benefits Program;

(iii) Any coverage issued under Chapter 55 of Title 10 of the United States Code and any coverage issued as a supplement to that coverage;

(iv) Any coverage issued as supplemental to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical-payment insurance; or

(vii) Any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Source: Laws 2013, LB147, § 4.

44-1305 Health carrier; covered person; notification; when; written notice; contents; health carrier; duties.

(1)(a) A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 44-1308, 44-1309, or 44-1310 and include the appropriate statements and information as set forth in subsection (2) of this section at the same time that the health carrier sends written notice of:

(i) An adverse determination upon completion of the health carrier's utilization review process set forth in the Utilization Review Act; and

(ii) A final adverse determination.

(b) As part of the written notice required under subdivision (1)(a) of this section, a health carrier shall include the following, or substantially equivalent, language: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Director of Insurance (insert address and telephone number of the office of the director).

(c) The director may prescribe by rule and regulation the form and content of the notice required under this section.

(2)(a) The health carrier shall include in the notice required under subsection (1) of this section:

(i) For a notice related to an adverse determination, a statement informing the covered person that:

(A) If the covered person has a medical condition in which the timeframe for completion of an expedited review of a grievance involving an adverse determination as set forth in section 44-7311 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to section 44-1309 or 44-1310 if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 44-7311, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

(B) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in section 44-7308, but if the health carrier has not issued a written decision to the covered person or his or her authorized representative within the time allowed for an internal grievance pursuant to section 44-7308 and the covered person or his or her authorized representative has not requested or agreed to a delay, the covered person or his or her authorized representative may file a request for external review pursuant to section 44-1306 and shall be considered to have exhausted the health carrier's internal grievance process for purposes of section 44-1307; and

(ii) For a notice related to a final adverse determination, a statement informing the covered person that:

(A) If the covered person has a medical condition in which the timeframe for completion of a standard external review pursuant to section 44-1308 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to section 44-1309; or

(B) If the final adverse determination concerns:

(I) An admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to section 44-1309; or

(II) A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to section 44-1310 or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or his or her authorized representative may request an expedited external review to be conducted under section 44-1310.

(b) In addition to the information to be provided pursuant to subdivision (2)(a) of this section, the health carrier shall include a copy of the description of both the standard and expedited external review procedures that the health carrier is required to provide pursuant to section 44-1317 and shall highlight the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and include any forms used to process an external review.

(c) As part of any forms provided under subdivision (2)(b) of this section, the health carrier shall include an authorization form or other document approved by the director that complies with the requirements of 45 C.F.R. 164.508, by which the covered person, for purposes of conducting an external review under the Health Carrier External Review Act, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

Source: Laws 2013, LB147, § 5; Laws 2016, LB840, § 1.

Cross References

Utilization Review Act, see section 44-5416.

44-1306 Request for external review.

(1)(a) Except for a request for an expedited external review as set forth in section 44-1309, all requests for external review shall be made in writing to the director.

(b) The director may prescribe by rule and regulation the form and content of external review requests required to be submitted under this section.

(2) A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Source: Laws 2013, LB147, § 6.

44-1307 Request for external review; exhaustion of internal grievance process; request for expedited external review of adverse determination; independent review organization; duties.

(1)(a) Except as provided in subsection (2) of this section, a request for an external review pursuant to section 44-1308, 44-1309, or 44-1310 shall not be made until the covered person has exhausted the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act.

(b) A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section if the covered person or the covered person's authorized representative:

(i) Has filed a grievance involving an adverse determination pursuant to section 44-7308; and

(ii) Except to the extent that the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within the time allowed for an internal grievance pursuant to section 44-7308.

(c) Notwithstanding subdivision (1)(b) of this section, a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination made pursuant to the Utilization Review Act until the covered person has exhausted the health carrier's internal grievance process.

(2)(a)(i) At the same time that a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in section 44-7311, the covered person or his or her authorized representative may file a request for an expedited external review of the adverse determination:

(A) Under section 44-1309 if the covered person has a medical condition in which the timeframe for completion of an expedited review of the grievance involving an adverse determination set forth in section 44-7311 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(B) Under section 44-1310 if the adverse determination involves a denial of coverage based upon a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended

or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(ii) Upon receipt of a request for an expedited external review under subdivision (2)(a)(i) of this section, the independent review organization conducting the external review in accordance with the provisions of section 44-1309 or 44-1310 shall determine whether the covered person shall be required to complete the expedited grievance review process set forth in section 44-7311 before it conducts the expedited external review.

(iii) Upon a determination made pursuant to subdivision (2)(a)(ii) of this section that the covered person must first complete the expedited grievance review process set forth in section 44-7311, the independent review organization shall immediately notify the covered person and, if applicable, the covered person's authorized representative of such determination and the fact that it will not proceed with the expedited external review set forth in section 44-1309 until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(b) A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures as set forth in section 44-7308 if the health carrier agrees to waive the exhaustion requirement.

(3) If the requirement to exhaust the health carrier's internal grievance procedures is waived under subdivision (2)(b) of this section, the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in section 44-1308 or 44-1310.

Source: Laws 2013, LB147, § 7; Laws 2016, LB840, § 2.

Cross References

Health Carrier Grievance Procedure Act, see section 44-7301.
Utilization Review Act, see section 44-5416.

44-1308 Request for external review; filing; director; duties; health carrier; duties; preliminary review; contents; director; powers; notice of initial determination; contents; independent review organization; powers; duties; decision; notice; contents.

(1)(a) Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 44-1305, a covered person or the covered person's authorized representative may file a request for an external review with the director.

(b) Within one business day after the date of receipt of a request for an external review pursuant to subdivision (1)(a) of this section, the director shall send a copy of the request to the health carrier.

(2) Within five business days following the date of receipt of the copy of the external review request from the director under subdivision (1)(b) of this section, the health carrier shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person in the health benefit plan at the time that the health care service was requested or, in the case of a retrospective

review, was a covered person in the health benefit plan at the time that the health care service was provided;

(b) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 44-1307; and

(d) The covered person has provided all the information and forms required to process an external review, including the release form provided under subsection (2) of section 44-1305.

(3)(a) Within one business day after completion of the preliminary review, the health carrier shall notify the director and covered person and, if applicable, the covered person's authorized representative, in writing whether:

(i) The request is complete; and

(ii) The request is eligible for external review.

(b) If the request:

(i) Is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the director in writing and include in the notice what information or materials are needed to make the request complete; or

(ii) Is not eligible for external review, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the director in writing and include in the notice the reasons for its ineligibility.

(c)(i) The director may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(ii) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the director.

(d)(i) The director may determine that a request is eligible for external review under subsection (2) of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(ii) In making a determination under subdivision (3)(d)(i) of this section, the director's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Health Carrier External Review Act.

(4)(a) Whenever the director receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection (3) of this section, the director shall, within one business day after the date of receipt of the notice:

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the director pursuant to section 44-1312 to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and

(ii) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(b) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in the Utilization Review Act or the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act.

(c) The director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or his or her authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to but may accept and consider additional information submitted after five business days.

(5)(a) Within five business days after the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

(b) Except as provided in subdivision (5)(c) of this section, failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in subdivision (5)(a) of this section shall not delay the conduct of the external review.

(c)(i) If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in subdivision (5)(a) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(ii) Within one business day after making the decision under subdivision (5)(c)(i) of this section, the independent review organization shall notify the covered person and, if applicable, the covered person's authorized representative, the health carrier, and the director.

(6)(a) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (5) of this section and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subdivision (4)(c) of this section.

(b) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision (4)(c) of this section, the assigned independent review organization shall forward the information to the health carrier within one business day.

(7)(a) Upon receipt of the information, if any, required to be forwarded pursuant to subdivision (6)(b) of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(b) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision (7)(a) of this section shall not delay or terminate the external review.

(c) The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.

(d)(i) Within one business day after making the decision to reverse its adverse determination or final adverse determination as provided in subdivision (7)(c) of this section, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative, the assigned independent review organization, and the director in writing of its decision.

(ii) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (7)(d)(i) of this section.

(8) In addition to the documents and information provided pursuant to subsection (5) of this section, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(e) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, or associations;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and

(g) The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions (8)(a) through (f) of this section to the extent that the information or documents are available and the clinical reviewer or reviewers consider it appropriate.

(9)(a) Within forty-five days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or

the final adverse determination to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the director.

(b) The independent review organization shall include in the notice sent pursuant to subdivision (9)(a) of this section:

(i) A general description of the reason for the request for external review;

(ii) The date that the independent review organization received the assignment from the director to conduct the external review;

(iii) The date that the external review was conducted;

(iv) The date of its decision;

(v) The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;

(vi) The rationale for its decision; and

(vii) References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

(c) Upon receipt of a notice of a decision pursuant to subdivision (9)(a) of this section reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(10) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection (4) of section 44-1313.

Source: Laws 2013, LB147, § 8.

Cross References

Health Carrier Grievance Procedure Act, see section 44-7301.
Utilization Review Act, see section 44-5416.

44-1309 Request for expedited external review; director; duties; health carrier; duties; notice of initial determination; contents; expedited external review; independent review organization; powers; duties; decision; notice; contents.

(1) Except as provided in subsection (6) of this section, a covered person or the covered person's authorized representative may make a request for an expedited external review with the director at the time that the covered person receives:

(a) An adverse determination if:

(i) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in section 44-7311 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(ii) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in section 44-7311; or

(b) A final adverse determination:

(i) If the covered person has a medical condition in which the timeframe for completion of a standard external review pursuant to section 44-1308 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.

(2)(a) Upon receipt of a request for an expedited external review, the director shall immediately send a copy of the request to the health carrier.

(b) Immediately upon receipt of the request pursuant to subdivision (2)(a) of this section, the health carrier shall determine whether the request meets the reviewability requirements set forth in subsection (2) of section 44-1308. The health carrier shall immediately notify the director and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(c)(i) The director may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.

(ii) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the director.

(d)(i) The director may determine that a request is eligible for external review under subsection (2) of section 44-1308 notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(ii) In making a determination under subdivision (2)(d)(i) of this section, the director's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Health Carrier External Review Act.

(e) Upon receipt of the notice that the request meets the reviewability requirements, the director shall immediately assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the director pursuant to section 44-1312. The director shall immediately notify the health carrier of the name of the assigned independent review organization.

(f) In reaching a decision in accordance with subsection (5) of this section, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in the Health Carrier Grievance Procedure Act or the Utilization Review Act.

(3) Upon receipt of the notice from the director of the name of the independent review organization assigned to conduct the expedited external review pursuant to subdivision (2)(e) of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(4) In addition to the documents and information provided or transmitted pursuant to subsection (3) of this section, the assigned independent review organization, to the extent that the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's pertinent medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(e) The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, or associations;

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and

(g) The opinion of the independent review organization's clinical reviewer or reviewers after considering subdivisions (4)(a) through (f) of this section to the extent that the information and documents are available and the clinical reviewer or reviewers consider it appropriate.

(5)(a) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in subsection (2) of section 44-1308, the assigned independent review organization shall:

(i) Make a decision to uphold or reverse the adverse determination or final adverse determination; and

(ii) Notify the covered person and, if applicable, the covered person's authorized representative, the health carrier, and the director of the decision.

(b) If the notice provided pursuant to subdivision (5)(a) of this section was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall:

(i) Provide written confirmation of the decision to the covered person and, if applicable, the covered person's authorized representative, the health carrier, and the director; and

(ii) Include the information set forth in subdivision (9)(b) of section 44-1308.

(c) Upon receipt of the notice of a decision pursuant to subdivision (5)(a) of this section reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(6) An expedited external review may not be provided for retrospective adverse or final adverse determinations.

(7) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection (4) of section 44-1313.

Source: Laws 2013, LB147, § 9.

Cross References

Health Carrier Grievance Procedure Act, see section 44-7301.
Utilization Review Act, see section 44-5416.

44-1310 Review of denial of coverage for service or coverage determined experimental or investigational; external review; expedited external review; director; duties; health carrier; duties; notice of initial determination; contents; appeal; clinical reviewer; duties; independent review organization; powers; duties; decision; notice; contents.

(1)(a) Within four months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to section 44-1305 that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the director.

(b)(i) A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subdivision (1)(a) of this section if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(ii) Upon receipt of a request for an expedited external review, the director shall immediately notify the health carrier.

(iii)(A) Upon notice of the request for expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements of subdivision (2)(b) of this section. The health carrier shall immediately notify the director and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.

(B) The director may specify the form for the health carrier's notice of initial determination under subdivision (1)(b)(iii)(A) of this section and any supporting information to be included in the notice.

(C) The notice of initial determination under subdivision (1)(b)(iii)(A) of this section shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the director.

(iv)(A) The director may determine that a request is eligible for external review under subdivision (2)(b) of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(B) In making a determination under subdivision (1)(b)(iii)(A) of this section, the director's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Health Carrier External Review Act.

(v) Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subdivision (2)(b) of this section, the director shall immediately assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the director pursuant to section 44-1312 and notify the health carrier of the name of the assigned independent review organization.

(vi) At the time the health carrier receives the notice of the assigned independent review organization pursuant to subdivision (1)(b)(v) of this section, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(2)(a) Except for a request for an expedited external review made pursuant to subdivision (1)(b) of this section, within one business day after the date of receipt of the request the director receives a request for an external review, the director shall notify the health carrier.

(b) Within five business days following the date of receipt of the notice sent pursuant to subdivision (2)(a) of this section, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(i) The individual is or was a covered person in the health benefit plan at the time that the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time that the health care service or treatment was provided;

(ii) The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(A) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(B) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(iii) The covered person's treating physician has certified that one of the following situations is applicable:

(A) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(B) Standard health care services or treatments are not medically appropriate for the covered person; or

(C) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subdivision (2)(b)(iv) of this section;

(iv) The covered person's treating physician:

(A) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care service or treatment; or

(B) Who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care service or treatment;

(v) The covered person has exhausted the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to section 44-1307; and

(vi) The covered person has provided all the information and forms required by the director that are necessary to process an external review, including the release form provided under subsection (2) of section 44-1305.

(3)(a) Within one business day after completion of the preliminary review, the health carrier shall notify the director and the covered person and, if applicable, the covered person's authorized representative in writing whether the request is complete and the request is eligible for external review.

(b) If the request:

(i) Is not complete, the health carrier shall inform, in writing, the director and the covered person and, if applicable, the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete; or

(ii) Is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, if applicable, and the director in writing and include in the notice the reasons for its ineligibility.

(c)(i) The director may specify the form for the health carrier's notice of initial determination under subdivision (3)(b) of this section and any supporting information to be included in the notice.

(ii) The notice of initial determination provided under subdivision (3)(b) of this section shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the director.

(d)(i) The director may determine that a request is eligible for external review under subdivision (2)(b) of this section notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(ii) In making a determination under subdivision (3)(d)(i) of this section, the director's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of the Health Carrier External Review Act.

(e) Whenever a request for external review is determined eligible for external review, the health carrier shall notify the director and the covered person and, if applicable, the covered person's authorized representative.

(4)(a) Within one business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subdivision (1)(b)(iv) of this section or subdivision (3)(e) of this section, the director shall:

(i) Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the director pursuant to section 44-1312 and notify the health carrier of the name of the assigned independent review organization; and

(ii) Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.

(b) The director shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five business days following the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section additional information that the independent review organization shall consider when conducting the external review. The independent review organization may accept and consider additional information submitted after five business days.

(c) Within one business day after the receipt of the notice of assignment to conduct the external review pursuant to subdivision (4)(a) of this section, the assigned independent review organization shall:

(i) Select one or more clinical reviewers, as it determines is appropriate, pursuant to subdivision (4)(d) of this section to conduct the external review; and

(ii) Based upon the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(d)(i) In selecting clinical reviewers pursuant to subdivision (4)(c)(i) of this section, the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in section 44-1313 and, through clinical experience in the past three years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(ii) Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.

(e) In accordance with subsection (8) of this section, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(f) In reaching an opinion, a clinical reviewer is not bound by any decisions or conclusions reached during the health carrier's utilization review process as

set forth in the Utilization Review Act or the health carrier's internal grievance process as set forth in the Health Carrier Grievance Procedure Act.

(5)(a) Within five business days after the date of receipt of the notice provided pursuant to subdivision (4)(a) of this section, the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or the final adverse determination.

(b) Except as provided in subdivision (5)(c) of this section, failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in subdivision (5)(a) of this section shall not delay the conduct of the external review.

(c)(i) If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in subdivision (5)(a) of this section, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(ii) Immediately upon making the decision under subdivision (5)(c)(i) of this section, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the director.

(6)(a) Each clinical reviewer selected pursuant to subsection (4) of this section shall review all of the information and documents received pursuant to subsection (5) of this section and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subdivision (4)(b) of this section.

(b) Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subdivision (4)(b) of this section, within one business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.

(7)(a) Upon receipt of the information required to be forwarded pursuant to subdivision (6)(b) of this section, the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(b) Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to subdivision (7)(a) of this section shall not delay or terminate the external review.

(c) The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(d)(i) Immediately upon making the decision to reverse its adverse determination or final adverse determination as provided in subdivision (7)(c) of this section, the health carrier shall notify the covered person, the covered person's authorized representative, if applicable, the assigned independent review organization, and the director in writing of its decision.

(ii) The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (7)(d)(i) of this section.

(8)(a) Except as provided in subdivision (8)(c) of this section, within twenty days after being selected in accordance with subsection (4) of this section to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection (9) of this section on whether the recommended or requested health care service or treatment should be covered.

(b) Except for an opinion provided pursuant to subdivision (8)(c) of this section, each clinical reviewer's opinion shall be in writing and include the following information:

(i) A description of the covered person's medical condition;

(ii) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risk of the recommended or requested health care service or treatment would not be substantially increased over that of available standard health care service or treatment;

(iii) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) A description and analysis of any evidence-based standard; and

(v) Information on whether the reviewer's rationale for the opinion is based on subdivision (9)(e)(i) or (ii) of this section.

(c) For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five calendar days after being selected in accordance with subsection (4) of this section.

(d) If the opinion provided pursuant to subdivision (8)(a) of this section was not in writing, within forty-eight hours following the date that the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under subdivision (8)(b) of this section.

(9) In addition to the documents and information provided pursuant to subdivision (1)(b) of this section or subsection (5) of this section, each clinical reviewer selected pursuant to subsection (4) of this section, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection (8) of this section:

(a) The covered person's pertinent medical records;

(b) The attending physician or health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, if applicable, or the covered person's treating physician or health care professional;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(e) Whether:

(i) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or

(ii) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care service or treatment.

(10)(a)(i) Except as provided in subdivision (10)(a)(ii) of this section, within twenty days after the date it receives the opinion of each clinical reviewer pursuant to subsection (9) of this section, the assigned independent review organization, in accordance with subdivision (10)(b) of this section, shall make a decision and provide written notice of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the director.

(ii)(A) For an expedited external review, within forty-eight hours after the date it receives the opinion of each clinical reviewer pursuant to subsection (9) of this section, the assigned independent review organization, in accordance with subdivision (10)(b) of this section, shall make a decision and provide notice of the decision orally or in writing to the persons listed in subdivision (10)(a)(i) of this section.

(B) If the notice provided under subdivision (10)(a)(ii)(A) of this section was not in writing, within forty-eight hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subdivision (10)(a)(i) of this section and include the information set forth in subdivision (10)(c) of this section.

(b)(i) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.

(ii) If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.

(iii)(A) If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subdivision (10)(b)(i) or (ii) of this section.

(B) The additional clinical reviewer selected under subdivision (10)(b)(iii)(A) of this section shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection (9) of this section.

(C) The selection of the additional clinical reviewer shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection (4) of this section pursuant to subdivision (4)(a) of this section.

(c) The independent review organization shall include in the notice provided pursuant to subdivision (10)(a) of this section:

(i) A general description of the reason for the request for external review;

(ii) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(iii) The date the independent review organization was assigned by the director to conduct the external review;

(iv) The date the external review was conducted;

(v) The date of its decision;

(vi) The principal reason or reasons for its decision; and

(vii) The rationale for its decision.

(d) Upon receipt of a notice of a decision pursuant to subdivision (10)(a) of this section reversing the adverse determination or final adverse determination, the health carrier shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

(11) The assignment by the director of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to subsection (4) of section 44-1313.

Source: Laws 2013, LB147, § 10.

Cross References

Health Carrier Grievance Procedure Act, see section 44-7301.
Utilization Review Act, see section 44-5416.

44-1311 External review decision; how treated; limitation on subsequent request.

(1) An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable state law.

(2) An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

(3) A covered person or the covered person's authorized representative, if applicable, shall not file a subsequent request for external review involving the

same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to the Health Carrier External Review Act.

Source: Laws 2013, LB147, § 11.

44-1312 Independent review organizations; approval; qualifications; application; contents; fee; termination of approval; director; powers and duties.

(1) The director shall approve independent review organizations eligible to be assigned to conduct external reviews under the Health Carrier External Review Act.

(2) In order to be eligible for approval by the director under this section to conduct external reviews under the act, an independent review organization:

(a) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the director has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under section 44-1313; and

(b) Shall submit an application for approval in accordance with subsection (4) of this section.

(3) The director shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(4)(a) Any independent review organization wishing to be approved to conduct external reviews under the act shall submit the application form and include with the form all documentation and information necessary for the director to determine if the independent review organization satisfies the minimum qualifications established under section 44-1313.

(b)(i) Subject to subdivision (4)(b)(ii) of this section, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the director has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under section 44-1313.

(ii) The director may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(c) The director may charge an application fee that independent review organizations shall submit to the director with an application for approval and reapproval.

(5)(a) An approval is effective for two years, unless the director determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under section 44-1313.

(b) Whenever the director determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 44-1313, the director shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to

conduct external reviews under the act that is maintained by the director pursuant to subsection (6) of this section.

(6) The director shall maintain and periodically update a list of approved independent review organizations.

(7) The director may adopt and promulgate rules and regulations to carry out the provisions of this section.

Source: Laws 2013, LB147, § 12.

44-1313 Independent review organization; minimum qualifications; clinical reviewers; qualifications; limitation on ownership or control; conflict of interests; presumption of compliance; director; powers; duties.

(1) To be approved under section 44-1312 to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in the Health Carrier External Review Act that include, at a minimum:

(a) A quality assurance mechanism in place that:

(i) Ensures that external reviews are conducted within the specified timeframes and that required notices are provided in a timely manner;

(ii) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(iii) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(iv) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of the act;

(b) A toll-free telephone service to receive information on a twenty-four-hours-per-day, seven-days-per-week basis related to external reviews that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(c) An agreement to maintain and provide to the director the information set out in section 44-1315.

(2) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(a) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(b) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(c) Hold a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized medical specialty board in the United States in the area or areas appropriate to the subject of the external review; and

(d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental, or professional competence or moral character.

(3) In addition to the requirements set forth in subsection (1) of this section, an independent review organization may not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

(4)(a) In addition to the requirements set forth in subsections (1), (2), and (3) of this section, to be approved pursuant to section 44-1312 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent review organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(i) The health carrier that is the subject of the external review;

(ii) The covered person whose treatment is the subject of the external review or the covered person's authorized representative, if applicable;

(iii) Any officer, director, or management employee of the health carrier that is the subject of the external review;

(iv) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(v) The facility at which the recommended health care service or treatment would be provided; or

(vi) The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(b) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial, or financial conflict of interest for purposes of subdivision (4)(a) of this section, the director shall take into consideration situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subdivision (4)(a) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(5)(a) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the director has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under section 44-1312.

(b) The director shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The director may accept a review conducted by the National Association of Insurance Commissioners for the purpose of the determination under this subdivision.

(c) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the director or the National Association of Insurance Commissioners in order for the director to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The director may exclude any private accrediting entity that is not reviewed by the National Association of Insurance Commissioners.

(6) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Source: Laws 2013, LB147, § 13.

44-1314 Liability for damages.

No independent review organization, clinical reviewer working on behalf of an independent review organization, or employee, agent, or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to the Health Carrier External Review Act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Source: Laws 2013, LB147, § 14.

44-1315 Records; report; contents.

(1)(a) An independent review organization assigned pursuant to section 44-1308, 44-1309, or 44-1310 to conduct an external review shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the director as required under subdivision (1)(b) of this section.

(b) Each independent review organization required to maintain written records on all requests for external review pursuant to subdivision (1)(a) of this section for which it was assigned to conduct an external review shall submit to the director, upon request, a report in the format specified by the director.

(c) The report shall include in the aggregate by state, and for each health carrier:

(i) The total number of requests for external review;

(ii) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(iii) The average length of time for resolution;

(iv) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the director;

(v) The number of external reviews pursuant to section 44-1308 that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(vi) Any other information the director may request or require.

(d) The independent review organization shall retain the written records required pursuant to this subsection for at least three years.

(2)(a) Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier, on all requests for external review that the health carrier receives notice of from the director pursuant to the Health Carrier External Review Act.

(b) Each health carrier required to maintain written records on all requests for external review pursuant to subdivision (2)(a) of this section shall submit to the director, upon request, a report in the format specified by the director.

(c) The report shall include in the aggregate, by state, and by type of health benefit plan:

(i) The total number of requests for external review;

(ii) From the total number of requests for external review reported under subdivision (2)(c)(i) of this section, the number of requests determined eligible for a full external review; and

(iii) Any other information the director may request or require.

(d) The health carrier shall retain the written records required pursuant to this section for at least three years.

Source: Laws 2013, LB147, § 15.

44-1316 Health carrier; cost.

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Source: Laws 2013, LB147, § 16.

44-1317 Health carrier; disclosure; format; contents.

(1)(a) Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to covered persons.

(b) The disclosure required by subdivision (1)(a) of this section shall be in a format prescribed by the director.

(2) The description required under subsection (1) of this section shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the director. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health

care setting, level of care, or effectiveness. The statement shall include the telephone number and address of the director.

(3) In addition to the contents required by subsection (2) of this section, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Source: Laws 2013, LB147, § 17.

44-1318 Applicability of act.

The Health Carrier External Review Act applies to any claim submitted on and after January 1, 2014.

Source: Laws 2013, LB147, § 18.

ARTICLE 14

NEBRASKA RIGHT TO SHOP ACT

Section
44-1401. Act, how cited.
44-1402. Terms, defined.
44-1403. Applicability of act; election; notice.
44-1404. Health care entity; disclose allowed amount or charge; updated estimate; other cost estimate.
44-1405. Insurance carrier; interactive mechanism on website; duties.
44-1406. Estimate of out-of-pocket amount.
44-1407. Shared savings incentive payment program; incentive payments; calculation.
44-1408. Availability of shared savings incentive payment program.
44-1409. Filing with department; review; confidentiality.
44-1410. Service from out-of-network provider; how treated.
44-1411. Incentive payment; how treated.
44-1412. Insurance carrier; annual filing; contents; report.
44-1413. Personnel division of Department of Administrative Services; program for state employees; report; contents.
44-1414. Rules and regulations.

44-1401 Act, how cited.

Sections 44-1401 to 44-1414 shall be known and may be cited as the Nebraska Right to Shop Act.

Source: Laws 2018, LB1119, § 11.

44-1402 Terms, defined.

For purposes of the Nebraska Right to Shop Act:

(1) Allowed amount means the contractually agreed-upon amount paid by an insurance carrier to a health care entity participating in the insurance carrier's network or the amount the health plan is required to pay under the health plan policy or certificate of insurance for out-of-network covered benefits provided to the patient;

(2) Department means the Department of Insurance;

(3) Director means the Director of Insurance;

(4) Enrollee means an individual receiving health insurance coverage from an insurance carrier;

(5) Health care entity means:

(a) A facility licensed under the Health Care Facility Licensure Act;

(b) A health care professional licensed under the Uniform Credentialing Act; and

(c) An organization or association of health care professionals licensed under the Uniform Credentialing Act;

(6) Incentive payment means a payment described in section 44-1407 that is made by an insurance carrier to an enrollee;

(7) Insurance carrier means any entity that provides health insurance in this state. Insurance carrier includes (a) an insurance company, (b) a fraternal benefit society, (c) a health maintenance organization, and (d) any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(8) Shared savings incentive payment program means a program established by an insurance carrier pursuant to section 44-1407 to provide incentive payments to enrollees; and

(9) Shoppable health care service means a health care service for which an insurance carrier offers incentive payments under a shared savings incentive payment program established by the insurance carrier. Shoppable health care service includes, at a minimum, health care services in the following categories:

(a) Physical and occupational therapy services;

(b) Obstetrical and gynecological services;

(c) Radiology and imaging services;

(d) Laboratory services;

(e) Infusion therapy;

(f) Inpatient or outpatient surgical procedures; and

(g) Outpatient nonsurgical diagnostic tests or procedures.

Source: Laws 2018, LB1119, § 12.

Cross References

Health Care Facility Licensure Act, see section 71-401.
Uniform Credentialing Act, see section 38-101.

44-1403 Applicability of act; election; notice.

The Nebraska Right to Shop Act shall apply to any insurance carrier that elects to be subject to the act. An insurance carrier making such election shall file a notice of the election with the department.

Source: Laws 2018, LB1119, § 13.

44-1404 Health care entity; disclose allowed amount or charge; updated estimate; other cost estimate.

(1) Prior to a nonemergency admission, procedure, or service and upon request by a patient or prospective patient, a health care entity within the patient's or prospective patient's insurer network shall, within three working days, disclose the allowed amount of the nonemergency admission, procedure, or service, including the amount for any facility fees required, to the patient or prospective patient.

(2) Prior to a nonemergency admission, procedure, or service and upon request by a patient or prospective patient, a health care entity outside the patient's or prospective patient's insurer network shall, within three working days, disclose the amount that will be charged for the nonemergency admission, procedure, or service, including the amount for any facility fees required, to the patient or prospective patient.

(3) If a health care entity is unable to quote a specific amount under subsection (1) or (2) of this section in advance due to the health care entity's inability to predict the specific treatment or diagnostic code, the health care entity shall disclose what is known for the estimated amount for a proposed nonemergency admission, procedure, or service, including the amount for any facility fees required. A health care entity shall disclose the incomplete nature of the estimate and shall inform the patient or prospective patient of his or her ability to obtain an updated estimate once additional information is determined.

(4) If a patient or prospective patient is covered by insurance, a health care entity that participates in an insurance carrier's network shall, upon request of a patient or prospective patient, provide, based on the information available to the health care entity at the time of the request, sufficient information regarding the proposed nonemergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from his or her insurance carrier to identify out-of-pocket costs, which could be through an insurance carrier's toll-free telephone number or website. A health care entity may assist a patient or prospective patient in using an insurance carrier's toll-free telephone number or website.

Source: Laws 2018, LB1119, § 14.

44-1405 Insurance carrier; interactive mechanism on website; duties.

An insurance carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the insurance carrier information on the payments made by the insurance carrier to network providers for health care services. The interactive mechanism must allow an enrollee seeking information about the cost of a particular health care service to compare costs among network providers.

Source: Laws 2018, LB1119, § 15.

44-1406 Estimate of out-of-pocket amount.

(1) Within two working days of an enrollee's request, an insurance carrier shall provide a good faith estimate of the amount the enrollee will be responsible to pay out-of-pocket for a proposed nonemergency procedure or service that is a medically necessary covered benefit from an insurance carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the insurance carrier at the time the request is made.

(2) Nothing in this section shall prohibit an insurance carrier from imposing cost-sharing requirements disclosed in the enrollee's certificate of coverage for unforeseen health care services that arise out of the nonemergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(3) An insurance carrier shall notify the enrollee that the amounts provided under subsection (1) of this section are estimated costs and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed nonemergency procedure or service.

Source: Laws 2018, LB1119, § 16.

44-1407 Shared savings incentive payment program; incentive payments; calculation.

(1) An insurance carrier shall develop and implement a shared savings incentive payment program that provides incentive payments for enrollees in a health plan who elect to receive shoppable health care services that are covered by the plan from providers that charge less than the average price paid by that insurance carrier for that shoppable health care service.

(2) Incentive payments may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology approved by the director. The insurance carrier must provide the incentive payment as a cash payment to the enrollee.

(3) The shared savings incentive payment program must provide enrollees with at least fifty percent of the insurance carrier's saved costs for each shoppable health care service or category of shoppable health care service resulting from shopping by enrollees. An insurance carrier is not required to provide an incentive payment or credit to an enrollee when the insurance carrier's saved cost is fifty dollars or less.

(4) An insurance carrier shall base the average price on the average amount paid to an in-network provider for the procedure or service under the enrollee's health plan within a reasonable timeframe not to exceed one year. An insurance carrier may determine an alternate methodology for calculating the average price if approved by the director.

Source: Laws 2018, LB1119, § 17.

44-1408 Availability of shared savings incentive payment program.

An insurance carrier shall make the shared savings incentive payment program available as a component of all health plans offered by the insurance carrier in this state. Annually at enrollment or renewal, an insurance carrier shall provide notice about the availability of the program to any enrollee who is enrolled in a health plan eligible for the program.

Source: Laws 2018, LB1119, § 18.

44-1409 Filing with department; review; confidentiality.

Prior to offering the shared savings incentive payment program to any enrollee, an insurance carrier shall file a description of the program with the department in the manner determined by the director. The department may review the filing made by the insurance carrier to determine if the insurance carrier's program complies with the requirements of the Nebraska Right to Shop Act. Filings and any supporting documentation submitted pursuant to this section are confidential until the filing has been reviewed by the department.

Source: Laws 2018, LB1119, § 19.

44-1410 Service from out-of-network provider; how treated.

If an enrollee elects to receive a shoppable health care service from an out-of-network provider that results in an incentive payment, the insurance carrier shall apply the amount paid for the shoppable health care service toward the enrollee's member cost sharing as specified in the enrollee's health plan as if the health care services were provided by an in-network provider.

Source: Laws 2018, LB1119, § 20.

44-1411 Incentive payment; how treated.

An incentive payment made by an insurance carrier in accordance with the Nebraska Right to Shop Act is not an administrative expense of the insurance carrier for rate development or rate filing purposes.

Source: Laws 2018, LB1119, § 21.

44-1412 Insurance carrier; annual filing; contents; report.

(1) On or before March 31 each year, each insurance carrier shall file with the department the following information for the most recent calendar year:

(a) The total number of incentive payments made pursuant to the insurance carrier's shared savings incentive payment program;

(b) The use of shoppable health care services by category of service for which incentive payments are made;

(c) The total amount of incentive payments made to enrollees;

(d) The average amount of incentive payments made by category of shoppable health care service;

(e) The total savings achieved below the average prices by category of shoppable health care service; and

(f) The total number and percentage of an insurance carrier's enrollees that participated in the shared savings incentive payment program.

(2) On or before July 1, 2019, and on or before July 1 of each year thereafter, the department shall electronically submit an aggregate report for all insurance carriers filing the information required by subsection (1) of this section to the Legislature.

Source: Laws 2018, LB1119, § 22.

44-1413 Personnel division of Department of Administrative Services; program for state employees; report; contents.

(1) The personnel division of the Department of Administrative Services, in its discretion, may develop and implement a program for state employees receiving health insurance coverage under sections 84-1601 to 84-1615 that is similar to the shared savings incentive payment program described in section 44-1407. If the division develops and implements such a program, the division may use the State Employees Insurance Fund to make incentive payments to state employees pursuant to such program.

(2) If a program for state employees is developed and implemented pursuant to this section, then on or before July 1 of each year after implementation of such program, the personnel division of the Department of Administrative Services shall electronically report to the Legislature the following information for the most recent calendar year:

(a) The total number of incentive payments made pursuant to the program;

(b) The use of shoppable health care services by category of service for which incentive payments are made;

(c) The total amount of incentive payments made to state employees;

(d) The average amount of incentive payments made by category of shoppable health care service;

(e) The total savings achieved below the average prices by category of shoppable health care service; and

(f) The total number and percentage of state employees that participated in the program.

Source: Laws 2018, LB1119, § 23.

44-1414 Rules and regulations.

The department may adopt and promulgate rules and regulations as necessary to carry out the Nebraska Right to Shop Act.

Source: Laws 2018, LB1119, § 24.

ARTICLE 15

UNFAIR PRACTICES

(a) UNFAIR INSURANCE TRADE PRACTICES ACT

Section

Section

(a) UNFAIR INSURANCE TRADE PRACTICES ACT

44-1501 Repealed. Laws 1973, LB 349, § 16.

44-1502 Repealed. Laws 1973, LB 349, § 16.

44-1503 Repealed. Laws 1973, LB 349, § 16.

44-1504 Repealed. Laws 1973, LB 349, § 16.

44-1505 Repealed. Laws 1973, LB 349, § 16.

44-1506 Repealed. Laws 1973, LB 349, § 16.

44-1507 Repealed. Laws 1973, LB 349, § 16.

44-1508 Repealed. Laws 1973, LB 349, § 16.

44-1509 Repealed. Laws 1973, LB 349, § 16.

44-1510 Repealed. Laws 1973, LB 349, § 16.

44-1511 Repealed. Laws 1973, LB 349, § 16.

44-1512 Repealed. Laws 1973, LB 349, § 16.

44-1513 Repealed. Laws 1973, LB 349, § 16.

44-1514 Repealed. Laws 1973, LB 349, § 16.

44-1515 Repealed. Laws 1973, LB 349, § 16.

44-1516 Repealed. Laws 1973, LB 349, § 16.

44-1517 Repealed. Laws 1973, LB 349, § 16.

44-1518 Repealed. Laws 1973, LB 349, § 16.

44-1519 Repealed. Laws 1973, LB 349, § 16.

44-1520 Repealed. Laws 1973, LB 349, § 16.

44-1521 Act, how cited.

Sections 44-1521 to 44-1535 shall be known and may be cited as the Unfair Insurance Trade Practices Act.

Source: Laws 1991, LB 234, § 3; Laws 2008, LB855, § 6.

44-1522 Purpose of act.

The purpose of the Unfair Insurance Trade Practices Act is to regulate unfair trade practices in the business of insurance, in accordance with the intent of the Congress of the United States as expressed in Public Law 79-15, by defining, or providing for the determination of, all acts and practices in this state which constitute unfair trade practices and by prohibiting the acts and practices so defined or determined.

Source: Laws 1973, LB 349, § 1; Laws 1991, LB 234, § 4.

Sections of Nebraska Unfair Competition Act and Trade Practices Act governing insurance business do not contemplate private suits but only suits by State Director of Insurance. Allied Financial Services, Inc. v. Foremost Ins. Co., 418 F.Supp. 157 (D. Neb. 1976).

44-1523 Terms, defined.

For purposes of the Unfair Insurance Trade Practices Act:

(1) Department shall mean the Department of Insurance;

(2) Director shall mean the Director of Insurance;

(3) Insured shall mean the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy or certificate;

(4) Insurer shall mean any person, reciprocal exchange, interinsurer, Lloyds-type insurer or other similar group which includes incorporated and individual unincorporated underwriters, fraternal benefit society, and other legal entity engaged in the business of insurance, including agents, brokers, insurance consultants, adjusters, and third-party administrators. Insurer shall also mean health maintenance organizations, prepaid limited health service organizations, and dental, optometric, and other similar health service plans. For purposes of the act, all such insurers shall be deemed to be engaged in the business of insurance;

(5) Person shall mean any natural or artificial entity, including, but not limited to, an individual, partnership, limited liability company, association, trust, or corporation; and

(6) Policy or certificate shall include any contract of insurance, indemnity, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any insurer.

Source: Laws 1973, LB 349, § 2; Laws 1989, LB 92, § 173; Laws 1991, LB 234, § 5; Laws 1993, LB 121, § 230; Laws 1994, LB 978, § 21.

44-1524 Unfair trade practice; prohibited acts.

It shall be an unfair trade practice in the business of insurance for any insurer to commit any act or practice defined in section 44-1525 if the act or practice (1) is committed flagrantly and in conscious disregard of the Unfair Insurance Trade Practices Act or any rule or regulation adopted pursuant to the

act or (2) has been committed with such frequency as to indicate a general business practice to engage in that type of conduct.

Source: Laws 1973, LB 349, § 3; Laws 1991, LB 234, § 6.

44-1525 Unfair trade practices; enumerated.

Any of the following acts or practices, if committed in violation of section 44-1524, shall be unfair trade practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

(b) Misrepresents the dividends or share of the surplus to be received on any policy;

(c) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any policy;

(d) Misleads as to or misrepresents the financial condition of any insurer or the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any policy or class of policies which misrepresents the true nature thereof;

(f) Misrepresents for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any policy, including intentionally misquoting any premium rate;

(g) Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(h) Misrepresents any policy as being shares of stock;

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any insurer in the conduct of his or her insurance business which is untrue, deceptive, or misleading;

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or derogatory to the financial condition of any insurer and which is calculated to injure such insurer;

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

(5)(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or

placed before the public, any false material statement of fact as to the financial condition of an insurer; or

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer;

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7)(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such policy or annuity;

(b) Making or permitting any unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, or rates charged for any sickness and accident insurance policy or in the benefits payable thereunder, in any of the terms or conditions of such policy, or in any other manner, except that this subdivision shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law, rule, or regulation;

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law, rule, or regulation;

(e) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual solely because of the sex or marital status of the individual. This subdivision shall not prohibit an insurer from taking marital status into account for the purpose of defining individuals eligible for dependent benefits; or

(f) Terminating or modifying coverage or refusing to issue or refusing to renew any property or casualty insurance policy solely because the applicant or insured or any employee of the applicant or insured is mentally or physically impaired unless:

(i) The termination, modification, or refusal is for a business purpose which is not a pretext for unfair discrimination; or

(ii) The termination, modification, or refusal is required by law, rule, or regulation.

This subdivision (f) shall not apply to any sickness and accident insurance policy sold by a casualty insurer and shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any policy;

(8)(a) Except as otherwise expressly provided by law:

(i) Knowingly permitting or offering to make or making any life insurance policy, annuity, or sickness and accident insurance policy, or agreement as to any such policy or annuity, other than as plainly expressed in the policy or annuity issued thereon, or paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such policy or annuity, any rebate of premiums payable on the policy or annuity, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy or annuity; or

(ii) Giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such policy or annuity or in connection therewith any stocks, bonds, or other securities of any insurer or other corporation, association, partnership, or limited liability company, or any dividends or profits accrued thereon, or anything of value not specified in the policy or annuity.

(b) Nothing in subdivision (7) or (8)(a) of this section shall be construed as including within the definition of discrimination or rebates any of the following acts or practices:

(i) In the case of any life insurance policy or annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance if such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the insurer and its policyholders;

(ii) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) Readjustment of the rate of premium for a group insurance policy based on the loss or expense thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(9) Failing of any insurer to maintain a complete record of all the complaints received since the date of its last examination conducted pursuant to the Insurers Examination Act. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subdivision, complaint shall mean any written communication primarily expressing a grievance;

(10) Making false or fraudulent statements or representations on or relative to an application for a policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual person;

(11) Failing of any insurer, upon receipt of a written inquiry from the department, to respond to such inquiry or request additional reasonable time to respond within fifteen working days;

(12) Accepting applications for or writing any policy of insurance sold, negotiated, or solicited by an insurance producer or business entity not licensed or appointed as required by the Insurance Producers Licensing Act; and

(13) Violating any provision of section 44-320, 44-348, 44-360, 44-361, 44-369, 44-393, 44-515 to 44-518, 44-522, 44-523, 44-7,101, 44-2132 to 44-2134, 44-3606, 44-4809, 44-4812, 44-4817, or 44-5266, the Privacy of Insurance Consumer Information Act, or the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Source: Laws 1973, LB 349, § 4; Laws 1978, LB 766, § 1; Laws 1980, LB 877, § 13; Laws 1984, LB 902, § 17; Laws 1985, LB 2, § 3; Laws 1989, LB 92, § 174; Laws 1989, LB 319, § 70; Laws 1991, LB 233, § 46; Laws 1991, LB 235, § 5; Laws 1991, LB 234, § 7; Laws 1993, LB 121, § 231; Laws 1993, LB 583, § 74; Laws 1994, LB 978, § 22; Laws 1994, LB 1222, § 59; Laws 1995, LB 473, § 3; Laws 1997, LB 53, § 48; Laws 1998, LB 1035, § 4; Laws 1999, LB 191, § 2; Laws 2001, LB 51, § 28; Laws 2001, LB 52, § 46; Laws 2003, LB 73, § 11.

Cross References

Insurance Producers Licensing Act, see section 44-4047.
Insurers Examination Act, see section 44-5901.
Privacy of Insurance Consumer Information Act, see section 44-901.
Unfair Discrimination Against Subjects of Abuse in Insurance Act, see section 44-7401.

Evidence held insufficient to establish a violation of this section, even if a private action were to exist hereunder and even if the statutory language were to fit the circumstances alleged; such question not presented, the existence of a private right of action is not decided. White v. Medico Life Ins. Co., 212 Neb. 901, 327 N.W.2d 606 (1982).

Sections of Nebraska Unfair Competition Act and Trade Practices Act governing insurance business do not contemplate private suits but only suits by State Director of Insurance. Allied Financial Services, Inc. v. Foremost Ins. Co., 418 F.Supp. 157 (D. Neb. 1976).

44-1526 Lender or creditor; prohibited acts; director; powers.

(1) No person who lends money or extends credit shall:

(a) Require, as a condition precedent to the lending of money or extension of credit or any renewal thereof, that the borrower, mortgagor, or purchaser to whom such money or credit is extended or whose obligation the creditor is to acquire or finance negotiate any policy or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers;

(b) Solicit insurance for the protection of real property after a borrower, mortgagor, or purchaser indicates interest in securing a first mortgage credit extension until such borrower, mortgagor, or purchaser has received a commitment in writing from the lender as to a loan or credit extension. This requirement for a commitment shall not apply when the premium for the required insurance is to be financed as part of the loan or extension of credit involving personal property transactions;

(c) Unreasonably reject a policy furnished by the borrower, mortgagor, or purchaser for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer and shall not call for

rejection of a policy because it contains coverage in addition to that required in the credit transaction;

(d) Require that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge in connection with the handling of any policy required as security for a loan on real property or pay a separate charge to substitute the policy of one insurer for that of another. This subdivision shall not include the interest which may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document;

(e) Use or disclose, without the prior written consent of the borrower, mortgagor, or purchaser taken at a time other than the making of the loan or extension of credit, information relative to a policy which is required by the credit transaction for the purpose of replacing such insurance; or

(f) Require any procedures or conditions of duly licensed agents, brokers, or insurers not customarily required of those agents, brokers, or insurers affiliated or in any way connected with the person who lends money or extends credit.

(2) The director may examine and investigate those insurance-related activities of any person who the director believes may be in violation of this section. Any affected person may submit to the director a complaint or material pertinent to the enforcement of this section.

(3) Nothing in this section shall prevent a person who lends money or extends credit from placing insurance on real or personal property in the event the borrower, mortgagor, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

(4) Nothing in this section shall apply to credit life or credit accident and health insurance.

Source: Laws 1973, LB 349, § 5; Laws 1991, LB 234, § 8.

44-1527 Director; investigatory powers; costs.

The director may examine and investigate the affairs of every insurer doing business in this state in order to determine whether such insurer has been or is engaged in any unfair trade practice defined in section 44-1524. An insurer other than an agent, broker, or insurance consultant shall reimburse the department for the expense of examination in the same manner as provided for examination of insurance companies in the Insurers Examination Act. In the case of a depository institution, the director may examine and investigate the insurance activities of a depository institution in order to determine whether the depository institution has been or is engaged in any unfair trade practice defined in section 44-1524. The director shall notify the appropriate state or federal banking agency of the director's intent to examine and investigate a depository institution and advise the appropriate state or federal banking agency of the suspected violations of state law prior to commencing the examination and investigation.

Source: Laws 1973, LB 349, § 6; Laws 1991, LB 234, § 9; Laws 1993, LB 583, § 75; Laws 2002, LB 1139, § 19.

Cross References

Insurers Examination Act, see section 44-5901.

44-1528 Practices; hearings; witnesses; appearances; production of books; service of process.

(1) Whenever the director has reason to believe that any insurer has engaged or is engaging in this state in any unfair trade practice whether or not defined in the Unfair Insurance Trade Practices Act and that a proceeding by him or her in respect thereto would be to the interest of the public, he or she shall issue and serve upon such insurer a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service thereof.

(2) At the time and place fixed for such hearing, such insurer shall have an opportunity to be heard and to show cause why an order should not be made by the director requiring such insurer to cease and desist from the acts or practices so complained of. Upon good cause shown, the director shall permit any person to intervene, appear, and be heard at such hearing by counsel or in person.

(3) Nothing contained in the Unfair Insurance Trade Practices Act shall require the observance at any such hearing of formal rules of pleading or evidence.

(4) The director, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he or she deems relevant to the inquiry. The director may, and upon the request of any interested party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the director shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued under this section or to testify with respect to any matter concerning which he or she may be lawfully interrogated, the district court of Lancaster County or the county where such party resides, on application of the director, may require such person to comply with such subpoena and to testify, and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

(5) Statements of charges, notices, orders, and other processes of the director under the act may be served by anyone duly authorized by the director, either in the manner provided by law for service of process in civil actions or by mailing a copy thereof to the person affected by such statement, notice, order, or other process at his, her, or its residence or principal office or place of business by either certified or registered mail, return receipt requested. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same, and the return receipt for such statement, notice, order, or other process, registered and mailed, shall be proof of the service of the same.

Source: Laws 1973, LB 349, § 7; Laws 1991, LB 234, § 10.

44-1529 Cease and desist order; monetary penalty; suspension or revocation of license or certificate.

If, after the hearing, the director finds that the insurer charged has engaged in an unfair trade practice, he or she shall reduce his or her findings to writing and shall issue and cause to be served upon the insurer charged with the violation a copy of such findings and an order requiring such insurer to cease

and desist from engaging in the act or practice and he or she may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly in conscious disregard of the Unfair Insurance Trade Practices Act, in which case the penalty shall be not more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the insurer's license or certificate of authority if the insurer knew or reasonably should have known that he, she, or it was in violation of the act.

Source: Laws 1973, LB 349, § 8; Laws 1991, LB 234, § 11.

44-1530 Appeals.

(1) Any insurer subject to an order of the director under section 44-1529 or 44-1532 may appeal the order. The appeal shall be in accordance with the Administrative Procedure Act.

(2) An order issued by the director under section 44-1529 shall become final:

(a) Upon the expiration of the time allowed for filing a petition for review if no such petition has been duly filed, except that the director may thereafter modify or set aside his or her order; or

(b) Upon the final decision of the court if the court directs that the order of the director be affirmed or the petition for review dismissed.

(3) No order of the director under the Unfair Insurance Trade Practices Act or order of a court to enforce such order shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Source: Laws 1973, LB 349, § 9; Laws 1988, LB 352, § 60; Laws 1991, LB 234, § 12.

Cross References

Administrative Procedure Act, see section 84-920.

44-1531 Intervenor; appeal.

If, after any hearing as provided by section 44-1528 or 44-1532, the report of the director does not charge a violation of the Unfair Insurance Trade Practices Act, then any intervenor as provided by section 44-1528 may, within ten days after the service of such report, appeal the findings of the director. The appeal shall be in accordance with the Administrative Procedure Act. Upon such appeal, the court may issue appropriate orders and decrees in connection therewith, including, if the court finds that it is in the interest of the public, orders enjoining and restraining the continuance of any act or practice which it finds, notwithstanding such report of the director, constitutes a violation of the Unfair Insurance Trade Practices Act and containing penalties pursuant to section 44-1529.

Source: Laws 1973, LB 349, § 10; Laws 1988, LB 352, § 61; Laws 1991, LB 234, § 13.

Cross References

Administrative Procedure Act, see section 84-920.

44-1532 Cease and desist orders; violations.

Any insurer who violates a cease and desist order of the director under section 44-1529 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the insurer's license or certificate of authority.

Source: Laws 1973, LB 349, § 11; Laws 1991, LB 234, § 14.

44-1533 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Unfair Insurance Trade Practices Act.

Source: Laws 1973, LB 349, § 12; Laws 1989, LB 92, § 175; Laws 1991, LB 234, § 15.

44-1534 Director; additional powers.

The powers vested in the director by the Unfair Insurance Trade Practices Act shall be additional to any other powers to enforce any penalties, fines, or forfeitures authorized by law with respect to the acts and practices defined and determined by such act to be unfair.

Source: Laws 1973, LB 349, § 13; Laws 1991, LB 234, § 16.

44-1534.01 Director; power to protect members of the United States Armed Forces; rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations to protect members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive, or unfair as required by the federal Military Personnel Financial Services Protection Act, Public Law 109-290, as such law existed on July 18, 2008.

Source: Laws 2008, LB855, § 7.

44-1535 Immunity from prosecution; when.

If any person asks to be excused from attending and testifying or from producing any books, papers, records, correspondence, or other documents at any hearing on the ground that the testimony or evidence required may tend to incriminate the person or subject the person to a penalty or forfeiture and the person is directed to give such testimony or produce such evidence, the person must comply with such direction but shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which the person may testify or produce evidence and no testimony so given or evidence produced shall be received against the person upon any criminal action, investigation, or proceeding. No such person so testifying shall be exempt from prosecution or punishment for any perjury

committed while so testifying, and the testimony or evidence so given or produced shall be admissible against the person in any criminal action, investigation, or proceeding concerning such perjury, nor shall the person be exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance laws of this state. Any such person may execute, acknowledge, and file in the office of the director a statement expressly waiving such immunity or privilege in respect to any transaction, matter, or thing specified in such statement, and thereupon the testimony of such person or such evidence in relation to such transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise, and if so received or produced such person shall not be entitled to any immunity or privilege on account of any testimony the person may so give or evidence so produced.

Source: Laws 1973, LB 349, § 14; Laws 1991, LB 234, § 17.

(b) UNFAIR INSURANCE CLAIMS SETTLEMENT PRACTICES ACT

44-1536 Act, how cited.

Sections 44-1536 to 44-1544 shall be known and may be cited as the Unfair Insurance Claims Settlement Practices Act.

Source: Laws 1991, LB 234, § 18.

44-1537 Purpose of act.

The purpose of the Unfair Insurance Claims Settlement Practices Act is to set forth standards for the investigation and disposition of claims arising under policies issued to residents of this state.

Source: Laws 1991, LB 234, § 19.

44-1538 Terms, defined.

(1) For purposes of the Unfair Insurance Claims Settlement Practices Act:

(a) Director shall mean the Director of Insurance;

(b) Insured shall mean the party named on a policy or certificate as the individual with legal rights to the benefits provided by such policy or certificate;

(c) Insurer shall mean any person, reciprocal exchange, interinsurer, Lloyds-type insurer or other similar group which includes incorporated and individual unincorporated underwriters, fraternal benefit society, and other legal entity engaged in the business of insurance, including agents, brokers, insurance consultants, adjusters, and third-party administrators. Insurer shall also mean health maintenance organizations, prepaid limited health service organizations, and dental, optometric, and other similar health service plans. For purposes of the act, all such insurers shall be deemed to be engaged in the business of insurance;

(d) Person shall mean any natural or artificial entity, including, but not limited to, an individual, partnership, limited liability company, association, trust, or corporation; and

(e) Policy or certificate shall include any contract of insurance, indemnity, or annuity issued, proposed for issuance, or intended for issuance by any insurer. Policy or certificate shall not include contracts of workers' compensation, fidelity, suretyship, or boiler and machinery insurance.

(2) The purpose of the definitions in this section is to include within the act and any rules and regulations adopted pursuant to the act all entities and activities to the extent not preempted by the federal Employee Retirement Income Security Act of 1974, as amended.

Source: Laws 1991, LB 234, § 20; Laws 1993, LB 121, § 232; Laws 1994, LB 978, § 23.

44-1539 Unfair claims settlement practice; conduct prohibited.

It shall be an unfair claims settlement practice for any domestic, foreign, or alien insurer transacting business in this state to commit an act or practice defined in section 44-1540 if the act or practice (1) is committed flagrantly and in conscious disregard of the Unfair Insurance Claims Settlement Practices Act or any rule or regulation adopted pursuant to the act or (2) has been committed with such frequency as to indicate a general business practice to engage in that type of conduct.

Source: Laws 1991, LB 234, § 21.

44-1540 Unfair claims settlement practice; acts and practices prohibited.

Any of the following acts or practices by an insurer, if committed in violation of section 44-1539, shall be an unfair claims settlement practice:

(1) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of property and casualty claims (a) in which coverage and the amount of the loss are reasonably clear and (b) for loss of tangible personal property within real property which is insured by a policy subject to section 44-501.02 and which is wholly destroyed by fire, tornado, windstorm, lightning, or explosion;

(6) Compelling insureds or beneficiaries to institute litigation to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in litigation brought by them;

(7) Refusing to pay claims without conducting a reasonable investigation;

(8) Failing to affirm or deny coverage of a claim within a reasonable time after having completed its investigation related to such claim;

(9) Attempting to settle a claim for less than the amount to which a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

(10) Attempting to settle claims on the basis of an application which was materially altered without notice to or knowledge or consent of the insured;

(11) Making a claims payment to an insured or beneficiary without indicating the coverage under which each payment is being made;

(12) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof-of-loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof-of-loss form;

(13) Failing, in the case of the denial of a claim or the offer of a compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such action;

(14) Failing to provide forms necessary to present claims with reasonable explanations regarding their use within fifteen working days of a request;

(15) Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or affiliated with the insurer are performed in a skillful manner. For purposes of this subdivision, a repairer is affiliated with the insurer if there is a preexisting arrangement, understanding, agreement, or contract between the insurer and repairer for services in connection with claims on policies issued by the insurer;

(16) Requiring the insured or claimant to use a particular company or location for motor vehicle repair. Nothing in this subdivision shall prohibit an insurer from entering into discount agreements with companies and locations for motor vehicle repair or otherwise entering into any business arrangements or affiliations which reduce the cost of motor vehicle repair if the insured or claimant has the right to use a particular company or reasonably available location for motor vehicle repair. If the insured or claimant chooses to use a particular company or location other than the one providing the lowest estimate for like kind and quality motor vehicle repair, the insurer shall not be liable for any cost exceeding the lowest estimate. For purposes of this subdivision, motor vehicle repair shall include motor vehicle glass replacement and motor vehicle glass repair;

(17) Failing to provide coverage information or coordinate benefits pursuant to section 68-928; and

(18) Failing to pay interest on any proceeds due on a life insurance policy as required by section 44-3,143.

Source: Laws 1991, LB 234, § 22; Laws 1992, LB 1006, § 16; Laws 1994, LB 978, § 24; Laws 1997, LB 543, § 1; Laws 2002, LB 58, § 1; Laws 2005, LB 589, § 9; Laws 2006, LB 1248, § 59; Laws 2011, LB72, § 5.

44-1541 Director; charges against insurer; notice; hearing.

If the director finds that any insurer doing business in this state is engaging in any unfair claims settlement practice and that a proceeding in respect thereto would be in the public interest, he or she shall issue and serve upon such insurer a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

Source: Laws 1991, LB 234, § 23.

44-1542 Director; cease and desist order; other orders; authorized.

If, after the hearing, the director finds an insurer has engaged in an unfair claims settlement practice, he or she shall reduce his or her findings to writing and shall issue and cause to be served upon the insurer charged with the

violation a copy of the findings and an order requiring the insurer to cease and desist from engaging in the act or practice and he or she may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Unfair Insurance Claims Settlement Practices Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the insurer's license or certificate of authority if the insurer knew or reasonably should have known it was in violation of the act.

Source: Laws 1991, LB 234, § 24.

44-1543 Violation of cease and desist order; penalties authorized.

Any insurer who violates a cease and desist order of the director under section 44-1542 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the insurer's license or certificate of authority.

Source: Laws 1991, LB 234, § 25.

44-1544 Director; rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Unfair Insurance Claims Settlement Practices Act.

Source: Laws 1991, LB 234, § 26.

(c) MOTOR VEHICLE INSURANCE DATABASE

44-1545 Noncompliance; effect.

Failure by an insurance company subject to sections 60-3,136 to 60-3,139 to comply with the requirements of such sections and the rules and regulations adopted and promulgated under such sections by the Department of Motor Vehicles shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 2002, LB 488, § 7; Laws 2005, LB 274, § 229.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

ARTICLE 16
GROUP INSURANCE

Cross References

Coverage of newly born children, see section 44-710.19.
Credit union members, insurance for, see section 21-1740.
Defined, see section 44-760.

Required provisions, see section 44-761 et seq.

Section

44-1601 Life insurance; policy; issuance; requirements.

No policy of group life insurance shall be delivered in this state unless it is issued under one of the provisions of sections 21-1740, 44-1602 to 44-1606.03, and 44-1615 or under a policy or contract issued to any other substantially similar group which, in the discretion of the Director of Insurance, may be subject to the issuance of a group life insurance policy or contract.

Source: Laws 1949, c. 150, § 1(1), p. 377; Laws 1961, c. 210, § 5, p. 628; Laws 1969, c. 361, § 3, p. 1286; Laws 1983, LB 298, § 1; Laws 1996, LB 948, § 123; Laws 2008, LB855, § 8.

44-1602 Life insurance; policy issued to an employer; requirements.

A policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer shall be subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer or all of any class or classes thereof. The policy may provide that the term employees shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, partners, and members of one or more affiliated corporations, proprietors, partnerships, or limited liability companies if the business of the employer and of such affiliated corporations, proprietors, partnerships, or limited liability companies is under common control. The policy may provide that the term employees shall include the individual proprietor, partners, or members if the employer is an individual proprietor, partnership, or limited liability company. The policy may provide that the term employee may include retired employees, former employees, and directors of a corporate employer; and

(2) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees or from both such funds. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject the coverage in writing, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

Source: Laws 1949, c. 150, § 1(1), p. 377; Laws 1957, c. 192, § 1, p. 670; Laws 1959, c. 212, § 1, p. 733; Laws 1993, LB 121, § 233; Laws 2006, LB 875, § 2; Laws 2008, LB855, § 9.

44-1603 Life insurance; policy issued to creditor; requirements.

A policy issued to a creditor or its parent holding company or to a trustee or agent designated by two or more creditors, which creditor, parent holding company, affiliate, trustee, or agent shall be deemed the policyholder, to insure debtors of the creditor shall be subject to the following requirements:

(1) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes of the creditors. The policy may provide that the term debtors shall include borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction, the debtors of one or more subsidiary corporations, and the debtors of one or more affiliated corporations, proprietors, partnerships, or limited liability companies if the business of the policyholder and of such affiliated corporations, proprietors, partnerships, or limited liability companies is under common control;

(2) The premium for the policy shall be paid by the policyholder from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which no part of the premiums is to be derived from the funds contributed by insured debtors specifically for their insurance must insure all eligible debtors or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(3) The amount of insurance on the life of any debtor shall at no time exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor, except that insurance written in connection with open-end credit having a credit limit exceeding ten thousand dollars may be in an amount not exceeding the credit limit;

(4) The insurance shall be payable to the creditor or any successor to the right, title, and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment, and any excess of the insurance shall be payable to the estate of the insured; and

(5) Notwithstanding subdivisions (1) through (4) of this section, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level-term plan and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

Source: Laws 1949, c. 150, § 1(2), p. 378; Laws 1955, c. 180, § 1, p. 508; Laws 1957, c. 192, § 2, p. 671; Laws 1967, c. 273, § 1, p. 737; Laws 1974, LB 944, § 1; Laws 1993, LB 121, § 234; Laws 2008, LB855, § 10.

44-1604 Life insurance; policy issued to a labor union or similar employee organization; requirements.

A policy issued to a labor union or similar employee organization, which shall be deemed the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents shall be subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof; and

(2) The premium for the policy shall be paid either from the union's or organization's funds or from funds contributed by the insured members specifically for their insurance or from both. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those

who reject the coverage in writing, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

Source: Laws 1949, c. 150, § 1(3), p. 379; Laws 1957, c. 192, § 3, p. 673; Laws 2008, LB855, § 11.

44-1605 Life insurance; policy issued to trust or trustees of a fund; requirements.

A policy issued to a trust or to the trustees of a fund established or adopted by two or more employers or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations shall be subject to the following requirements:

(1) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term employees shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, members, and partners of one or more affiliated corporations, proprietorships, or partnerships if the business of the employer and of the affiliated corporations, proprietorships, or partnerships is under common control. The policy may provide that the term employees shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term employees may include retired employees, former employees, and directors of a corporate employer. The policy may provide that the term employees shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship; and

(2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance shall insure all eligible persons, except those who reject the coverage in writing, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

Source: Laws 1949, c. 150, § 1(4), p. 380; Laws 1957, c. 192, § 4, p. 674; Laws 1969, c. 376, § 1, p. 1336; Laws 1989, LB 92, § 176; Laws 1993, LB 121, § 235; Laws 2008, LB855, § 12.

44-1606 Life insurance; policy issued to an association of public employees; requirements.

A policy issued to an association of public employees having, when the policy is placed in force, a membership in the classes eligible for insurance of not less than seventy-five percent of the number of employees eligible for membership in such classes, which association shall be deemed the policyholder, to insure members of such association for the benefit of persons other than the association or any of its officials, shall be subject to the following requirements:

(1) The persons eligible for insurance under the policy shall be all of the members of the association, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the association, or both.

(2) The premium for the policy shall be paid by the policyholder, either from the association's own funds, or from charges collected from the insured members specifically for the insurance, or from both. Any charges collected from the insured members specifically for the insurance, and the dues of the association if they include the cost of the insurance, shall be collected through deductions by the employer from the salaries of the members. Such deductions from salary may be paid by the employer to the association or directly to the insurer. No policy may be placed in force unless and until at least seventy-five percent of the then eligible members of the association, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, have elected to be covered and have authorized their employer to make the required deductions from salary.

(3) The policy must cover at least twenty-five persons at date of issue.

(4) As used in this section, public employees mean employees of the United States Government, or of any state, county, city, village, or political subdivision thereof.

Source: Laws 1949, c. 150, § 1(5), p. 382.

44-1606.01 Life insurance; policy issued to association or trust; requirements.

(1) A policy may be issued to an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of one hundred persons, shall have been organized and maintained in good faith for purposes other than that of obtaining insurance, shall have been in active existence for at least two years, and shall have a constitution and bylaws which provide that (a) the association or associations shall hold regular meetings not less than annually to further the purposes of the members, (b) except for credit unions, the association or associations shall collect dues or solicit contributions from members, and (c) the members shall have voting privileges and representation on the governing board and committees.

(2) The policy shall be subject to the following requirements:

(a) The policy may insure members of the association or associations, employees thereof or employees of members, or one or more of the preceding or all of any class or classes thereof for the benefit of persons other than the employee's employer;

(b) The premium for the policy shall be paid from funds contributed by the association or associations, by the employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the associations or employer members; and

(c) A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject the coverage in writing, or all

except any as to whom evidence of individual insurability is not satisfactory to the insurer.

Source: Laws 1957, c. 192, § 5, p. 675; Laws 1967, c. 274, § 1, p. 739; Laws 1972, LB 1189, § 1; Laws 2008, LB855, § 13.

Where policy issued was not life policy but accident policy, insurer could deny certain coverage to wife of member. Simmons v. Continental Cas. Co., 410 F.2d 881 (8th Cir. 1969).

44-1606.02 Life insurance; policy issued to credit union or trust; requirements.

A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees, or agent shall be deemed the policyholder, to insure members of the credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, shall be subject to the following requirements:

(1) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes of the members; and

(2) The premium for the policy shall be paid by the policyholder from the credit union's funds and shall insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

Source: Laws 2008, LB855, § 14.

44-1606.03 Group life insurance; policy; requirements.

(1) Group life insurance offered to a resident of this state under a group life insurance policy issued to a group other than one described in sections 21-1740, 44-1602 to 44-1606.02, and 44-1615 shall be subject to the following requirements:

(a) A group life insurance policy shall not be delivered in this state unless the Director of Insurance finds that:

(i) The issuance of the group policy is not contrary to the best interests of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged;

(b) A group life insurance policy shall not be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in subdivision (1)(a) of this section has made a determination that the requirements have been met;

(c) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both; and

(d) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

(2)(a) In the case of a program of insurance which, if issued on a group basis, would not qualify under sections 21-1740, 44-1602 to 44-1606.02, and 44-1615, the insurer shall cause to be distributed to prospective insureds a written notice

that compensation shall or may be paid, if compensation of any kind shall or may be paid, to:

(i) A policyholder or sponsoring or endorsing entity in the case of a group policy; or

(ii) A sponsoring or endorsing entity in the case of an individual, blanket, or franchise policy marketed by means of direct response solicitation.

(b) The notice shall be distributed:

(i) Whether compensation is direct or indirect; and

(ii) Whether the compensation is paid to or retained by the policyholder or sponsoring or endorsing entity, or paid to or retained by a third party at the direction of the policyholder or sponsoring or endorsing entity, or an entity affiliated therewith by way of ownership, contract, or employment.

(c) The notice required by this section shall be placed on or accompany an application or enrollment form provided to prospective insureds.

(d) For purposes of this section:

(i) Direct response solicitation means a solicitation by a sponsoring or endorsing entity through the mail, telephone, or other mass communications media; and

(ii) Sponsoring or endorsing entity means an organization that has arranged for the offering of a program of insurance in a manner that communicates that eligibility for participation in the program is dependent upon affiliation with the organization or that it encourages participation in the program.

Source: Laws 2008, LB855, § 15.

44-1607 Life insurance; policy; contents.

No policy of group life insurance shall be delivered in this state unless it contains in substance the following provisions or provisions which in the opinion of the Director of Insurance are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder, except that provisions of subdivisions (6) through (10) of this section shall not apply to policies insuring the lives of debtors, that the standard provisions required for individual life insurance policies shall not apply to group life insurance policies, and that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Director of Insurance is or are equitable to the insured persons and to the policyholder, but nothing in this section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her. This provision shall not preclude the assertion at any time of defenses based upon provisions in the policy that relate to eligibility for coverage;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of death or incapacity of the insured person, to his or her beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage;

(5) A provision specifying that an equitable adjustment of premiums, of benefits, or of both is to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(6) A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding two thousand dollars to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured;

(7) A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he or she is entitled, to whom the insurance benefits are payable, a statement as to any dependent's coverage included in the certificate, and the rights and conditions set forth in subdivisions (8), (9), and (10) of this section;

(8) A provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him or her by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits if application for the individual policy is made and the first premium paid to the insurer within thirty-one days after such termination and if (a) the individual policy shall, at the option of such person, be on any one

of the forms customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance, (b) the individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, less the amount of any life insurance for which the person becomes eligible under the same or any other group policy within thirty-one days after termination, except that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this subdivision, be included in the amount which is considered to cease because of such termination, (c) the premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his or her age attained on the effective date of the individual policy, and (d) subject to the conditions set forth in subdivisions (8)(a) through (c) of this section, the conversion privilege shall also be available (i) to a spouse and a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy that terminates by reason of death and (ii) to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy;

(9) A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by subdivision (8) of this section, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within thirty-one days after such termination, and ten thousand dollars;

(10) A provision that if a person insured under the group policy or the insured dependent of a covered person dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with subdivision (8) or (9) of this section and before such an individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made;

(11) If active employment is a condition of insurance, a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium-paying basis for a period of six months from the date on which the total disability started, but not beyond the earlier of:

(a) Approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain; or

(b) The discontinuance of the group insurance policy; and

(12) In the case of a policy insuring the lives of debtors, a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that any death benefit shall first be applied to reduce or extinguish the indebtedness.

Source: Laws 1949, c. 150, § 2, p. 383; Laws 1957, c. 192, § 7, p. 677; Laws 1989, LB 92, § 177; Laws 2008, LB855, § 16.

44-1607.01 Life insurance; individual policies; issuance; restrictions.

Individual life insurance policies, uniform as to amounts of insurance for each reasonable class eligible therefor, may be issued on a franchise or wholesale basis to five or more employees of a common employer or ten or more members of any trade or professional association, of a labor union or similar employee organization, or of any other association having had an active existence for at least two years when such association or union or organization has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance. Nothing in this section shall be construed to prohibit the issuance of individual life insurance policies on salary savings, bank draft, or similar type plans.

Source: Laws 1955, c. 181, § 1, p. 510; Laws 1989, LB 92, § 178; Laws 2008, LB855, § 17.

44-1607.02 Life insurance; employees, defined.

The term employees, as used in section 44-1607.01, may include the individual proprietors, partners, or members, if the employer is an individual proprietor, partnership, or limited liability company, and the directors of a corporate employer, if each individual proprietor, partner, member, or director devotes a substantial part of his or her time to the business of the proprietorship, partnership, limited liability company, or corporate employer.

Source: Laws 1955, c. 181, § 2, p. 511; Laws 1993, LB 121, § 236.

44-1608 Public employees; premiums; withholding from wages; written order.

Any employee of the State of Nebraska, of any political subdivision thereof, of any municipal corporation, or of any public body or agency created by the laws of this state, who desires to participate, voluntarily, in a plan of insurance, designed and intended for the benefit of a specific group of public employees, participation in which is restricted to the employees of a specific agency, public body, municipal corporation, political subdivision of the state, or any department of the state, may execute an order, authorizing the withholding from any wages or salary paid to such employee of a sum each month which is equivalent in amount to the sum fixed by an insurance carrier as the monthly premium to be paid by the employee for participation in such group, franchise, or wholesale plan of insurance, or a sum, each month, which is equivalent in amount to the sum fixed by an employees association which association may be the policy-

holder and premium payer of such group, franchise, or wholesale plan of insurance.

Source: Laws 1949, c. 132, § 1, p. 346.

44-1609 Public employees; revocation of order to withhold wages.

The order or any revocation thereof, shall be executed and acknowledged, in the same manner that conveyances of real estate are required to be signed and acknowledged by the laws of this state, and where the employee is a married person, the order shall be executed and acknowledged by both husband and wife.

Source: Laws 1949, c. 132, § 2, p. 347.

44-1610 Public employees; order or revocation; filing; effective date.

The order and any revocation thereof, shall be filed with the officer or body whose duty it is to approve and allow claims or vouchers for salaries or wages or the payroll for the agency, public body, municipal corporation, political subdivision, or department of the state and shall be effective on the first day of the month subsequent to such filing. The order shall be in full force and effect from and after its effective date for the balance of the period of employment of the employee unless revoked by the employee.

Source: Laws 1949, c. 132, § 3, p. 347.

44-1611 Public employees; wages withheld; payment to insurance company; warrants.

The sum so withheld from an employee's salary or wages, together with the sums so withheld from the wages or salaries of all other employees participating voluntarily in such group, franchise, or wholesale plan of insurance for a specific group of employees, shall be paid to the insurance company or employees association, designated in the orders, in a lump sum each month; and the appropriate public officer who issues the warrants in payment of the wages or salary of public employees participating voluntarily in such group, franchise, or wholesale plan of insurance is authorized to issue warrants to the appropriate insurance carrier or carriers or employees association, each month, for the composite amounts of the sums so withheld, upon the filing with, and allowance by, the officer or body whose duty it is to approve and allow claims or vouchers for money due and owing from the state, any political subdivision, municipal corporation, public body or agency.

Source: Laws 1949, c. 132, § 4, p. 347.

44-1612 Repealed. Laws 1959, c. 213, § 5.

44-1613 Life insurance; individual policy; time within which to exercise rights; notice.

If any individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of such policy to have an individual policy of life insurance issued without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least fifteen days prior to the expiration date of such period, then in such event the individual shall have an additional period within

which to exercise such right, but nothing herein contained shall be construed to continue any insurance beyond the period provided in such policy. This additional period shall expire fifteen days after the individual is given such notice but in no event shall such additional period extend beyond sixty days after the expiration date of the period provided in such policy. Written notice presented to the individual or mailed by the policyholder to the last-known address of the individual or mailed by the insurer to the last-known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this section.

Source: Laws 1957, c. 192, § 8, p. 681; Laws 2008, LB855, § 18.

44-1614 Life insurance; extension to spouse and children of employee or member; limitation.

Insurance under any group life insurance policy issued pursuant to section 44-1602, 44-1604, 44-1605, 44-1606, 44-1606.01, 44-1606.02, or 44-1606.03 may be extended to insure the employees or members against loss due to the death of their spouses and dependent children, or any class or classes thereof. Premiums for the insurance shall be paid either from funds contributed by the employer, the labor union or similar employee organization, or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both. A policy on which no part of the premium for the spouse's and dependent child's coverage is to be derived from funds contributed by the covered persons shall insure all eligible employees or members with respect to their spouses and dependent children, or any class or classes of employees or members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer. The amount of insurance for any covered spouse or dependent child under the policy may not exceed fifty percent of the amount of insurance for which the employee or member is insured.

Source: Laws 1957, c. 192, § 9, p. 681; Laws 1961, c. 224, § 1, p. 666; Laws 1972, LB 1189, § 2; Laws 1989, LB 92, § 179; Laws 2008, LB855, § 19.

Where policy issued was not life policy but accident policy, insurer could deny certain coverage to wife of member. Simmons v. Continental Cas. Co., 410 F.2d 881 (8th Cir. 1969).

44-1615 Public employees; coverage authorized.

Any political subdivision, community college, municipal corporation, or public body of the State of Nebraska, except a state agency defined in section 81-8,239.01, may establish, participate in, and administer plans for the benefit of its employees or its employees and their dependents, which will provide hospitalization, medical, surgical, sickness and accident, and term life insurance coverage or any one or more of such coverages. The plans shall be purchased from an insurer holding a certificate of authority to transact the business of insurance in this state except as provided in the Political Subdivisions Self-Funding Benefits Act.

Source: Laws 1959, c. 213, § 1, p. 735; Laws 1963, c. 269, § 1, p. 804; Laws 1971, LB 177, § 1; Laws 1976, LB 37, § 1; Laws 1981, LB 273, § 5; Laws 1991, LB 167, § 27.

Cross References

Political Subdivisions Self-Funding Benefits Act, see section 13-1601.

44-1615.01 Public employees; abortion coverage; limitations.

No group insurance contract or health maintenance agreement providing hospitalization, medical, surgical, accident, sickness, or other health coverage paid for in whole or in part with public funds shall include coverage for abortion, as defined in section 28-326. This section shall not apply to coverage for an abortion which is verified in writing by the attending physician as necessary to prevent the death of the woman or to coverage for medical complications arising from an abortion. This section shall not prohibit the insurer from offering individual employees special coverage for abortion if the costs for such coverage are borne solely by the employee.

Source: Laws 1981, LB 125, § 1.

44-1616 Public employees; premiums or dues; payment; withhold from wages.

Such political subdivision, municipal corporation, or public body, as set forth in section 44-1615, except a state agency defined in section 81-8,239.01, may approve and expend funds to pay premiums or dues to cover the cost of such plans in whole or in part, and may authorize deductions from salaries or wages of such employees and take such other steps as may be necessary to effectuate and continue such plans.

Source: Laws 1959, c. 213, § 2, p. 735; Laws 1981, LB 273, § 6.

Cross References

For other provisions permitting payroll deductions for payment of insurance premiums, see section 36-213.

44-1617 Public employees; contributions; voluntary; commission to officer or employee prohibited.

Participation by employees in any plans requiring contributions from such employees shall be voluntary and no portion of any commission or other compensation paid by the corporation writing such coverage shall be received, directly or indirectly, by any officer or other person in the employment of the political subdivision, municipal corporation, public body, or agency, even though such person may be licensed by the Department of Insurance.

Source: Laws 1959, c. 213, § 3, p. 735.

44-1618 Repealed. Laws 1976, LB 37, § 2.

44-1619 Insured; assignment of rights, privileges, and incidents of ownership.

No provisions in sections 44-1601 to 44-1617 shall prohibit a person whose life is insured under any such policy of group life insurance from making an assignment or transfer of all or any part of his rights, privileges, and incidents of ownership under such policy, including specifically, but not by way of limitation, any right to designate a beneficiary thereunder and any right to have an individual policy issued in accordance with subdivisions (8) and (9) of section 44-1607, to any person other than the group policyholder. Subject to the terms of the policy relating to assignment of rights, privileges, and incidents of ownership thereunder, such an assignment by an insured, made either before or after December 25, 1969, is valid for the purpose of vesting in the assignee, in accordance with any provision included therein as to the time at which it is

to be effective, all of such rights, privileges, and incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with subdivisions (8) and (9) of section 44-1607 prior to receipt of notice of the assignment.

Source: Laws 1969, c. 353, § 1, p. 1233.

44-1620 Transferred to section 84-1601.

44-1620.01 Transferred to section 84-1611.

44-1620.02 Repealed. Laws 1978, LB 923, § 3.

44-1620.03 Repealed. Laws 1978, LB 923, § 3.

44-1620.04 Repealed. Laws 1978, LB 923, § 3.

44-1620.05 Repealed. Laws 1978, LB 923, § 3.

44-1621 Transferred to section 84-1602.

44-1622 Transferred to section 84-1603.

44-1622.01 Transferred to section 84-1606.

44-1623 Transferred to section 84-1605.

44-1624 Transferred to section 84-1607.

44-1625 Transferred to section 84-1608.

44-1626 Transferred to section 84-1609.

44-1627 Transferred to section 84-1604.

44-1628 Transferred to section 84-1610.

44-1629 Transferred to section 84-1612.

44-1630 Transferred to section 84-1613.

44-1631 Transferred to section 84-1614.

44-1632 Transferred to section 84-1615.

44-1633 Repealed. Laws 1987, LB 491, § 24.

44-1634 Repealed. Laws 1987, LB 491, § 24.

44-1635 Repealed. Laws 1987, LB 491, § 24.

44-1636 Repealed. Laws 1987, LB 491, § 24.

44-1637 Repealed. Laws 1987, LB 491, § 24.

44-1638 Repealed. Laws 1987, LB 491, § 24.

44-1639 Repealed. Laws 1985, LB 24, § 1.

44-1640 Employee; involuntary termination of employment; coverage continued; conditions; premium rate.

An employer or employer trust group policy or contract delivered or issued for delivery in this state which provides coverage to a group which, based on the number of employees, is not a group subject to section 4980B of the Internal Revenue Code and which provides hospital, surgical, or major medical coverage, or any combination of such coverages, on an expense-incurred or service basis by an insurance company or health maintenance organization for employees or their families, but not a policy or contract which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee whose hospital, surgical, or major medical coverage under the group policy or contract would otherwise be terminated because of the involuntary termination of employment of such employee, for reasons other than misconduct in connection with employment, shall be entitled to continue such coverage subject to the provisions of the group policy or contract and the following conditions:

(1) Such coverage shall be continued on a monthly renewal basis until the earliest of the following dates:

(a) The date of expiration of a period of six months following the date the coverage of the terminated employee would otherwise be terminated;

(b) The date the terminated employee becomes eligible for other group hospital, surgical, or medical coverage, whether insured or self-insured, or the date the terminated employee becomes eligible for medicare;

(c) The date of expiration of the monthly period for which premiums were paid in the event of a nonpayment of premium;

(d) The date the terminated employee exercises the privilege provided under the group policy or contract for conversion to an individual or family policy or contract; or

(e) The date on which the group insurance policy or health maintenance organization agreement is terminated or the date the employer or employer trust trustee terminates participation under such policy or agreement;

(2) The monthly premium rate to be charged for such coverage shall not exceed one hundred two percent of the total premium which would have been charged for such coverage had the terminated employee still been a member of the insured group. Such total premium rate shall be paid by the terminated employee. The experience of such coverage shall be charged to the group policy or contract which is in force; and

(3) The interruption of employment due to a labor dispute shall not be considered to be an involuntary termination of employment.

Source: Laws 1989, LB 318, § 1; Laws 1993, LB 583, § 76; Laws 1994, LB 978, § 25; Laws 1995, LB 574, § 46.

44-1641 Employee; termination of employment; notice; contents.

Not later than ten days following the date of termination of employment of the employee, the employer shall send a notice by certified mail with return receipt requested to the terminated employee at his or her home address as shown on the records of the employer. Such notice shall set forth (1) the right of the terminated employee to elect to continue coverage in accordance with section 44-1640 and the election form to be used in exercising such right, (2) the amount of each monthly premium to be paid by the terminated employee,

and (3) the manner, time, and to whom the election form shall be completed and returned and each monthly premium shall be paid.

Source: Laws 1989, LB 318, § 2.

44-1642 Terminated employee; election to continue coverage; procedure.

If the terminated employee elects to continue such coverage, the election form and the first monthly premium shall be sent by certified mail with return receipt requested to the insurance company or health maintenance organization within ten days after the date of receipt of the notice. Premiums for each subsequent month shall be paid by the terminated employee without further notice to the insurance company or health maintenance organization.

Source: Laws 1989, LB 318, § 3.

44-1643 Employee; death; coverage continued; conditions; premium rate.

An employer or employer trust group policy or contract delivered, issued for delivery, or renewed in this state which provides coverage to a group which, based on the number of employees, is not a group subject to section 4980B of the Internal Revenue Code and which provides hospital, surgical, or major medical coverage, or any combination of such coverages, on an expense-incurred or service basis by an insurance company or health maintenance organization for employees and their dependents, but not including any policy or contract which provides benefits for specific diseases or for accidental injuries only, shall provide that the covered surviving spouse or covered surviving dependent children whose hospital, surgical, or major medical coverage under the group policy or contract would otherwise be terminated because of the death of such employee shall be entitled to continue such coverage subject to the provisions of the group policy or contract and the following conditions:

(1) Such coverage shall be continued on a monthly renewal basis until the earliest of the following dates:

(a) The date the covered surviving spouse or covered surviving dependent children become eligible for other group hospital, surgical, or major medical coverage, whether insured or self-insured, and with respect to the covered surviving spouse, the date such spouse remarries or the date such spouse becomes eligible for medicare or is covered by medicaid;

(b) The date of expiration of the monthly period for which premiums were paid for the covered surviving spouse or covered surviving dependent children in the event of nonpayment of premium;

(c) The date the covered surviving spouse or covered surviving dependent children exercise any privilege provided under the group policy or contract for conversion to an individual or family policy or contract;

(d) The date on which the group insurance policy or health maintenance organization agreement is terminated or the date the employer or employer trust trustee terminates participation under such policy or agreement; or

(e) The date of expiration of a period of one year following the date the coverage of the deceased employee would otherwise terminate; and

(2) The monthly premium rate to be charged for such coverage shall not exceed one hundred two percent of the total premium which would have been established for such coverage for the covered surviving spouse or covered

surviving dependent children had the deceased employee still been a member of the insured group. Such total premium rate shall be paid by the covered surviving spouse or covered surviving dependent children. The experience of such coverage shall be charged to the group policy or contract which is in force.

Source: Laws 1989, LB 318, § 4; Laws 1994, LB 978, § 26; Laws 1995, LB 574, § 47.

44-1644 Employee; death; coverage continued; notice; contents.

Not later than ten working days following the date of the death of the employee, the employer shall send a notice by certified mail with return receipt requested to the covered surviving spouse or, if there is no covered surviving spouse, to any covered surviving dependent children of the deceased employee at his, her, or their home address as shown on the records of the employer. Such notice shall set forth (1) the right of the covered surviving spouse or the covered surviving dependent children to elect to continue coverage in accordance with section 44-1643 and the election form to be used in exercising such right, (2) the amount of each monthly premium to be paid by the covered surviving spouse or covered surviving dependent children, and (3) the manner, time, and to whom the completed election form shall be returned and each monthly premium shall be paid.

Source: Laws 1989, LB 318, § 5.

44-1645 Employee; death; election to continue coverage; procedure.

If the covered surviving spouse or covered surviving dependent children elect to continue such coverage, the election form and the first monthly premium shall be sent by certified mail with return receipt requested to the insurance company or health maintenance organization within thirty-one days after the date of the death of the employee. Premiums for each subsequent month shall be paid by the covered surviving spouse or covered surviving dependent children without further notice.

Source: Laws 1989, LB 318, § 6.

ARTICLE 17

CREDIT LIFE AND CREDIT HEALTH AND ACCIDENT INSURANCE

Section

44-1701 Sections, purpose.

The purpose of sections 44-1701 to 44-1713 is to promote the public welfare by regulating credit life insurance and credit accident and health insurance. Nothing in sections 44-1701 to 44-1713 is intended to prohibit or discourage reasonable competition. The provisions of sections 44-1701 to 44-1713 shall be liberally construed.

Source: Laws 1959, c. 214, § 1, p. 737.

44-1702 Terms, defined.

As used in sections 44-1701 to 44-1713, unless the context otherwise requires:

(1) Credit life insurance shall mean insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;

(2) Credit accident and health insurance means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(3) Creditor shall mean the lender of money or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

(4) Debtor shall mean a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;

(5) Indebtedness shall mean the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction; and

(6) Director shall mean the Director of the Department of Insurance of Nebraska.

Source: Laws 1959, c. 214, § 2, p. 737.

44-1703 Insurance sold with credit transaction; applicability of law; exceptions.

All life insurance and all accident and health insurance sold in connection with loans or other credit transactions shall be subject to sections 44-1701 to 44-1713 except such insurance sold in connection with a loan or other credit transaction of more than ten years duration or fifteen years duration when made by licensees under the Nebraska Installment Loan Act. No insurance shall be subject to sections 44-1701 to 44-1713 when the issuance of such insurance is an isolated transaction on the part of the insurer and not related to an agreement or a plan for insuring debtors of the creditor.

Source: Laws 1959, c. 214, § 3, p. 738; Laws 1969, c. 377, § 1, p. 1338; Laws 1987, LB 306, § 1; Laws 1997, LB 555, § 2; Laws 2001, LB 53, § 27.

Cross References

Nebraska Installment Loan Act, see section 45-1001.

44-1704 Forms of policy.

Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan;

(2) Individual policies of accident and health insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; or

(4) Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

Source: Laws 1959, c. 214, § 4, p. 738.

44-1705 Limitation on amount of insurance issued.

(1) The amount of credit life insurance shall not exceed the initial indebtedness. If an indebtedness repayable in substantially equal installments is secured by an individual policy of credit life insurance, the amount of insurance shall at no time exceed the scheduled amount of indebtedness and, if the said indebtedness is secured by a group policy of credit life insurance, the amount of insurance shall at no time exceed the amount of unpaid indebtedness.

(2) The total amount of indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

Source: Laws 1959, c. 214, § 5, p. 738.

44-1706 Term of policy.

The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, if a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. The term of such insurance shall not extend more than fifteen days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness and if the indebtedness is discharged due to a prepayment, the insurance in force shall be terminated as of the date of the prepayment. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in section 44-1709.

Source: Laws 1959, c. 214, § 6, p. 739; Laws 1969, c. 377, § 2, p. 1338.

44-1707 Policy or certificate of insurance; type issued; when delivered; application; acceptance.

(1) All credit life insurance and credit accident and health insurance sold shall be evidenced by an individual policy, or in case of group insurance, by a

certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit life insurance, credit accident and health insurance, or combination thereof, shall, in addition to other requirements of law, set forth the name and home office address of the insurer, the name of the debtor, the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and health insurance, a description of the amount, term and coverage including any exceptions, limitations, or restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to the beneficiary, other than the creditor, named by the debtor or to his estate.

(3) Said individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.

(4) If said individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name of the debtor, the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance, a description of the amount, term and coverage provided, shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application for, or notice of proposed insurance, shall refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as of the date the indebtedness is incurred.

Source: Laws 1959, c. 214, § 7, p. 739.

Debtor was aware that total credit insurance was fifteen thousand dollars and failure to deliver policy or certificate to debtor did not preclude recovery on note for larger amount. Elm Creek State Bank v. Johnson, 195 Neb. 131, 236 N.W.2d 838 (1975).

44-1708 Policy form, certificates of insurance, notices, applications, endorsements, and riders; filing requirements; approval; exception.

(1) Except as otherwise provided by the director, all policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders, to be delivered in this state, shall be filed with the director who shall acknowledge receipt of the filings and shall, within thirty days after the receipt of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge or if it contains provisions which are unjust, unfair, inequitable, misleading, or deceptive, encourage misrepresentation of the coverage, or are contrary to any provision of the statutes of the State of Nebraska

or of any rule or regulation adopted and promulgated thereunder. The director shall have an additional thirty days to examine the proposed policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders upon notifying the issuing company within the first thirty-day period that such additional time is needed.

(2) If the director notifies the insurer that the form is disapproved, it shall be unlawful thereafter for such insurer to issue or use such form. In such notice, the director shall specify the reason for his or her disapproval and state that a hearing will be granted within twenty days after request in writing by the insurer. The request shall be received by the director not more than ten days after the date of the notice of disapproval. No such policy, certificate of insurance, notice of proposed insurance, application, endorsement, or rider shall be issued or used until the expiration of thirty days after it has been so filed or until the expiration of the additional thirty days provided in this section, unless the director shall give his or her prior written approval thereto.

(3) The director may, at any time after a hearing held not less than twenty days after written notice to the insurer, withdraw his or her approval of any such form for any reason set forth in subsection (1) of this section. The written notice of such hearing shall state the reason for the proposed withdrawal.

(4) It shall be unlawful for an insurer to issue or use such forms after the effective date of such withdrawal.

Source: Laws 1959, c. 214, § 8, p. 740; Laws 1989, LB 92, § 180.

44-1709 Schedule of premium rates; revision; filing requirements; refunds.

(1) Each insurer issuing credit life insurance or credit accident and health insurance shall file with the director its schedule of premium rates for use in connection with such insurance. Any insurer may revise such schedules from time to time, and shall file such revised schedules with the director. No insurer shall issue any credit life insurance policy or credit accident and health insurance policy for which the premium rates exceed that determined by the schedules of such insurer as then on file with the director.

(2) Each individual policy, group certificate or notice of proposed insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; *Provided,* that the director shall permit a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the director.

(3) If a creditor required a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(4) The amount charged by the creditor to the debtor for credit life insurance or credit accident and health insurance shall not exceed the premium rate filed with the director for the coverage provided.

(5) Nothing in sections 44-1701 to 44-1713 shall be construed to authorize any payments for insurance now prohibited under any statute, or rule thereunder, governing credit transactions.

Source: Laws 1959, c. 214, § 9, p. 740.

44-1710 Delivery and issuance of policy; requirements.

All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses granted by the director.

Source: Laws 1959, c. 214, § 10, p. 742.

44-1711 Claims; payment.

(1) All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(2) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.

(3) No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; *Provided*, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

Source: Laws 1959, c. 214, § 11, p. 743.

44-1712 Additional security; insurance; existing policies; acceptance.

When credit life insurance or credit accident and health insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

Source: Laws 1959, c. 214, § 12, p. 743.

44-1713 Violations; revocation or suspension; appeal.

Whenever the director finds, after due notice and hearing, that there has been a violation of any of the provisions of sections 44-1701 to 44-1713 or of any rules or regulations adopted and promulgated pursuant thereto, he or she may revoke or suspend the license or certificate of authority of the person or insurer guilty of such violation or make such other order or directive as he or she may deem adequate and appropriate to secure compliance with sections 44-1701 to 44-1713 or of any rules or regulations adopted and promulgated pursuant thereto. Any action taken by the director pursuant to the provisions of this section shall not preclude such criminal prosecutions as may be otherwise

provided by law. An appeal from the decision of the director may be taken, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1959, c. 214, § 13, p. 743; Laws 1969, c. 359, § 31, p. 1281; Laws 1988, LB 352, § 62.

Cross References

Administrative Procedure Act, see section 84-920.

ARTICLE 18
UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

Section
44-1801. Purpose of sections.
44-1802. Terms, defined.
44-1803. Unlawful advertising; director; notice to insurer.
44-1804. Failure to cease making misrepresentation; action by director.
44-1805. Subject to personal jurisdiction.
44-1806. Act, how cited.

44-1801 Purpose of sections.

(1) The purpose of sections 44-1801 to 44-1806 is to subject to the jurisdiction of the Director of Insurance and to the jurisdiction of the courts of this state insurers not authorized to transact business in this state which place in or send into this state any false advertising designed to induce residents of this state to purchase insurance from insurers not authorized to transact business in this state. The Legislature declares it is in the interest of the citizens of this state who purchase insurance from insurers which solicit insurance business in this state in the manner set forth in the preceding sentence that such insurers be subject to the provisions of sections 44-1801 to 44-1806. In furtherance of such state interest, the Legislature herein exercises its power to protect its residents and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states, the authority provided herein to be in addition to any existing powers of this state.

(2) The provisions of sections 44-1801 to 44-1806 shall be liberally construed.

Source: Laws 1965, c. 247, § 1, p. 698; Laws 1983, LB 447, § 62.

44-1802 Terms, defined.

For purposes of the Unauthorized Insurers False Advertising Process Act:

(1) Director shall mean the Director of Insurance; and

(2) Residents shall mean and include persons, partnerships, limited liability companies, or corporations, domestic, alien, or foreign.

Source: Laws 1965, c. 247, § 2, p. 698; Laws 1989, LB 6, § 9; Laws 1993, LB 121, § 237.

44-1803 Unlawful advertising; director; notice to insurer.

No unauthorized foreign or alien insurer of the kind described in section 44-1801 shall make, issue, circulate, or cause to be made, issued, or circulated to residents of this state any estimate, illustration, circular, pamphlet, or letter

or cause to be made in any newspaper, magazine, or other publication or over any radio or television station any announcement or statement to such residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon in violation of the Unfair Insurance Trade Practices Act. Whenever the director has reason to believe that any such insurer is engaging in such unlawful advertising, it shall be his or her duty to give notice of such fact by either registered or certified mail to such insurer and to the insurance supervisory official of the domiciliary state of such insurer. For the purpose of this section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.

Source: Laws 1965, c. 247, § 3, p. 699; Laws 1989, LB 6, § 10; Laws 1991, LB 234, § 27.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-1804 Failure to cease making misrepresentation; action by director.

If after thirty days following the giving of the notice mentioned in section 44-1803 such insurer has failed to cease making, issuing, or circulating such false misrepresentations or causing the same to be made, issued, or circulated in this state and if the director has reason to believe that a proceeding by him or her in respect to such matters would be to the interest of the public and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in section 44-1805, he or she shall take action against such insurer under the Unfair Insurance Trade Practices Act.

Source: Laws 1965, c. 247, § 4, p. 699; Laws 1989, LB 6, § 11; Laws 1991, LB 234, § 28.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-1805 Subject to personal jurisdiction.

Any of the following acts in this state, effected by mail or otherwise, by any such unauthorized foreign or alien insurer: (1) The issuance or delivery of contracts of insurance to residents of this state; (2) the solicitation of applications for such contracts; (3) the collection of premiums, membership fees, assessments, or other considerations for such contracts; or (4) any other transaction of insurance business, shall constitute sufficient contact with the state for the exercise of personal jurisdiction over such insurer in any proceeding instituted in respect to the misrepresentation set forth in section 44-1803 under the Unfair Insurance Trade Practices Act or in any action, suit, or proceeding for the recovery of any penalty provided in the act.

Source: Laws 1965, c. 247, § 5, p. 700; Laws 1983, LB 447, § 63; Laws 1989, LB 6, § 12; Laws 1991, LB 234, § 29.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-1806 Act, how cited.

Sections 44-1801 to 44-1806 shall be known and may be cited as the Unauthorized Insurers False Advertising Process Act.

Source: Laws 1965, c. 247, § 7, p. 702; Laws 1989, LB 92, § 181.

ARTICLE 19

TITLE INSURANCE

(a) TITLE INSURANCE ACT

Section

44-1901. Transferred to section 44-1928.
44-1902. Transferred to section 44-1946.
44-1903. Repealed. Laws 1991, LB 235, § 59.
44-1904. Repealed. Laws 1991, LB 235, § 59.
44-1905. Transferred to section 44-1947.
44-1906. Transferred to section 44-1948.
44-1907. Transferred to section 44-1950.
44-1908. Transferred to section 44-1951.
44-1909. Transferred to section 44-1958.
44-1910. Transferred to section 44-1959.
44-1911. Transferred to section 44-1960.
44-1912. Transferred to section 44-1961.
44-1913. Transferred to section 44-1962.
44-1914. Transferred to section 44-1963.
44-1915. Transferred to section 44-1976.
44-1916. Transferred to section 44-1977.
44-1917. Transferred to section 44-1927.
44-1918. Repealed. Laws 1991, LB 235, § 59.
44-1919. Transferred to section 44-1952.
44-1920. Repealed. Laws 1989, LB 6, § 13.
44-1921. Repealed. Laws 1991, LB 235, § 59.
44-1922. Transferred to section 44-1953.
44-1923. Transferred to section 44-1954.
44-1924. Transferred to section 44-1955.
44-1925. Transferred to section 44-1956.
44-1926. Transferred to section 44-1957.
44-1927. Repealed. Laws 1997, LB 53, § 52.
44-1928. Repealed. Laws 1997, LB 53, § 52.
44-1929. Repealed. Laws 1997, LB 53, § 52.
44-1930. Repealed. Laws 1997, LB 53, § 52.
44-1931. Repealed. Laws 1997, LB 53, § 52.
44-1932. Repealed. Laws 1997, LB 53, § 52.
44-1933. Repealed. Laws 1997, LB 53, § 52.
44-1934. Repealed. Laws 1997, LB 53, § 52.
44-1935. Repealed. Laws 1997, LB 53, § 52.
44-1936. Repealed. Laws 1997, LB 53, § 52.
44-1937. Repealed. Laws 1997, LB 53, § 52.
44-1938. Repealed. Laws 1997, LB 53, § 52.
44-1939. Repealed. Laws 1997, LB 53, § 52.
44-1940. Repealed. Laws 1997, LB 53, § 52.
44-1941. Repealed. Laws 1997, LB 53, § 52.
44-1942. Repealed. Laws 1997, LB 53, § 52.
44-1943. Repealed. Laws 1997, LB 53, § 52.
44-1944. Repealed. Laws 1997, LB 53, § 52.
44-1945. Repealed. Laws 1997, LB 53, § 52.
44-1946. Repealed. Laws 1997, LB 53, § 52.
44-1947. Repealed. Laws 1997, LB 53, § 52.
44-1948. Repealed. Laws 1997, LB 53, § 52.
44-1949. Repealed. Laws 1997, LB 53, § 52.
44-1950. Repealed. Laws 1997, LB 53, § 52.
44-1951. Repealed. Laws 1997, LB 53, § 52.

Section

(a) TITLE INSURANCE ACT

44-1901 Transferred to section 44-1928.

44-1902 Transferred to section 44-1946.

44-1903 Repealed. Laws 1991, LB 235, § 59.

44-1904 Repealed. Laws 1991, LB 235, § 59.

44-1905 Transferred to section 44-1947.

44-1906 Transferred to section 44-1948.

44-1907 Transferred to section 44-1950.

44-1908 Transferred to section 44-1951.

44-1909 Transferred to section 44-1958.

44-1910 Transferred to section 44-1959.

44-1911 Transferred to section 44-1960.

44-1912 Transferred to section 44-1961.

44-1913 Transferred to section 44-1962.

44-1914 Transferred to section 44-1963.

44-1915 Transferred to section 44-1976.

44-1916 Transferred to section 44-1977.

44-1917 Transferred to section 44-1927.

44-1918 Repealed. Laws 1991, LB 235, § 59.

44-1919 Transferred to section 44-1952.

44-1920 Repealed. Laws 1989, LB 6, § 13.

44-1921 Repealed. Laws 1991, LB 235, § 59.

44-1922 Transferred to section 44-1953.

44-1923 Transferred to section 44-1954.

44-1924 Transferred to section 44-1955.

44-1925 Transferred to section 44-1956.

44-1926 Transferred to section 44-1957.

44-1927 Repealed. Laws 1997, LB 53, § 52.

44-1928 Repealed. Laws 1997, LB 53, § 52.

44-1929 Repealed. Laws 1997, LB 53, § 52.

44-1930 Repealed. Laws 1997, LB 53, § 52.

44-1931 Repealed. Laws 1997, LB 53, § 52.

44-1932 Repealed. Laws 1997, LB 53, § 52.

44-1933 Repealed. Laws 1997, LB 53, § 52.

44-1934 Repealed. Laws 1997, LB 53, § 52.

44-1935 Repealed. Laws 1997, LB 53, § 52.

44-1936 Repealed. Laws 1997, LB 53, § 52.

44-1937 Repealed. Laws 1997, LB 53, § 52.

44-1938 Repealed. Laws 1997, LB 53, § 52.

44-1939 Repealed. Laws 1997, LB 53, § 52.

44-1940 Repealed. Laws 1997, LB 53, § 52.

44-1941 Repealed. Laws 1997, LB 53, § 52.

44-1942 Repealed. Laws 1997, LB 53, § 52.

44-1943 Repealed. Laws 1997, LB 53, § 52.

44-1944 Repealed. Laws 1997, LB 53, § 52.

44-1945 Repealed. Laws 1997, LB 53, § 52.

44-1946 Repealed. Laws 1997, LB 53, § 52.

44-1947 Repealed. Laws 1997, LB 53, § 52.

44-1948 Repealed. Laws 1997, LB 53, § 52.

44-1949 Repealed. Laws 1997, LB 53, § 52.

44-1950 Repealed. Laws 1997, LB 53, § 52.

44-1951 Repealed. Laws 1997, LB 53, § 52.

44-1952 Repealed. Laws 1997, LB 53, § 52.

44-1953 Repealed. Laws 1997, LB 53, § 52.

44-1954 Repealed. Laws 1997, LB 53, § 52.

44-1955 Repealed. Laws 1997, LB 53, § 52.

44-1956 Repealed. Laws 1997, LB 53, § 52.

44-1957 Repealed. Laws 1997, LB 53, § 52.

44-1958 Repealed. Laws 1997, LB 53, § 52.

44-1959 Repealed. Laws 1997, LB 53, § 52.

44-1960 Repealed. Laws 1997, LB 53, § 52.

44-1961 Repealed. Laws 1997, LB 53, § 52.

44-1962 Repealed. Laws 1997, LB 53, § 52.

44-1963 Repealed. Laws 1997, LB 53, § 52.

44-1964 Repealed. Laws 1997, LB 53, § 52.

44-1965 Repealed. Laws 1997, LB 53, § 52.

44-1966 Repealed. Laws 1997, LB 53, § 52.

44-1967 Repealed. Laws 1997, LB 53, § 52.

44-1968 Repealed. Laws 1997, LB 53, § 52.

44-1969 Repealed. Laws 1997, LB 53, § 52.

44-1970 Repealed. Laws 1997, LB 53, § 52.

44-1971 Repealed. Laws 1997, LB 53, § 52.

44-1972 Repealed. Laws 1997, LB 53, § 52.

44-1973 Repealed. Laws 1997, LB 53, § 52.

44-1974 Repealed. Laws 1997, LB 53, § 52.

44-1975 Repealed. Laws 1997, LB 53, § 52.

44-1976 Repealed. Laws 1997, LB 53, § 52.

44-1977 Repealed. Laws 1997, LB 53, § 52.

(b) TITLE INSURERS ACT

44-1978 Act, how cited.

Sections 44-1978 to 44-19,105 shall be known and may be cited as the Title Insurers Act.

Source: Laws 1997, LB 53, § 1.

44-1979 Purpose of act.

The purpose of the Title Insurers Act is to provide for the effective regulation and supervision of title insurance and title insurers authorized to issue title insurance policies or otherwise transact the business of title insurance in this state.

Source: Laws 1997, LB 53, § 2.

44-1980 Applicability of act and laws.

The Title Insurers Act shall apply to all persons engaged in the business of title insurance in this state.

Except as otherwise expressly provided in the act and except when the context otherwise requires, all provisions of the laws of this state applying to insurance and insurers generally shall apply to title insurance and title insurers.

Source: Laws 1997, LB 53, § 3.

44-1981 Terms, defined.

For purposes of the Title Insurers Act:

(1) Abstract of title means a compilation in orderly arrangement of the materials and facts of record affecting the title to a specific piece of land, issued under a certificate certifying to the matters contained in such compilation;

(2) Affiliate means a specific person that directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the person specified;

(3) Bona fide employee of the title insurer means an individual who devotes substantially all of his or her time to performing services on behalf of a title insurer and whose compensation for the services is in the form of salary or its equivalent paid by the title insurer;

(4) Control, including the terms controlling, controlled by, and under common control with, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

(5) Direct operations means that portion of a title insurer's operations which are attributable to title insurance business written by a bona fide employee of the title insurer;

(6) Director means the Director of Insurance;

(7) Escrow means written instruments, money, or other items deposited by one party with a depository, escrow agent, or escrow for delivery to another party upon the performance of a specified condition or the happening of a certain event;

(8) Escrow, settlement, or closing fee means the consideration for supervising or handling the actual execution, delivery, or recording of transfer and lien documents and for disbursing funds;

(9) Foreign title insurer means any title insurer incorporated or organized under the laws of any other state of the United States, the District of Columbia, or any other jurisdiction of the United States;

(10) Net retained liability means the total liability retained by a title insurer for a single risk, after taking into account any ceded liability and collateral, acceptable to the director, maintained by the title insurer;

(11) Non-United-States title insurer means any title insurer incorporated or organized under the laws of any foreign nation or any foreign province or territory;

(12) Person means any natural person, partnership, association, cooperative, corporation, trust, or other legal entity;

(13) Producer of title insurance business has the same meaning as in section 44-19,108;

(14) Qualified financial institution means an institution that is:

(a) Organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state and has been granted authority to operate with fiduciary powers;

(b) Regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies;

(c) Insured by the appropriate federal entity; and

(d) Qualified under any additional rules and regulations adopted and promulgated by the director;

(15) Referral has the same meaning as in section 44-19,108;

(16) Security or security deposit means funds or other property received by a title insurer as collateral to secure an indemnitor's obligation under an indemnity agreement pursuant to which the title insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage;

(17) Title insurance agent has the same meaning as in section 44-19,108;

(18) Title insurance business or business of title insurance means:

(a) Issuing as a title insurer or offering to issue as a title insurer a title insurance policy;

(b) Transacting or proposing to transact by a title insurer any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(i) Soliciting or negotiating the issuance of a title insurance policy;

(ii) Guaranteeing, warranting, or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units, and proprietary leases and for all liens or charges affecting the same;

(iii) Handling of escrows, settlements, or closings;

(iv) Executing title insurance policies;

(v) Effecting contracts of reinsurance;

(vi) Searching or examining titles; or

(vii) Guaranteeing, warranting, or otherwise insuring the correctness of the search or filing results obtained from public registries established for determining liens or security interests in personal property or fixtures;

(c) Guaranteeing, warranting, or insuring searches or examinations of title to real property or any interest in real property;

(d) Guaranteeing or warranting the status of title as to ownership of or liens on real property by any person other than the principals to the transaction;

(e) Transacting or proposing to transact any business substantially equivalent to any of the activities listed in this subdivision in a manner designed to evade the provisions of the Title Insurers Act;

(f) Guaranteeing, warranting, or insuring the search or filing results obtained from public registries established for determining liens or security interests in personal property or fixtures; or

(g) Guaranteeing or warranting adverse claims to title, liens, encumbrances upon, or security interests in personal property or fixtures by any person other than the principals to the transaction;

(19) Title insurance commitment means a preliminary commitment, report, or binder issued prior to the issuance of a title insurance policy containing the terms, conditions, exceptions, and any other matters incorporated by reference under which the title insurer is willing to issue its title insurance policy;

(20) Title insurance policy means:

(a) A contract insuring or indemnifying owners of, or other persons lawfully interested in, real property or any interest in real property, against loss or damage arising from any or all of the following conditions existing on or before the policy date and not excepted or excluded:

(i) Defects in or liens or encumbrances on the insured title;

(ii) Unmarketability of the insured title;

(iii) Invalidity, lack of priority, or unenforceability of liens or encumbrances on the stated property;

(iv) Lack of legal right of access to the land; or

(v) Unenforceability of rights in title to the land; or

(b) A contract insuring or indemnifying owners of personal property or secured parties or others interested therein against loss or damage pertaining to adverse claims to title, liens, encumbrances upon, or security interests in personal property or fixtures, including the existence or nonexistence of the attachment, perfection, or priority of security interests in personal property or fixtures under the Uniform Commercial Code or other laws, rules, or regulations establishing procedures for the attachment, perfection, or priority of security interests in personal property or fixtures, or the accuracy or completeness of the search or filing results obtained from public registries established for determining liens or security interests in personal property or fixtures, and arising from any or all of the following conditions not excepted or excluded:

(i) Other liens or encumbrances on the stated personal property or fixtures;

(ii) Invalidity, lack of priority, or unenforceability of liens or other security interests in the stated personal property or fixtures; or

(iii) Any other matters relating directly or indirectly to the lien status of the stated personal property or fixtures;

(21) Title insurer means any insurer organized under the laws of this state for the purpose of transacting the business of title insurance and any foreign or non-United-States title insurer authorized to transact the business of title insurance in this state; and

(22) Title plant means a set of records consisting of documents, maps, surveys, or entries affecting title to real property or any interest in or encumbrance on the property which have been filed or recorded in the jurisdiction for which the title plant is established or maintained.

Source: Laws 1997, LB 53, § 4; Laws 2001, LB 360, § 9; Laws 2015, LB180, § 2.

44-1982 Transaction of title insurance business; requirements.

No person other than a domestic, foreign, or non-United-States title insurer organized on the stock plan and authorized under section 44-202 as a title insurer shall issue a title insurance policy or otherwise transact the business of title insurance in this state.

Source: Laws 1997, LB 53, § 5.

44-1983 Authorized activities of title insurers.

Subject to the exceptions and restrictions contained in the Title Insurers Act, a title insurer shall have the power to:

(1) Transact only title insurance business; and

(2) Reinsure title insurance policies.

Source: Laws 1997, LB 53, § 6.

44-1984 Limitations on powers.

(1) No insurer that transacts any line of business other than title insurance shall be eligible for the issuance or renewal of a certificate of authority to transact the business of title insurance in this state nor shall title insurance be transacted, underwritten, or issued by any insurer transacting or authorized to transact any other line of business.

(2)(a) Notwithstanding subsection (1) of this section, and to the extent such coverage is lawful within this state, a title insurer shall issue closing or settlement protection covering a proposed insured if the title insurer or its title insurance agent engages in any escrow, settlement, or closing services relating to the issuance of a title insurance commitment or title insurance policy to a proposed insured. Such closing or settlement protection shall conform to the terms of coverage and form of instrument as required by the director and shall indemnify a proposed insured solely against loss of settlement funds only because of the following acts of a title insurer's named title insurance agent:

(i) Theft of settlement funds; and

(ii) Failure to comply with written closing instructions by the proposed insured when agreed to by the title insurance agent relating to title insurance coverage.

(b) The director may prescribe or approve a required charge for providing the coverage.

(c) A title insurer shall not provide any other coverage which purports to indemnify against improper acts or omissions of a person with regard to escrow, settlement, or closing services.

Source: Laws 1997, LB 53, § 7; Laws 2002, LB 1139, § 20; Laws 2004, LB 155, § 1; Laws 2019, LB221, § 1.

44-1985 Minimum capital and surplus requirements.

Before being authorized to transact the business of title insurance in this state, a title insurer shall establish and maintain a minimum paid-in capital of not less than one million dollars and, in addition, paid-in initial surplus of at least one million dollars.

Source: Laws 1997, LB 53, § 8.

44-1986 Single risk limit.

(1) The net retained liability of a title insurer for a single risk in regard to property, whether assumed directly or as reinsurance, shall not exceed the aggregate of fifty percent of surplus as regards policyholders plus the statutory premium reserve less the title insurer's investment in title plants, all as shown on the most recent annual statement of the title insurer on file with the director.

(2) For purposes of the Title Insurers Act:

(a) A single risk shall be the insured amount of any title insurance policy, except that when two or more title insurance policies are issued simultaneously covering different estates in the same real property, a single risk shall be the sum of the insured amounts of all the title insurance policies; and

(b) A title insurance policy under which a claim payment reduces the amount of title insurance under one or more other title insurance policies shall be included in computing the single risk sum only to the extent that its amount exceeds the aggregate amount of the title insurance policy or policies whose amount of title insurance is reduced.

Source: Laws 1997, LB 53, § 9.

44-1987 Admitted asset standards.

In determining the financial condition of a title insurer transacting the business of title insurance under the Title Insurers Act, the general investment provisions of the Insurers Investment Act shall apply, except that an investment in a title plant or title plants in an amount equal to the actual cost shall be allowed as an admitted asset for title insurers. The aggregate amount of the investment shall not exceed the lesser of twenty percent of admitted assets or forty percent of surplus to policyholders, as shown on the most recent annual statement of the title insurer on file with the director.

Source: Laws 1997, LB 53, § 10.

Cross References

Insurers Investment Act, see section 44-5101.

44-1988 Reserves.

(1) In determining the financial condition of a title insurer transacting the business of title insurance under the Title Insurers Act, the general provisions of

the insurance laws of this state requiring the establishment of reserves sufficient to cover all known and unknown liabilities, including allocated and unallocated loss adjustment expense, shall apply except as provided in subsections (2) through (4) of this section.

(2) A title insurer shall establish and maintain a known claim reserve in an amount estimated to be sufficient to cover all unpaid losses, claims, and allocated loss adjustment expenses arising under title insurance policies, guaranteed certificates of title, guaranteed searches, and guaranteed abstracts of title and all unpaid losses, claims, and allocated loss adjustment expenses for which the title insurer may be liable and for which the title insurer has received notice by or on behalf of the insured, holder of a guarantee or escrow, or security depositor.

(3)(a) If a title insurer is a foreign or non-United-States title insurer, the title insurer shall establish and maintain a statutory or unearned premium reserve consisting of the amount of statutory or unearned premium reserve required by the laws of the domiciliary state of the title insurer.

(b)(i) If a title insurer is a domestic insurer of this state, the title insurer shall establish and maintain a statutory or unearned premium reserve in an amount equal to seventeen cents per one thousand dollars of net retained liability for each insurance policy.

(ii) The amount set aside in the reserve required under subdivision (3)(b)(i) of this section shall be released from the reserve and restored to net profits over a period of twenty years pursuant to the following formula: Thirty percent of the aggregate sum in the year next succeeding the year of addition; fifteen percent of the aggregate sum in the next succeeding year; ten percent of the aggregate sum in each of the next succeeding two years; five percent of the aggregate sum in each of the next succeeding two years; three percent of the aggregate sum in each of the next succeeding two years; two percent of the aggregate sum in each of the next succeeding seven years; and one percent of the aggregate sum in each of the next succeeding five years. For each year in which a release of statutory or unearned premium reserve is authorized under this subdivision, such reserve shall be released over the course of the year in twelve equal monthly amounts, beginning on July 1.

(c)(i) If a title insurer that is organized under the laws of another state transfers its domicile to this state, the statutory or unearned premium reserve shall be that amount required by the laws of the state of the title insurer's former state of domicile as of the date of transfer of domicile. Thereafter, the aggregate of such statutory or unearned premium reserve shall be released from the reserve and restored to profits over a period of twenty years pursuant to the formula set forth in subdivision (3)(c)(iii) of this section.

(ii) Following the transfer of domicile to this state of the title insurer described in subdivision (3)(c)(i) of this section, for business written after the date of transfer of domicile, the title insurer shall add to and set aside in the statutory or unearned premium reserve such amount as provided in subdivision (3)(b)(i) of this section.

(iii) The amounts set aside in the reserve required under subdivision (3)(c)(i) of this section shall be released from the reserve and restored to net profits over a period of twenty years pursuant to the following formula: An initial release of thirty percent of the aggregate of such reserves on the forty-fifth day following the last day of the calendar quarter in which the insurer transfers its domicile;

fifteen percent of the aggregate sum in the next succeeding year; ten percent of the aggregate sum in each of the next succeeding two years; five percent of the aggregate sum in each of the next succeeding two years; three percent of the aggregate sum in each of the next succeeding two years; two percent of the aggregate sum in each of the next succeeding seven years; and one percent of the aggregate sum in each of the next succeeding five years. For each year in which a release of statutory or unearned premium reserve is authorized under this subdivision, such reserve shall be released over the course of the year in twelve equal monthly amounts, beginning on July 1.

(4) A title insurer shall establish and maintain a supplemental reserve consisting of any other reserves necessary, when taken in combination with the reserves required by subsections (2) and (3) of this section, to cover the title insurer's liabilities with respect to all losses, claims, and loss adjustment expenses.

(5) Each title insurer subject to the Title Insurers Act shall file with its annual financial statement required under section 44-322 a certification by a member in good standing of the American Academy of Actuaries. The actuarial certification required of a title insurer shall conform to the National Association of Insurance Commissioners' annual statement instructions for title insurers.

Source: Laws 1997, LB 53, § 11; Laws 2006, LB 875, § 3; Laws 2009, LB192, § 2.

44-1989 Liquidation, dissolution, or insolvency.

(1) The Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act shall apply to all title insurers subject to the Title Insurers Act except as otherwise provided in this section. In applying the provisions of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, the court shall consider the unique aspects of title insurance and shall have broad authority to fashion relief that provides for the maximum protection of the title insurance policyholders.

(2) Security and escrow funds held by or on behalf of a title insurer shall not become general assets and shall be administered as secured creditor claims as defined in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

(3) Title insurance policies that are in force at the time an order of liquidation is entered shall not be canceled except upon a showing to the court of good cause by the liquidator. The determination of good cause shall be within the discretion of the court. In making this determination, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

(4) The court may set appropriate dates that potential claimants must file their claims with the liquidator. The court may set different dates for claims based upon a title insurance policy than for all other claims. In setting dates, the court shall consider the unique aspects of title insurance and all other relevant circumstances.

(5) As of the date of the order of insolvency or liquidation, all premiums paid, due, or to become due under title insurance policies of the title insurer shall be fully earned. It shall be the obligation of title insurance agents, insureds, or

representatives of the title insurer to pay fully earned premiums to the liquidator or rehabilitator.

Source: Laws 1997, LB 53, § 12.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-1990 Restrictions on dividends.

A title insurer shall only declare or distribute a dividend to shareholders without the prior written approval of the director as would be permitted under section 44-2134 for insurers other than life insurers.

Source: Laws 1997, LB 53, § 13.

44-1991 Diversification requirement.

(1) Without the prior written approval of the director, a domestic title insurer shall not accept:

(a) Additional title insurance business from a title insurance agent that is not affiliated with the title insurer if, when added to other title insurance business written through the title insurance agent during the same calendar year, that title insurance agent's aggregate premiums written on behalf of the title insurer will exceed twenty percent of the title insurer's gross premiums written during the prior calendar year as shown on the title insurer's most recent annual statement on file with the director; or

(b) Additional direct operations from a single source if, when added to other direct operations from the single source during the same calendar year, the aggregate premiums written on the direct operations of the single source will exceed twenty percent of the title insurer's gross premiums written during the prior calendar year as shown on the title insurer's most recent annual statement on file with the director. For purposes of this section, single source means a person that refers title insurance business to the title insurer and any other person that controls, is controlled by, or is under common control with that person.

(2) In determining whether prior approval may be given, the director shall consider:

(a) The potential that the acceptance of more title insurance business from the title insurance agent or source may adversely affect the financial solidity of the title insurer;

(b) The availability of competing title insurance agents or additional sources in the territories in which the title insurer accepts risks;

(c) The number of years the title insurer has been in business;

(d) Reinsurance arrangements mitigating the concentration of title insurance business from the title insurance agent or single source;

(e) The comparative profitability of the title insurance agent's or single source's book of title insurance business;

(f) The degree of oversight of the title insurance agent's operations exercised by the title insurer; and

(g) Any other circumstances deemed by the director to be appropriate.

Source: Laws 1997, LB 53, § 14.

44-1992 Title insurance commitment; notice.

(1) When a title insurance commitment includes an offer to issue an owner's title insurance policy covering the resale of owner-occupied residential property, the title insurance commitment shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing. If the title insurance commitment cannot be delivered prior to the day of closing, the title insurer shall document the reasons for the delay.

(2) A title insurer issuing a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan, when no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the director, to the purchaser-mortgagor at the time the title insurance commitment is prepared. The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage lender and that the lender's title insurance policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased. The notice shall explain what a title insurance policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's title insurance policy. The notice shall also explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost if the proposed coverages or amount of title insurance is not then known. A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least five years after the effective date of the lender's title insurance policy.

Source: Laws 1997, LB 53, § 15; Laws 1999, LB 259, § 4; Laws 2001, LB 360, § 10.

44-1993 Duties of title insurers utilizing the services of title insurance agents; liability.

(1) A title insurer shall not accept title insurance business from a title insurance agent unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, when both parties share responsibility for a particular function, specifies the division of responsibilities.

(2) For each title insurance agent under contract with a title insurer, the title insurer shall have on file a statement of financial condition of each title insurance agent as of the end of the previous calendar year setting forth an income statement of title insurance business done during the preceding year and a balance sheet showing the condition of its affairs as of the prior December 31 certified by the title insurance agent as being a true and accurate representation of the title insurance agent's financial condition. Attorneys actively engaged in the practice of law, other than that related to title insurance business, are exempt from the requirements of this subsection.

(3) A title insurer shall, at least annually, conduct an onsite review of the underwriting, claims, and escrow practices of the title insurance agent which shall include a review of the title insurance agent's title insurance policy form inventory and processing operations. If the title insurance agent does not maintain separate financial institution or trust accounts for each title insurer it represents, the title insurer shall verify that the funds held on its behalf are

reasonably ascertainable from the books of account and records of the title insurance agent.

(4) Within thirty days after executing or terminating a contract with a title insurance agent, a title insurer shall provide written notification of the appointment or termination and the reason for termination to the director. Notices of appointment of a title insurance agent shall be made on a form prescribed or approved by the director.

(5) A title insurer shall maintain an inventory of all title insurance policy forms or title insurance policy numbers allocated to each title insurance agent.

(6) A title insurer shall have on file proof that each title insurance agent is licensed by this state.

(7) A title insurer shall establish the underwriting guidelines and, when applicable, limitations on title claims settlement authority to be incorporated into contracts with its title insurance agents.

(8)(a) A title insurer is liable for the defalcation, conversion, or misappropriation by a title insurance agent appointed by or under written contract with such title insurer of escrow, settlement, closing, or security deposit funds handled by such title insurance agent in contemplation of or in conjunction with the issuance of a title insurance commitment or title insurance policy by such title insurer. However, if no such title insurance commitment or title insurance policy was issued, each title insurer which appointed or maintained a written contract with such title insurance agent at the time of the discovery of the defalcation, conversion, or misappropriation shares in the liability for the defalcation, conversion, or misappropriation in the same proportion that the premium remitted to the title insurer by such title insurance agent during the twelve-month period immediately preceding the date of the discovery of the defalcation, conversion, or misappropriation bears to the total premium remitted to all title insurers by such title insurance agent during the twelve-month period immediately preceding the date of the discovery of the defalcation, conversion, or misappropriation.

(b) For purposes of this subsection, title insurance agent includes (i) a person with whom a title insurer maintains a title insurance agency agreement and (ii) an employer or employee of a title insurance agent or of a person with whom a title insurer maintains a title insurance agency agreement.

Source: Laws 1997, LB 53, § 16; Laws 2004, LB 155, § 2.

44-1994 Conditions for maintaining escrow and security deposit accounts.

(1)(a) A title insurer may operate as an escrow, security, settlement, or closing agent subject to the requirements of subdivisions (b) through (e) of this subsection.

(b) All funds deposited with the title insurer in connection with an escrow, security deposit, settlement, or closing shall be submitted for collection to or deposited in a separate fiduciary trust account or accounts in a qualified financial institution no later than the close of the next business day in accordance with the following requirements:

(i) The funds shall be the property of the person or persons entitled to them under the provisions of the escrow, security deposit, settlement, or closing agreement and shall be segregated for each depository by escrow, security

deposit, settlement, or closing in the records of the title insurer in a manner that permits the funds to be identified on an individual basis; and

(ii) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

(c) Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom such funds may be disbursed.

(d) Funds held in a security deposit account shall be disbursed only pursuant to a written agreement specifying:

(i) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(ii) The duties of the title insurer with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(iii) Any other provisions the director may require.

(e)(i) Disbursements may be made out of an escrow, security deposit, settlement, or closing account only if deposits in amounts at least equal to the disbursement have first been made directly relating to the transaction disbursed against and if the deposits are in one of the following forms:

(A) Lawful money of the United States;

(B) Wired funds when unconditionally held by the title insurer;

(C) Cashier's checks, certified checks, bank money orders, or teller's checks issued by a federally insured financial institution and unconditionally held by the title insurer; and

(D) United States treasury checks, federal reserve bank checks, federal home loan bank checks, State of Nebraska warrants, and warrants of a city of the metropolitan or primary class.

(ii) For purposes of this subdivision, federally insured financial institution means an institution in which monetary deposits are insured by the Federal Deposit Insurance Corporation or National Credit Union Administration.

(2) Nothing in this section is intended to amend, alter, or supersede other sections of the Title Insurers Act or the laws of this state or the United States regarding an escrow holder's duties and obligations.

(3) The director may prescribe a standard agreement for escrow, settlement, closing, or security deposit funds.

Source: Laws 1997, LB 53, § 17; Laws 2003, LB 216, § 9.

44-1995 Prohibition of rebate and fee splitting.

A title insurer or other person shall not provide or receive, directly or indirectly, any consideration for the referral of title insurance business or escrow or other services provided by a title insurer.

Source: Laws 1997, LB 53, § 18.

44-1996 Favored agent of title insurer.

A title insurer shall not participate in any transaction in which it knows that a producer of title insurance business or other person requires, directly or

indirectly, or through a trustee, director, officer, agent, employee, or affiliate, as a condition, agreement, or understanding to selling or furnishing any other person a loan, loan extension, credit, sale, property, contract, lease, or service, that the other person place a title insurance policy of any kind with the title insurer or through a particular title insurance agent.

Source: Laws 1997, LB 53, § 19.

44-1997 Premium rate filings and standards.

(1) No title insurer may charge any rates regulated by the state after September 13, 1997, except in accordance with the premium rate schedule and manual filed with and approved by the director in accordance with applicable statutes and rules and regulations governing rate filings.

(2) The director may adopt and promulgate rules and regulations, including rules and regulations providing statistical plans, for use by all title insurers and title insurance agents in the recording and reporting of revenue, loss, and expense experience in such form and detail as is necessary to aid him or her in the establishment of rates and fees.

(3) The director may require that the information provided under this section be verified by oath of the title insurer's or title insurance agent's president, vice president, secretary, or actuary, as applicable. The director may further require that the information required under this section be subject to an audit conducted by an independent certified public accountant. The director shall have the authority to establish a minimum threshold level at which an audit would be required.

(4) Information filed with the director relating to the experience of a particular title insurance agent shall be kept confidential unless the director finds it in the public interest to disclose the information required of title insurers or title insurance agents under this section.

Source: Laws 1997, LB 53, § 20.

44-1998 Form filing.

(1)(a) A title insurer or rate service organization shall not deliver or issue for delivery or permit any of its title insurance agents to deliver in this state any form, in connection with title insurance business written, unless it has been filed with the director and approved by the director or thirty days have elapsed and it has not been disapproved. The waiting period may be extended for an additional period not to exceed thirty days if the director gives written notice within such waiting period to the title insurer or authorized rate service organization which made the filing that additional time is needed for consideration of the filing.

(b) Forms shall not (i) be unjust, unfair, or inequitable, (ii) be misleading, be deceptive, or encourage misrepresentation of the coverage, (iii) be contrary to public policy, or (iv) provide coverage that is of such a limited nature so as to be contrary to public interest.

(2) Forms covered by this section shall include:

(a) Title insurance policies, including standard form endorsements; and

(b) Title insurance commitments.

(3) After notice and opportunity to be heard are given to the title insurer or rate service organization which submitted a form for approval, the director may withdraw approval of the form on finding that the use of the form is contrary to the legal requirements applicable at the time of withdrawal. The effective date of withdrawal of approval shall not be less than ninety days after notice of withdrawal is given.

(4) An approved title insurance policy form or endorsement providing coverage for which no identifiable premium is assessed shall be incorporated into every applicable title insurance policy. The title insurer shall disclose any additional coverage to the insured. The provisions of this section shall not operate to eliminate any underwriting standard of conditions relating to the approved title insurance policy forms or endorsements.

(5) Any term or condition related to insurance coverage provided by an approved title insurance policy or any exception to the coverage, except those ascertained from a search and examination of records relating to a title or an inspection or survey of a property to be insured, may only be included in the title insurance policy after the term, condition, or exception has been filed with the director and approved.

Source: Laws 1997, LB 53, § 21.

44-1999 Filing by rate service organization.

(1) A title insurer or title insurance agent may satisfy its obligation to file premium rates, rating manuals, and forms as required by the Title Insurers Act by becoming a member of, or a subscriber to, a rate service organization, organized and licensed under the insurance laws of this state, when the organization makes the filings, and by authorizing the director in writing to accept the filings on the title insurer's behalf.

(2) Nothing in the act shall be construed as requiring any title insurer or title insurance agent to become a member of, or a subscriber to, any rate service organization. Nothing in the act shall be construed as prohibiting the filing of deviations from rate service organization filings by any member or subscriber.

Source: Laws 1997, LB 53, § 22.

44-19,100 Record retention requirements.

Evidence of the examination of title and determination of insurability for title insurance business written by a title insurer and records relating to escrow and security deposits shall be preserved and retained by the title insurer for as long as appropriate to the circumstances but, in no event, less than fifteen years after the title insurance policy has been issued or ten years after the escrow or security deposit account has been closed. This section shall not apply to a title insurer acting as coinsurer if one of the other coinsurers has complied with this section.

Source: Laws 1997, LB 53, § 23.

44-19,101 Rules and regulations.

The director may adopt and promulgate rules and regulations and issue orders as necessary to carry out the Title Insurers Act.

Source: Laws 1997, LB 53, § 24.

44-19,102 Penalties and liabilities.

(1) If the director determines that a title insurer or any other person has violated the Title Insurers Act or any rule or regulation adopted and promulgated pursuant to the act, after notice and opportunity to be heard, the director may order:

(a) A penalty not exceeding one thousand dollars for each violation; and

(b) Revocation or suspension of the title insurer's certificate of authority.

(2) Nothing in this section shall affect the right of the director to impose any other penalties provided for in the insurance laws of this state.

(3) Nothing in the act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and creditors.

Source: Laws 1997, LB 53, § 25.

44-19,103 Unfair trade practices.

In addition to any other remedies available under the laws of this state, each violation of the Title Insurers Act and any rules and regulations adopted and promulgated thereunder shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 1997, LB 53, § 26.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-19,104 Violations of Real Estate Settlement Procedures Act of 1974.

The director or Attorney General may bring an action in a court of competent jurisdiction to enjoin violations of the federal Real Estate Settlement Procedures Act of 1974, as amended, 12 U.S.C. 2601.

Source: Laws 1997, LB 53, § 27.

44-19,105 Applicability of act.

The Title Insurers Act applies to all transactions entered into on or after September 13, 1997, except that:

(1) If the capital and surplus required prior to September 13, 1997, was less than that required by section 44-1985, a title insurer shall have two years after September 13, 1997, to comply with such section; and

(2) Section 44-1988 provides for a multiyear compliance period during which requisite reserves must be established.

Source: Laws 1997, LB 53, § 28.

(c) TITLE INSURANCE AGENT ACT

44-19,106 Act, how cited.

Sections 44-19,106 to 44-19,123 shall be known and may be cited as the Title Insurance Agent Act.

Source: Laws 1997, LB 53, § 29; Laws 2004, LB 155, § 3.

44-19,107 Purpose of act.

The purpose of the Title Insurance Agent Act is to provide the State of Nebraska with a comprehensive body of law for the effective regulation and supervision of title insurance agents.

Source: Laws 1997, LB 53, § 30.

44-19,108 Terms, defined.

For purposes of the Title Insurance Agent Act:

(1) Abstract of title has the same meaning as in section 44-1981;

(2) Affiliated business means any portion of a title insurance agent's title insurance business written in this state that was referred to it by a producer of title insurance business or by an associate of the producer of title insurance business, if the producer of title insurance business or associate, or both, have a financial interest in the title insurance agent;

(3) Associate means any:

(a) Business organized for profit in which a producer of title insurance business is a director, an officer, a partner, an employee, or an owner of a financial interest;

(b) Employee of a producer of title insurance business;

(c) Franchisor or franchisee of a producer of title insurance business;

(d) Spouse, parent, or child of a producer of title insurance business who is a natural person;

(e) Person, other than a natural person, that controls, is controlled by, or is under common control with, a producer of title insurance business; and

(f) Person with whom a producer of title insurance business or any associate of the producer of title insurance business has an agreement, arrangement, or understanding, or pursues a course of conduct, the purpose or effect of which is to provide financial benefits to that producer of title insurance business or associate for the referral of title insurance business;

(4) Bona fide employee of the title insurance agent means an individual who devotes substantially all of his or her time to performing services on behalf of a title insurance agent and whose compensation for the services is in the form of salary or its equivalent paid by the title insurance agent;

(5) Bona fide employee of the title insurer has the same meaning as in section 44-1981;

(6) Director means the Director of Insurance;

(7) Escrow has the same meaning as in section 44-1981;

(8) Financial interest means a direct or indirect interest, legal or beneficial, when the holder is or will be entitled to five percent or more of the net profits or net worth of the entity in which the interest is held;

(9) Person means any natural person, partnership, association, cooperative, corporation, trust, or other legal entity;

(10) Producer of title insurance business means any person, including an officer, director, or owner of five percent or more of the equity or capital of any person, engaged in this state in the trade, business, occupation, or profession of:

(a) Buying or selling interests in real property;

(b) Making loans secured by interests in real property; or

(c) Acting as broker, agent, representative, or attorney of a person who buys or sells any interest in real property or who lends or borrows money with the interest as security;

(11) Qualified financial institution has the same meaning as in section 44-1981;

(12) Referral means the directing or the exercising of any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral;

(13) Security or security deposit means funds or other property received by a title insurance agent as collateral to secure an indemnitor's obligation under an indemnity agreement pursuant to which a title insurer is granted a perfected security interest in the collateral in exchange for agreeing to provide coverage in a title insurance policy for a specific title exception to coverage;

(14) Title insurance agent means an authorized person, other than a bona fide employee of the title insurer, who, on behalf of the title insurer, performs the following acts in conjunction with the issuance of a title insurance commitment or title insurance policy:

(a) Determines insurability and issues title insurance commitments or title insurance policies, or both, based upon the performance or review of a title search or an abstract of title; and

(b) Performs one or more of the following functions:

(i) Collects or disburses premiums, escrow, or security deposits or other funds;

(ii) Handles escrows, settlements, or closings;

(iii) Solicits or negotiates title insurance business; or

(iv) Records closing documents;

(15) Title insurance business or business of title insurance means:

(a) Issuing as a title insurer or offering to issue as a title insurer a title insurance policy;

(b) Transacting or proposing to transact by a title insurance agent any of the following activities when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy:

(i) Soliciting or negotiating the issuance of a title insurance policy;

(ii) Guaranteeing, warranting, or otherwise insuring the correctness of title searches for all instruments affecting titles to real property, any interest in real property, cooperative units, and proprietary leases and for all liens or charges affecting the same;

(iii) Handling of escrows, settlements, or closings;

(iv) Executing title insurance policies;

(v) Effecting contracts of reinsurance; or

(vi) Searching or examining titles;

(c) Guaranteeing, warranting, or insuring searches or examinations of title to real property or any interest in real property;

(d) Guaranteeing or warranting the status of title as to ownership of or liens on real property by any person other than the principals to the transaction; or

(e) Transacting or proposing to transact any business substantially equivalent to any of the activities listed in this subdivision in a manner designed to evade the provisions of the Title Insurance Agent Act;

(16) Title insurance commitment has the same meaning as in section 44-1981;

(17) Title insurance policy has the same meaning as in section 44-1981; and

(18) Title insurer has the same meaning as in section 44-1981.

Source: Laws 1997, LB 53, § 31; Laws 2001, LB 360, § 11.

44-19,109 Licensing requirements.

(1) A person shall not act in the capacity of a title insurance agent and a title insurer shall not contract with any person to act in the capacity of a title insurance agent with respect to risks located in this state unless the person is a licensed title insurance agent in this state pursuant to the Insurance Producers Licensing Act.

(2)(a) Every title insurance agent licensed in this state shall:

(i) Exclude or eliminate the word insurer or underwriter or similar term from its agency's name; and

(ii) Provide, in a timely fashion, each title insurer with which it places business any information the title insurer requests in order to comply with reporting requirements of the director.

(b) A title insurance agent licensed in this state immediately prior to September 13, 1997, shall be deemed on and after such date to be in compliance with the requirements of this subsection.

(3) The director shall require the title insurance agent and any bona fide employee of the title insurance agent handling escrow or security deposits to maintain a surety bond, letter of credit, certificate of deposit, or deposit of cash or securities in an amount not less than one hundred thousand dollars covering all of the title insurance agent's employees.

(4) If the title insurance agent delegates the title search to a third party, the third party shall provide the title insurance agent and the title insurer with access to and the right to copy all accounts and records maintained by the third party with respect to title insurance business placed with the title insurer.

Source: Laws 1997, LB 53, § 32.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-19,110 Examination of title insurance agents.

The director may, during normal business hours, examine, audit, and inspect any and all books and records maintained by a title insurance agent under the provisions of the Title Insurance Agent Act. The title insurance agent shall reimburse the director for the expense of examination, audit, and inspection.

Source: Laws 1997, LB 53, § 33.

44-19,111 Prohibition of rebate and fee splitting.

A title insurance agent or other person shall not provide or receive, directly or indirectly, any consideration for the referral of title insurance business or escrow or other services provided by a title insurance agent.

Source: Laws 1997, LB 53, § 34.

44-19,112 Affiliated business provisions.

(1) Whenever title insurance business to be written constitutes affiliated business, prior to commencing the transaction, the title insurance agent shall ensure that its customer has been provided with a written disclosure of the existence of the affiliated business arrangement and a written estimate of the charge or range of charges generally made for the title insurance services provided by the title insurance agent.

(2) The director may establish rules for use by all title insurance agents in the recording and reporting of the title insurance agent's owners and of the title insurance agent's ownership interests in other persons or businesses and of material transactions between the parties.

(3) The director shall require each title insurance agent to file, on forms prescribed by the director, reports setting forth the names and addresses of those persons, if any, that have a financial interest in the title insurance agent and who the title insurance agent knows or has reason to believe are producers of title insurance business or associates of producers of title insurance business.

(4) Nothing in the Title Insurance Agent Act shall be construed as prohibiting affiliated business arrangements in the provision of title insurance business so long as:

(a) The title insurance agent or party making a referral constituting affiliated business, at or prior to the time of the referral, discloses the arrangement and, in connection with the referral, provides the person being referred with a written estimate of the charge or range of charges likely to be assessed and otherwise complies with the disclosure obligations of this section;

(b) The person being referred is not required to use a specified title insurance agent or title insurer; and

(c) The only thing of value that is received by the title insurance agent or party making the referral, other than payments otherwise permitted, is a return on an ownership interest. For purposes of this subsection, the terms required use and return on an ownership interest have the meaning accorded to them under the federal Real Estate Settlement Procedures Act of 1974, as amended, 12 U.S.C. 2601, and Regulation X, 24 C.F.R. 3500 et seq.

Source: Laws 1997, LB 53, § 35.

44-19,113 Favored agent of title insurer.

A title insurance agent shall not participate in any transaction in which it knows that a producer of title insurance business or other person requires, directly or indirectly, or through a trustee, director, officer, agent, employee, or affiliate, as a condition, agreement, or understanding to selling or furnishing any other person a loan, loan extension, credit, sale, property, contract, lease, or service, that the other person place a title insurance policy of any kind with a particular title insurer or through a particular title insurance agent.

Source: Laws 1997, LB 53, § 36.

44-19,114 Required provisions of underwriting contract with title insurer.

(1) A person, firm, association, or corporation acting in the capacity of a title insurance agent shall not place title insurance business with a title insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, when both parties share responsibility for a particular function, specifies the division of such responsibilities subject to the requirements of subsections (2) through (16) of this section.

(2)(a) The title insurer may terminate the contract required under subsection (1) of this section upon written notice under the following circumstances:

(i) Fraud, insolvency, appointment of a receiver or conservator, bankruptcy, cancellation of the title insurance agent's license to do business, or the commencement of legal proceedings by the state of domicile of the title insurance agent which, if successful, would lead to cancellation of the title insurance agent's license to do business;

(ii) Material breach of any provision of the contract; or

(iii) Notice of cancellation provided in accordance with contract termination requirements.

(b) Upon notice of termination, the title insurance agent shall immediately discontinue all underwriting. Nothing in this subdivision is intended to relieve the title insurance agent or title insurer of any other contractual obligation.

(3) The title insurance agent shall render accounts to the title insurer detailing all transactions and remit all funds due under the contract required under subsection (1) of this section to the title insurer within the time specified by the underwriting contract.

(4) All funds collected for the account of a title insurer by a title insurance agent shall be held in a fiduciary capacity in a qualified financial institution.

(5) At the title insurer's request, the title insurance agent or its successor in interest, transferee, or receiver shall provide access to and the right to copy all escrow files and underwriting files involving a transaction in which a title insurance commitment or title insurance policy is or is to be issued.

(6) Separate records of title insurance business written by the title insurance agent shall be maintained for each title insurer. The title insurer shall have access to and a right to copy all accounts and records related to its business in a form acceptable to the title insurer. The director shall have access to all books, financial institution accounts, and records of the title insurance agent in a form usable to the director. The records shall be retained according to section 44-19,117.

(7) The contract required under subsection (1) of this section shall not be assigned in whole or in part by the title insurance agent without the express written consent of the title insurer.

(8) The contract required under subsection (1) of this section shall include appropriate guidelines relating to:

(a) The basis of the rates to be charged;

(b) The types of risks which may be written;

(c) Maximum limits of liability;

(d) Territorial limitations;

(e) Title searches and examinations; and

(f) Underwriting.

(9) It shall be the duty of the title insurance agent to immediately report and forward to the title insurer all title-related escrow claims and title claims reported to the title insurance agent by policyholders or other persons. However, if the contract required under subsection (1) of this section permits the title insurance agent to settle claims on behalf of the title insurer:

(a) A copy of the claim file shall be sent to the title insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount established by the title insurer;

(ii) Involves a coverage dispute;

(iii) May exceed the title insurance agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment exceeding an amount established by the title insurer;

(b) All title and title-related escrow claims files settled by the title insurance agent shall be the property of the title insurer; and

(c) Any settlement authority granted to the title insurance agent may be terminated immediately upon the title insurer's written notice to the title insurance agent or upon the termination of the contract. The title insurer may suspend the settlement authority during the pendency of a dispute regarding the cause for termination. Nothing in this subdivision is intended to relieve the title insurance agent or title insurer of any other contractual obligation.

(10) If electronic claims files are in existence, the contract required under subsection (1) of this section shall address the immediate transmission of the data.

(11) The title insurance agent shall not bind reinsurance or retrocessions on behalf of the title insurer.

(12) The contract required under subsection (1) of this section shall include specific terms of a title insurance agent's compensation.

(13) The title insurance agent shall maintain an inventory of all policy forms or policy numbers assigned to the agent by the title insurer.

(14) For each title insurance agent under contract with a title insurer, the title insurer shall have on file a statement of financial condition of each title insurance agent as of the end of the previous calendar year setting forth an income statement of title insurance business done during the preceding year and a balance sheet showing the condition of its affairs as of the prior December 31 certified by the title insurance agent as being a true and accurate representation of the title insurance agent's financial condition. Attorneys actively engaged in the practice of law, other than that related to title insurance business, are exempt from the requirements of this subsection.

(15) The title insurance agent shall annually, concurrent with the renewal date of its contract, furnish the title insurer with proof that the title insurance agent is in compliance with section 44-19,109.

(16) The title insurance agent shall provide the title insurer with access to and the right to copy all accounts and records maintained by the title insurance agent with respect to title insurance business placed with the title insurer.

Source: Laws 1997, LB 53, § 37; Laws 1999, LB 259, § 5.

44-19,115 Title insurance commitment; notice.

(1) When constituting an offer to issue an owner's title insurance policy covering the resale of owner-occupied residential property, a title insurance commitment shall be furnished to the purchaser-mortgagor or its representative as soon as reasonably possible prior to closing. If the title insurance commitment cannot be delivered prior to the day of closing, the title insurance agent shall document the reasons for the delay.

(2) A title insurance agent issuing a lender's title insurance policy in conjunction with a mortgage loan made simultaneously with the purchase of all or part of the real estate securing the loan, when no owner's title insurance policy has been requested, shall give written notice, on a form prescribed or approved by the director, to the purchaser-mortgagor at the time the title insurance commitment is prepared. The notice shall explain that a lender's title insurance policy is to be issued protecting the mortgage lender and that the lender's title insurance policy does not provide title insurance protection to the purchaser-mortgagor as the owner of the property being purchased. The notice shall explain what a title insurance policy insures against and what possible exposures exist for the purchaser-mortgagor that could be insured against through the purchase of an owner's title insurance policy. The notice shall also explain that the purchaser-mortgagor may obtain an owner's title insurance policy protecting the property owner at a specified cost or approximate cost if the proposed coverages or amount of title insurance is not then known. A copy of the notice, signed by the purchaser-mortgagor, shall be retained in the relevant underwriting file at least five years after the effective date of the lender's title insurance policy.

Source: Laws 1997, LB 53, § 38; Laws 1999, LB 259, § 6; Laws 2001, LB 360, § 12.

44-19,116 Conditions for providing escrow, security, settlement, or closing services and maintaining escrow and security deposit accounts.

(1)(a) A title insurance agent may operate as an escrow, security, settlement, or closing agent subject to the requirements of subdivisions (b) through (f) of this subsection.

(b) All funds deposited with the title insurance agent in connection with an escrow, settlement, closing, or security deposit shall be submitted for collection to or deposited in a separate fiduciary trust account or accounts in a qualified financial institution no later than the close of the next business day in accordance with the following requirements:

(i) The funds shall be the property of the person or persons entitled to them under the provisions of the escrow, settlement, security deposit, or closing agreement and shall be segregated for each depository by escrow, settlement, security deposit, or closing in the records of the title insurance agent in a manner that permits the funds to be identified on an individual basis; and

(ii) The funds shall be applied only in accordance with the terms of the individual instructions or agreements under which the funds were accepted.

(c) Funds held in an escrow account shall be disbursed only pursuant to a written instruction or agreement specifying how and to whom such funds may be disbursed.

(d) Funds held in a security deposit account shall be disbursed only pursuant to a written agreement specifying:

(i) What actions the indemnitor shall take to satisfy his or her obligation under the agreement;

(ii) The duties of the title insurance agent with respect to disposition of the funds held, including a requirement to maintain evidence of the disposition of the title exception before any balance may be paid over to the depositing party or his or her designee; and

(iii) Any other provisions the director may require.

(e)(i) Disbursements may be made out of an escrow, settlement, or closing account only if funds in an amount at least equal to the disbursement have first been received and if the funds received are in one of the following forms:

(A) Lawful money of the United States;

(B) Wired funds when unconditionally held by the title insurance agent;

(C) Cashier's checks, certified checks, bank money orders, or teller's checks issued by a federally insured financial institution and unconditionally held by the title insurance agent; and

(D) United States treasury checks, federal reserve bank checks, federal home loan bank checks, State of Nebraska warrants, and warrants of a city of the metropolitan or primary class.

(ii) For purposes of this subdivision, federally insured financial institution means an institution in which monetary deposits are insured by the Federal Deposit Insurance Corporation or National Credit Union Administration.

(f) A title insurance agent who holds funds relating to an exchange under section 1031 of the Internal Revenue Code shall provide written disclosure, at or before closing, to the person whose funds are being held, on a separate paper with no other information on the paper, which states that:

(i) Such services performed by a title insurance agent are not regulated by the Department of Banking and Finance, the Department of Insurance, or any other agency of the State of Nebraska or by any agency of the United States Government;

(ii) The safety and security of such funds is not guaranteed by any agency of the State of Nebraska or of the United States Government or otherwise protected by law; and

(iii) The owner of such funds should satisfy himself or herself as to the safety and security of such funds.

(2) If the title insurance agent is appointed by two or more title insurers and maintains fiduciary trust accounts in connection with providing escrow, closing, or settlement services, the title insurance agent shall allow each title insurer access to the accounts and any or all of the supporting account information in order to ascertain the safety and security of the funds held by the title insurance agent.

(3) Nothing in the Title Insurance Agent Act shall be deemed to prohibit the recording of documents prior to the time funds are available for disbursement with respect to a transaction if all parties consent to the transaction in writing.

(4) Nothing in this section is intended to amend, alter, or supersede other sections of the act or the laws of this state or the United States regarding an escrow holder's duties and obligations.

(5) The director may prescribe a standard agreement for escrow, settlement, closing, or security deposit funds.

Source: Laws 1997, LB 53, § 39; Laws 1999, LB 259, § 7; Laws 2002, LB 1139, § 21; Laws 2003, LB 216, § 10; Laws 2004, LB 155, § 4.

44-19,117 Record retention requirements.

The title insurance agent shall maintain sufficient records of its affairs, including its escrow operations and escrow trust accounts, so that the director may adequately ensure that the title insurance agent is in compliance with all provisions of the Title Insurance Agent Act. The director may prescribe the specific record entries and documents to be kept and the length of time for which the records must be maintained.

Source: Laws 1997, LB 53, § 40.

44-19,118 Application of other laws.

A title insurance agent shall be subject to all other applicable provisions of the insurance laws of this state unless specifically addressed by the Title Insurance Agent Act.

Source: Laws 1997, LB 53, § 41.

44-19,119 Rules and regulations.

The director may adopt and promulgate rules and regulations and issue orders as necessary to carry out the Title Insurance Agent Act.

Source: Laws 1997, LB 53, § 42.

44-19,120 Penalties and liabilities.

(1) If the director determines that a title insurance agent or any other person has violated the Title Insurance Agent Act or any rule or regulation adopted and promulgated pursuant to the act, after notice and opportunity to be heard, the director may order:

(a) A penalty not exceeding one thousand dollars for each violation; and

(b) Revocation or suspension of the title insurance agent's license.

(2) If an order of rehabilitation or liquidation of a title insurer has been entered pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, and the receiver appointed under that order determines that a title insurance agent or any other person has not complied with the Title Insurance Agent Act or any related rule, regulation, or order, and the title insurer suffered any resulting loss or damage, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the title insurer and its policyholders and creditors.

(3) Nothing in this section shall affect the right of the director to impose any other penalties provided for in the insurance laws of this state.

(4) Nothing in the act is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and creditors.

Source: Laws 1997, LB 53, § 43.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-19,120.01 Summary cease and desist order; authorized; procedure.

Whenever the director has reasonable cause to believe that a title insurance agent is violating the Title Insurance Agent Act or any rules and regulations adopted and promulgated thereunder, the director may, without notice, and before a hearing, issue a summary cease and desist order. At the same time the order is issued, the director shall serve notice to the title insurance agent of the reasons for such order and that the title insurance agent may request a hearing in writing within ten business days after receipt of the order. If a hearing is requested, the director shall schedule a hearing within ten business days after receipt of the request. The hearing shall be conducted in accordance with the Administrative Procedure Act. If a hearing is not requested and none is ordered by the director, the order shall remain in effect until modified or vacated by the director. Any title insurance agent aggrieved by a final order of the director may appeal the order. The appeal shall be in accordance with the Administrative Procedure Act. In the event of noncompliance with a summary cease and desist order, the director may cause a complaint to be filed in the district court to enforce the order.

Source: Laws 2004, LB 155, § 5.

Cross References

Administrative Procedure Act, see section 84-920.

44-19,121 Unfair trade practice.

In addition to any other remedies available under the laws of this state, each violation of the Title Insurance Agent Act and any rules and regulations adopted and promulgated thereunder shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 1997, LB 53, § 44.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-19,122 Violations of Real Estate Settlement Procedures Act of 1974.

The director or Attorney General may bring an action in a court of competent jurisdiction to enjoin violations of the federal Real Estate Settlement Procedures Act of 1974, 12 U.S.C. 2601.

Source: Laws 1997, LB 53, § 45.

44-19,123 Applicability of act.

The Title Insurance Agent Act applies to all activities or agreements of a title insurance agent engaged in or entered into on or after September 13, 1997. The title insurance agent shall amend all existing agreements to comply with section 44-19,114 within sixty days after September 13, 1997.

Source: Laws 1997, LB 53, § 46.

ARTICLE 20

UNAUTHORIZED INSURERS

(a) UNAUTHORIZED INSURERS ACT

Section
44-2001. Act; purpose.

Section

(b) UNAUTHORIZED INSURERS PROCESS ACT

(a) UNAUTHORIZED INSURERS ACT

44-2001 Act; purpose.

The purpose of the Unauthorized Insurers Act is to subject certain insurers to the jurisdiction of the Department of Insurance and the courts of this state in administrative proceedings and in suits by or on behalf of the state. The Legislature declares that it is concerned with the protection of residents of this state against acts by insurers not authorized to do an insurance business in this state, by the maintenance of fair and honest insurance markets, by protecting authorized insurers which are subject to regulation from unfair competition by unauthorized insurers, and by protecting against the evasion of the insurance regulatory laws of this state. In furtherance of such state interest, the Legislature exercises its powers to protect residents of this state and to define what constitutes transacting an insurance business in this state and also exercises powers and privileges available to this state by virtue of Public Law 79-15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, 59 Stat. 33; 15 U.S.C. 1011 to 1015 inclusive, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

Source: Laws 1969, c. 351, § 1, p. 1222; Laws 1983, LB 447, § 64; Laws 1995, LB 162, § 3.

44-2002 Certificate of authority; required; exceptions.

(1) It shall be unlawful for any insurer to transact insurance business in this state, as set forth in subsection (2) of this section, without a certificate of authority from the director. This section shall not apply to:

(a) The lawful transaction of surplus lines insurance;

(b) The lawful transaction of reinsurance by insurers;

(c) Transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy;

(d) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses;

(e) Transactions in this state involving group life and group sickness and accident or blanket sickness and accident insurance or group annuities when

the master policy of such groups was lawfully issued and delivered in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and when the policyholder is domiciled or otherwise has a bona fide situs; or

(f) Transactions in this state relative to a policy issued or to be issued outside this state involving insurance on vessels, craft or hulls, cargoes, marine builder's risk, marine protection, and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy.

(2) Any of the following acts in this state effected by mail or otherwise by or on behalf of an unauthorized insurer shall constitute the transaction of an insurance business in this state. The venue of an act committed by mail shall be at the point where the matter transmitted by mail is delivered and takes effect. For purposes of this section, unless the context otherwise requires, insurer shall include all corporations, associations, partnerships, and individuals engaged as principals in the business of insurance and shall also include interinsurance exchanges and mutual benefit societies:

(a) The making of or proposing to make, as an insurer, an insurance contract;

(b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(c) The taking or receiving of any application for insurance;

(d) The receiving or collection of any premium, commission, membership fees, assessments, dues, or other consideration for any insurance or any part thereof;

(e) The issuance or delivery of contracts of insurance to residents of this state or to persons authorized to do business in this state;

(f) Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state. This subsection shall not operate to prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of such employer;

(g) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance; or

(h) The transacting or proposing to transact any insurance business in substance equivalent to any of the provisions of subdivisions (a) through (g) of this subsection in a manner designed to evade the provisions of the statutes.

(3)(a) The failure of an insurer transacting insurance business in this state to obtain a certificate of authority shall not impair the validity of any act or contract of such insurer and shall not prevent such insurer from defending any action at law or suit in equity in any court of this state, but no insurer

transacting insurance business in this state without a certificate of authority shall be permitted to maintain an action in any court of this state to enforce any right, claim, or demand arising out of the transaction of such business until such insurer shall have obtained a certificate of authority.

(b) In the event of failure of any such unauthorized insurer to pay any claim or loss within the provisions of any insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of such insurance contract shall be liable to the insured for the full amount of the claim or loss in the manner provided by the provisions of such insurance contract.

Source: Laws 1969, c. 351, § 2, p. 1223; Laws 1986, LB 811, § 21; Laws 1989, LB 92, § 187; Laws 1989, LB 279, § 1; Laws 1994, LB 978, § 27.

44-2003 Certificate of authority; failure to procure; violation; injunction; cease and desist order; appeal.

(1) Whenever the Director of Insurance believes, from evidence satisfactory to him or her, that any insurer is violating or about to violate section 44-2002, the director may, through the Attorney General, cause a complaint to be filed in the district court to enjoin and restrain such insurer from continuing such violation or engaging therein or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order or judgment awarding such preliminary or final injunctive relief as in its judgment is proper.

(2) Whenever the Director of Insurance believes that any insurer is violating or about to violate section 44-2002, the director may, without notice, and before a hearing, issue a summary cease and desist order. At the same time the order is issued, the director shall serve notice to the insurer of the reasons for such order and that the insurer may request a hearing in writing within ten business days after receipt of the order. If a hearing is requested, the director shall schedule a hearing within ten business days after receipt of the request. The hearing shall be conducted in accordance with the Administrative Procedure Act. If a hearing is not requested and none is ordered by the director, the order shall remain in effect until modified or vacated by the director. Any insurer aggrieved by a final order of the director may appeal the order. The appeal shall be in accordance with the Administrative Procedure Act. In the event of noncompliance with a summary cease and desist order, the director may, through the Attorney General, cause a complaint to be filed in the district court to enforce the order. For purposes of this subsection, insurer shall include a person or other entity.

Source: Laws 1969, c. 351, § 3, p. 1226; Laws 1995, LB 162, § 4.

Cross References

Administrative Procedure Act, see section 84-920.

44-2004 Personal jurisdiction.

Any act of transacting an insurance business as set forth in section 44-2002 by any unauthorized insurer shall constitute sufficient contact with this state for the exercise of personal jurisdiction over such insurer in any action, suit, or proceeding in any court by the Director of Insurance or by the state or in any

proceeding before the director and which arises out of transacting an insurance business in this state by such insurer.

Source: Laws 1969, c. 351, § 4, p. 1226; Laws 1983, LB 447, § 65.

44-2005 Unauthorized insurer; court action; requirements.

(1) Before any unauthorized insurer files or causes to be filed any pleading or other response in any court action, suit, or proceeding or in any such administrative proceeding before the Director of Insurance instituted against such person or insurer, by services made as provided in section 44-2004, such insurer shall either:

(a) Deposit with the clerk of the court in which such action, suit, or proceeding is pending, or with the Director of Insurance in administrative proceedings before the director, cash or securities, or file with such clerk of the court or director a bond with good and sufficient sureties, to be approved by the clerk or director in an amount to be fixed by the court or director sufficient to secure the payment of any final judgment which may be rendered in such action or administrative proceeding; or

(b) Procure a certificate of authority to transact the business of insurance in this state. In considering the application of an insurer for a certificate of authority, for the purposes of this subsection, the Director of Insurance need not assert the provisions of Chapter 44, against such insurer with respect to its application if he determines that such company would otherwise comply with the requirements for such certificate of authority.

(2) The Director of Insurance, in any administrative proceeding in which service is made as provided in section 44-2004, may in his discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (1) of this section and to defend such action.

(3) Nothing in subsection (1) of this section shall be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in section 44-2004, on the ground that such unauthorized insurer has not done any of the acts enumerated in section 44-2002.

Source: Laws 1969, c. 351, § 5, p. 1228.

44-2006 Attorney General; powers; terms, defined.

The Attorney General upon request of the Director of Insurance may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the director.

(1) As used in this section:

(a) Reciprocal state shall mean any state or territory of the United States the laws of which contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders in equity issued by courts located in other states or territories of the United States against any insurer incorporated or authorized to do business in such state or territory;

(b) Foreign decree shall mean any decree or order in equity of a court located in a reciprocal state, including a court of the United States located in such

reciprocal state, against any insurer incorporated or authorized to do business in this state; and

(c) Qualified party shall mean a state regulatory agency acting in its capacity to enforce the insurance laws of its state.

(2) The Director of Insurance shall determine which states and territories qualify as reciprocal states and shall maintain at all times an up-to-date list of such states.

(3) A copy of any foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any district court of this state. The clerk shall record the foreign decree in the same manner as a decree of a district court of this state. A foreign decree so filed shall have the same effect and shall be deemed as a decree of a district court of this state, shall be subject to the same procedures, defenses, and proceedings for reopening, vacating, or staying as a decree of a district court of this state, and may be enforced or satisfied in like manner.

(4)(a) At the time of the filing of the foreign decree, the Attorney General shall make and file with the clerk of the court an affidavit setting forth the name and last-known post office address of the defendant.

(b) Promptly upon the filing of the foreign decree and the affidavit, the clerk of the court shall mail notice of the filing of the foreign decree to the defendant at the address given and to the Director of Insurance and shall file notice of the mailing on the record. In addition, the Attorney General may mail a notice of the filing of the foreign decree to the defendant and to the Director of Insurance and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the Attorney General has been filed.

(c) No execution or other process for enforcement of a foreign decree filed under this section shall issue until thirty days after the date the decree is filed.

(5)(a) If the defendant shows the district court that an appeal from the foreign decree is pending or will be taken or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(b) If the defendant shows the district court any ground upon which enforcement of a decree of any district court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.

(6) Any person filing a foreign decree shall pay to the clerk of the district court the docket fee established in section 33-106. Fees for transcribing or other enforcement proceedings shall be as provided for decrees of the district court.

Source: Laws 1969, c. 351, § 6, p. 1229; Laws 1989, LB 279, § 2; Laws 2018, LB193, § 82.

44-2007 Violations; penalty.

Any unauthorized insurer who transacts any unauthorized act of an insurance business as set forth in sections 44-2001 to 44-2008 shall be guilty of a Class I misdemeanor.

Source: Laws 1969, c. 351, § 7, p. 1231; Laws 1977, LB 40, § 247.

44-2008 Act, how cited.

Sections 44-2001 to 44-2008 shall be known and may be cited as the Unauthorized Insurers Act.

Source: Laws 1969, c. 351, § 8, p. 1231; Laws 1989, LB 92, § 188; Laws 1993, LB 583, § 82.

(b) UNAUTHORIZED INSURERS PROCESS ACT

44-2009 Act, how cited.

Sections 44-2009 to 44-2013 shall be known and may be cited as the Unauthorized Insurers Process Act.

Source: Laws 1949, c. 134, § 7, p. 353; R.S.1943, (1988), § 44-137.10; Laws 1989, LB 92, § 27.

44-2010 Act; legislative purpose.

The purpose of the Unauthorized Insurers Process Act is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts. The Legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while such insurers are not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interest, the Legislature exercises its power to protect its residents.

Source: Laws 1949, c. 134, § 1, p. 350; Laws 1983, LB 447, § 54; R.S.1943, (1988), § 44-137.01; Laws 1989, LB 92, § 25.

Purpose of this act, entitled Unauthorized Insurers Process Act (§§ 44-137.01 through 44-137.10), is to protect residents of this state from having to resort to distant forums to assert legal rights; act is constitutional. Abel v. Southwest Cas. Ins. Co., 182 Neb. 605, 156 N.W.2d 166 (1968).

44-2011 Unauthorized insurers; personal jurisdiction.

Any of the following systematic or continuous acts in this state, effected by mail or otherwise, by an unauthorized foreign or alien insurer: (1) The issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein, (2) the solicitation of applications for such contracts, (3) the collection of premiums, membership fees, assessments, or other considerations for such contracts, (4) the investigation or payment of claims, or (5) any other transaction of business shall constitute sufficient contact with this state for the exercise of personal jurisdiction over such foreign or alien insurer in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such activities.

Source: Laws 1949, c. 134, § 2, p. 350; Laws 1983, LB 447, § 55; R.S.1943, (1988), § 44-137.02.

Conditions of this section met where contractor, with insurer's authorization, included general guaranty bond in individual construction contracts which were solicited in this state. Abel v. Southwest Cas. Ins. Co., 182 Neb. 605, 156 N.W.2d 166 (1968).

44-2012 Action; attorney fee; allowance.

In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twelve and one-half percent of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than twenty-five dollars. Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

Source: Laws 1949, c. 134, § 4, p. 352; R.S.1943, (1988), § 44-137.07.

44-2013 Act; applicability.

The Unauthorized Insurers Process Act shall not apply to any action, suit, or proceeding against any nonadmitted foreign or alien insurer arising out of any contract of insurance (1) effected in accordance with the Surplus Lines Insurance Act, (2) covering reinsurance, ocean marine, aircraft, or railway insurance risks, (3) against legal liability arising out of the ownership, operation, or maintenance of any property having a permanent situs outside this state, or (4) against loss of or damage to any property having a permanent situs outside this state, when such contract of insurance contains a provision designating a Nebraska resident agent duly licensed under the Surplus Lines Insurance Act to be the true and lawful attorney of such nonadmitted insurer upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance or when the insurer enters a general appearance in any action, suit, or proceeding.

Source: Laws 1949, c. 134, § 5, p. 353; Laws 1969, c. 359, § 6, p. 1270; Laws 1969, c. 360, § 2, p. 1283; Laws 1983, LB 447, § 56; R.S.1943, (1988), § 44-137.08; Laws 1989, LB 92, § 26; Laws 1992, LB 1006, § 17.

Cross References

Surplus Lines Insurance Act, see section 44-5501.

ARTICLE 21
HOLDING COMPANIES

Section
44-2101. Repealed. Laws 1991, LB 236, § 89.
44-2102. Repealed. Laws 1991, LB 236, § 89.
44-2103. Repealed. Laws 1991, LB 236, § 89.
44-2104. Repealed. Laws 1991, LB 236, § 89.
44-2105. Repealed. Laws 1991, LB 236, § 89.
44-2106. Repealed. Laws 1991, LB 236, § 89.

Section

44-2101 Repealed. Laws 1991, LB 236, § 89.

44-2102 Repealed. Laws 1991, LB 236, § 89.

44-2103 Repealed. Laws 1991, LB 236, § 89.

44-2104 Repealed. Laws 1991, LB 236, § 89.

44-2105 Repealed. Laws 1991, LB 236, § 89.

44-2106 Repealed. Laws 1991, LB 236, § 89.

44-2107 Repealed. Laws 1991, LB 236, § 89.

44-2108 Repealed. Laws 1991, LB 236, § 89.

44-2109 Repealed. Laws 1991, LB 236, § 89.

44-2110 Repealed. Laws 1991, LB 236, § 89.

44-2111 Repealed. Laws 1991, LB 236, § 89.

44-2112 Repealed. Laws 1991, LB 236, § 89.

44-2113 Repealed. Laws 1991, LB 236, § 89.

44-2114 Repealed. Laws 1991, LB 236, § 89.

44-2115 Repealed. Laws 1991, LB 236, § 89.

44-2116 Repealed. Laws 1991, LB 236, § 89.

44-2117 Repealed. Laws 1991, LB 236, § 89.

44-2118 Repealed. Laws 1991, LB 236, § 89.

44-2119 Repealed. Laws 1991, LB 236, § 89.

44-2120 Act, how cited.

Sections 44-2120 to 44-2155 shall be known and may be cited as the Insurance Holding Company System Act.

Source: Laws 1991, LB 236, § 1; Laws 2012, LB887, § 3; Laws 2016, LB772, § 10.

44-2121 Terms, defined.

For purposes of the Insurance Holding Company System Act:

(1) An affiliate of, or person affiliated with, a specific person means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified;

(2) Control, including controlling, controlled by, and under common control with, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection (11) of section 44-2132 that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific

findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

(3) Director means the Director of Insurance;

(4) Enterprise risk means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in section 44-6011 or would cause the insurer to be in hazardous financial condition as defined by rule and regulation adopted and promulgated by the director to define standards for companies deemed to be in hazardous financial condition;

(5) Group-wide supervisor means the chief insurance regulatory official, including the director, who (a) is authorized to conduct and coordinate group-wide supervision activities of an international insurance group and (b) is from the jurisdiction determined or acknowledged by the director under section 44-2155 to have sufficient contacts with the international insurance group;

(6) An insurance holding company system shall consist of two or more affiliated persons, one or more of which is an insurer;

(7) Insurer has the same meaning as in section 44-103, except that insurer does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(8) International insurance group means an insurance holding company system that has been determined by the director to be an international insurance group under section 44-2154;

(9) Person means an individual, a corporation, a partnership, a limited partnership, an association, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of such entities acting in concert but does not include any joint-venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property;

(10) Security holder of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any such stock or obligations;

(11) Subsidiary of a specified person means an affiliate controlled by such person directly or indirectly through one or more intermediaries; and

(12) Voting security includes any security convertible into or evidencing a right to acquire a voting security.

Source: Laws 1991, LB 236, § 2; Laws 2001, LB 360, § 13; Laws 2012, LB887, § 4; Laws 2016, LB772, § 11.

The purpose of the Insurance Holding Company System Act is to protect policyholders by probing the competence of those seeking to control insurance companies. The Insurance Holding Company System Act applies equally, regardless of whether the would-be acquiring party is a Nebraska resident, and as such does not resemble the principal objects of dormant Commerce Clause scrutiny, which are statutes that discriminate against interstate commerce. The Insurance Holding Company System Act poses no threat of inconsistent regulations, because it regulates only the internal affairs of insurers registered in this state and thus survives scrutiny under the Commerce Clause. CenTra, Inc. v. Chandler Ins. Co., 248 Neb. 844, 540 N.W.2d 318 (1995).

44-2122 Subsidiaries of insurers; authorized.

In addition to the authority granted in Chapter 44, any domestic insurer, either by itself or in cooperation with one or more persons, may, subject to the

limitations set forth in the Insurance Holding Company System Act, organize or acquire one or more subsidiaries engaged in the following kinds of business:

(1) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(2) Acting as an insurance broker or as an insurance agent for its parent or for any subsidiaries of its parent which are insurers;

(3) Investing, reinvesting, or trading in securities for its own account or that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

(4) Management of any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

(5) Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

(6) Rendering investment advice to governments, government agencies, corporations, or other organizations or groups;

(7) Rendering other services related to the operations of an insurance business, including actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal, and collection services;

(8) Ownership and management of assets which the parent could itself own or manage. The aggregate investment by the insurer and its subsidiaries acquired or organized pursuant to this section shall not exceed the limitations applicable to such investments by the insurer;

(9) Acting as administrative agent for a governmental instrumentality which is performing an insurance function;

(10) Financing of insurance premiums, agents, and other forms of consumer financing;

(11) Any other business activity determined by the director to be reasonably ancillary to an insurance business; or

(12) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

Source: Laws 1991, LB 236, § 3.

44-2123 Additional investments authorized.

In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under Chapter 44, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of five percent of such insurer's assets or fifty percent of such insurer's policyholders surplus if, after such investments, the insurer's policyholders surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries shall be excluded and there shall be included:

(a) Total net funds or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or

not represented by the purchase of capital stock or issuance of other securities; and

(b) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

(2) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each such subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subdivision (1) of this section or in Chapter 44 applicable to the insurer. For purposes of this subdivision, the total investment of the insurer shall include:

(a) Any direct investment by the insurer in an asset; and

(b) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which share shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of such subsidiary; and

(3) With the approval of the director, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries if after such investment the insurer's policyholders surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

Source: Laws 1991, LB 236, § 4; Laws 1993, LB 583, § 83.

44-2124 Additional investments; qualification; when determined.

Whether any investment pursuant to section 44-2123 meets the applicable requirements thereof shall be determined before such investment is made by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

Source: Laws 1991, LB 236, § 5.

44-2125 Investments in subsidiary; disposal; when.

If an insurer ceases to control a subsidiary, it shall dispose of any investment made in the subsidiary pursuant to sections 44-2122 to 44-2124 within three years from the time of the cessation of control or within such further time as the director may prescribe unless, at any time after such investment has been made, such investment has met the requirements for investment under any other provision of Chapter 44 and the insurer has notified the director thereof.

Source: Laws 1991, LB 236, § 6.

44-2126 Acquisition of control of or merger with domestic insurer; notice of proposed divestiture; filing requirements; director; powers.

(1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities

for, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of such insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the director and has sent to such insurer, a statement containing the information required by this section and such offer, request, invitation, agreement, or acquisition has been approved by the director in the manner prescribed in section 44-2127.

(2) For purposes of this section, any controlling person of a domestic insurer seeking to divest his, her, or its controlling interest in the domestic insurer, in any manner, shall file with the director, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty days prior to the cessation of control. The director shall determine those instances in which the party or parties seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the director, in his or her discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in subsection (1) of this section is otherwise filed, this subsection shall not apply.

(3) For purposes of this section, a domestic insurer includes any person controlling a domestic insurer unless such person as determined by the director is either directly or through its affiliates primarily engaged in business other than the business of insurance. For purposes of this section, person does not include any securities broker holding, in the usual and customary brokers function, less than twenty percent of the voting securities of an insurance company or of any person which controls an insurance company.

(4) The statement required to be filed with the director under subsection (1) of this section shall be made under oath and shall contain the following:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) of this section is to be effected and either:

(i) If such person is an individual, his or her principal occupation, all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years; or

(ii) If such person is not an individual, a report of the nature of its business operations during the past five years or for such lesser period as such person and any predecessors thereof have been in existence, an informative description of the business intended to be done by such person and such person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of such person or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subdivision (i) of this subdivision;

(b) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction in which funds were or are to be obtained for any such purpose, including any pledge of the insurer's stock or the stock of any of its subsidiaries

or controlling affiliates, and the identity of persons furnishing such consideration, except that when a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing such statement so requests;

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each such acquiring party or for such lesser period as such acquiring party and any predecessors thereof have been in existence and similar unaudited information as of a date not earlier than ninety days prior to the filing of the statement;

(d) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(e) The number of shares of any security referred to in subsection (1) of this section which each acquiring party proposes to acquire, the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (1) of this section, and a statement as to the method by which the fairness of the proposal was arrived at;

(f) The amount of each class of any security referred to in subsection (1) of this section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (1) of this section in which any acquiring party is involved, including transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss, guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been entered into;

(h) A description of the purchase of any security referred to in subsection (1) of this section during the twelve calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor;

(i) A description of any recommendations to purchase any security referred to in subsection (1) of this section made during the twelve calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of such acquiring party;

(j) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) of this section and, if distributed, of additional soliciting material relating thereto;

(k) The term of any agreement, contract, or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (1) of this section for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto;

(l) An agreement by the person required to file the statement referred to in subsection (1) of this section that he, she, or it will provide the annual report specified in subsection (12) of section 44-2132 for as long as control exists;

(m) An acknowledgment by the person required to file the statement referred to in subsection (1) of this section that the person and all subsidiaries within his, her, or its control in the insurance holding company system will provide information to the director upon request as necessary to evaluate enterprise risk to the insurer; and

(n) Such additional information as the director may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(5) If the person required to file the statement is a partnership, limited partnership, syndicate, or other group, the director may require that the information called for by subsection (4) of this section shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group, and each person who controls such partner or member. If any such partner, member, or person is a corporation or the person required to file the statement is a corporation, the director may require that the information called for by subsection (4) of this section shall be given with respect to such corporation, each officer and director of such corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of such corporation.

(6) If any material change occurs in the facts set forth in the statement filed with the director and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the director and sent to such insurer within two business days after the person learns of such change.

(7) If any offer, request, invitation, agreement, or acquisition referred to in subsection (1) of this section is proposed to be made by means of a registration statement under the Securities Act of 1933, in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement may utilize such documents in furnishing the information called for by the statement.

Source: Laws 1991, LB 236, § 7; Laws 2012, LB887, § 5.

The Insurance Holding Company System Act affords the Director of Insurance a chance to review the financial stability of an acquiring company so that the director can determine whether acquisition is in the best interests of state policyholders. CenTra, Inc. v. Chandler Ins. Co., 248 Neb. 844, 540 N.W.2d 318 (1995).

44-2127 Merger; acquisition; approval by director; hearings; experts.

(1) The director shall approve any merger or other acquisition of control referred to in subsection (1) of section 44-2126 unless, after a public hearing thereon, he or she finds that:

(a) After the change of control, the domestic insurer would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein;

(c) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of policyholders of the insurer;

(d) The plans or proposals which the acquiring party has to liquidate the insurer, to sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure of management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(e) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control;

(f) To the extent required under section 44-6115, an acquisition has not been approved by the director; or

(g) The acquisition is likely to be hazardous or prejudicial to the public.

(2) Except as provided in subsection (3) of this section, the public hearing referred to in subsection (1) of this section shall be held within thirty days after the statement required by subsection (1) of section 44-2126 is filed, and at least twenty days' notice thereof shall be given by the director to the person filing the statement. Not less than seven days' notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the director. The director shall make a determination within the sixty-day period preceding the effective date of the proposed transaction. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the district court. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control will require the approval of more than one director or commissioner of insurance, the public hearing required by this section may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (1) of section 44-2126. Such person shall file the statement with the National Association of Insurance Commissioners within five days after making the request for a public hearing. A director or commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt out within ten days after the receipt of the statement. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the directors or commissioners of the states in which the insurers are domiciled. Such directors or commissioners shall hear and receive evidence. A director or commissioner may attend such hearing in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the director that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws, rules, and regulations of this state shall be made not later than sixty days after the date of the director's determination. The director may retain at the acquiring person's expense any attorneys, actuaries, accountants, and other experts who are not employees of the Department of Insurance as

may be reasonably necessary to assist the director in reviewing the proposed acquisition of control.

Source: Laws 1991, LB 236, § 8; Laws 1997, LB 52, § 3; Laws 2002, LB 1139, § 22; Laws 2012, LB887, § 6.

44-2128 Merger; acquisition; exempt transactions.

Section 44-2126 shall not apply to:

(1) Any transaction which is subject to the provisions of the Nebraska Model Business Corporation Act and sections 44-224.01 to 44-224.10, except as otherwise provided in Chapter 44, dealing with the merger or consolidation of two or more insurers; or

(2) Any offer, request, invitation, agreement, or acquisition which the director by order shall exempt therefrom as (a) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer or (b) otherwise not comprehended within the purposes of section 44-2126.

Source: Laws 1991, LB 236, § 9; Laws 1995, LB 109, § 221; Laws 2014, LB749, § 287.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-2129 Acquisition; divestiture; merger; prohibited acts.

(1) It shall be a violation of section 44-2126 to fail to file any statement, amendment, or other material required to be filed under such section.

(2) It shall be a violation of section 44-2127 to effectuate or attempt to effectuate an acquisition of control of, divestiture of, or merger with a domestic insurer unless the director has given his or her approval thereto.

Source: Laws 1991, LB 236, § 10; Laws 2012, LB887, § 7.

44-2130 Merger; acquisition; jurisdiction; consent to service of process.

The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the director under section 44-2126 and over all actions involving such person arising out of violations of section 44-2126 or 44-2127, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the director to be such person's attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of such sections. Copies of all such lawful process shall be served on the director and transmitted by registered or certified mail by the director to such person at his or her last-known address.

Source: Laws 1991, LB 236, § 11.

44-2131 Fees.

The total fee for filing the documents required by sections 44-2126 to 44-2130 and all amendments to such filings shall be one thousand dollars. The initial fee for registration required by the provisions of section 44-2132 shall be one thousand dollars, and an additional fee of two hundred dollars shall be payable on May 1 of each calendar year thereafter so long as such registration

continues. The fees provided for by this section shall be payable to the Department of Insurance and shall be remitted to the State Treasurer for credit to the Department of Insurance Cash Fund.

Source: Laws 1991, LB 236, § 34; Laws 1993, LB 583, § 84; Laws 2005, LB 119, § 10.

44-2132 Registration of insurers; filings required.

(1) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the director, except that registration shall not be required for a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section, subsection (1) of section 44-2133, sections 44-2134 and 44-2136, and either subsection (2) of section 44-2133 or a provision such as the following: Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen days after the end of the month in which it learns of each such change or addition. Any insurer which is subject to registration under this section shall register within fifteen days after it becomes subject to registration and annually thereafter by May 1 of each year for the previous calendar year unless the director for good cause shown extends the time for such initial or annual registration and then within such extended time. The director may require any insurer which is authorized to do business in the state, which is a member of an insurance holding company system, and which is not subject to registration under this section to furnish a copy of the registration statement, the summary specified in subsection (3) of this section, or other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(2) Every insurer subject to registration shall file the registration statement with the director on a form and in a format prescribed by the National Association of Insurance Commissioners which shall contain the following current information:

(a) The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(b) The identity and relationship of every member of the insurance holding company system;

(c) The following agreements in force and transactions currently outstanding or which have occurred during the last calendar year between such insurer and its affiliates:

(i) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) Purchases, sales, or exchanges of assets;

(iii) Transactions not in the ordinary course of business;

(iv) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) All management agreements, service contracts, and cost-sharing arrangements;

(vi) Reinsurance agreements;

(vii) Dividends and other distributions to shareholders; and

(viii) Consolidated tax allocation agreements;

(d) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) If requested by the director, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this subdivision may satisfy the request by providing the director with the most recently filed parent corporation financial statements that have been filed with the Securities and Exchange Commission;

(f) Statements that show that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures;

(g) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the director; and

(h) Any other information required by rules and regulations which the director may adopt and promulgate.

(3) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(4) It shall not be necessary to disclose on the registration statement information which is not material for the purposes of this section. Unless the director by rule, regulation, or order provides otherwise, sales, purchases, exchanges, loans, or extensions of credit, investments, or guarantees involving one-half of one percent or less of an insurer's admitted assets as of December 31 next preceding shall not be deemed material for purposes of this section.

(5) Subject to the requirements of section 44-2134, each registered insurer shall give notice to the director of all dividends and other distributions to shareholders within five business days following the declaration thereof and shall not pay any such dividends or other distributions to shareholders within ten business days following receipt of such notice by the director unless for good cause shown the director has approved such payment within such ten-business-day period.

(6) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer when such information is reasonably necessary to enable the insurer to comply with the Insurance Holding Company System Act.

(7) The director shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(8) The director may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement.

(9) The director may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) of this section and to file all information and material required to be filed under this section.

(10) This section shall not apply to any insurer, information, or transaction if and to the extent that the director by rule, regulation, or order exempts the same from this section.

(11) Any person may file with the director a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the director, within thirty days after receipt of a complete disclaimer, notifies the filing party that the disclaimer is disallowed. If the disclaimer is disallowed, the disclaiming party may request and shall be entitled to an administrative hearing. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the director or if the disclaimer is deemed to have been approved.

(12) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state director or commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(13) The failure to file a registration statement or any summary of the registration statement thereto or enterprise risk report required by this section within the time specified for such filing shall be a violation of this section.

Source: Laws 1991, LB 236, § 12; Laws 1996, LB 689, § 2; Laws 2005, LB 119, § 11; Laws 2012, LB887, § 8.

44-2133 Transactions within an insurance holding company system; standards.

(1) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost-sharing services and management shall include such provisions as are required by rules and regulations which the director may adopt and promulgate;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and

details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(f) The insurer's policyholders surplus following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section which are subject to any materiality standards contained in subdivisions (2)(a) through (e) of this section, shall not be entered into unless the insurer has notified the director in writing of its intention to enter into such transaction at least thirty days prior thereto or such shorter period as the director may permit and the director has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty days after a termination of a previously filed agreement, to the director for determination of the type of filing required, if any:

(a) Sales, purchases, exchanges, loans, or extensions of credit, guarantees, or investments if such transactions are equal to or exceed (i) with respect to an insurer other than a life insurer, the lesser of three percent of the insurer's admitted assets or twenty-five percent of policyholders surplus as of December 31 next preceding and (ii) with respect to life insurers, three percent of the insurer's admitted assets as of December 31 next preceding;

(b) Loans or extensions of credit to any person who is not an affiliate, when the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in any affiliate of the insurer making such loans or extensions of credit if such transactions are equal to or exceed (i) with respect to an insurer other than a life insurer, the lesser of three percent of the insurer's admitted assets or twenty-five percent of policyholders surplus as of December 31 next preceding and (ii) with respect to life insurers, three percent of the insurer's admitted assets as of December 31 next preceding;

(c) Reinsurance agreements or modifications thereto, including (i) all reinsurance pooling agreements and (ii) agreements in which the reinsurance premium or a change in the insurer's liabilities or the projected reinsurance premium or change in the insurer's liabilities in any of the next three years equals or exceeds five percent of the insurer's policyholders surplus as of December 31 next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements, service contracts, tax-allocation agreements, and cost-sharing arrangements; and

(e) Any material transactions, specified by rule and regulation, which the director determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the director determines that such separate transactions were entered into over any twelve-month period for such purpose, the director may exercise his or her authority under sections 44-2143 to 44-2147.

(4) The director, in reviewing transactions pursuant to subsection (2) of this section, shall consider whether the transactions comply with the standards set forth in subsection (1) of this section and whether they may adversely affect the interests of policyholders.

(5) The director shall be notified within thirty days of any investment of the domestic insurer in any one corporation if the total investment in such corporation by the insurance holding company system exceeds ten percent of such corporation's voting securities.

Source: Laws 1991, LB 236, § 13; Laws 2012, LB887, § 9.

44-2134 Extraordinary dividends and distributions.

(1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until (a) thirty days after the director has received notice of the declaration thereof and the director has not within such period disapproved such payment or (b) the director has approved such payment within such thirty-day period.

(2) For purposes of this section, an extraordinary dividend or distribution shall include any dividend or distribution of cash or other property the fair market value of which together with that of other dividends or distributions made within the preceding twelve months exceeds the greater of (a) ten percent of such insurer's policyholders surplus as of December 31 next preceding or (b) the net gain from operations of such insurer if such insurer is a life insurer or the net income if such insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending December 31 next preceding but shall not include pro rata distributions of any class of the insurer's own securities. In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carryforward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(3) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the director's approval thereof, and such a declaration shall confer no rights upon shareholders until (a) the director has approved the payment of such a dividend or distribution or (b) the director has not disapproved such payment within the thirty-day period referred to in subsection (1) of this section.

Source: Laws 1991, LB 236, § 14; Laws 1996, LB 689, § 3.

44-2135 Management of domestic insurer.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with the Insurance Holding Company System Act.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property, or services with one or more other persons under arrangements meeting the standards of subsection (1) of section 44-2133.

(3) Not less than one-third of the directors of a domestic insurer which is a member of an insurance holding company system shall be persons who are not officers or employees of such insurer or of any entity controlling, controlled by, or under common control with such insurer and who are not beneficial owners of a controlling interest in the voting stock of such insurer or any such entity. At least one such person shall be included in any quorum for the transaction of business at any meeting of the board of directors.

(4) Subsection (3) of this section shall not apply to a domestic insurer if the person controlling such insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors that meets the requirements of such subsection with respect to such controlling entity.

(5) An insurer may make application to the director for a waiver from the requirements of this section if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and the national flood insurance program as defined in section 31-1014, is less than three hundred million dollars. An insurer may also make application to the director for a waiver from the requirements of this section based upon unique circumstances. The director may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or ownership or organizational structure of the entity.

Source: Laws 1991, LB 236, § 15; Laws 2012, LB887, § 10.

44-2136 Adequacy of surplus; factors.

For purposes of the Insurance Holding Company System Act, in determining whether an insurer's policyholders surplus is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among the several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification, and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's investment portfolio;

(8) The policyholders surplus maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves; and

(10) The quality and liquidity of investments in affiliates. The director may treat any such investment as a disallowed asset for purposes of determining the adequacy of policyholders surplus whenever in his or her judgment such investment so warrants.

Source: Laws 1991, LB 236, § 16.

44-2137 Examination by director; director; powers; penalty.

(1)(a) Subject to the limitation contained in this section and in addition to the powers which the director has under the Insurers Examination Act relating to the examination of insurers, the director may examine any insurer registered under section 44-2132 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(b) The director may order any insurer registered under section 44-2132 to produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with Chapter 44.

(c) To determine compliance with Chapter 44, the director may order any insurer registered under section 44-2132 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or another method. If the insurer cannot obtain the information requested by the director, the insurer shall provide the director a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of the information. If it appears to the director that the detailed explanation is without merit, the director may require, after notice and hearing, the insurer to pay a penalty of one hundred dollars for each day's delay, not to exceed an aggregate penalty of ten thousand dollars, or may suspend or revoke the insurer's certificate of authority.

(2) The director may retain at the registered insurer's expense such attorneys, actuaries, accountants, and other experts who are not employees of the Department of Insurance as shall be reasonably necessary to assist in the conduct of the examination under this section. Any persons so retained shall be under the direction and control of the director and shall act in a purely advisory capacity.

(3) Each registered insurer producing for examination records, books, and papers pursuant to this section shall be liable for and shall pay the expense of such examination in accordance with the Insurers Examination Act.

(4) If the insurer fails to comply with an order, the director may examine the affiliates to obtain the information. The director may also issue subpoenas, administer oaths, and examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the director may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness

to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable by contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the district court, which fees, mileage, and actual expenses, if any, necessarily incurred in securing the attendance of witnesses and their testimony, shall be itemized, charged against, and paid by the entity being examined.

Source: Laws 1991, LB 236, § 17; Laws 1993, LB 583, § 85; Laws 2012, LB887, § 11.

Cross References

Insurers Examination Act, see section 44-5901.

44-2137.01 Director; participate in supervisory college; powers; insurer; payment of expenses.

(1) With respect to any insurer registered under section 44-2132 and in accordance with subsection (3) of this section, the director may participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance with Chapter 44 by the insurer. The powers of the director with respect to supervisory colleges include, but are not limited to, the following:

(a) Initiating the establishment of a supervisory college;

(b) Clarifying the membership and participation of other supervisors in the supervisory college;

(c) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(d) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(e) Establishing a crisis management plan.

(2) Each insurer subject to this section shall be liable for and shall pay the reasonable expenses of the director's participation in a supervisory college in accordance with subsection (3) of this section, including reasonable travel expenses.

(3) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management, and governance processes, and as part of the examination of individual insurers in accordance with section 44-2137, the director may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The director may enter into agreements in accordance with section 44-2138 providing the basis for cooperation between the director and the other regulatory agencies and the activities of the supervisory college.

(4) For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the director may establish a regular assessment to the insurer for the payment of such expenses.

(5) Nothing in this section shall delegate to the supervisory college the authority of the director to regulate or supervise the insurer or its affiliates within its jurisdiction.

Source: Laws 2012, LB887, § 12.

44-2138 Information; confidential treatment; sharing of information; restrictions.

(1) All information, documents, and copies thereof obtained by or disclosed to the director or any other person in the course of an examination or investigation made pursuant to section 44-2137 and all information reported or provided to the director pursuant to sections 44-2132 to 44-2136 and 44-2155 shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the director, the National Association of Insurance Commissioners and its affiliates and subsidiaries, or any other person, except to other state, federal, foreign, and international regulatory and law enforcement agencies if the recipient agrees in writing to maintain the confidentiality of the information, without the prior written consent of the insurer to which it pertains unless the director, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event he or she may publish all or any part thereof in such manner as he or she may deem appropriate.

(2) The director may receive information, documents, and copies of information and documents disclosed to other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to an examination of an insurance holding company system. The director shall maintain information, documents, and copies of information and documents received pursuant to this subsection as confidential or privileged if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subsection, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subsection as a result of information sharing authorized by this section.

(3) In order to assist in the performance of the director's duties, the director may share information with state, federal, and international regulatory agencies, the National Association of Insurance Commissioners and its affiliates and subsidiaries, state, federal, and international law enforcement authorities, including members of any supervisory college described in section 44-2137.01, the International Association of Insurance Supervisors, and the Bank for International Settlements under the conditions set forth in section 44-154 if the recipient agrees in writing to maintain the confidentiality and privileged status

of the document, material, or other information and has verified in writing the legal authority to maintain confidentiality. The director may only share confidential and privileged documents, material, or information reported pursuant to subsection (12) of section 44-2132 with directors or commissioners of states having statutes or regulations substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information.

(4) The director shall enter into written agreements with the National Association of Insurance Commissioners governing sharing and use of information provided pursuant to this section that shall:

(a) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this section, including procedures and protocols for sharing by the association with other state, federal, or international regulators;

(b) Specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this section remains with the director and the association's use of the information is subject to the direction of the director;

(c) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners pursuant to this section is subject to a request or subpoena to the association for disclosure or production; and

(d) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the association and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the association and its affiliates and subsidiaries pursuant to this section.

(5) The sharing of information by the director pursuant to this section shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution, and enforcement of this section.

(6) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized by this section.

(7) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners pursuant to this section shall be confidential and privileged, shall not be subject to public disclosure under section 84-712, shall not be subject to subpoena, and shall not be subject to discovery or admissible as evidence in any private civil action.

Source: Laws 1991, LB 236, § 18; Laws 2001, LB 52, § 47; Laws 2012, LB887, § 13; Laws 2016, LB772, § 14.

44-2139 Director; rules and regulations.

The director may adopt and promulgate such rules and regulations and issue such orders as necessary to carry out the Insurance Holding Company System Act.

Source: Laws 1991, LB 236, § 19; Laws 2012, LB887, § 14.

The director of the Department of Insurance should not be impeded in choices of remedy and protective measures by the enumerated powers of the Insurance Holding Company System Act. The importance of the director's duties as a watchdog for policyholders, and the fact that the director is the only watchdog whose authority can bind domestic insurers, counsel in favor of a broad construction of the Insurance Holding Company System Act and the remedies provided therein. CenTra, Inc. v. Chandler Ins. Co., 248 Neb. 844, 540 N.W.2d 318 (1995).

44-2140 Injunctions.

Whenever it appears to the director that any insurer or any director, officer, employee, or agent thereof has committed or is about to commit a violation of the Insurance Holding Company System Act or of any rule, regulation, or order of the director, the director may apply to the district court of Lancaster County for an order enjoining such insurer, director, officer, employee, or agent from violating or continuing to violate the act or any such rule, regulation, or order and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

Source: Laws 1991, LB 236, § 20.

44-2141 Voting of securities; when prohibited; injunction.

No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of the Insurance Holding Company System Act or of any rule, regulation, or order of the director may be voted at any shareholder's meeting or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding, but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the director has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the act or of any rule, regulation, or order of the director, the insurer or the director may apply to the district court of Lancaster County for an order to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of sections 44-2126 to 44-2130 or any rule, regulation, or order of the director to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

Source: Laws 1991, LB 236, § 21.

44-2142 Seizure or sequestration of voting securities.

In any case when a person has acquired or is proposing to acquire any voting securities in violation of the Insurance Holding Company System Act or any rule, regulation, or order of the director, the district court of Lancaster County may, on such notice as the court deems appropriate, upon the application of the insurer or the director seize or sequester any voting securities of the insurer owned directly or indirectly by such person and issue such order with respect thereto as may be appropriate to effectuate the act. Notwithstanding any other provisions of law, for purposes of the act the sites of the ownership of the securities of domestic insurers shall be deemed to be in this state.

Source: Laws 1991, LB 236, § 22.

44-2143 Prohibited acts; administrative penalties; unfair trade practice.

(1) Any insurer which fails, without just cause, to file any registration statement as required by section 44-2132 may be required by the director, after notice and hearing, to pay an administrative penalty of one hundred dollars for each day's delay not to exceed an aggregate penalty of ten thousand dollars. The director may reduce the penalty if the insurer demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the insurer.

(2) Any insurer which fails to notify the director of any transaction, dividend, or distribution as required by sections 44-2132 to 44-2134 may be required by the director, after notice and hearing, to pay an administrative penalty of not more than two thousand five hundred dollars per violation.

(3) Any violation of sections 44-2132 to 44-2134 shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act in addition to any other remedies and penalties available under the laws of this state.

Source: Laws 1991, LB 236, § 23; Laws 1994, LB 978, § 28.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-2144 Director or officer; administrative penalty; when.

Any director or officer of an insurance holding company system who knowingly violates or assents to or permits any officer or agent of the insurer to violate the requirements of subsection (1) of section 44-2132 or section 44-2133 or 44-2134 may be required by the director, after notice and hearing, to pay in his or her individual capacity an administrative penalty of not more than five thousand dollars per violation. In determining the amount of the penalty, the director shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

Source: Laws 1991, LB 236, § 24.

44-2145 Cease and desist orders; other orders.

Whenever it appears to the director that any insurer or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which is subject to sections 44-2133 to 44-2136 and which would not have been approved had such approval been requested, the director may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the director may also order the insurer to void any such contracts and restore the status quo if such action is in the best interest of the policyholders, the creditors, or the public.

Source: Laws 1991, LB 236, § 25.

44-2146 Violations; criminal penalty.

Any insurer which willfully violates the Insurance Holding Company System Act shall be guilty of a Class IV felony. Any director, officer, employee, or agent of an insurer who willfully violates the act shall be guilty of a Class IV felony.

Source: Laws 1991, LB 236, § 26.

44-2147 False reporting; criminal penalty.

Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements, false reports, or false filings with the intent to deceive the director in the performance of his or her duties under the Insurance Holding Company System Act shall be guilty of a Class IV felony.

Source: Laws 1991, LB 236, § 27.

44-2147.01 Violations; effect.

If it appears to the director that any person has committed a violation of sections 44-2126 to 44-2130 which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 2012, LB887, § 15.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-2148 Insurer; supervision, rehabilitation, and liquidation.

If it appears to the director that any person has committed a violation of the Insurance Holding Company System Act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, or shareholders or the public, the director may proceed as provided in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act to take possession of the property of such domestic insurer and to conduct the business thereof.

Source: Laws 1991, LB 236, § 28.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-2149 Recovery by receiver.

(1) If an order for rehabilitation or liquidation of a domestic insurer has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer (a) from any parent or holding company or person or affiliate who otherwise controlled the insurer, the amount of any distribution, other than distribution of shares of the same class of stock, paid by the insurer on its capital stock or (b) any payment in the form of a bonus, termination settlement, or extraordinary lump-sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee, when the distribution or payment pursuant to subdivision (a) or (b) of this subsection is made at any time during the one year preceding the filing of the petition for rehabilitation or liquidation subject to the limitations of subsections (2), (3), and (4) of this section.

(2) No such distribution or payment shall be recoverable if the parent or affiliate shows that when paid such distribution or payment was lawful and

reasonable and that the insurer did not know and could not reasonably have known that such distribution or payment might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was a parent or holding company or a person who otherwise controlled the insurer or affiliate at the time such distribution or payment was paid shall be liable up to the amount of distribution or payment under subsection (1) of this section such person received. Any person who otherwise controlled the insurer at the time such distribution or payment was declared shall be liable up to the amount of distribution or payment he would have received if it had been paid immediately. If two or more persons are liable with respect to the same distribution or payment, they shall be jointly and severally liable.

(4) The maximum amount recoverable under subsection (3) of this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that any person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due from it pursuant to such subsection, its parent or holding company or the person who otherwise controlled it at the time the distribution or payment was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from such parent or holding company or person who otherwise controlled it.

Source: Laws 1991, LB 236, § 29.

44-2150 Suspension, revocation, or nonrenewal of license or authority.

If it appears to the director that any person has committed a violation of the Insurance Holding Company System Act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the director may, after giving notice and an opportunity to be heard, determine to suspend, revoke, or refuse to renew such insurer's license or authority to do business in this state for such period as the director finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

Source: Laws 1991, LB 236, § 30.

44-2151 Appeal; writ of mandamus.

Any person aggrieved by any act, determination, order, or other action of the director pursuant to the Insurance Holding Company System Act may appeal. The appeal shall be in accordance with the Administrative Procedure Act.

Any person aggrieved by any failure of the director to act or make a determination required by the Insurance Holding Company System Act may petition the district court of Lancaster County for a writ in the nature of a mandamus or a peremptory mandamus directing the director to act or make such determination forthwith.

Source: Laws 1991, LB 236, § 31.

Cross References

Administrative Procedure Act, see section 84-920.

44-2152 Inconsistent laws; superseded.

All laws and parts of laws of this state inconsistent with the Insurance Holding Company System Act shall be superseded with respect to matters covered by the act.

Source: Laws 1991, LB 236, § 32.

44-2153 Act; cumulative.

The powers, remedies, procedures, and penalties provided in the Insurance Holding Company System Act shall be in addition to, and not in limitation of, any other powers, remedies, procedures, and penalties provided by law.

Source: Laws 1991, LB 236, § 33.

The director of the Department of Insurance should not be impeded in choices of remedy and protective measures by the enumerated powers of the Insurance Holding Company System Act. The importance of the director's duties as a watchdog for policyholders, and the fact that the director is the only watchdog whose authority can bind domestic insurers, counsel in favor of a broad construction of the Insurance Holding Company System Act and the remedies provided therein. CenTra, Inc. v. Chandler Ins. Co., 248 Neb. 844, 540 N.W.2d 318 (1995).

44-2154 International insurance group; criteria; determination by director.

The director may determine whether or not an insurance holding company system is an international insurance group. An insurance holding company system shall be considered an international insurance group if the insurance holding company system includes an insurer registered under section 44-2132 and:

(1) Meets the following criteria:

(a) The insurance holding company system has premiums written in at least three countries;

(b) The percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's gross written premiums; and

(c) Based on a three-year rolling average, the total assets of the insurance holding company system are at least fifty billion dollars or the total gross written premiums of the insurance holding company system are at least ten billion dollars; or

(2) Does not meet the criteria in subdivision (1) of this section but is determined by the director to have significant international insurance business operations. Such a determination may be made anytime by the director or after a request by an insurance holding company system.

Source: Laws 2016, LB772, § 12.

44-2155 International insurance group; director; identify group-wide supervisor; factors; director; powers; duties; supervision activities; expenses.

(1) In cooperation with other state, federal, and international regulatory agencies, the director may identify a group-wide supervisor for an international insurance group in accordance with this section. The director may determine that the director is the appropriate group-wide supervisor, or he or she may acknowledge that a chief insurance regulatory official from another jurisdiction is the appropriate group-wide supervisor.

(2) The director may determine that the director is the appropriate group-wide supervisor for:

(a) An international insurance group that conducts substantial insurance operations in this state;

(b) An international insurance group with substantial insurance operations conducted by subsidiary insurance companies domiciled in this state whose ultimate controlling person is domiciled outside of this state;

(c) An international insurance group with an insurance company domiciled in this state that conducts substantial insurance operations from offices in this state;

(d) An international insurance group whose ultimate controlling person is domiciled in this state or whose top-tiered insurance company subsidiary is domiciled in this state; or

(e) Any other international insurance group, under the factors set forth in subsection (4) of this section.

(3) The director may acknowledge that a chief insurance regulatory official from another jurisdiction is the appropriate group-wide supervisor if the international insurance group:

(a) Does not have substantial insurance operations in the United States;

(b) Has substantial insurance operations in the United States, but not in this state; or

(c) Has substantial insurance operations in the United States and this state, but the director has determined pursuant to the factors set forth in subsections (4) and (10) of this section that the chief insurance regulatory official from another jurisdiction is the appropriate group-wide supervisor.

(4) The director shall consider, but shall not be limited to, the following factors when making a determination or acknowledgment regarding a group-wide supervisor under this section:

(a) The place of domicile of the ultimate controlling person of the international insurance group, if the chief insurance regulatory official of that place has significant insurance regulatory authority over such ultimate controlling person;

(b) The place of domicile of the insurer within the international insurance group that holds the largest share of the group's written premiums, assets, or liabilities;

(c) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the international insurance group;

(d) The location of the executive offices of the international insurance group;

(e) Whether another chief insurance regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the director determines is accredited by the National Association of Insurance Commissioners or has substantially similar laws when compared to the insurance laws of this state, especially with regard to the provision of group-wide supervision, enterprise risk analysis, and cooperation with other chief insurance regulatory officials;

(f) Whether another chief insurance regulatory official acting or seeking to act as the group-wide supervisor provides the director with reasonably reciprocal recognition and cooperation;

(g) Whether substantial insurance operations are conducted by subsidiary insurance companies domiciled in this state;

(h) Whether another chief insurance regulatory official acting or seeking to act as the group-wide supervisor and key staff maintain the requisite skill, experience, and tenure necessary to act as group-wide supervisor; and

(i) Whether the international insurance group's current group-wide supervisor is carrying out such duty reasonably.

(5) An international insurance group for which the director has not determined or acknowledged a group-wide supervisor may request that the director make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

(6) A group-wide supervisor may determine that it is appropriate to acknowledge another chief insurance regulatory official to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in subsection (4) of this section and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the international insurance group and in consultation with the international insurance group.

(7) Notwithstanding any other provision of law, when another chief insurance regulatory official is acting as the group-wide supervisor of an international insurance group, the director may acknowledge that chief insurance regulatory official as the group-wide supervisor. Such acknowledgment shall not remove any obligation of an insurer to provide information to the director pursuant to the Insurance Holding Company System Act. However, if there is a material change in the international insurance group that results in (a) the international insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities or (b) this state being the place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the international insurance group, the director shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an international insurance group pursuant to this section.

(8) Pursuant to section 44-2137, the director is authorized to collect from any insurer registered pursuant to section 44-2132 all information necessary to determine whether the director may act as the group-wide supervisor of an international insurance group or if the director may acknowledge another chief insurance regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an international insurance group is subject to group-wide supervision by the director, the director shall notify the insurer registered pursuant to section 44-2132 and the ultimate controlling person within the international insurance group. The international insurance group shall have not less than thirty days to provide the director with additional information pertinent to the pending determination. The director shall publish on the website of the Department of Insurance the identity of international insurance groups that the director has determined are subject to group-wide supervision by the director.

(9) If the director is the group-wide supervisor for an international insurance group, the director may engage in any of the following group-wide supervision activities:

(a) Assess the enterprise risks within the international insurance group to ensure that:

(i) The material financial condition and liquidity risks to the members of the international insurance group that are engaged in the business of insurance are identified by management; and

(ii) Reasonable and effective mitigation measures are in place;

(b) Request, from any member of an international insurance group subject to the director's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the international insurance group regarding:

(i) Governance, risk assessment, and management;

(ii) Capital adequacy; and

(iii) Material intercompany transactions;

(c) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the international insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the international insurance group is able to timely recognize and mitigate enterprise risks to members of such international insurance group that are engaged in the business of insurance;

(d) Communicate with other state, federal, and international regulatory agencies for members within the international insurance group and share relevant information, subject to the confidentiality provisions of section 44-2138, through supervisory colleges as set forth in section 44-2137.01 or otherwise;

(e) Enter into agreements with or obtain documentation from any insurer registered under section 44-2132, any member of the international insurance group, and any other state, federal, and international regulatory agencies for members of the international insurance group, providing the basis for or otherwise clarifying the director's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(f) Other group-wide supervision activities, consistent with the authorities and purposes enumerated in this section, as considered necessary by the director.

(10) If the director acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the director may reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor if:

(a) The director's cooperation is in compliance with the laws of this state; and

(b) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the director's activities as a group-wide supervisor for other international insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the director may refuse recognition and cooperation.

(11) The director may enter into agreements with or obtain documentation from any insurer registered under section 44-2132, any affiliate of the insurer,

and other state, federal, and international regulatory agencies for members of the international insurance group that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(12) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the director's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

Source: Laws 2016, LB772, § 13.

ARTICLE 22

VARIABLE ANNUITIES

Section

44-2201 Insurance corporation; variable annuities; issuance; certificate of authority; required; expiration.

An insurance corporation may be formed for the purpose of issuing variable annuities. Variable annuities are policies issued on an individual or group basis by which an insurer promises to pay a variable sum of money either in a lump sum or periodically for life or for some other specified period. No company shall issue or offer to issue variable annuities in this state until it has received a certificate of authority from the Director of Insurance to do so. The certificate of authority shall expire on the last day of April each year and shall be renewed annually if the company has continued to comply with the laws of this state and the rules and regulations adopted and promulgated by the director and the director has not issued an order suspending, revoking, or refusing to renew the company's certificate of authority.

Source: Laws 1969, c. 358, § 1, p. 1259; Laws 1989, LB 92, § 192.

44-2202 Insurance company; variable annuities; requirements.

Before a company may apply to issue variable annuities in this state, it must have an initial amount of capital and surplus, if a stock company, or an amount of surplus, if a mutual company, of at least two million dollars and shall maintain a surplus, if either a stock company or a mutual company, of at least one million five hundred thousand dollars. The Director of Insurance may make exceptions to this provision if he or she deems it in the public interest to do so. In addition to meeting the requirements of this section, a foreign company must be licensed to do a variable annuity or life insurance business in its state of domicile before it may apply to issue variable annuities in this state.

Source: Laws 1969, c. 358, § 2, p. 1260; Laws 1991, LB 237, § 64.

44-2203 Qualifications to issue variable annuities.

A company, meeting the requirements of section 44-2202, that desires to make application to issue variable annuities in this state shall submit to the Director of Insurance:

(1) A certified copy of its articles of incorporation;

(2) A copy of its bylaws attested to by an officer of the applicant;

(3) A certified copy of a resolution adopted by the board of directors establishing one or more separate accounts;

(4) In the case of foreign companies, a copy of any management or service contract entered into between the company and a third party or between the separate account and a third party the terms of which contain provisions for the third party to provide services to the separate account or company;

(5) A copy of the applicant's latest report of examination and annual statement;

(6) A general description of the type of variable annuity business contemplated or in effect and as to variable annuities, commission schedules, a five-year sales and expense projection, a statement of reserving procedures, the kinds and types of investments to be made, and, in the case of foreign companies, a copy of the prospectus to be filed with the Securities and Exchange Commission, if applicable;

(7) In the case of foreign companies, written permission by a duly authorized representative of any third party rendering services to the insurer or separate account, that all books and records maintained in connection with the offer and sale of the variable annuity contracts are open to inspection by the director;

(8) In the case of foreign companies, the variable annuity laws and regulations of the company's home state, if requested by the director;

(9) Biographical statements, financial and character reports concerning officers and directors of the insurance company, management company or separate account if the same is requested by the director;

(10) A corporate certification that the applicant has the corporate authority to issue variable annuities;

(11) In the case of foreign companies, certification by the insurance director of the applicant's state of domicile that the applicant has a current license to do a life insurance or variable annuity business in such state;

(12) In the case of foreign companies, a copy of any sales material to be used in connection with the sale of variable annuities in this state, if requested by the director;

(13) A copy of the variable annuity contract and application and, in the case of a group contract, the certificate evidencing variable benefits issued pursuant to a master group contract; and

(14) The director may require any additional information that relates to the applicant's financial soundness, method of operation, trustworthiness or business reputation.

Source: Laws 1969, c. 358, § 3, p. 1260.

44-2204 Applicant, defined.

For purposes of sections 44-2201 to 44-2221, applicant shall be deemed to include all of the officers, directors, and shareholders.

Source: Laws 1969, c. 358, § 4, p. 1262; Laws 1989, LB 92, § 193.

44-2205 Shareholder, defined.

For purposes of sections 44-2201 to 44-2221, shareholder shall mean a person owning, directly or indirectly, whether through another person or a holding company, beneficial interest, including such interest of any member of his or her immediate family, of more than ten percent of the outstanding equity securities of the applicant.

Source: Laws 1969, c. 358, § 5, p. 1262; Laws 1989, LB 92, § 194.

44-2206 Order denying application for authority to issue variable annuities; conditions.

The Director of Insurance may issue an order denying the application for authority to issue variable annuities if:

(1) The applicant has failed to comply with any prerequisite of law for the issuance of such license;

(2) The applicant is insolvent or has failed to submit a satisfactory financial statement;

(3) The applicant's condition or method of operation in connection with the issuance of variable annuities is such as to render its operation hazardous to the public, its shareholders, or other policyholders;

(4) The applicant's previous conduct indicates that it is untrustworthy;

(5) The applicant has attempted to obtain such license through willful misrepresentation or fraud;

(6) The applicant has been denied a similar license in any other state; or

(7) The applicant's license to conduct a similar business has been suspended or revoked in any other state.

Source: Laws 1969, c. 358, § 6, p. 1262; Laws 1989, LB 92, § 195.

44-2207 Variable annuity contract; approval; requirements.

A variable annuity contract will not be approved by the Director of Insurance unless such contract indicates:

(1) The procedure to be used by the company in establishing the dollar amount of variable benefits or other variable contractual payments or variable values to be paid to the contract holder; that such benefits or other contractual

payments or values may decrease or increase in accordance with such procedure; and that an increase in variable benefits is not in any way guaranteed;

(2) That in the event of default in the payment of any consideration beyond the period of grace allowed by the contract for the payment thereof, the company will make payment of the current value of the variable contract, commencing not later than the date contractual payments by the company were otherwise to have commenced in accordance with the contract;

(3) The expense, mortality and investment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values are stipulated and a guarantee that expense and mortality results shall not adversely affect such dollar amounts;

(4) In an individual variable annuity contract sold in correlation with a life insurance policy or fixed annuity contract, there is a disclosure that shows the consideration paid for the variable annuity contract separately from all other charges and shows the value of such life insurance policy or fixed annuity separately from any other values; and

(5) In individual annuity contracts which provide for both fixed and variable dollar benefits, which are specified at the time of the sale of such contracts, there is indicated, separately, the consideration to be paid for the fixed dollar benefits and for the variable dollar benefits.

Source: Laws 1969, c. 358, § 7, p. 1262.

44-2208 Illustrations of benefits payable under variable annuity contracts; conditions.

Illustrations of benefits payable under any variable annuity contract shall not involve projections of past investment experience into the future, nor shall they attempt predictions of future investment experience.

Source: Laws 1969, c. 358, § 8, p. 1263.

44-2209 Variable annuity contract; disapproval; when.

The Director of Insurance may disapprove any variable annuity contract, application or certificate issued pursuant to a group contract if it contains provisions which are contrary to law, unjust, unfair, inequitable, ambiguous or misleading, or which are likely to result in misrepresentation; or if the sales of such contracts are being solicited by any means of advertising, communication, or dissemination of information which involves misleading or inadequate descriptions of the provisions of the contract.

Source: Laws 1969, c. 358, § 9, p. 1263.

44-2210 Insurance company; accounting; statement; contents.

Every company licensed to sell variable annuities in this state must file with the Director of Insurance, on or before March 1 of each year, a statement under oath for the year ending December 31, immediately preceding, for the business of its separate accounts. Such statement shall be in a form as prescribed by the director and shall include as a minimum details as to all of the income, disbursements, assets and liability items associated with the separate accounts. The director shall not issue any license to any company, either domestic or foreign, until such company has complied with the provisions of this section. For good and sufficient cause shown, the director may grant a reasonable

extension of time within which such statement may be filed, in no event to exceed thirty days.

Source: Laws 1969, c. 358, § 10, p. 1264.

44-2211 Insurance company; reserve liability; requirements.

The reserve liability for variable annuities shall be established pursuant to the requirements of the standard valuation law in accordance with actuarial procedures that recognize the variable nature of the benefits provided. To the extent that the company's reserve liability with regard to (1) benefits guaranteed as to dollar amount and duration, and (2) funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be, except as the Director of Insurance may otherwise approve, invested in accordance with the laws of this state governing the investments of life insurance companies.

Source: Laws 1969, c. 358, § 11, p. 1264.

44-2212 Separate investment account.

A separate investment account shall not be chargeable with any liabilities arising out of any other separate investment account or any other business of the company which has no specific and determinable relation to or dependence upon such separate account. Any surplus or deficit which may arise in any separate account by virtue of mortality experience guaranteed by the company or by expense costs shall be adjusted by withdrawals from or additions to such separate account so that the assets of such account shall equal the liabilities.

Source: Laws 1969, c. 358, § 12, p. 1264.

44-2213 Sales, transfers, exchange of investments; requirements.

Any sales, transfers, or exchange of investments made by a domestic company between any of the separate accounts or between any other investment account of the company and one or more of the separate accounts shall be in accordance with section 44-402.03, and the provisions or lack of provisions concerning transfers of investments in the laws of foreign companies shall be taken into consideration in admission of a foreign company.

Source: Laws 1969, c. 358, § 13, p. 1265; Laws 1991, LB 237, § 65.

44-2214 Separate account; accounting not reflected; when.

When annuity benefit payments have commenced and the amount of the annuity payments are not dependent upon investment experience then the accounting for the annuity cannot be reflected in or be a part of the separate account.

Source: Laws 1969, c. 358, § 14, p. 1265.

44-2215 Statement to holder of variable annuity contracts; contents.

A company shall mail to the holder of its variable annuity contracts at least once in each year after the first, at his last-known address, a statement reporting:

(1) The number of units credited to such contract and the dollar value of a unit as of a date not more than two months previous to the date of mailing; and

(2) The investments held in the variable annuity account.

Such statement shall be mailed not more than two months prior to the annual meeting electing the governing board of the separate account when an election of a governing board of a separate account is required.

Source: Laws 1969, c. 358, § 15, p. 1265.

44-2216 Agents; license required.

All individuals selling individual variable annuities must be licensed to write variable contracts in this state under the Insurance Producers Licensing Act.

Source: Laws 1969, c. 358, § 16, p. 1265; Laws 1995, LB 162, § 5.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-2217 Officer, director, trustee; general provisions.

(1) No person while serving as an elected or appointed officer, director, or trustee of a company licensed pursuant to sections 44-2201 to 44-2221, nor any person serving on the board of managers, trustees, or directors of a separate account of such company shall receive either directly or indirectly any commission or other form of compensation which is related to the purchase or disposal of assets of such a company or of any of its separate accounts.

(2) Where the statutes or regulations of the place of domicile of a licensed company or applicant prevent compliance with the provisions of sections 44-2201 to 44-2221 and the regulations promulgated thereunder, such company shall advise the director in writing. If the statutes or regulations of the place of domicile provide a degree of protection to the contract holder and the public which is substantially equal to that protection provided by sections 44-2201 to 44-2221 and the regulations thereunder, the director may consider this as compliance with sections 44-2201 to 44-2221.

Source: Laws 1969, c. 358, § 17, p. 1265.

44-2218 Certificate of authority; suspend, revoke, refuse to renew; conditions.

The Director of Insurance may issue an order suspending, revoking or refusing to renew the certificate of authority of any company to issue variable annuities in this state if he finds that any of the following conditions exist:

(1) Any cause for which the issuance of a certificate of authority could have been refused had it existed and been known to the director at the time the license was originally issued;

(2) The company has violated or committed acts contrary to the provisions of Chapter 44;

(3) The company has obtained or attempted to obtain such license through willful misrepresentation or fraud;

(4) The company's authority to do a life insurance business or variable annuity business has been suspended, denied, or revoked in any other state; or

(5) The company has shown itself to be untrustworthy or incompetent.

Source: Laws 1969, c. 358, § 18, p. 1266.

44-2219 Certificate of authority; suspend, deny, revoke, refuse to renew; notice; hearing.

Upon the entry of an order suspending, denying, revoking, or refusing to renew a company's certificate of authority to issue variable annuities in this state, the Director of Insurance shall promptly notify the company, by registered or certified mail, that the order has been entered and the reasons therefor and that within fifteen days after the receipt of a written request the matter will be set down for hearing. If no hearing is requested within fifteen days and none is ordered by the director, the director shall enter his or her written findings of fact and conclusions of law and the order will remain in effect until it is modified or vacated by the director. If a hearing is requested or ordered, it shall be held pursuant to the Administrative Procedure Act.

Source: Laws 1969, c. 358, § 19, p. 1266; Laws 1989, LB 92, § 196.

Cross References

Administrative Procedure Act, see section 84-920.

44-2220 Rules and regulations.

The Director of Insurance shall have the authority to adopt and promulgate rules and regulations as are reasonable, necessary, and appropriate for the effective administration of sections 44-2201 to 44-2221. Such rules and regulations may include, but shall not be limited to, (1) qualifications to issue variable annuities, (2) requirements as to advertising, sales promotion, and contract provisions, (3) accounting, (4) the filing of contracts and certificates, and (5) the licensing of annuity agents.

Source: Laws 1969, c. 358, § 20, p. 1267; Laws 1989, LB 92, § 197.

44-2221 Laws applicable.

A company licensed to issue variable annuities in this state shall be subject to all of the provisions of Chapter 44, relating to a company authorized to do a life insurance business in this state, which are not inconsistent with sections 44-2201 to 44-2221.

Source: Laws 1969, c. 358, § 21, p. 1267.

ARTICLE 23
HEARINGS AND APPEALS

Section

44-2301 Hearings; authorized; powers of director.

In addition to examinations expressly authorized under Chapter 44, the Director of Insurance may hold hearings to procure information helpful in the lawful administration of any of the provisions of such chapter. For the purpose of holding a hearing and the production of documents and attendance of witnesses, the director shall have the power to appoint one or more special employees as his assistant or assistants, and to employ such counsels and clerks as may be deemed necessary and give each such person such powers to assist the department as the director may consider proper.

Source: Laws 1969, c. 357, § 1, p. 1254; Laws 1971, LB 891, § 1.

44-2302 Repealed. Laws 1971, LB 891, § 3.

44-2303 Repealed. Laws 1971, LB 891, § 3.

44-2304 Repealed. Laws 1971, LB 891, § 3.

44-2305 Repealed. Laws 1971, LB 891, § 3.

44-2306 Repealed. Laws 1971, LB 891, § 3.

44-2307 Repealed. Laws 1971, LB 891, § 3.

44-2308 Repealed. Laws 1971, LB 891, § 3.

44-2309 Repealed. Laws 1971, LB 891, § 3.

44-2310 Repealed. Laws 1971, LB 891, § 3.

44-2311 Repealed. Laws 1971, LB 891, § 3.

44-2312 Hearings, appeals; law governing.

Hearings and appeals in contested cases under the provisions of Chapter 44 as the same now provide or may hereafter from time to time be amended shall be in accordance with the Administrative Procedure Act.

Source: Laws 1971, LB 891, § 2; Laws 1988, LB 352, § 63.

Cross References

Administrative Procedure Act, see section 84-920.

ARTICLE 24

NEBRASKA PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION ACT

Section

Section

44-2401 Purpose of act.

The purpose of the Nebraska Property and Liability Insurance Guaranty Association Act is to provide a method for the payment of certain claims against insolvent insurance companies, as defined in the act, to avoid unnecessary delay in payment of such claims, to avoid financial loss to claimants or to policyholders, to assist in the detection and prevention of insurer insolvencies, and to provide an association of insurers against which the cost of such protection may be assessed in an equitable manner.

Source: Laws 1971, LB 722, § 1; Laws 2019, LB380, § 1.

44-2402 Kinds of insurance covered.

The Nebraska Property and Liability Insurance Guaranty Association Act shall apply to all kinds of direct insurance except ocean marine, motor vehicle service contract reimbursement, and those lines of insurance specified in subdivisions (1) through (4), (13) through (17), (19), and (20) of section 44-201.

Source: Laws 1971, LB 722, § 2; Laws 1989, LB 92, § 198; Laws 1990, LB 1136, § 99.

44-2403 Terms, defined.

As used in the Nebraska Property and Liability Insurance Guaranty Association Act, unless the context otherwise requires:

(1) Account shall mean any one of the three accounts created by section 44-2404;

(2) Director shall mean the Director of Insurance or his or her duly authorized representative;

(3) Association shall mean the Nebraska Property and Liability Insurance Guaranty Association created by section 44-2404;

(4)(a) Covered claim shall mean an unpaid claim as provided for in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act and which arises out of and is within the coverage of an insurance policy to which the Nebraska Property and Liability Insurance Guaranty Association Act applies issued by a member insurer that becomes insolvent after May 26, 1971, and (i) the claimant or insured is a resident of this state at the time of the insured event or (ii) the property from which the claim arises is permanently located in

this state. Covered claim shall also include the policyholder's unearned premiums paid by the policyholder on an insurance policy to which the act applies issued by a member insurer that becomes insolvent on or after July 9, 1988. Nothing in this section shall be construed to supersede, abrogate, or limit the common-law ownership of accounts receivable for earned premium, unearned premium, or unearned commission;

(b) Covered claim shall not include any amount due any reinsurer, insurer, liquidator, insurance pool, or underwriting association, as subrogation recoveries or otherwise, a self-insured portion of the claim, a claim for any premium calculated on a retrospective basis, any premiums subject to adjustment after the date of liquidation, or any amount due an attorney or adjuster as fees for services rendered to the insolvent insurer. Covered claim shall also not include any amount as punitive or exemplary damages or any amount claimed for incurred but not reported damages. Covered claim shall also not include any claim filed with the guaranty fund after the earlier of twenty-five months after the date of the order of liquidation or the final date set by the court for the filing of claims against the liquidator or receiver. This subdivision (4)(b) shall not prevent a person from presenting the excluded claim to the insolvent insurer or its liquidator, but the claim shall not be asserted against any other person, including the person to whom benefits were paid or the insured of the insolvent insurer, except to the extent that the claim is outside the coverage or is in excess of the limits of the policy issued by the insolvent insurer;

(5) Insolvent insurer shall mean a member insurer licensed to transact the business of insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation, with a finding of insolvency, has been entered by a court of competent jurisdiction in the company's state of domicile after September 2, 1977;

(6) Member insurer shall mean any person licensed to write any kind of insurance to which the Nebraska Property and Liability Insurance Guaranty Association Act applies by the provisions of section 44-2402, including the exchange of reciprocal or interinsurance contracts, that is licensed to transact insurance in this state, except assessment associations operating under Chapter 44, article 8, and also excepting unincorporated mutuals;

(7) Net direct written premiums shall mean direct gross premiums written in this state on insurance policies to which the Nebraska Property and Liability Insurance Guaranty Association Act applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. Net direct written premiums shall not include premiums on contracts between insurers or reinsurers;

(8) Person shall mean any individual, corporation, partnership, limited liability company, association, voluntary organization, or reciprocal insurance exchange; and

(9) Insurance shall mean those contracts defined in section 44-102.

Source: Laws 1971, LB 722, § 3; Laws 1974, LB 1014, § 1; Laws 1977, LB 366, § 5; Laws 1988, LB 700, § 1; Laws 1989, LB 319, § 71; Laws 1993, LB 121, § 239; Laws 2019, LB380, § 2.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

A claim need not be a ''covered claim'' as defined in subsection (4)(a) of this section to be barred by subsection (4)(b) of this section. Alsobrook v. Jim Earp Chrysler-Plymouth, 274 Neb. 374, 740 N.W.2d 785 (2007).

44-2404 Nebraska Property and Liability Insurance Guaranty Association; legal entity; members; functions.

There is hereby created a nonprofit unincorporated legal entity to be known as the Nebraska Property and Liability Insurance Guaranty Association. All insurers defined as member insurers in subdivision (6) of section 44-2403 shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved pursuant to section 44-2408 and shall exercise its powers through a board of directors established by section 44-2405. For purposes of administration and assessment, the association shall be divided into three separate accounts: (a) The workers' compensation insurance account; (b) the automobile insurance account; and (c) the account for all other insurance to which the Nebraska Property and Liability Insurance Guaranty Association Act applies.

Source: Laws 1971, LB 722, § 4; Laws 1974, LB 1014, § 2; Laws 1986, LB 811, § 22.

44-2405 Association; board of directors; members; number; selection; qualifications; expenses.

(1) The board of directors of the association shall consist of seven persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. At least four members of the board shall represent domestic insurers. Vacancies on the board shall be filled for the remaining period of the term in the same manner as initial appointments. If no members are selected within sixty days after May 26, 1971, the director may appoint the initial members of the board of directors.

(2) Subject to the limitations in subsection (1) of this section, the director shall, in approving selections to the board, consider among other things whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors as provided in sections 81-1174 to 81-1177 for state employees.

Source: Laws 1971, LB 722, § 5; Laws 1981, LB 204, § 71.

44-2406 Claims; filing; determination.

(1) The association shall be obligated only to the extent of the covered claims existing prior to the date a member insurer becomes an insolvent insurer or arising within thirty days after it has been determined that the insurer is an insolvent insurer, before the policy expiration date, if less than thirty days after such determination, or before the insured replaces the policy or on request effects cancellation, if he or she does so within thirty days of such dates, but such obligation shall include only the amount of each covered claim that does not exceed three hundred thousand dollars, except that the association shall pay the amount required by law on any covered claim arising out of a workers' compensation policy. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the face amount of the

policy from which the claim arises. The association shall be obligated on covered claims, including those under a workers' compensation policy, for unearned premiums only for the amount of each covered claim that does not exceed ten thousand dollars per policy.

(2) The director shall transmit to the association all covered claims timely filed with him or her pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. The association shall thereupon be considered to have been designated the director's representative pursuant to the act, and it shall proceed to investigate, hear, settle, and determine such claims unless the claimant shall, within thirty days from the date the claim is filed with the director, file with the director a written demand that the claim be processed in the liquidation proceedings as a claim not covered by the Nebraska Property and Liability Insurance Guaranty Association Act. In regard to those claims transmitted to the association by the director, the association and claimants shall have all of the rights and obligations and be subject to the same limitations and procedures as are specified in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act for the determination of claims.

(3) In the case of claims arising from bodily injury, sickness, or disease, including death resulting therefrom, the amount of any such award shall not exceed the claimant's reasonable expenses incurred for necessary medical, surgical, X-ray, and dental services, including prosthetic devices and necessary ambulance, hospital, professional nursing, and funeral services, and any amounts actually lost by reason of claimant's inability to work and earn wages or salary or their equivalent, but not other income, that would otherwise have been earned in the normal course of such injured claimant's employment. Such award may also include payments in fact made to others, not members of claimant's household, which were reasonably incurred to obtain from such other persons ordinary and necessary services for the production of income in lieu of those services the claimant would have performed for himself or herself had he or she not been injured. The amount of any such award under this subsection shall be reduced by the amount the claimant is entitled to receive as the beneficiary under any health, accident, or disability insurance, under any salary or wage continuation program under which he or she is entitled to benefits, or from his or her employer in the form of workers' compensation benefits, or any other such benefits to which the claimant is legally entitled, and any claimant who intentionally fails to correctly disclose his or her rights to any such benefits shall forfeit all rights which he or she may have by the provisions of the Nebraska Property and Liability Insurance Guaranty Association Act.

(4) A third party having a covered claim against any insured of an insolvent insurer may file such claim with the director pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, and the association shall process such claim in the manner specified in subsections (2) and (3) of this section. The filing of such claim shall constitute an unconditional general release of all liability of such insured in connection with the claim unless the association thereafter denies the claim for the reason that the insurance policy issued by the insolvent insurer does not afford coverage or unless the claimant, within thirty days from the date of filing his or her claim with the director, files with the director a written demand that the claim be processed in the liqui-

dation proceedings as a claim not covered by the Nebraska Property and Liability Insurance Guaranty Association Act.

Source: Laws 1971, LB 722, § 6; Laws 1977, LB 366, § 6; Laws 1981, LB 275, § 1; Laws 1986, LB 811, § 23; Laws 1988, LB 352, § 64; Laws 1988, LB 700, § 2; Laws 1989, LB 319, § 72; Laws 2019, LB380, § 3.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

A person who has a liability claim against an insured of an insolvent member insurer may be a third party under subsection (4) of this section. Peterson v. Minden Beef Co., 231 Neb. 18, 434 N.W.2d 681 (1989).

44-2407 Association; duties; powers; enumerated.

(1) The association shall:

(a) Allocate claims paid and expenses incurred among the three accounts separately and assess member insurers separately for each account in the amounts necessary to pay the obligations of the association under section 44-2406, the expenses of handling covered claims, the cost of examinations under sections 44-2412 and 44-2413, and other expenses authorized by the Nebraska Property and Liability Insurance Guaranty Association Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of such member insurer, on the basis of the insurance in the account involved, bears to the net direct written premiums of all member insurers for the same period and in the same account for the calendar year preceding the date of the assessment. The association may make an assessment for the purpose of meeting administrative costs and other general expenses not related to a particular impaired insurer, not to exceed fifty dollars per member insurer in any one year. Each member insurer shall be notified of the assessment not later than thirty days before it is due. Except for such administrative assessment, no member insurer may be assessed in any year on any account an amount greater than one percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. The association may defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact business as an insurer. Deferred assessments shall be paid when such payment will not reduce capital or surplus below such required minimum amounts. Such deferred assessments when paid shall be refunded to those member insurers that received larger assessments by virtue of such deferment or, in the discretion of any such insurer, credited against future assessments. No member insurer may pay a dividend to shareholders or policyholders while such insurer has an unpaid deferred assessment;

(b) Handle claims through its employees or through one or more insurers or other persons designated by the association as a servicing facility, except that the designation of a servicing facility shall be subject to the approval of the director and such designation may be declined by a member insurer;

(c) Reimburse any servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and such other expenses of the association as are

authorized by the Nebraska Property and Liability Insurance Guaranty Association Act;

(d) Issue to each insurer paying an assessment under this section a certificate of contribution in appropriate form and terms as prescribed by the director for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. The insurer may offset against its premium and related retaliatory tax liability to this state pursuant to sections 44-150 and 77-908 accrued with respect to business transacted in such year an amount equal to twenty percent of the original face amount of the certificate of contribution, beginning with the first calendar year after the year of issuance through the fifth calendar year after the year of issuance. If the association recovers any sum representing amounts previously written off by member insurers and offset against premium and related retaliatory taxes imposed by sections 44-150 and 77-908, such recovered sum shall be paid by the association to the director who shall handle such funds in the same manner as provided in Chapter 77, article 9;

(e) Be deemed the insolvent insurer to the extent of the association's obligation for covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer, subject to the limitations provided in the act, as if the insurer had not become insolvent, with the exception that the liquidator shall retain the sole right to recover any reinsurance proceeds. The association's rights under this section include, but are not limited to, the right to pursue and retain salvage and subrogation recoveries on paid covered claim obligations to the extent paid by the guaranty fund; and

(f) Have access to insolvent insurer records. The liquidator of an insolvent insurer shall permit access by the association or its authorized representatives, and by any similar organization in another state or its authorized representatives, to the insolvent insurer's records which are necessary for the association or such similar organization in carrying out its functions with regard to covered claims. In addition, the liquidator shall provide the association or its representative or such similar organization with copies of such records upon the request and at the expense of the association or similar organization.

(2) The association may:

(a) Appear in, defend, and appeal any action;

(b) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(c) Borrow funds necessary to effect the purposes of the Nebraska Property and Liability Insurance Guaranty Association Act in accord with the plan of operation;

(d) Sue or be sued, and such power to sue shall include the power and right to intervene as a party before any court that has jurisdiction over an insolvent insurer as defined by such act;

(e) Negotiate and become a party to such contracts as are necessary to carry out the purpose of such act;

(f) Perform such other acts as are necessary or proper to effectuate the purpose of such act; and

(g) Bring any action against any third-party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all files, records, and electronic data related to an insolvent insurer that is

appropriate or necessary for the association, or a similar organization in another state, to carry out duties under such act.

Source: Laws 1971, LB 722, § 7; Laws 1977, LB 366, § 7; Laws 1986, LB 1114, § 5; Laws 1987, LB 302, § 5; Laws 1989, LB 92, § 199; Laws 2000, LB 930, § 6; Laws 2019, LB380, § 4.

44-2408 Association; plan of operation; amendments; submit to director.

(1)(a) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the affairs of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the director.

(b) If the association fails to submit suitable amendments to the plan, the director shall, after allowing the association the opportunity to present its views, adopt and promulgate reasonable rules and regulations as are necessary and advisable to effectuate the Nebraska Property and Liability Insurance Guaranty Association Act. Such rules and regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall:

(a) Establish the procedures whereby all the powers and duties of the association under the act will be performed;

(b) Establish procedures for handling the assets of the association;

(c) Establish the amount and method of reimbursing members of the board of directors under section 44-2405;

(d) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;

(e) Establish regular places and times for meetings of the board of directors;

(f) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(g) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the director within sixty days after the action or decision;

(h) Establish the procedures whereby selection of the board of directors will be submitted to the director for approval; and

(i) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association are delegated to a corporation, association, or other organization which performs, or will perform, functions similar to those of the association, or its equivalent, in two or more states. Such corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director and may be made only to a

corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by the act.

Source: Laws 1971, LB 722, § 8; Laws 1989, LB 92, § 200.

44-2409 Director; duties.

(1) The director shall:

(a) Notify the association of the existence of any insolvent insurer not later than three days after he or she receives notice of the determination of the insolvency and order of liquidation pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act; and

(b) Upon request of the board of directors of the association, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The director may:

(a) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due, unless such payment was deferred by the association in the manner provided in the Nebraska Property and Liability Insurance Guaranty Association Act, or fails to comply with the plan of operation; and

(b) Revoke the designation of any servicing facility if he or she finds the claims are not being handled in good faith. Designation of a new servicing facility shall be accomplished in the manner set out in subdivision (1)(b) of section 44-2407.

Source: Laws 1971, LB 722, § 9; Laws 1989, LB 319, § 73; Laws 2019, LB380, § 5.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-2410 Assignment of rights; notice of claims; settlement; effect; statement of claims; file with director.

(1) Any person recovering under the Nebraska Property and Liability Insurance Guaranty Association Act shall be deemed to have assigned his or her rights under the policy to the association to the extent of such recovery from the association. Every insured or claimant seeking recovery under the act shall be required to cooperate with the association to the same extent he or she would have been required to cooperate with the insolvent insurer.

(2) Notice of claims to the liquidator or receiver of the insolvent member insurer shall be deemed notice to the association or its agent, and a list of covered claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(3) The receiver, liquidator, or statutory successor of an insolvent member insurer shall be bound by settlements of covered claims by the association or a similar organization in another state.

(4) The association shall periodically file with the director statements of covered claims paid by the association and estimates of anticipated claims against the association.

Source: Laws 1971, LB 722, § 10; Laws 1977, LB 366, § 8; Laws 2019, LB380, § 6.

44-2411 Exhaustion of remedies.

(1) Any person having a claim against any insurer under any provisions of any insurance policy, which claim is also a covered claim against an insolvent insurer under the Nebraska Property and Liability Insurance Guaranty Association Act, shall be required to exhaust all rights under such policy before the association is obligated to pay the covered claim under such act. Any amount payable on a covered claim by the provisions of such act shall be reduced by the amount of such recovery under any other insurance policy.

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

Source: Laws 1971, LB 722, § 11; Laws 1986, LB 811, § 24; Laws 2019, LB380, § 7.

44-2412 Board of directors; director; duties.

To aid in the detection and prevention of insurer insolvencies:

(1) It shall be the duty of the board of directors, upon majority vote, to notify the director of any information indicating that any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public;

(2) The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty days of the receipt of such request, the director shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such qualified persons as the director designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director but it shall not be open to public inspection prior to the release of the examination report to the public;

(3) It shall be the duty of the director to report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined may be insolvent or in a financial condition hazardous to the policyholders or the public. Such report to the board of directors shall not be considered a release to the public under applicable insurer examination statutes;

(4) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents;

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer insolvencies; and

(6) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the director.

Source: Laws 1971, LB 722, § 12.

44-2413 Association; director; examine; regulate; financial report; furnish.

The association shall be subject to examination and regulation by the director. Any such examination conducted pursuant to the provisions of this section shall be paid for by the association. The board of directors shall submit to the director, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the director.

Source: Laws 1971, LB 722, § 13.

44-2414 Association; fees and taxes; exempt.

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

Source: Laws 1971, LB 722, § 14.

44-2415 Exemption from liability.

There shall be no liability on the part of, and no cause of action of any nature shall rise against, any member insurer, the association or its agents or employees, the board of directors of the association, any servicing facility designated by the association in accordance with the Nebraska Property and Liability Insurance Guaranty Association Act or the agents or employees or officers of such servicing facility, or the director or his or her representatives for any action taken by them in the performance of their powers and duties under the act.

Source: Laws 1971, LB 722, § 15; Laws 2019, LB380, § 8.

44-2416 Advertisements by member insurers of coverage by association; prohibited.

Advertisements by member insurers which include a reference to the coverage of the insurance guaranty association are specifically prohibited.

Source: Laws 1971, LB 722, § 16.

44-2417 Assessments made by insurance guaranty associations of other states; not considered taxes, fees, licenses, obligations, prohibitions, or restrictions.

Assessments made by the insurance guaranty associations, or similar entities, pursuant to the laws of any other state shall not be considered taxes, licenses, other fees, other material obligations, prohibitions, or restrictions as those terms are defined in section 44-150.

Source: Laws 1971, LB 722, § 17.

44-2418 Act, how cited.

Sections 44-2401 to 44-2419 shall be known and may be cited as the Nebraska Property and Liability Insurance Guaranty Association Act.

Source: Laws 1971, LB 722, § 18; Laws 1974, LB 1014, § 3; Laws 2019, LB380, § 9.

44-2419 Order of liquidation; stay.

All proceedings arising out of a claim under a policy of insurance written by an insolvent insurer shall be stayed for one hundred twenty days from the date of entry of the order of liquidation to permit proper defense by the association of all such pending causes of action. Nothing in this section shall be deemed to limit the powers of a receiver appointed pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act or to stay any proceeding brought pursuant to such act.

Source: Laws 2019, LB380, § 10.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

ARTICLE 25
UNAUTHORIZED TRANSACTIONS

Section
44-2501. Domestic insurer; prohibited acts.
44-2502. Reciprocal state, defined.
44-2503. Department; reciprocal states; listing.
44-2504. Unauthorized act; violation; penalty.

44-2501 Domestic insurer; prohibited acts.

No domestic insurer shall enter into any contract of insurance upon the life or person of a resident of a reciprocal state, or covering property or risks located in a reciprocal state, unless the insurer is authorized pursuant to the laws of such reciprocal state to do business therein, except that a domestic insurer may:

(a) Enter into a contract when the prospective insured is personally present in the state in which the insurer is authorized to do business when he signs the application;

(b) Issue a certificate under any lawfully transacted group life or group disability policy, when the master policy is entered into in a state in which the insurer is authorized to do business;

(c) Make a contract pursuant to a pension or retirement plan of an employer when such contract is applied for in a state where the employer is personally present or doing business and the insurer is authorized to do business; and

(d) Renew, reinstate, convert, or continue in force, with or without modification, any contract otherwise lawfully entered into and which was not originally entered into in violation of this section.

Source: Laws 1973, LB 425, § 1.

44-2502 Reciprocal state, defined.

For purposes of sections 44-2501 to 44-2504, reciprocal state shall mean any state the laws of which impose substantially similar restrictions upon an insurer organized under the laws of that state as are imposed upon domestic insurers by section 44-2501.

Source: Laws 1973, LB 425, § 2; Laws 1989, LB 92, § 201.

44-2503 Department; reciprocal states; listing.

The department shall make available to any domestic insurer upon request a listing specifying the several reciprocal states.

Source: Laws 1973, LB 425, § 3; Laws 1989, LB 92, § 202.

44-2504 Unauthorized act; violation; penalty.

Any domestic insurer who transacts any unauthorized act of insurance business as regulated by sections 44-2501 to 44-2504 shall be guilty of a misdemeanor and shall, upon conviction thereof, be fined not more than ten thousand dollars.

Source: Laws 1973, LB 425, § 4.

ARTICLE 26
INSURANCE CONSULTANTS

Section

44-2601 Repealed. Laws 1980, LB 481, § 33.

44-2602 Repealed. Laws 1980, LB 481, § 33.

44-2603 Repealed. Laws 1980, LB 481, § 33.

44-2604 Repealed. Laws 1980, LB 481, § 33.

44-2605 Repealed. Laws 1980, LB 481, § 33.

44-2606 Definitions; where found.

For the purpose of sections 44-2606 to 44-2635, unless the context otherwise requires, the definitions found in sections 44-2607 to 44-2613 shall be used.

Source: Laws 1980, LB 481, § 1; Laws 1989, LB 92, § 203.

44-2607 Insurance consultant, defined.

Insurance consultant shall mean any person who, for a fee, engages in the business of offering to the public any advice, counsel, opinion, or service with respect to insurable risks, or concerning the benefits, coverages, or provisions under any policy of insurance that could be issued in this state, or involving the advantages or disadvantages of any such policy of insurance, or any formal plan of managing pure risk. Insurance consultant does not include a public adjuster licensed under the Public Adjusters Licensing Act.

Source: Laws 1980, LB 481, § 2; Laws 2018, LB743, § 20.

Cross References

Public Adjusters Licensing Act, see section 44-9201.

44-2608 Risk manager, defined.

Risk manager shall mean any person who is a full-time employee who deals with matters of insurance within the scope of his or her employment, including the supervision of employee benefits.

Source: Laws 1980, LB 481, § 3.

44-2609 Agent, defined.

Agent shall mean and include insurance agent, surplus lines licensee, and broker.

Source: Laws 1980, LB 481, § 4; Laws 1989, LB 92, § 204.

44-2610 Person, defined.

Person shall mean any individual, corporation, partnership, limited liability company, or other entity.

Source: Laws 1980, LB 481, § 5; Laws 1993, LB 121, § 240.

44-2611 Pure risk, defined.

Pure risk shall mean any risk that involves the chance of loss or no loss only with no possibility of gain.

Source: Laws 1980, LB 481, § 6.

44-2612 Director, defined.

Director shall mean the Director of Insurance.

Source: Laws 1980, LB 481, § 7.

44-2613 Department, defined.

Department shall mean the Department of Insurance.

Source: Laws 1980, LB 481, § 8.

44-2614 Insurance consultant; acts requiring licensure.

No person shall, in or on advertisements, cards, signs, circulars, letterheads, or elsewhere or in any other manner by which public announcements are made, use the title insurance consultant or any similar title or any title, word, combination of words, or abbreviation indicating that he or she gives or is engaged in the business of offering to the public any advice, counsel, opinion, or service with respect to insurable risks, concerning the benefits, coverages, or provisions under any policy of insurance that could be issued in this state, or involving the advantages or disadvantages of any such policy of insurance, unless such person holds a license as an insurance consultant under sections 44-2606 to 44-2635.

Source: Laws 1980, LB 481, § 9; Laws 1989, LB 92, § 205; Laws 2018, LB743, § 21.

44-2615 Insurance consultant; license; violation; penalty.

No person shall act as an insurance consultant until he or she has been licensed as provided by sections 44-2606 to 44-2635. Any person violating this section shall be guilty of a Class IV misdemeanor.

Source: Laws 1980, LB 481, § 10; Laws 1989, LB 92, § 206.

44-2616 Person; not acting as insurance consultant; when.

A person shall not be deemed to be acting as an insurance consultant under any of the following circumstances:

(1) If a licensed agent gives advice incidental to the normal course of the agent's insurance business and does not charge a fee other than commissions received from insurance written;

(2) If any attorney, actuary, certified public accountant, teacher of insurance, or trust officer of a bank consults during the normal course of his or her usual business, and only incidental to such business; or

(3) If a person employed as a risk manager consults during the normal course of his or her full-time employment to the company by which such person is employed.

Source: Laws 1980, LB 481, § 11.

44-2617 Corporation, partnership, or limited liability company; licensed as insurance consultant; requirements.

Any corporation, partnership, or limited liability company engaged in the business of insurance consulting may become licensed as an insurance consultant. No license shall be granted to a corporation, partnership, or limited liability company unless the corporation, partnership, or limited liability company designates a licensed consultant who shall have full responsibility for all insurance consulting transactions of the corporation, partnership, or limited liability company within the state. Such designated consultant shall be an officer of the corporation or a member of the partnership or limited liability company and shall have a substantial interest in or be an active participant in the management of the corporation, partnership, or limited liability company. If a corporation, partnership, or limited liability company has more than one office, it shall designate a consultant for each office. In the event a designated consultant of a licensed corporation, partnership, or limited liability company shall either leave the corporation, partnership, or limited liability company or have his or her license revoked, the corporation, partnership, or limited liability company shall have sixty days after such revocation in which to designate another qualified licensed consultant, or have its license revoked. Any individual associated with a licensed corporation, partnership, or limited liability company who acts as an insurance consultant shall be a licensed consultant.

Source: Laws 1980, LB 481, § 12; Laws 1993, LB 121, § 241.

44-2618 Nonresident consultant; rights and privileges.

A nonresident applicant may qualify for a license under sections 44-2606 to 44-2635 as a nonresident consultant. A license issued to a nonresident shall grant the same rights and privileges offered a resident licensee, except that whenever, by the laws, rules, or regulations of any other state or jurisdiction, any limitation of rights and privileges, conditions precedent, or other requirements are imposed upon residents of Nebraska who are nonresident applicants or licensees of such other state or jurisdiction in addition to or in excess of those imposed on nonresidents under sections 44-2606 to 44-2635, the same requirements shall be imposed upon the residents of such other state or jurisdiction.

Source: Laws 1980, LB 481, § 13; Laws 1989, LB 92, § 207.

44-2619 Nonresident consultant; applicant; examination.

Any nonresident applicant whose resident state does not license insurance consultants may qualify for a license as a nonresident consultant in this state only upon examination, except as provided in section 44-2625.

Source: Laws 1980, LB 481, § 14.

44-2620 Nonresident consultant; personal jurisdiction.

Obtaining a nonresident license shall constitute sufficient contact with this state for the exercise of personal jurisdiction over such a person in any action, suit, or proceeding instituted by or on behalf of any interested person arising out of the applicant's consulting business in Nebraska.

Source: Laws 1980, LB 481, § 15; Laws 1983, LB 447, § 66.

44-2621 Insurance consultant's license; type; fee; qualifications.

Every individual applicant for a license under sections 44-2606 to 44-2635 shall have attained the age of majority, shall be competent, trustworthy, financially responsible, and of good personal and business reputation, and shall have been licensed as an agent, broker, or consultant in this state or another state for the three years immediately preceding the date of application or have successfully completed a specific program of study which has a broad national or regional recognition as determined by the director. Application shall be made to the director on forms prescribed by the director and shall be accompanied by a license fee as established by the director not to exceed one hundred dollars for each resident individual license, not to exceed one hundred fifty dollars for each nonresident individual license, not to exceed one hundred fifty dollars for each resident corporate, partnership, or limited liability company license, and not to exceed one hundred fifty dollars for each nonresident corporate, partnership, or limited liability company license. If the applicant is an individual, the application shall include the applicant's social security number. The director may issue an insurance consultant's license in two areas: Property and casualty insurance; and life, health, and annuities. A person may become licensed in either one or both of such areas.

Source: Laws 1980, LB 481, § 16; Laws 1989, LB 92, § 208; Laws 1993, LB 121, § 242; Laws 1993, LB 583, § 86; Laws 1997, LB 752, § 111.

44-2622 Insurance consultant's license; examination.

All individual applicants for licensure under sections 44-2606 to 44-2635 shall be examined by the director in such manner and form as the director prescribes. The applicant shall pass the examination with a grade determined by the director to indicate satisfactory knowledge and understanding of the area of insurance for which the applicant seeks qualification as a consultant.

Source: Laws 1980, LB 481, § 17; Laws 1989, LB 92, § 209.

44-2623 Insurance consultant's license; examination; reexamination; fee.

An applicant for a license under sections 44-2606 to 44-2635 shall pay or cause to be paid an examination fee as established by the director in advance of such examination. The fee shall not exceed one hundred dollars and shall cover all of the examinations given to the applicant at the same time and place. The fee shall not be refunded to the applicant. Examination fees collected under sections 44-2606 to 44-2635 shall be remitted to the State Treasurer for credit to the Department of Insurance Cash Fund unless the director contracts with an independent testing organization, in which case the applicant shall pay the examination fee directly to such independent testing organization and the fee shall be the amount charged by the testing organization.

Source: Laws 1980, LB 481, § 18; Laws 1989, LB 92, § 210.

44-2624 Insurance consultant; reexamination; when.

The director may require a consultant, after notice and hearing and a finding that the consultant lacks competency, to submit to reexamination if the director has reason to believe that the consultant lacks competence.

Source: Laws 1980, LB 481, § 19.

44-2625 Nonresident applicant; reciprocity.

The director may exempt from examination any nonresident applicant whose resident state or province has examination standards substantially the same as those of Nebraska, if such state or province has been recognized by the director by reciprocal arrangement. The director may accept, in lieu of examination of such nonresident, a certificate of the director or commissioner of the other state or province to the effect that the applicant is licensed in the state or province in a capacity similar to that for which a license is sought in this state. In instances when a reciprocal agreement has not been reached, the director shall require an examination.

Source: Laws 1980, LB 481, § 20.

44-2626 Insurance consultant's license; denial; when.

The director may refuse to issue a consultant's license to an applicant if such applicant has failed to comply with any prerequisite for the issuance of such license, has made a material misstatement in the application for license, or has demonstrated untrustworthiness, financial irresponsibility, or incompetency.

Source: Laws 1980, LB 481, § 21.

44-2627 Insurance consultant's license; contents; expiration; reissuance.

(1) The license shall state the name and resident address of the licensee, date of issuance, whether the licensee is qualified to consult in property and casualty, life, health, and annuities, and such other information as the director considers proper.

(2) All corporate, partnership, and limited liability company licenses shall expire on June 30 of each year, and all individual licenses shall expire on the last day of the month of the licensee's birthday in the first year after issuance in which his or her age is divisible by two and such individual licenses may be reissued within the ninety-day period before their expiration dates and all individual licenses also may be reissued within the thirty-day period after their expiration dates upon payment of a late reissuance fee as established by the director not to exceed one hundred twenty-five dollars in addition to the applicable fee otherwise required for reissuance of individual licenses as established by the director pursuant to section 44-2621. All individual licenses reissued within the thirty-day period after their expiration dates pursuant to this subsection shall be deemed to have been reissued before their expiration dates. The department shall establish procedures for the reissuance of licenses.

(3) Every licensed consultant shall notify the department within thirty days of any change in his or her residential or business address.

Source: Laws 1980, LB 481, § 22; Laws 1989, LB 92, § 211; Laws 1993, LB 121, § 243; Laws 1993, LB 583, § 87; Laws 1999, LB 260, § 2.

44-2628 Insurance consultant's license; fee.

A person holding a license issued under sections 44-2606 to 44-2635 shall pay to the department the required license fee as prescribed by section 44-2621. The department shall not issue a license to any person who fails to pay the required

license fee when it becomes due except as otherwise provided in subsection (2) of section 44-2627.

Source: Laws 1980, LB 481, § 23; Laws 1989, LB 92, § 212; Laws 1999, LB 260, § 3.

44-2629 Insurance consultant; obligation.

A consultant is obligated, under his or her license, to serve with objectivity and complete loyalty the interests of his or her client and to render his or her client such information, counsel, and service as within the knowledge, understanding, and opinion, in good faith of the licensee, best serves the client's insurance needs and interest.

Source: Laws 1980, LB 481, § 24.

44-2630 Insurance consultant; contract or agreement; conditions.

No contract or agreement with an insurance consultant shall be enforceable by such consultant unless it is in writing and executed in duplicate by the person to be charged or by the authorized representative of such person. The agreement shall define the subject matter of the consulting services, outline the nature of the work to be performed by the consultant, and state the fee for the work. The consultant shall retain a copy of the agreement for not less than five years after completion of the services.

Source: Laws 1980, LB 481, § 25; Laws 1981, LB 57, § 1.

44-2631 Insurance consultant; commission or compensation; receipt; unlawful; when.

It shall be unlawful for any consultant, or any agency or sales organization with which he or she is connected, to receive any part of any commission or compensation paid by an insurer or agent of an insurer in connection with the sale or writing of any insurance which is within the subject matter of any consulting service performed prior to the sale of insurance and for which such consultant has contracted to receive a fee. For purposes of this section, a renewal of insurance shall not be considered a sale of insurance.

Source: Laws 1980, LB 481, § 26; Laws 1981, LB 57, § 2.

44-2632 Insurance consultant; contract; department approval; procedure.

If a consultant is required to obtain approval of a contract by the department, such consultant shall complete and mail to the department a copy of the contract, attached to a departmental form, specifying the nature of the work to be performed, the fee arrangement, and an explanation of the necessity for charging a consulting fee. The director may refuse to approve any contract if the potential conflict of interest outweighs any benefit received by the client. If disapproval is not received by the consultant within ten days, the contract shall be considered approved.

Source: Laws 1980, LB 481, § 27.

44-2633 Insurance consultant's license; revoked; suspended; placed on probation; grounds.

The director may revoke, suspend, or place on probation, for such period as he or she may determine, the license of any consultant if, after notice and hearing, he or she determines that the licensee has:

(1) Violated any of the provisions of sections 44-2606 to 44-2635, any insurance laws, or any lawful rule, regulation, or order of the director or of a director or commissioner of another state or province;

(2) Recommended the purchase of insurance, annuities, or securities from any authorized insurer in which the consultant or any member of his or her immediate family holds an executive position or holds a substantial interest;

(3) Received compensation in any form from any agency or other insurance organization for recommending such agency or organization to the consultant's client;

(4) Knowingly and willfully misrepresented the terms of any actual or proposed insurance contract;

(5) Been found guilty of any unfair trade practice or of fraud;

(6) Been convicted of any felony, or convicted of a Class I, II, or III misdemeanor evidencing that such licensee is not worthy of the public trust;

(7) Had a consultant's license suspended, revoked, or placed on probation in any other state;

(8) Failed to submit to a reexamination for competence or failed to pass such examination;

(9) Demonstrated incompetency, untrustworthiness, or failure to comply with the provisions of his or her insurance consultant's contract; or

(10) Obtained the license through misrepresentation, fraud, or any cause for which issuance could have been refused had it been known to the director at the time of issuance.

Source: Laws 1980, LB 481, § 28; Laws 1989, LB 92, § 213.

44-2634 Violations; administrative fine; enforcement.

Any person violating sections 44-2606 to 44-2635 may after notice and hearing be subject to an administrative fine of not more than five hundred dollars per violation. Such fine may be enforced in the same manner as civil judgments and may be in addition to any denial, suspension, probation, or revocation of a license. Any person charged with a violation of sections 44-2606 to 44-2635 may waive his or her right to a hearing and consent to such discipline as the director determines to be appropriate. All hearings held pursuant to sections 44-2606 to 44-2635 shall be governed by the Administrative Procedure Act.

Source: Laws 1980, LB 481, § 29; Laws 1989, LB 92, § 214.

Cross References

Administrative Procedure Act, see section 84-920.

44-2635 Rules and regulations.

The director may adopt and promulgate reasonable rules and regulations for the implementation and administration of sections 44-2606 to 44-2635.

Source: Laws 1980, LB 481, § 30; Laws 1989, LB 92, § 215.

ARTICLE 27

NEBRASKA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Section

44-2701 Purpose of act.

The purpose of the Nebraska Life and Health Insurance Guaranty Association Act is to protect resident policyowners, insureds, including certificate holders under group insurance policies or contracts, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts of member insurers, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the member insurer issuing such policies or contracts and to assist in the detection and prevention of insurer insolvencies. To provide this protection, (1) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, as limited in the act, and (2) members of the association are made subject to assessment to provide funds to carry out the purposes of the act.

Source: Laws 1975, LB 217, § 1; Laws 1986, LB 593, § 3.

Resident employees, and not a nonresident trustee, are entitled to protection under this section. Unisys Corp. v. Nebraska Life & Health Ins. Guar. Assn., 267 Neb. 158, 673 N.W.2d 15 (2004).

44-2702 Terms, defined.

As used in the Nebraska Life and Health Insurance Guaranty Association Act, unless the context otherwise requires:

(1) Account means any of the three accounts created pursuant to section 44-2705;

(2) Association means the Nebraska Life and Health Insurance Guaranty Association created by section 44-2705;

(3) Authorized, when used in the context of assessments, or authorized assessment means a resolution by the board of directors has passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

(4) Called, when used in the context of assessments, or called assessment means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

(5) Director means the Director of Insurance;

(6) Contractual obligation means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under section 44-2703;

(7) Covered policy means any policy or contract or portion of such policy or contract for which coverage is provided under section 44-2703;

(8) Extra-contractual claims include, but are not limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs;

(9) Benefit plan means a specific employee, union, or association of natural persons benefit plan;

(10) Health benefit plan means any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or any other similar health contract. Health benefit plan does not include:

(a) Accident only insurance;

(b) Credit insurance;

(c) Dental only insurance;

(d) Vision only insurance;

(e) Medicare supplement insurance;

(f) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(g) Disability income insurance;

(h) Coverage for onsite medical clinics; or

(i) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates;

(11) Impaired insurer means a member insurer which, after August 24, 1975, (a) is deemed by the director to be potentially unable to fulfill its contractual obligations and is not an insolvent insurer and (b) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(12) Insolvent insurer means a member insurer which, after August 24, 1975, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(13) Member insurer means an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind

of insurance or health maintenance organization business for which coverage is provided for under section 44-2703. Member insurer includes any insurer or health maintenance organization whose license or certificate of authority may have been suspended, revoked, not renewed, or voluntarily withdrawn. Member insurer does not include:

(a) A hospital or medical service organization, whether profit or nonprofit;

(b) A fraternal benefit society;

(c) A mandatory state pooling plan;

(d) A mutual assessment company or other person that operates on an assessment basis;

(e) An assessment association operating under Chapter 44 which issues only policies or contracts subject to assessment;

(f) An insurance exchange;

(g) An organization that has a certificate or license limited to the issuance of charitable gift annuities;

(h) A viatical settlement provider, a viatical settlement broker, or a financing entity under the Viatical Settlements Act; or

(i) An entity similar to any entity listed in subdivisions (13)(a) through (h) of this section;

(14) Moody's corporate bond yield average means the monthly average of corporate bond yields published by Moody's Investment Service, Incorporated, or any successor to Moody's Investment Service, Incorporated;

(15) Owner of a policy or contract, policyholder, policy owner, and contract owner mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. Owner, policy owner, and contract owner do not include persons with a mere beneficial interest in a policy or contract;

(16) Person means any individual, corporation, partnership, limited liability company, association, government body or entity, or voluntary organization;

(17) Plan sponsor means:

(a) In the case of a benefit plan established or maintained by a single employer, the employer;

(b) In the case of a benefit plan established or maintained by an employee organization, the employee organization; or

(c) In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan;

(18) Premiums means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits. Premiums does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under subsection (2) of section 44-2703, except that assessable premiums shall not be

reduced on account of subdivision (2)(b)(iii) of section 44-2703 relating to interest limitations and subdivision (3)(b) of section 44-2703 relating to limitations with respect to one individual, one participant, and one policy or contract owner. Premiums does not include:

(a) Premiums on an unallocated annuity contract; or

(b) With respect to multiple nongroup life insurance policies owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, premiums exceeding five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

(19)(a) Principal place of business of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy or contract for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function. The association shall in its reasonable judgment determine the principal place of business considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors or similar governing person or persons of the entity conducts the majority of meetings;

(iv) The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in subdivisions (19)(a)(i) through (v) of this section, except that in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

(20) Receivership court means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer;

(21) Resident means any person to whom a contractual obligation is owed who resides in this state at the date of entry of a court order that determines that a member insurer is an impaired or insolvent insurer, whichever occurs first. A person may be a resident of only one state. A person other than a

natural person shall be a resident of its principal place of business. Citizens of the United States that are residents of foreign countries, or are residents of a United States possession, territory, or protectorate that does not have an association similar to the association created by the Nebraska Life and Health Insurance Guaranty Association Act, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

(22) State means a state, the District of Columbia, Puerto Rico, and any United States possession, territory, or protectorate;

(23) Structured settlement annuity means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

(24) Supplemental contract means any agreement entered into between a member insurer and an owner or beneficiary for the distribution of policy or contract proceeds under a covered policy or contract; and

(25) Unallocated annuity contract means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Source: Laws 1975, LB 217, § 2; Laws 1986, LB 593, § 4; Laws 1993, LB 121, § 244; Laws 2001, LB 360, § 14; Laws 2012, LB887, § 16; Laws 2019, LB159, § 1.

Cross References

Viatical Settlements Act, see section 44-1101.

A broker of viatical settlements was never a ''member insurer'' as defined in subsection (8) of this section under the Nebraska Life and Health Insurance Guaranty Association Act, and therefore, the Life and Health Insurance Guaranty Association was not obligated to guarantee agreements between the broker and investors under which the investors had agreed to purchase death benefits of life insurance policies after the broker breached the agreements. Harvey v. Nebraska Life & Health Ins. Guar. Assn., 277 Neb. 757, 765 N.W.2d 206 (2009).

Resident employees, and not a nonresident trustee, are entitled to protection under this section. Unisys Corp. v. Nebraska Life & Health Ins. Guar. Assn., 267 Neb. 158, 673 N.W.2d 15 (2004).

This section does not encompass the liability of an insolvent insurer arising under law rather than under the provisions of the policy such insurer issued. Nebraska Life & Health Ins. Guar. Assn. v. Dobias, 247 Neb. 900, 531 N.W.2d 217 (1995).

44-2703 Coverages authorized.

(1)(a) The Nebraska Life and Health Insurance Guaranty Association Act shall provide coverage for the policies and contracts specified in subsection (2) of this section:

(i) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subdivision (1)(a)(ii) of this section; and

(ii) To persons who are owners of or certificate holders under the policies or contracts, other than structured settlement annuities, and in each case who:

(A) Are residents; or

(B) Are not residents and all of the following conditions apply:

(I) The member insurer that issued the policies or contracts is domiciled in this state;

(II) The states in which the persons reside have associations similar to the association created by the act; and

(III) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(b) For structured settlement annuities specified in subsection (2) of this section, subdivisions (1)(a)(i) and (ii) of this section do not apply. The act shall, except as provided in subdivisions (1)(c) and (d) of this section, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) Is a resident, regardless of where the contract owner resides; or

(ii) Is not a resident, but only under the following conditions:

(A)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by the act; and

(B) The payee or beneficiary and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

(c) The act shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this state if the payee or beneficiary is afforded any coverage by the association of another state.

(d) The act is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under the act is provided coverage under the laws of any other state, the person shall not be provided coverage under the act. In determining the application of the provisions of this subdivision in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, the act shall be construed in conjunction with other state laws to result in coverage by only one association.

(2)(a) The act shall provide coverage to the persons specified in subsection (1) of this section for direct nongroup life insurance, health insurance, which for purposes of the act includes health maintenance organization subscriber contracts and certificates, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by the act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(b) The act shall not apply to:

(i) Any portion of any policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract holder;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract, except any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits, to the extent that the rate of interest on which it is based or

the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) On and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as described in 29 U.S.C. 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) A portion of a policy or contract to the extent that the assessments required by section 44-2708 with respect to the policy or contract are preempted by federal or state law;

(viii) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, contract holder, contract owner, or policy owner, including, without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form, filing, or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(ix) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution

benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(x) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture as of the date the member insurer becomes an impaired or insolvent insurer under the act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(xi) An unallocated annuity contract, a funding agreement, a guaranteed interest contract, a guaranteed investment contract, a synthetic guaranteed investment contract, or a deposit administration contract;

(xii) Any such policy or contract issued by:

(A) A hospital or medical service organization, whether profit or nonprofit;

(B) A fraternal benefit society;

(C) A mandatory state pooling plan;

(D) An unincorporated mutual association;

(E) An assessment association operating under Chapter 44 which issues only policies or contracts subject to assessment;

(F) An insurance exchange; or

(G) An organization that has a certificate or license limited to the issuance of charitable gift annuities;

(xiii) Any policy or contract issued by any person, corporation, or organization which is not licensed by the Department of Insurance under Chapter 44;

(xiv) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Title 42, Chapter 7, Subchapter XVIII, Part C or D, commonly known as Medicare Part C and D, or Title 42, Chapter 7, Subchapter XIX, commonly known as Medicaid, of the United States Code, any regulations issued pursuant thereto, or any other policy or contract issued pursuant to the Medical Assistance Act; or

(xv) A viatical settlement contract as defined in section 44-1102 or a viaticated policy as defined in section 44-1102.

(3) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to one life, regardless of the number of policies or contracts:

(A) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(B) In health insurance benefits: (I) Five hundred thousand dollars for health benefit plans; (II) three hundred thousand dollars for disability insurance or long-term care insurance as defined in section 44-4509. For purposes of this subdivision, disability insurance means the type of policy which pays a monthly or weekly amount if an individual is disabled and cannot work; and (III) one hundred thousand dollars for coverages not defined as disability insurance, long-term care insurance, or health benefit plans, including any net cash surrender and net cash withdrawal values; or

(C) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) With respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars in the present value of annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iii) The association shall not be obligated to cover more than:

(A) An aggregate of three hundred thousand dollars in benefits with respect to any one life under subdivisions (3)(b)(i) and (ii) of this section, except that with respect to benefits for health benefit plans under subdivision (3)(b)(i)(B)(I) of this section, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or

(B) With respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits regardless of the number of policies and contracts held by the owner;

(iv) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under the act may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights; and

(v) For purposes of the act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(4) In performing its obligations to provide coverage under section 44-2707, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Source: Laws 1975, LB 217, § 3; Laws 1986, LB 593, § 5; Laws 2001, LB 360, § 15; Laws 2004, LB 1047, § 8; Laws 2012, LB887, § 17; Laws 2019, LB159, § 2.

Cross References

Medical Assistance Act, see section 68-901.

44-2704 Act; how construed.

The Nebraska Life and Health Insurance Guaranty Association Act shall be construed to effect the purposes enumerated in section 44-2701.

Source: Laws 1975, LB 217, § 4; Laws 1986, LB 593, § 6; Laws 2012, LB887, § 18.

44-2705 Nebraska Life and Health Insurance Guaranty Association; created; members; board of directors; accounts; supervision.

(1) There is hereby created a nonprofit unincorporated legal entity to be known as the Nebraska Life and Health Insurance Guaranty Association. All member insurers shall be members of the association as a condition of their authority to transact the business of insurance in this state. The association shall perform its functions under the plan of operation established and approved according to section 44-2709 and shall exercise its powers through a board of directors established pursuant to the provisions of section 44-2706. For purposes of administration and assessment, the association shall maintain three accounts: (a) A health insurance account; (b) a life insurance account; and (c) an annuity account.

(2) The association shall be under the direct supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state.

Source: Laws 1975, LB 217, § 5; Laws 1989, LB 92, § 216.

44-2706 Board of directors; members; how selected; voting rights; represent insurers; expenses.

(1) The board of directors of the association shall consist of not less than seven nor more than eleven members serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. Vacancies on the board shall be filled for the remaining period of the term in the manner described in the plan of operation. To select the initial board of directors and initially organize the association, the director shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the director may appoint the initial members.

(2) In approving selections or in appointing members to the board, the director shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board as provided in sections 81-1174 to 81-1177 for state employees but shall not otherwise be compensated by the association for their services.

Source: Laws 1975, LB 217, § 6; Laws 1981, LB 204, § 72; Laws 2019, LB159, § 3.

44-2707 Association; powers and duties; enumerated.

In addition to the powers and duties enumerated in the Nebraska Life and Health Insurance Guaranty Association Act:

(1) If a member insurer is an impaired insurer, the association may, at its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(a) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all the covered policies or contracts of the impaired insurer; and

(b) Provide such money, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision (1)(a) of this section and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1)(a) of this section;

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)(A) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the covered policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide such money, pledges, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties; or

(b) Provide benefits in accordance with the following provisions:

(i) With respect to covered policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(A) With respect to group policies and contracts, not later than the earlier of the next renewal date under these policies or contracts or forty-five days but not less than thirty days after the date on which the association becomes obligated with respect to the policies and contracts; and

(B) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date if any under the policies or contracts or one year but not less than thirty days after the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, thirty days' notice of the termination made pursuant to subdivision (2)(b)(i) of this section of the benefits provided;

(iii) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured, enrolled, or an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (2)(b)(iv) of this section if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a

specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(iv)(A) In providing the substitute coverage required under subdivision (2)(b)(iii) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the director.

(B) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.

(C) The association may reinsure any alternative or reissued policy or contract;

(v)(A) Alternative policies or contracts adopted by the association shall be subject to the approval of the director. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(C) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the director;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy owner, the insured, the enrollee, or the association; and

(viii) When proceeding under subdivision (2)(b) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision (2)(b)(iii) of section 44-2703;

(3) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under the act with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of the act;

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of the insolvent insurer requests, the association shall provide a report to the liquidator regarding such premiums collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

(5) The protection provided by the act shall not apply if guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state;

(6) In carrying out its duties under subdivision (2) of this section, the association may, subject to approval by a court in this state:

(a) Impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if:

(i) The association finds that the amounts which can be assessed under the act are less than the amounts needed to assure full and prompt performance of the association's duties under the act; or

(ii) That the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(b) Impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts in addition to any contractual provisions for deferral of cash or policy loan value.

If the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court;

(7) A deposit in this state which is held pursuant to law or required by the director for the benefit of creditors, including policy and contract owners, and not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to section 44-4852, shall be promptly paid to the association. The association shall be entitled to retain a portion of such amount equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency. The association shall remit to the domiciliary receiver the amount so paid to the association and not retained pursuant to this subdivision. Any amount paid to the association less the amount not retained by it shall be treated as a distribution of estate assets pursuant to section 44-4834 or similar provision of the state of domicile of the impaired or insolvent insurer;

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subdivision (2) of this section, the

director shall have the powers and duties of the association under the act with respect to the insolvent insurer;

(9) At the request of the director, the association may give assistance and advice to the director concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer;

(10) The association shall have standing to appear before any court or administrative agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under the act or with jurisdiction over any person or property against which the association may have rights through subrogation or other basis. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts and contractual obligations of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person against whom the association may have rights through subrogation or otherwise;

(11)(a) Any person receiving benefits under the act shall be deemed to have assigned his or her rights under and any causes of action against any person for losses arising under the covered policy or contract to the association to the extent of the benefits received because of the act whether the benefits are payments of, or on account of, contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights by any enrollee, payee, policy or contract owner, certificate holder, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by such act upon such person.

(b) The subrogation rights of the association under this subdivision shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under such act.

(c) In addition to subdivisions (11)(a) and (b) of this section, the association shall have all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts. Such common-law rights and equitable or legal remedies include, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to the act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor. Nothing in this subdivision shall include any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the Internal Revenue Code.

(d) If the provisions of this subdivision are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is

attributable to the policies or contracts or portion of such amount covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in subdivision (11) of this section, the person shall pay to the association the portion of the recovery attributable to the policies or contracts or any portion of such recovery covered by the association;

(12) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of the act;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 44-2708 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of the act. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association and to perform such other functions as become necessary or proper under the act;

(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(f) Take such legal action as may be necessary to avoid or recover payment of improper claims;

(g) Exercise, for the purposes of the act and to the extent approved by the director, the powers of a domestic life or health insurer or health maintenance organization, but in no case may the association issue insurance policies or contracts other than those issued to perform its obligations under the act;

(h) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(i) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under the act with respect to the person, and the person shall promptly comply with the request;

(j) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under the act;

(k) Take other necessary or appropriate action to discharge its duties and obligations under the act or to exercise its powers under the act; and

(l) Join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association;

(13)(a) At any time within one hundred eighty days after the coverage date, the association may elect to succeed to the rights and obligations of the ceding member insurer that accrue on or after the coverage date and that relate to policies, contracts, or annuities covered, in whole or in part, by the association under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association. For purposes of this section, coverage date means the date on which the association becomes responsible for the obligations of a member insurer. The election shall

be effected by the association, or the National Organization of Life and Health Insurance Guaranty Associations on behalf of the association, sending written notice, return receipt requested, to the affected reinsurers. To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association, or the National Organization of Life and Health Insurance Guaranty Associations on behalf of the association, as soon as possible after commencement of formal delinquency proceedings copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts. If the association makes an election, subdivisions (13)(a)(i) through (vi) of this section apply to the reinsurance contracts selected by the association:

(i) The association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the coverage date and shall be responsible for the performance of all other obligations to be performed after the coverage date in each case that relates to policies, contracts, or annuities covered, either in whole or in part, by the association. The association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

(ii) The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the coverage date and that relate to policies, contracts, or annuities covered by the association, in whole or in part, except that on receiving such amounts, the association shall pay to the beneficiary under the policy, contract, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of: (A) The amount received by the association, and (B) the excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract, or annuity, less the retention by the insurer applicable to the loss or event;

(iii) Within thirty days after the association's election, the association and each reinsurer under the contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election with respect to policies, contracts, or annuities covered, in whole or in part, by the association, giving full credit to all items paid by either the member insurer, or its receiver, rehabilitator, or liquidator, or the reinsurer during the period between the coverage date and the date of the association's election. The association or reinsurer shall pay the net balance due the other within five days after the completion of such calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to subdivision (13)(a)(ii) of this section, the receiver, rehabilitator, or liquidator shall, as promptly as practicable, pay such amounts to the association. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by

arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law;

(iv) If the association, or receiver on behalf of the association, within sixty days after the election, pays the unpaid premiums due for periods both before and after the coverage date that relate to policies, contracts, or annuities covered by the association in whole or in part, the reinsurer shall not be entitled to terminate the reinsurance agreements for failure to pay premiums to the extent that the agreements relate to policies, contracts, or annuities covered by the association either wholly or partially and may not set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association;

(v) During the period from the coverage date until the election date or, if the election date does not occur, one hundred eighty days after the date of the order of liquidation, (A) neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under subdivision (13)(a) of this section, whether for periods prior to or after the date of the order of liquidation, and (B) the reinsurer, the receiver, and the association shall, to the extent practicable, provide each other data and records upon reasonable request, provided that once the association has elected to assume a reinsurance contract, the rights and obligations of the parties shall be governed by subdivision (13)(a) of this section; and

(vi) If the association does not elect to assume a reinsurance contract by the election date pursuant to subdivision (13)(a) of this section, the association shall have no rights or obligations, in each case for periods both before and after the coverage date, with respect to the reinsurance contract;

(b) When policies, contracts, or annuities or covered obligations with respect thereto are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the association, in the case of contracts assumed under subdivision (13)(a) of this section, subject to the following:

(i) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

(ii) The obligations described in subdivision (13)(a) of this section shall not apply on and after the date the reinsurance contract is transferred to the third party insurer; and

(iii) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty days prior to the effective date of the transfer;

(c) The provisions of subdivision (13) of this section shall supersede the provisions of any law of this state or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the coverage date to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance contract with respect to losses or events that occur in periods prior to the coverage date, subject to applicable setoff provisions; and

(d) Except as otherwise expressly set forth in subdivision (13) of this section, nothing in such subdivision shall alter or modify the terms and conditions of any reinsurance contract. Nothing in the subdivision shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in such subdivision shall give a policyowner, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section shall limit or affect the association's rights as a creditor of the estate against the assets of the estate. Nothing in this section shall apply to reinsurance agreements covering property or casualty risks;

(14) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of the act in an economical and efficient manner;

(15) If the association has arranged or offered to provide the benefits of the act to a covered person under a plan or arrangement that fulfills the association's obligations under the act, such person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement; and

(16) Venue in an action against the association arising under the act shall be in the district court of Lancaster County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under the act.

Source: Laws 1975, LB 217, § 7; Laws 1986, LB 593, § 7; Laws 2001, LB 360, § 16; Laws 2003, LB 216, § 11; Laws 2019, LB159, § 4.

This section does not encompass the liability of an insolvent insurer arising under law rather than under the provisions of the policy such insurer issued. Nebraska Life & Health Ins. Guar. Assn. v. Dobias, 247 Neb. 900, 531 N.W.2d 217 (1995).

44-2708 Assessments against member insurers; procedure; effect; protest or appeal.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. The board shall collect the assessments after thirty days' written notice to the member insurers before payment is due, and the assessments shall accrue interest at the rate calculated pursuant to section 45-103 on and after the due date.

(2) There shall be two classes of assessments as follows:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative costs and other general expenses, including expenses for examinations conducted under the authority of subdivision (3) of section 44-2711. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer; and

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 44-2707 with regard to an impaired or insolvent domestic insurer.

(3)(a) The amount of any Class A assessment for each account shall be determined by the board and may be authorized and called on a pro rata or non-pro-rata basis. If pro rata, the board may provide that it be credited against

future Class B assessments. The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances. The amount of any Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the director. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

(b) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account bears, for the three most recent calendar years for which information is available preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, to such premiums received on business in this state for such calendar years by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of the Nebraska Life and Health Insurance Guaranty Association Act. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth pursuant to this subsection, the amount by which such assessment is abated or deferred shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a) Subject to the provisions of subdivision (b) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for the life insurance account, the annuity account, and the health account shall not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(b) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar

years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (a) of this subsection shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated pursuant to this section.

(c) If the maximum assessment, together with the other assets of the association in an account, does not provide in any one year in an account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by the act.

(d) The board may provide in the plan of operation a method of allocating funds among other claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(e) If the maximum assessment for an account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then the board shall access the other accounts for the necessary additional amount, subject to the provisions of subdivision (5)(a) of this section.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers in proportion to the contribution of each insurer to that account the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that amount, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance or health maintenance organization business within the scope of the act, to consider the amount reasonably necessary to meet its assessment obligations under the act.

(8) The association shall issue to each insurer paying a Class B assessment under the act a certificate of contribution in a form prescribed by the director for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. A statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest shall accompany the payment.

(b) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision.

Within sixty days after receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with a request.

Source: Laws 1975, LB 217, § 8; Laws 1986, LB 593, § 8; Laws 2000, LB 930, § 7; Laws 2001, LB 360, § 17; Laws 2019, LB159, § 5.

44-2709 Association; plan of operation; requirements.

(1)(a) The association shall submit to the director a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments shall become effective upon approval in writing by the director or, if it has not been disapproved by the director, thirty days after submission.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty days following August 24, 1975, or if at any time thereafter the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the Nebraska Life and Health Insurance Guaranty Association Act. Such rules and regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated in the Nebraska Life and Health Insurance Guaranty Association Act:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under section 44-2706;

(c) Establish regular places and times for meetings of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(e) Establish the procedures whereby selections for the board of directors shall be made and submitted to the director;

(f) Establish any additional procedures for assessments pursuant to section 44-2708;

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(h) Establish procedures whereby a member of the board of directors may be removed for cause including, but not limited to, instances in which a member insurer becomes an impaired or insolvent insurer; and

(i) Require the board of directors to establish a policy and procedures for addressing conflicts of interest.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under subdivision (12)(c) of section 44-2707 and section 44-2708, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation made under this subsection shall take effect only with the approval of both the board of directors and the director and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 9; Laws 1986, LB 593, § 9; Laws 2001, LB 360, § 18; Laws 2019, LB159, § 6.

44-2710 Director; powers and duties; enumerated.

In addition to the powers and duties enumerated in the Nebraska Life and Health Insurance Guaranty Association Act:

(1) The director shall:

(a) Notify the board of directors of the existence of an impaired or insolvent insurer not later than three days after a determination of impairment or insolvency is made or he or she receives notice of impairment or insolvency;

(b) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer;

(c) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under the act;

(d) In any liquidation or rehabilitation proceeding under Nebraska law involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the director shall be appointed conservator; and

(e) Transmit to the association all claims on covered policies timely filed with him or her pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. The association shall then be considered to have been designated as the director's representative pursuant to the act, and it shall proceed to investigate, hear, settle, and determine such claims unless the claimant shall, within thirty days from the date the claim is filed with the director, file with the director a written demand that the claim be processed in the liquidation proceedings as a claim not covered by the Nebraska Life and Health Insurance Guaranty Association Act. In regard to those claims transmitted to the associa-

tion by the director, the association and claimants shall have all of the rights and obligations and be subject to the same limitations and procedures as are specified in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act for the determination of claims;

(2) The director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the director may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars per month;

(3) Any action of the board of directors or the association may be appealed to the director by any member insurer if such appeal is taken within thirty days of the action being appealed. Any final action or order of the director may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act; and

(4) The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 10; Laws 1986, LB 593, § 10; Laws 1988, LB 352, § 65; Laws 1989, LB 319, § 74.

Cross References

Administrative Procedure Act, see section 84-920.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-2711 Detection and prevention of insurer impairments or insolvencies; powers and duties of board and director.

To aid in the detection and prevention of insurer impairments or insolvencies:

(1) The board of directors shall, upon majority vote, notify the director of any information indicating any member insurer may be unable or potentially unable to fulfill its contractual obligations;

(2) The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations. The director may conduct such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the director may designate. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors of the association prior to its release to the public, but this shall not excuse the director from his or her obligation to comply with subdivision (3) of this section. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director, but it shall not be open to public inspection prior to the release of the examination report to the public and shall be released at that time only if the examination discloses that the examined insurer is unable or potentially unable to meet its contractual obligations;

(3) The director shall report to the board of directors when he or she has reasonable cause to believe that any member insurer examined at the request of the board of directors may be unable or potentially unable to fulfill its contractual obligations;

(4) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. Such reports and recommendations shall not be considered public documents;

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer impairments or insolvencies; and

(6) The board of directors shall, at the conclusion of any insurer impairment or insolvency in which the association carried out its duties under the Nebraska Life and Health Insurance Guaranty Association Act or exercised any of its powers under such act, prepare a report on the history and causes of such impairment or insolvency based on the information available to the association and submit such report to the director.

Source: Laws 1975, LB 217, § 11; Laws 1986, LB 593, § 11.

44-2712 Association; recommend special deputy.

The association may recommend a natural person to serve as a special deputy to act for the director and under his supervision in the liquidation, rehabilitation, or conservation of any member insurer.

Source: Laws 1975, LB 217, § 12.

44-2713 Impaired or insolvent insurer; effect; procedure.

(1) Nothing in the Nebraska Life and Health Insurance Guaranty Association Act shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties pursuant to section 44-2707. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities as provided in section 44-2714.

(3) For the purpose of carrying out its obligations under the Nebraska Life and Health Insurance Guaranty Association Act, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subdivision (11) of section 44-2707. All assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by the act. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such

policies bear to the reserve that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4)(a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the impaired or insolvent insurer, and any other party with a bona fide interest in making an equitable distribution of the ownership rights of such impaired or insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(b) No distribution to shareholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of assessments levied by the association with respect to such insurer have been fully recovered by the association.

(5) It shall be a prohibited unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act for any person to make use in any manner of the protection afforded by the Nebraska Life and Health Insurance Guaranty Association Act in the sale of insurance.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions (b), (c), and (d) of this subsection.

(b) No such dividend shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate of the insurer at the time the distributions were paid shall be liable up to the amount of distributions such person received. Any person who was an affiliate of the insurer at the time the distributions were declared shall be liable up to the amount of distributions such person would have received if they had been paid immediately. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer.

(e) If any person liable under subdivision (c) of this subsection is insolvent, all affiliates of such person at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Source: Laws 1975, LB 217, § 13; Laws 1986, LB 593, § 12; Laws 1989, LB 92, § 217; Laws 2001, LB 360, § 19; Laws 2019, LB159, § 7.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-2714 Association; subject to examination and regulation; annual report.

The association shall be subject to examination and regulation by the director. The board of directors shall submit to the director, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the director and a report of its activities during the preceding calendar year.

Source: Laws 1975, LB 217, § 14.

44-2715 Association; exempt from fees and taxes; exception.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Source: Laws 1975, LB 217, § 15.

44-2716 Insurer; offset against tax liability; handling of refund sums.

(1) The insurer may offset against its premium and related retaliatory tax liability to this state pursuant to sections 44-150 and 77-908 accrued with respect to business transacted in such year an amount equal to twenty percent of the original face amount of the certificate of contribution, beginning with the first calendar year after the year of issuance through the fifth calendar year of issuance.

(2) Any sums acquired by refund pursuant to subsection (6) of section 44-2708 from the association which have previously been written off by contributing insurers and offset against premium and related retaliatory taxes as provided in subsection (1) of this section and are not then needed for purposes of Chapter 44 shall be paid by the association to the director who shall handle such funds in the same manner as provided for in section 77-912.

Source: Laws 1975, LB 217, § 16; Laws 1986, LB 1114, § 6; Laws 1987, LB 302, § 6; Laws 2000, LB 930, § 8.

44-2717 Exemption from liability.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its directors, officers, agents, or employees, the association or its agents or employees, members of its board of directors, or the director or his or her representatives for any action taken by them in the performance of their powers and duties under the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 17; Laws 1986, LB 593, § 13.

44-2718 Stay of proceedings against impaired insurer; purpose; association; apply to set aside judgment or defend.

All proceedings in which the impaired insurer is a party in any court in this state shall be stayed one hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits. Nothing in this section shall be deemed to limit the powers of a receiver

appointed pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, or to stay any proceeding brought pursuant to such act.

Source: Laws 1975, LB 217, § 18; Laws 2019, LB159, § 8.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-2719 Assessments made by associations of other states; effect.

Assessments made by the insurance guaranty associations, or similar entities, pursuant to the laws of any other state shall not be considered taxes, licenses, other fees, other material obligations, prohibitions, or restrictions as defined in section 44-150.

Source: Laws 1975, LB 217, § 19.

44-2719.01 Using name of association; when prohibited.

No person, including an insurer, agent, or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio station or television station, or in any other way any advertisement, announcement, or statement, written or oral, which uses the existence of the Nebraska Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Nebraska Life and Health Insurance Guaranty Association Act, except that this section shall not apply to the Nebraska Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

Source: Laws 1986, LB 593, § 14; Laws 2019, LB159, § 9.

44-2719.02 Insurer under court order; provisions applicable; act; applicability.

(1) Any insurer under an order of liquidation, rehabilitation, or conservation on February 12, 1986, shall be subject to the provisions of the Nebraska Life and Health Insurance Guaranty Association Act in effect on the day prior to February 12, 1986.

(2) Notwithstanding any other provision of law, the provisions of the Nebraska Life and Health Insurance Guaranty Association Act in effect on the date the association first becomes obligated for the policies or contracts of an insolvent or impaired member govern the association's rights or obligations to the policyowners, contract owners, or enrollees of the insolvent or impaired member insurer.

Source: Laws 1986, LB 593, § 15; Laws 2012, LB887, § 19; Laws 2019, LB159, § 10.

44-2720 Act, how cited.

Sections 44-2701 to 44-2720 shall be known and may be cited as the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 1975, LB 217, § 21; Laws 1986, LB 593, § 16.

ARTICLE 28

NEBRASKA HOSPITAL-MEDICAL LIABILITY ACT

Section

44-2801 Legislative findings and intent.

(1) The Legislature finds and declares that it is in the public interest that competent medical and hospital services be available to the public in the State of Nebraska at reasonable costs, and that prompt and efficient methods be provided for eliminating the expense as well as the useless expenditure of time of physicians and courts in nonmeritorious malpractice claims and for efficiently resolving meritorious claims. It is essential in this state to assure continuing availability of medical care and to encourage physicians to enter into the practice of medicine in Nebraska and to remain in such practice as long as such physicians retain their qualifications.

(2) The Legislature further finds that at the present time under the system in effect too large a percentage of the cost of malpractice insurance is received by individuals other than the injured party. The intent of sections 44-2801 to 44-2855 is to serve the public interest by providing an alternative method for determining malpractice claims in order to improve the availability of medical care, to improve its quality and to reduce the cost thereof, and to insure the availability of malpractice insurance coverage at reasonable rates.

Source: Laws 1976, LB 434, § 1.

The Nebraska Hospital-Medical Liability Act does not establish a public policy requiring that a professional liability insurance policy must provide coverage for sexual abuse inflicted by a physician upon his or her patient. R.W. v. Schrein, 263 Neb. 708, 642 N.W.2d 505 (2002).

This act held constitutional in regard to all questions of constitutionality raised in the answer. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

44-2802 Terms, defined; common-law meaning; when.

(1) As used in the Nebraska Hospital-Medical Liability Act, unless the context otherwise requires, the definitions in sections 44-2803 to 44-2817 shall apply.

(2) Any legal word or term of art used in the Nebraska Hospital-Medical Liability Act and not otherwise defined shall have such meaning as is consistent with common law.

Source: Laws 1976, LB 434, § 2; Laws 1984, LB 692, § 3.

44-2803 Health care provider, defined.

Health care provider means: (1) A physician; (2) a certified registered nurse anesthetist; (3) an individual, partnership, limited liability company, corporation, association, facility, institution, or other entity authorized by law to provide professional medical services by physicians or certified registered nurse anesthetists; (4) a hospital; or (5) a personal representative as defined in section 30-2209 who is successor or assignee of any health care provider designated in subdivisions (1) through (4) of this section.

Source: Laws 1976, LB 434, § 3; Laws 1993, LB 121, § 245; Laws 1995, LB 563, § 1; Laws 2005, LB 256, § 17.

44-2804 Physician, defined.

Physician shall mean a person with an unlimited license to practice medicine in this state pursuant to the Medicine and Surgery Practice Act or a person with a license to practice osteopathic medicine or osteopathic medicine and surgery in this state pursuant to sections 38-2029 to 38-2033.

Source: Laws 1976, LB 434, § 4; Laws 1988, LB 1100, § 3; Laws 2007, LB463, § 1136.

Cross References

Medicine and Surgery Practice Act, see section 38-2001.

44-2805 Patient, defined.

Patient shall mean a natural person who receives or should have received health care from a licensed health care provider under a contract, express or implied.

Source: Laws 1976, LB 434, § 5.

44-2806 Hospital, defined.

Hospital shall mean a public or private institution licensed pursuant to the Health Care Facility Licensure Act.

Source: Laws 1976, LB 434, § 6; Laws 2000, LB 819, § 73.

Cross References

Health Care Facility Licensure Act, see section 71-401.

44-2807 Director, defined.

Director shall mean the Director of Insurance.

Source: Laws 1976, LB 434, § 7.

44-2808 Representative, defined.

Representative shall mean the spouse, parent, guardian, adult child, executor, administrator, trustee, attorney, or other legal agent of the patient.

Source: Laws 1976, LB 434, § 8.

44-2809 Tort, defined.

Tort shall mean any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

Source: Laws 1976, LB 434, § 9.

44-2810 Malpractice or professional negligence, defined.

Malpractice or professional negligence shall mean that, in rendering professional services, a health care provider has failed to use the ordinary and reasonable care, skill, and knowledge ordinarily possessed and used under like circumstances by members of his profession engaged in a similar practice in his or in similar localities. In determining what constitutes reasonable and ordinary care, skill, and diligence on the part of a health care provider in a particular community, the test shall be that which health care providers, in the same community or in similar communities and engaged in the same or similar lines of work, would ordinarily exercise and devote to the benefit of their patients under like circumstances.

Source: Laws 1976, LB 434, § 10.

The applicable standard of care in medical malpractice cases is established by the Nebraska Hospital-Medical Liability Act and has a locality focus, but otherwise is consistent with the general common-law standard of care. Hemsley v. Langdon, 299 Neb. 464, 909 N.W.2d 59 (2018).

Hospital policies and rules do not conclusively determine the standard of care owed. Green v. Box Butte General Hosp., 284 Neb. 243, 818 N.W.2d 589 (2012).

This section of the Nebraska Hospital-Medical Liability Act specifically provides for use of the locality rule. Fales v. Books, 253 Neb. 491, 570 N.W.2d 841 (1997).

Plaintiff failed to allege that defendants, in rendering professional services, failed to use the ordinary and reasonable care, skill, and knowledge ordinarily possessed and used under like circumstances by health care providers practicing in the community. Hitzemann v. Adam, 246 Neb. 201, 518 N.W.2d 102 (1994).

44-2811 Health care, defined.

Health care shall mean any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's care, treatment, or confinement.

Source: Laws 1976, LB 434, § 11.

44-2812 Risk manager, defined.

Risk manager shall mean an insurance company admitted to write insurance in Nebraska, which company shall be appointed by the director to manage the Residual Malpractice Insurance Authority.

Source: Laws 1976, LB 434, § 12.

44-2813 Occurrence, defined.

Occurrence shall mean the event, incident, or happening, and the acts or omissions incident thereto, which proximately cause injuries or damages for which reimbursement is or may be claimed by the patient or his representative.

Source: Laws 1976, LB 434, § 13.

44-2814 Insurer, defined.

Insurer shall mean the authority or an insurance company engaged in writing malpractice liability insurance in this state.

Source: Laws 1976, LB 434, § 14.

44-2815 Authority, defined.

Authority shall mean the Residual Malpractice Insurance Authority established pursuant to section 44-2837.

Source: Laws 1976, LB 434, § 15.

44-2816 Informed consent, defined.

Informed consent shall mean consent to a procedure based on information which would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities. Failure to obtain informed consent shall include failure to obtain any express or implied consent for any operation, treatment, or procedure in a case in which a reasonably prudent health care provider in the community or similar communities would have obtained an express or implied consent for such operation, treatment, or procedure under similar circumstances.

Source: Laws 1976, LB 434, § 16.

Informed consent under this section does not need to be given in writing. Bank v. Mickels, 302 Neb. 1009, 926 N.W.2d 97 (2019).

Disclosure of a doctor's disciplinary history is necessary only when mandated by the standard of care. Curran v. Buser, 271 Neb. 332, 711 N.W.2d 562 (2006).

To be ''properly informed'' under section 44–2820, a patient must be informed under the standard articulated in this section. Curran v. Buser, 271 Neb. 332, 711 N.W.2d 562 (2006).

This section has been construed as a legislative enactment of the ''professional theory'' of a physician's duty to disclose the risks of a treatment or procedure. Cerny v. Longley, 270 Neb. 706, 708 N.W.2d 219 (2005).

A physician's duty to obtain informed consent is measured by what information would ordinarily be provided to the patient under like circumstances by health care providers engaged in a similar practice in the locality or in similar localities. Hamilton v. Bares, 267 Neb. 816, 678 N.W.2d 74 (2004).

There are two parts to the definition of informed consent. The first part refers to the information that is provided to the patient regarding the procedure that is to be performed. The second part refers to the obligation of the health care provider to obtain the patient's express or implied consent to perform any operation, treatment, or procedure. Walls v. Shreck, 265 Neb. 683, 658 N.W.2d 686 (2003).

A hospital does not have a duty to obtain a patient's informed consent merely because it meets the statutory definition of ''health care provider'' as that term is used in this section. Giese v. Stice, 252 Neb. 913, 567 N.W.2d 156 (1997).

The standard of care in a medical malpractice or negligence action based on inadequate information for a patient's consent to an operation, treatment, or procedure is not determined by a defendant physician's personal or customary routine, but, rather, is based on information which physicians ordinarily supply to patients in like circumstances in the locality or similar localities. Under this section, Nebraska has adopted a ''professional'' theory, under which expert evidence is indispensable to establish what information would ordinarily be provided under the prevailing circumstances by physicians in the relevant and similar localities. Eccleston v. Chait, 241 Neb. 961, 492 N.W.2d 860 (1992).

The language of this statute is adopted for the purposes of malpractice actions against chiropractors. Jones v. Malloy, 226 Neb. 559, 412 N.W.2d 837 (1987).

Because of the definition of ''informed consent'' as outlined in this provision, the Legislature has committed this state to the ''professional'' theory of the duty of a physician to disclose the risks of a treatment. The professional theory provides that expert evidence is necessary to determine if the physician acted the same as a reasonable medical practitioner under the same or similar circumstances and similar locality. Smith v. Weaver, 225 Neb. 569, 407 N.W.2d 174 (1987).

44-2817 Nonrefundable payments, benefits, or damages, defined.

Nonrefundable payments, benefits, or damages shall mean those payments, benefits, or damages which are not required to be refunded in event of recovery of damages pursuant to sections 44-2801 to 44-2855.

Source: Laws 1976, LB 434, § 17.

44-2818 Health care provider; express or implied contract assuring results; liability; when.

No liability shall be imposed upon any health care provider on the basis of an alleged breach of an express or implied contract assuring results to be obtained from any procedure undertaken in the course of health care, unless such contract is expressly set forth in writing and is signed by such health care provider or by an authorized agent of such health care provider. Nothing in this section shall exempt any health care provider from the standard of due care in administering any procedure undertaken.

Source: Laws 1976, LB 434, § 18.

Plaintiff's petition did not allege a contract expressly set forth in writing, signed by defendants or their authorized agents regarding an express or implied contract ensuring the results to be obtained from the procedures undertaken by defendant in the health care of plaintiff. Hitzemann v. Adam, 246 Neb. 201, 518 N.W.2d 102 (1994).

44-2819 Bodily injuries or wrongful death actions; evidence of medical reimbursement insurance inadmissible; credit against judgment; damages recoverable.

(1) In any action for damages for bodily injuries or for wrongful death when it is alleged that the claimant suffered damages for the cost of medical care, custodial care or rehabilitation services, evidence which tends to establish that the claimant or another person so damaged has been or shall be reimbursed or paid for any such item of damage, cost, or expense, in whole or in part, by any nonrefundable medical reimbursement insurance shall not be admissible in evidence or brought to the attention of the jury, but such nonrefundable medical reimbursement insurance benefits, less all premiums paid by or for the claimant, may be taken as a credit against any judgment rendered. The matter of any credit to be deducted from a judgment shall be determined by the court in a separate hearing or upon the stipulation of the parties.

(2) Damages recoverable in any action shall be those losses which have been or shall be sustained by the claimant as a direct and proximate result of the defendant's wrongful acts as established by a preponderance of the evidence. In wrongful death actions, pecuniary loss to a widow or widower, any dependent, or next of kin shall be subject to all of the terms and provisions of sections 44-2801 to 44-2855.

Source: Laws 1976, LB 434, § 19.

44-2820 Action based on failure to obtain informed consent; burden of proof.

Before the plaintiff may recover any damages in any action based on failure to obtain informed consent, it shall be established by a preponderance of the evidence that a reasonably prudent person in the plaintiff's position would not have undergone the treatment had he or she been properly informed and that the lack of informed consent was the proximate cause of the injury and damages claimed.

Source: Laws 1976, LB 434, § 20; Laws 1984, LB 692, § 4.

To be ''properly informed'' under this section, a patient must be informed under the standard articulated in section 44-2816. Curran v. Buser, 271 Neb. 332, 711 N.W.2d 562 (2006).

The language of this statute is adopted for the purposes of malpractice actions against chiropractors. Jones v. Malloy, 226 Neb. 559, 412 N.W.2d 837 (1987).

44-2821 Health care provider; failure to qualify under act; liability under common law; qualified under act; remedy; election not to be bound by act; procedure; post sign; contents.

(1) Any health care provider who fails to qualify under the Nebraska Hospital-Medical Liability Act shall not be covered by the provisions of such act and shall be subject to liability under doctrines of common law. If a health care provider shall not so qualify, the patient's remedy shall not be affected by the terms and provisions of the act.

(2) If a health care provider shall qualify under the act, the patient's exclusive remedy against the health care provider or his or her partner, limited liability company member, employer, or employees for alleged malpractice, professional negligence, failure to provide care, breach of contract relating to providing medical care, or other claim based upon failure to obtain informed consent for an operation or treatment shall be as provided by the act unless the patient shall have elected not to come under the provisions of the act. Unless the patient or his or her representative shall have (a) elected not to be bound by the

terms of the act, (b) filed such election with the director in advance of any treatment, act, or omission upon which any claim or cause of action is based, and (c) notified the health care provider of election as soon as is reasonable under the circumstances that such patient has so elected, it shall be conclusively presumed that the patient has elected to be bound by the terms and provisions of the act. Such election may be made by either legal parent for an unborn or newborn child. Unless a legal parent of an unborn child or the guardian or other representative of a minor or incompetent makes the election in the manner provided in the act for such unborn person, minor, or incompetent, such person shall be deemed to be subject to the terms and provisions of the act.

(3) An election of a patient not to be bound by the act shall be effective for a period of two years after filing unless such election is withdrawn by the patient and shall be ineffective after such two-year period unless renewed in writing and filed with the director. The patient or his or her representative may revoke the election in writing at any time and a copy of such revocation shall be forwarded to the director within five days after the same is made.

(4) Each health care provider who has qualified under the act shall post and keep posted in his or her waiting room or other suitable location a sign of a size and type to be prescribed by the director stating: (name of health care provider) has qualified under the provisions of the Nebraska Hospital-Medical Liability Act. Patients will be subject to the terms and provisions of that act unless they file a refusal to be bound by the act with the Director of Insurance of the State of Nebraska.

Source: Laws 1976, LB 434, § 21; Laws 1984, LB 692, § 5; Laws 1993, LB 121, § 246; Laws 1994, LB 884, § 58.

Whether or not a hospital did in fact qualify under the act was unimportant as no prejudice resulted from the standard of care instruction given to the jury. Gilbert v. Archbishop Bergan Mercy Hospital, 228 Neb. 148, 421 N.W.2d 760 (1988).

The health care provider and patient both remain subject to the act until disposition, if the claim arose when both were so subject. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

44-2822 Claim for bodily injury or death; petition or complaint; file; damages.

Subject to the requirements of sections 44-2840 to 44-2846, a patient or his or her representative having a claim under the Nebraska Hospital-Medical Liability Act for bodily injury or death on account of alleged malpractice, professional negligence, failure to provide care, breach of contract, or other claim based upon failure to obtain informed consent for an operation or treatment may file a petition or complaint in any court of law having requisite jurisdiction. No dollar amount or figure shall be included in the demand in any malpractice petition or complaint, but the petition shall ask for such damages as are reasonable in the premises.

Source: Laws 1976, LB 434, § 22; Laws 1984, LB 692, § 6.

44-2823 Repealed. Laws 2003, LB 216, § 25.

44-2824 Health care provider; qualify under act; conditions.

(1) To be qualified under the Nebraska Hospital-Medical Liability Act, a health care provider or such health care provider's employer, employee, partner, or limited liability company member shall:

(a) File with the director proof of financial responsibility, pursuant to section 44-2827 or 44-2827.01, in the amount of five hundred thousand dollars for each occurrence. In the case of physicians or certified registered nurse anesthetists and their employers, employees, partners, or limited liability company members an aggregate liability amount of one million dollars for all occurrences or claims made in any policy year for each named insured shall be provided. In the case of hospitals and their employees, an aggregate liability amount of three million dollars for all occurrences or claims made in any policy year or risk-loss trust year shall be provided. Such policy may be written on either an occurrence or a claims-made basis. Any risk-loss trust shall be established and maintained only on an occurrence basis. Such qualification shall remain effective only as long as insurance coverage or risk-loss trust coverage as required remains effective; and

(b) Pay the surcharge and any special surcharge levied on all health care providers pursuant to sections 44-2829 to 44-2831.

(2) Subject to the requirements in subsections (1) and (4) of this section, the qualification of a health care provider shall be either on an occurrence or claims-made basis and shall be the same as the insurance coverage provided by the insured's policy.

(3) The director shall have authority to permit qualification of health care providers who have retired or ceased doing business if such health care providers have primary insurance coverage under subsection (1) of this section.

(4) A health care provider who is not qualified under the act at the time of the alleged occurrence giving rise to a claim shall not, for purposes of that claim, qualify under the act notwithstanding subsequent filing of proof of financial responsibility and payment of a required surcharge.

(5) Qualification of a health care provider under the Nebraska Hospital-Medical Liability Act shall continue only as long as the health care provider meets the requirements for qualification. A health care provider who has once qualified under the act and who fails to renew or continue his or her qualification in the manner provided by law and by the rules and regulations of the Department of Insurance shall cease to be qualified under the act.

Source: Laws 1976, LB 434, § 24; Laws 1984, LB 692, § 7; Laws 1986, LB 1005, § 1; Laws 1990, LB 542, § 3; Laws 1993, LB 121, § 247; Laws 1994, LB 884, § 59; Laws 2004, LB 998, § 1; Laws 2005, LB 256, § 18.

The Nebraska Hospital-Medical Liability Act does not have application to acts of negligence committed by otherwise qualified health care providers outside the boundaries of this state. Harper v. Silva, 224 Neb. 645, 399 N.W.2d 826 (1987).

44-2825 Action for injury or death; maximum amount recoverable; settlement; manner.

(1) The total amount recoverable under the Nebraska Hospital-Medical Liability Act from any and all health care providers and the Excess Liability Fund for any occurrence resulting in any injury or death of a patient may not exceed (a) five hundred thousand dollars for any occurrence on or before December 31, 1984, (b) one million dollars for any occurrence after December 31, 1984, and on or before December 31, 1992, (c) one million two hundred fifty thousand dollars for any occurrence after December 31, 1992, and on or before December 31, 2003, (d) one million seven hundred fifty thousand dollars for

any occurrence after December 31, 2003, and on or before December 31, 2014, and (e) two million two hundred fifty thousand dollars for any occurrence after December 31, 2014.

(2) A health care provider qualified under the act shall not be liable to any patient or his or her representative who is covered by the act for an amount in excess of five hundred thousand dollars for all claims or causes of action arising from any occurrence during the period that the act is effective with reference to such patient.

(3) Subject to the overall limits from all sources as provided in subsection (1) of this section, any amount due from a judgment or settlement which is in excess of the total liability of all liable health care providers shall be paid from the Excess Liability Fund pursuant to sections 44-2831 to 44-2833.

Source: Laws 1976, LB 434, § 25; Laws 1984, LB 692, § 8; Laws 1986, LB 1005, § 2; Laws 1992, LB 1006, § 18; Laws 2003, LB 146, § 1; Laws 2004, LB 998, § 2; Laws 2014, LB961, § 3.

The cap on damages in subsection (1) of this section does not violate principles of special legislation, equal protection, the open courts provision, the right to a remedy, the right to a jury trial, the taking of property, and the separation of powers. Gourley v. Nebraska Methodist Health Sys., 265 Neb. 918, 663 N.W.2d 43 (2003).

44-2826 Advance payment; not construed as admission of liability; inadmissible as evidence; reduction or adjustment of judgment; claim not assignable.

(1) Any payment made by a health care provider or his insurer to or for the patient or any other person in the patient's behalf in advance of a final determination of liability of all health care providers shall not be construed as an admission of liability for injuries or damages suffered in any action brought under sections 44-2801 to 44-2855.

(2) Evidence of an advance payment shall not be admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff by the amount of such advance payment. The advance payment shall inure to the exclusive benefit of the defendant making the payment. If the advance payment exceeds the liability of the defendant, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of the amount found to be due from any health care provider be repayable to the health care provider making it.

(3) A patient's claim for compensation under sections 44-2801 to 44-2855 shall not be assignable.

Source: Laws 1976, LB 434, § 26.

44-2827 Health care provider; proof of financial responsibility; filing by insurer.

Financial responsibility of a health care provider may be established only by filing with the director proof that the health care provider is insured pursuant to sections 44-2837 to 44-2839 or by a policy of professional liability insurance in a company authorized to do business in Nebraska. Such insurance shall be in the amount of five hundred thousand dollars per occurrence and, in cases involving physicians or certified registered nurse anesthetists, but not with respect to hospitals, an aggregate liability of at least one million dollars for all occurrences or claims made in any policy year shall be provided. In the case of hospitals and their employees, an aggregate liability amount of three million

dollars for all occurrences or claims made in any policy year shall be provided. The filing shall state the premium charged for the policy of insurance.

Source: Laws 1976, LB 434, § 27; Laws 1986, LB 1005, § 3; Laws 2003, LB 146, § 2; Laws 2004, LB 998, § 3; Laws 2005, LB 256, § 19.

44-2827.01 General acute hospital; psychiatric or mental hospital operated by Board of Regents; physician employed by Board of Regents; risk-loss trust authorized; requirements; director; powers and duties; surcharge.

(1) Any general acute hospital as defined in section 71-412 or a psychiatric or mental hospital as defined in section 71-426 operated by the Board of Regents of the University of Nebraska or any physician employed by the Board of Regents of the University of Nebraska may, in addition to the methods of establishing financial responsibility provided in section 44-2827, establish financial responsibility by a risk-loss trust.

(2) In order to establish financial responsibility through the use of a risk-loss trust, the risk-loss trust shall be approved in writing by the director. Such approval shall expire on the last day of April in each year and shall be renewed annually thereafter if the risk-loss trust continues to comply with the requirements of the Nebraska Hospital-Medical Liability Act and any rules and regulations adopted and promulgated thereunder.

(3) The director shall approve the use of a risk-loss trust to establish financial responsibility if he or she determines from a review of the plan of operation or feasibility study for the risk-loss trust that (a) the risk-loss trust will comply with all of the applicable requirements of the act, (b) the risk-loss trust has a financial plan which provides for adequate funding and adequate reserves to establish and maintain financial responsibility, and (c) the risk-loss trust has a plan of management designed to provide for its competent operation and management.

(4) Any risk-loss trust shall be established and maintained only on an occurrence basis, shall maintain reserves for payment of claims, and shall process and act upon claims in accordance with guidelines acceptable for Nebraska domestic insurance companies. The funds, or any part thereof, of any risk-loss trust may be invested as authorized under the Insurers Investment Act for any domestic property and casualty insurance company.

(5) Any risk-loss trust shall file with the director, on or before March 1 of each year, a financial statement under oath for the year ending December 31 immediately preceding which shall include an actuarial or loss reserve specialist's opinion. The trust shall annually be audited by an independent accountant, and such audit shall be filed with the director.

(6) The director may examine the business affairs, records, and assets of such risk-loss trust to assure that it will be able to establish and maintain financial responsibility. Any examination conducted by the director or his or her authorized representative shall be at the expense of the risk-loss trust.

(7) If the director finds after notice to the Board of Regents of the University of Nebraska and a hearing that the risk-loss trust is not maintaining financial responsibility, he or she may order the board to take such action as is necessary to establish financial responsibility and upon failure by the board to comply therewith may revoke approval of such trust.

(8) If any hospital or physician establishes financial responsibility as provided in subsection (1) of this section, the annual surcharge amount which shall be levied against the board pursuant to section 44-2829 shall be established annually by the director after giving consideration to the following factors:

(a) The surcharge rate for hospitals and physicians set by the director pursuant to such section;

(b) The average rates charged by insurers of Nebraska hospitals and physicians;

(c) Variations in coverage provisions, liability limits, or deductibles between insurance provided by private insurers and the coverage provided by the risk-loss trust; and

(d) The loss experience of the board.

(9) The director may adopt and promulgate reasonable rules and regulations necessary and proper to carry out this section.

Source: Laws 1990, LB 542, § 4; Laws 1991, LB 237, § 66; Laws 1998, LB 1035, § 5; Laws 2000, LB 819, § 74.

Cross References

Insurers Investment Act, see section 44-5101.

44-2828 Action to recover damages; limitation of action.

Except as provided in section 25-213, any action to recover damages based on alleged malpractice or professional negligence or upon alleged breach of warranty in rendering or failing to render professional services shall be commenced within two years next after the alleged act or omission in rendering or failing to render professional services providing the basis for such action, except that if the cause of action is not discovered and could not be reasonably discovered within such two-year period, the action may be commenced within one year from the date of such discovery or from the date of discovery of facts which would reasonably lead to such discovery, whichever is earlier. In no event may any action be commenced to recover damages for malpractice or professional negligence or breach of warranty in rendering or failing to render professional services more than ten years after the date of rendering or failing to render such professional service which provides the basis for the cause of action.

Source: Laws 1976, LB 434, § 28; Laws 1984, LB 692, § 9.

While section 30-810 includes a general statute of limitations applicable to wrongful death actions, this section is a subsequently enacted special statute of limitations applicable to all personal injury and wrongful death actions against health care providers who have taken the necessary steps to qualify under the Nebraska Hospital-Medical Liability Act. Alegent Health Bergan Mercy Med. Ctr. v. Haworth, 260 Neb. 63, 615 N.W.2d 460 (2000).

The discovery exception contained in this section is a tolling provision which permits the filing of an action after the 2-year period only in those circumstances where the cause of action was not discovered and could not reasonably have been discovered within that period. Weaver v. Cheung, 254 Neb. 349, 576 N.W.2d 773 (1998).

The language in this section is identical in all material respects to that contained in section 25-222, which applies to professional negligence actions governed by the common law. Giese v. Stice, 252 Neb. 913, 567 N.W.2d 156 (1997).

In medical malpractice cases, the period of limitations or repose begins to run when the treatment rendered after and relating to the allegedly wrongful act or omission is completed. Healy v. Langdon, 245 Neb. 1, 511 N.W.2d 498 (1994).

The Nebraska Hospital-Medical Liability Act provides for the filing of medical malpractice claims against health care providers within 2 years from the date of the negligent treatment. Jacobson v. Shresta, 21 Neb. App. 102, 838 N.W.2d 19 (2013).

The Nebraska Hospital-Medical Liability Act provides a 2-year statute of limitations for medical malpractice claims unless the cause of action could not have been reasonably discovered within the 2 years, and then the action may be brought within 1 year from the date of discovery. Hampton v. Shaw, 14 Neb. App. 499, 710 N.W.2d 341 (2006).

44-2829 Excess Liability Fund; created; how funded; use surcharge; premiums.

(1) There is hereby created an Excess Liability Fund to be collected and received by the director for the exclusive use and purposes stated in the Nebraska Hospital-Medical Liability Act. Such fund and any income from it shall be held by the State Treasurer in trust, deposited in a separate account, and invested and reinvested pursuant to law.

(2) To create the fund, an annual surcharge shall be levied on all health care providers in Nebraska who have qualified under sections 44-2824 and 44-2827. The surcharge for each health care provider shall be determined by the director subject to the following limitations:

(a) The annual surcharge shall not exceed fifty percent of the annual premium paid by such health care provider for maintenance of current financial responsibility as provided in sections 44-2827 and 44-2837 to 44-2839; and

(b) The charge shall not exceed the amount necessary to maintain the fund in the amount stated in section 44-2830.

(3) Such surcharge and any primary insurance premiums due under sections 44-2837 to 44-2839 shall be due and payable within thirty days after the health care provider has qualified in Nebraska pursuant to section 44-2824 and shall be payable annually thereafter in such amounts as may be determined by the director insofar as the surcharge is concerned and by the risk manager insofar as primary liability coverage is concerned.

(4) The net premiums payable for primary insurance provided by the risk manager pursuant to sections 44-2837 to 44-2839 shall be deposited in the fund at least annually by the risk manager.

(5) If the annual premium surcharge or premiums for primary insurance under sections 44-2837 to 44-2839 are not paid within the time specified in subsection (3) of this section, the qualification of the health care provider under section 44-2824 shall be suspended until the annual premiums are paid. Such suspension shall not be effective as to patients claiming against the health care provider unless, at least thirty days before the effective date of the suspension, a written notice giving the date upon which the suspension becomes effective has been provided by the director to the health care provider.

(6) The Director of Insurance, as administrator of the fund, shall be responsible for legal defense of the fund. The director, using money from the fund as deemed necessary, appropriate, or desirable, may purchase the services of persons, firms, and corporations to aid in protecting the fund against claims. The Department of Justice shall not be responsible for legal defense of the fund. All expenses of collecting, protecting, and administering the fund shall be paid from the fund.

Source: Laws 1976, LB 434, § 29; Laws 1984, LB 692, § 10; Laws 1986, LB 1005, § 4; Laws 2003, LB 146, § 3; Laws 2004, LB 998, § 4.

44-2830 Excess Liability Fund; surcharge, adjusted; when; reinsurance; effect.

If the fund shall exceed the sum of four million five hundred thousand dollars at the end of any calendar year after the payment of all claims and expenses and after adding all reversions to the fund, and if no reinsurance is involved, the director shall reduce the surcharge required by section 44-2829 in order to maintain the fund at an approximate level of five million dollars. Beginning on January 1, 1985, and on January 1 of each succeeding year, the director shall

adjust the amount of the surcharge to maintain the fund at a level which is sufficient to pay all anticipated claims for the next year and to maintain an adequate reserve for future claims. Prior to making such an adjustment, the director shall conduct a public hearing concerning the proposed adjustment and shall give due regard to the size of the existing fund, the number and size of potential claims against the fund, the number of participating providers, changes in the cost of living, and sound actuarial principles. If the fund is reinsured, the director shall determine a lesser level at which the fund shall be maintained because of the reinsurance carried and may reduce the surcharge to provide for the reinsurance and maintain the fund at the lesser level determined by him or her to be reasonable under the circumstances.

Source: Laws 1976, LB 434, § 30; Laws 1984, LB 692, § 11.

44-2831 Excess Liability Fund; special surcharge; reinsurance.

(1) The director may, at any time, analyze the fund to determine if the amount in such fund is inadequate to pay in full all claims allowed or to be allowed during the calendar year. Upon such determination, the director shall have the power to levy a special surcharge on all health care providers who have qualified under the Nebraska Hospital-Medical Liability Act, which special surcharge shall be an amount sufficient to permit full payment of all claims allowed against the fund during a calendar year. The special surcharge shall be levied against all health care providers who have qualified under the Nebraska Hospital-Medical Liability Act on the date of the special surcharge or at any time during the preceding twelve months and shall be in an amount proportionate to the surcharge each health care provider has paid to the fund. Such special surcharge shall be due and payable within thirty days after the same is levied.

(2) The director shall have authority to cause all or any part of the potential liability of the Excess Liability Fund to be reinsured, if such reinsurance is available, on a fair and reasonable basis. The cost of such reinsurance shall be paid by the fund and the fact of the reinsurance shall be taken into account in determining the surcharge as provided in sections 44-2829 and 44-2830, but in no event shall the surcharge exceed fifty percent of the annual premium paid by a health care provider for maintenance of current financial responsibility.

Source: Laws 1976, LB 434, § 31; Laws 1984, LB 692, § 12; Laws 2003, LB 146, § 4; Laws 2004, LB 998, § 5.

44-2831.01 Applicability of change to law.

(1) Any health care provider who has furnished proof of financial responsibility prior to January 1, 2005, under sections 44-2824 and 44-2827 shall be qualified under section 44-2824 for the remainder of the policy year or risk-loss trust year.

(2) The increases in coverage requirements made by Laws 2004, LB 998, in sections 44-2824 and 44-2827 shall apply to policies issued or renewed and risk-loss trust years which commence after January 1, 2005.

(3) The changes made to sections 44-2825, 44-2832, and 44-2833 by Laws 2004, LB 998, apply commencing with policies issued or renewed and risk-loss trust years which commence after January 1, 2005.

Source: Laws 2004, LB 998, § 6.

44-2832 Claims; paid; procedure; limitation.

(1) The Director of Administrative Services shall issue a warrant drawn on the fund in the amount of each claim submitted by the director. All claims against the fund shall be made on a voucher or other appropriate request by the director after he or she has received:

(a) A certified copy of a final judgment in excess of five hundred thousand dollars against a health care provider and in excess of the amount recoverable from all health care providers;

(b) A certified copy of a court-approved settlement in excess of five hundred thousand dollars against a health care provider and in excess of the amount recoverable from all health care providers; or

(c) In case of claims based on primary insurance issued by the risk manager under sections 44-2837 to 44-2839, a certified copy of a final judgment or court-approved settlement requiring payment from the fund.

(2) The amount paid from the fund for excess liability when added to the payments by all health care providers may not exceed the maximum amount recoverable pursuant to subsection (1) of section 44-2825. The amount paid from the fund on account of a primary insurance policy issued by the risk manager to a health care provider under sections 44-2837 to 44-2839 may not exceed five hundred thousand dollars for any one occurrence covered by such policy under any circumstances.

Source: Laws 1976, LB 434, § 32; Laws 1984, LB 692, § 13; Laws 1986, LB 1005, § 5; Laws 2004, LB 998, § 7.

44-2833 Claim; agreement to settle; procedure; settlement; judgment; appeal.

(1) If the insurer of a health care provider shall agree to settle its liability on a claim against its insured by payment of its policy limits of five hundred thousand dollars and the claimant shall demand an amount in excess thereof for a complete and final release and if no other health care provider is involved, the procedures prescribed in this section shall be followed.

(2) A motion shall be filed by the claimant with the court in which the action is pending against the health care provider or, if no action is pending, the claimant shall file a complaint in one of the district courts of the State of Nebraska, seeking approval of an agreed settlement, if any, or demanding payment of damages from the Excess Liability Fund.

(3) A copy of such motion or complaint shall be served on the director, the health care provider, and the health care provider's insurer and shall contain sufficient information to inform the parties concerning the nature of the claim and the additional amount demanded. The health care provider and his or her insurer shall have a right to intervene and participate in the proceedings.

(4) The director, with the consent of the health care provider, may agree to a settlement with the claimant from the Excess Liability Fund. Either the director or the health care provider may file written objections to the payment of the amount demanded. The agreement or objections to the payment demanded shall be filed within twenty days after the motion or complaint is filed.

(5) After the motion or complaint, agreement, and objections, if any, have been filed, the judge shall set the matter for trial as soon as practicable. The court shall give notice of the trial to the claimant, the health care provider, and the director.

(6) At the trial, the director, the claimant, and the health care provider may introduce relevant evidence to enable the court to determine whether or not the settlement should be approved if it has been submitted on agreement without objections. If the director, the health care provider, and the claimant shall be unable to agree on the amount, if any, to be paid out of the Excess Liability Fund, the amount of claimant's damages, if any, in excess of the five hundred thousand dollars already paid by the insurer of the health care provider shall be determined at trial.

(7) The court shall determine the amount for which the fund is liable and render a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the Excess Liability Fund in such a case, the court shall consider the liability of the health care provider as admitted and established by evidence.

(8) Any settlement approved by the court may not be appealed. Any judgment of the court fixing damages recoverable in any such contested proceeding shall be appealable pursuant to the rules governing appeals in any other civil case.

Source: Laws 1976, LB 434, § 33; Laws 1984, LB 692, § 14; Laws 1986, LB 1005, § 6; Laws 2002, LB 876, § 74; Laws 2004, LB 998, § 8.

44-2834 Cause of action; attorney's fees; court costs; loss of earnings; when payable.

(1) In all cases against a health care provider for malpractice or professional negligence, upon motion of either party the court shall review the attorney's fees incurred by that party and allow such compensation as the court shall deem reasonable.

(2) In all cases against health care providers for malpractice or professional negligence, the court may, upon application by the prevailing party, in its discretion and in an amount determined in its discretion tax as costs payable to the prevailing party the reasonable costs of preparation and trial including reasonable attorney's fees and the reasonable loss of earnings by the prevailing party occasioned by the trial if the court finds that the losing party did not have a reasonable chance of recovery or a reasonable chance of a successful defense.

(3) A patient shall have the right to agree with his attorney to pay for the attorney's services on a mutually satisfactory per diem basis. Such election shall be exercised in written form at the time of employment or by written agreement thereafter entered into with his attorney.

Source: Laws 1976, LB 434, § 34.

Review by the court of arrangement for attorney's fees held constitutional. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

44-2835 Malpractice claim; settled or adjudicated to final judgment; report; contents; forwarded to Department of Health and Human Services.

(1) Each malpractice claim settled or adjudicated to final judgment against a health care provider under the Nebraska Hospital-Medical Liability Act shall be reported to the director by the plaintiff's attorney and by the health care provider or his or her insurer or risk manager within sixty days following final disposition of the claim. Such report to the director shall state the following:

(a) The nature of the claim;

(b) The alleged injury and the damages asserted;

(c) Attorney's fees and expenses incurred in connection with the claim or defense; and

(d) The amount of any settlement or judgment.

(2) The director shall forward the name of every health care provider, except a hospital, against whom a settlement has been made or judgment has been rendered under the act to the Department of Health and Human Services for such action, if any, as it deems to be appropriate under the circumstances.

Source: Laws 1976, LB 434, § 35; Laws 1994, LB 1223, § 1; Laws 1996, LB 1044, § 241; Laws 2007, LB296, § 180.

44-2836 Malpractice liability insurance; limitation on liability; when; required policy provisions; insurer; failure to pay final judgment; effect.

(1) As long as malpractice liability insurance remains in force under the qualification set forth in section 44-2824 and unless the patient has elected not to come under sections 44-2801 to 44-2855, the health care provider and his insurer shall be liable to a patient, or his representative, for malpractice, professional negligence, failure to provide care, breach of contract relating to providing medical care, or other claim based on failure to obtain informed consent to an operation or treatment, only to the extent and in the manner specified in sections 44-2801 to 44-2855.

(2) The filing of proof of financial responsibility with the director shall constitute, on the part of the insurer and the health care provider, a conclusive and unqualified acceptance of the provisions of sections 44-2801 to 44-2855.

(3) Failure of the patient or his representative to file his refusal to be bound by sections 44-2801 to 44-2855 shall constitute conclusive and unqualified acceptance of sections 44-2801 to 44-2855.

(4) Any provision in a policy attempting to limit or modify the liability of the insurer contrary to the provisions of sections 44-2801 to 44-2855 shall be void.

(5) Each policy issued under sections 44-2801 to 44-2855 shall be deemed to include the following provisions and any amendments thereto which may be occasioned by legislation passed by the Legislature of the State of Nebraska, as fully as if written in such policy:

(a) The insurer shall assume all obligations to pay an award imposed against its insured under the provisions of sections 44-2801 to 44-2855; and

(b) Any termination of the policy by cancellation shall not be effective as to patients claiming against the insured covered thereby unless, at least thirty days before the effective date of the cancellation, a written notice giving the date upon which termination becomes effective has been mailed to the insured at his last-known address and to the director at his office by certified or registered mail with sufficient postage attached.

(6) If an insurer shall fail or refuse to pay a final judgment, or shall fail or refuse to comply with any provisions of sections 44-2801 to 44-2855, in addition to any other legal remedy, the director may also revoke the approval of its policy form until the insurer shall pay the award or judgment or shall comply with the violated provisions of sections 44-2801 to 44-2855 and has resubmitted its policy form and received the approval of the director.

Source: Laws 1976, LB 434, § 36.

This section held constitutional. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

44-2837 Residual Malpractice Insurance Authority; created; purpose; risk manager; powers and duties; compensation.

(1) The purpose of sections 44-2837 to 44-2839 is to make malpractice liability insurance available to risks as defined in this section.

(2) There is hereby created the Residual Malpractice Insurance Authority. The Department of Insurance is hereby designated as the authority for the purposes of the Nebraska Hospital-Medical Liability Act. The authority shall be empowered to engage in writing medical malpractice liability insurance in this state pursuant to existing law and authorized to insure the health care provider against other liability for injury to persons or property caused by agents, employees, partners, or limited liability company members of the health care provider or by property used in or activities arising from the operations or business of the health care provider. Such insurance coverage against other liability may be provided to the health care provider by the authority only as supplemental professional liability insurance.

(3) The director may appoint a risk manager for the authority. The separate, personal, or independent assets of the risk manager shall not be liable for or subject to use or expenditure for the purpose of providing insurance by the authority.

(4) In the administration and provision for malpractice liability insurance by the authority, the risk manager shall:

(a) Be subject to all laws and regulations of this state which apply to malpractice insurance as provided in existing law;

(b) Prepare and file appropriate forms with the Department of Insurance;

(c) Prepare and file premium rates with the Department of Insurance which shall be based on accepted actuarial principles and accepted practices in the insurance industry;

(d) Perform the underwriting function;

(e) Dispose of all claims and litigation arising out of insurance policies;

(f) Maintain adequate books and records;

(g) File an annual financial statement regarding its operations under the Nebraska Hospital-Medical Liability Act with the Department of Insurance on forms prescribed by the director;

(h) Obtain private reinsurance for the authority, if available, and the cost thereof shall be paid from the Excess Liability Fund;

(i) Prepare and file a plan of operations with the director for approval; and

(j) Act fairly, reasonably, and responsibly in administering the plan.

(5) The risk manager shall receive as compensation for his or her services a percentage of all premiums received under the terms of this section which shall be computed on a fair and equitable basis as determined by the director. The compensation may be adjusted by the director from time to time.

Source: Laws 1976, LB 434, § 37; Laws 1984, LB 692, § 15; Laws 1993, LB 121, § 248; Laws 1994, LB 884, § 60.

44-2838 Health care provider; unable to obtain coverage; apply to risk manager; decision; appeal.

(1) If, after diligent effort to obtain coverage, a health care provider has been declined by at least two insurers, the risk may forward his application to the risk manager together with evidence of the two declinations.

(2) If the risk manager declines to accept the risk, notice of declination, together with the reasons, shall be sent to the applicant and the director. The applicant shall have ten days from the date of notice by the risk manager to request review by the director. On appeal, the director shall review the decision of the risk manager and enter an appropriate order.

Source: Laws 1976, LB 434, § 38.

44-2839 Health care professional liability insurance plan; contents; premiums; use.

The director shall adopt and promulgate a health care professional liability insurance plan pursuant to sections 44-2837 to 44-2839 which shall contain a requirement that the Excess Liability Fund shall participate in such plan. Such plan may contain such other reasonable provisions as the director shall deem necessary or sufficient to make the plan effective. The Excess Liability Fund shall receive all premiums paid under the plan, except the portion payable to the risk manager or paid in settlement of claims, and shall assume the risks relating to policies issued under the plan. The Department of Insurance shall be reimbursed from the fund for necessary expenses incurred in the administration of the Nebraska Hospital-Medical Liability Act. The director shall certify such expenses to the State Treasurer who shall reimburse the Department of Insurance for such services.

Source: Laws 1976, LB 434, § 39; Laws 2021, LB509, § 3.
Effective date August 28, 2021.

44-2840 Medical review panels; review claims; procedure; waiver.

(1) Provision is hereby made for the establishment of medical review panels to review all malpractice claims against health care providers covered by the Nebraska Hospital-Medical Liability Act in advance of filing such actions.

(2) No action against a health care provider may be commenced in any court of this state before the claimant's proposed complaint has been presented to a medical review panel established pursuant to section 44-2841 and an opinion has been rendered by the panel.

(3) The proceedings for action by the medical review panel shall be initiated by the patient or his or her representative by notice in writing with copy of a proposed complaint served upon the director personally or by registered or certified mail. Such notice shall designate the claimant's choice of the physician to serve on the panel, claimant's suggestion of an attorney to serve, and the court where the action shall be filed, if necessary.

(4) The claimant may affirmatively waive his or her right to a panel review, and in such case the claimant may proceed to file his or her action directly in court. If the claimant waives the panel review, the claimant shall serve a copy

of the complaint upon the director personally or by registered or certified mail at the time the action is filed in court.

Source: Laws 1976, LB 434, § 40; Laws 1984, LB 692, § 16; Laws 2002, LB 876, § 75; Laws 2003, LB 146, § 5.

The language of the Political Subdivisions Tort Claims Act at subsection (4) of section 13-919 contemplates that a claim under the act must be filed and disposed of or withdrawn prior to presentation of the proposed petition to a medical review panel, or the waiver of a medical review panel, under this section. Keller v. Tavarone, 262 Neb. 2, 628 N.W.2d 222 (2001).

The requirement that a copy of the petition must be served upon the director of the Department of Insurance when medical panel review is waived is merely a notice requirement and neither confers nor denies jurisdiction of the court. The filing of an action in court is affirmative conduct which constitutes waiver of medical panel review. Brewington v. Rickard, 235 Neb. 843, 457 N.W.2d 814 (1990); Ourada v. Cochran, 234 Neb. 63, 449 N.W.2d 211 (1989).

A plaintiff's right to amend the wording of his specimen petition filed under this section in his petition later filed in the district court is the same as plaintiff's right to amend any other petition, so long as the matter submitted to the court is the same matter submitted to the medical review panel. Jacobs v. Goetowski, 221 Neb. 281, 376 N.W.2d 773 (1985).

A specimen petition alleging medical malpractice is filed pursuant to this section when the parties fall under the coverage of the Nebraska Hospital-Medical Liability Act. Jacobs v. Goetowski, 221 Neb. 281, 376 N.W.2d 773 (1985).

44-2841 Medical review panel; members; selection; procedure.

(1) The medical review panel shall consist of one attorney admitted to practice law in the State of Nebraska and three physicians who hold unlimited licenses under the laws of this state to practice medicine. The attorney shall act in an advisory capacity and as chairperson of the panel, but shall have no vote.

(2) The medical review panel shall be selected in the following manner:

(a) All physicians engaged in the active practice of medicine in this state, whether in the teaching profession or otherwise, who hold a license to practice medicine shall be available for selection;

(b) Each party to the action shall have the right to select one physician and, upon selection, such physician shall be required to serve. The two physicians thus selected shall select the third physician panelist. If one of the health care providers involved is a hospital, a fourth panelist shall be selected who shall be a hospital administrator selected by the hospital;

(c) When there are multiple plaintiffs or defendants, there shall be only one physician or hospital administrator selected per side. The plaintiff, whether single or multiple, shall have the right to select one physician and the defendant, whether single or multiple, shall have the right to select one physician;

(d) A panelist so selected shall serve, except that for good cause shown he or she may be excused. To show good cause for relief from serving, the panelist shall be required to serve an affidavit upon a judge of a court having jurisdiction over the claim when filed. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. The court may excuse the proposed panelist from serving;

(e) Within twenty days after receipt of notification of a proposed panelist by the plaintiff, the defendants shall select a proposed panelist and advise the plaintiff or his or her attorney;

(f) Within twenty days of receipt of notice of any selection, written challenge without cause may be made to the panel member. Upon challenge, a party shall select another panelist. If multiple plaintiffs or defendants are unable to agree on a physician panelist or if two such challenges are made and submitted, the judge shall submit a list consisting of three qualified panelists and each side shall strike one and the remaining member shall serve in place of the challenged panelist designated by the party; and

(g) The parties may agree on the attorney member of the board or, if no agreement can be reached, then five proposed attorney members shall be designated by the judge having jurisdiction of the cause. The parties shall then each strike two names alternately with the claimant striking first until both sides have stricken two names and the remaining name shall be the attorney member of the panel.

(3) If the members of the medical review panel have not been selected within one hundred twenty days following filing of the complaint required by section 44-2840, the court shall have authority to select members of the panel and to set a specific date for the hearing.

Source: Laws 1976, LB 434, § 41; Laws 1984, LB 692, § 17; Laws 2002, LB 876, § 76.

When a medical malpractice action is filed under the Nebraska Hospital-Medical Liability Act, the medical review panel is selected pursuant to this section. Jacobs v. Goetowski, 221 Neb. 281, 376 N.W.2d 773 (1985).

44-2842 Medical review panel; evidence considered; depositions; chairperson; duties.

(1) The evidence to be considered by the medical review panel shall be promptly submitted by the respective parties in written form only. If any party to the proceedings fails to submit his or her evidence within a reasonable time after notice from the panel requesting such evidence, the panel may proceed to decide the matter on the evidence previously submitted. The determination of reasonable time shall be made by the panel. The evidence submitted may consist of medical charts, X-rays, laboratory test results, excerpts of treatises, depositions of witnesses including parties, and any other form of evidence allowable by the medical review panel.

(2) Depositions of parties and witnesses may be taken prior to the convening of the panel and prior to the commencement of the action, but in such event the attorney for the medical care provider shall be furnished with a copy of the complaint which the claimant proposes to file at least ten days before any deposition is taken. The patient shall have the right to request and receive all medical and hospital records relating to his or her case which would be admissible in evidence in a court of law. The chairperson of the panel shall advise the panel relative to any legal question involved in the review proceeding and shall prepare the opinion of the panel. A copy of the evidence shall be sent to each member of the panel.

(3) Either party, after submission of all evidence and upon ten days' notice to the other side, shall have the right to convene the panel at a time and place agreeable to the members of the panel. At such time either party shall have the right to present argument concerning any matters relevant to issues to be decided by the panel before the issuance of its report. The chairperson of the panel shall preside at all meetings, which meetings shall be informal.

(4) If the members of the medical review panel have not convened within six months of the initiation of the proceeding, the judge may terminate the proceeding at the request of either party.

Source: Laws 1976, LB 434, § 42; Laws 1984, LB 692, § 18; Laws 2002, LB 876, § 77; Laws 2003, LB 146, § 6.

44-2843 Medical review panel; access to information; written opinion; issuance; basis for.

(1) The panel shall have the right and duty to request all necessary information. The panel may consult with medical authorities and may examine reports of such health care providers as may be necessary to fully inform itself regarding the issue to be decided. Both parties shall have full access to any material submitted to the panel.

(2) The panel shall have the sole duty to express its expert opinion in writing to each of the parties as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the complaint and as to the issue of damages proximately caused by failure to act in accordance with such standards. Any issue relating to informed consent shall be considered as a charge of failure to act within the appropriate standard of care.

(3) After reviewing all evidence and, unless waived, after argument by counsel representing either party, the panel shall, within thirty days, render one or more of the following expert opinions which shall be in writing and mailed to each of the parties:

(a) The evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care as charged in the complaint in specified particulars;

(b) The evidence supports the conclusion that the defendant involved met the applicable standard of care required under the circumstances; or

(c) There is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury in specified particulars.

(4) No dollar amounts or percentages of disability shall be provided by the panel. A majority vote of the voting members shall control action by the panel. The report of the panel shall be signed only by the chairman who shall certify that the report reflects the opinion of a majority of the voting members. If requested, a minority report shall be provided to any party.

Source: Laws 1976, LB 434, § 43.

44-2844 Request for review of a claim; filed; toll statute of limitations; panel report; admissible as evidence; panelist; immunity.

(1) The filing of the request for review of a claim shall toll the applicable statute of limitations for a period of ninety days following the issuance of the opinion by the medical review panel. The request for review of a claim shall be deemed filed when copy of the request together with a copy of the proposed complaint is delivered or mailed by registered or certified mail to the director, who shall immediately forward a copy to each health care provider named as a defendant at his last and usual place of residence or his office.

(2) The report or any minority report of the medical review panel shall be admissible as evidence in any action subsequently brought by the claimant in a court of law, but such report shall not be conclusive and either party shall have the right to call any member of the medical review panel as a witness. If called, the witness shall be required to appear and testify.

(3) A panelist shall have absolute immunity from civil liability for all communications, findings, opinions and conclusions made in the course and scope of duties prescribed by sections 44-2801 to 44-2855.

Source: Laws 1976, LB 434, § 44.

The word toll, as used in this section, means to interrupt, suspend, or temporarily stop the running of the statute of limitations. Jacobs v. Goetowski, 221 Neb. 281, 376 N.W.2d 773 (1985).

Under this section, the running of the statute of limitations, as set out in section 44-2828, is interrupted during the medical review proceedings and recommences ninety days after the medical review panel issues its opinion. Jacobs v. Goetowski, 221 Neb. 281, 376 N.W.2d 773 (1985).

Statute of limitations is tolled while a claim is before the medical review panel and for ninety days following its opinion. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

The report, or any minority report, of the review panel is admissible evidence if suit follows. Prendergast v. Nelson, 199 Neb. 97, 256 N.W.2d 657 (1977).

44-2845 Medical review panel; members; compensation; expert witness fee.

Each member of the medical review panel shall be paid fifty dollars per day for all work performed as a member of the panel, exclusive of time and services involved if called as a witness to testify in court and reasonable expenses incurred. Fees of the panel, including expenses, shall be paid equally by each side. If a panel member is called as an expert witness at the trial, the panel member shall be paid the customary expert witness fee.

Source: Laws 1976, LB 434, § 45; Laws 2002, LB 1139, § 23.

44-2846 Proceedings before panel; confidential; exception; waiver of privileges; when; witnesses; rights.

(1) Except for the introduction into evidence of the report of the panel, all proceedings before the medical review panel, all actions taken by any party or his counsel in preparation for such proceedings, and the submission of any matter to the medical review panel shall be handled on a confidential basis. Such hearing may not be conducted as a public hearing and the proceedings before the panel shall not be matters of public record.

(2) Initiation of proceedings before a medical review panel by a patient or his representative shall constitute waiver of any privilege or rights conferred by Chapter 27, article 5, as to any hospital records or testimony or records of any physician or surgeon who is attending or has attended such patient for physical or mental conditions or injuries or conditions involved in such proceeding to the same extent and with like effect as provided in Chapter 27, article 5. Any witness providing information or facts or opinions to the medical review panel shall be entitled to the immunities and protection provided to witnesses generally in court proceedings.

Source: Laws 1976, LB 434, § 46.

44-2847 Medical review panel; not to consider disputed questions of law; adviser to panel.

(1) Medical review panels shall be concerned only with the determination of the questions set forth in section 44-2843. Such panels shall not consider or report on disputed questions of law.

(2) To provide for uniformity of procedure, the Department of Health and Human Services may appoint a doctor of medicine from the members of the Board of Medicine and Surgery who may sit with each panel as an observer and as an adviser on procedure but without a vote.

Source: Laws 1976, LB 434, § 47; Laws 1996, LB 1044, § 242; Laws 1999, LB 828, § 5; Laws 2000, LB 1115, § 4; Laws 2007, LB296, § 181.

44-2848 Repealed. Laws 1994, LB 1223, § 135.

44-2849 Repealed. Laws 1994, LB 1223, § 135.

44-2850 Repealed. Laws 1994, LB 1223, § 135.

44-2851 Repealed. Laws 1994, LB 1223, § 135.

44-2852 Repealed. Laws 1994, LB 1223, § 135.

44-2853 Repealed. Laws 1994, LB 1223, § 135.

44-2854 Director; contract for administrative duties and responsibilities; supervisory authority.

The Director of Insurance may contract with an insurance company licensed to do business in the State of Nebraska to perform any administrative duties and responsibilities of the Department of Insurance pursuant to sections 44-2801 to 44-2855, with the Director of Insurance retaining supervisory authority over such insurance company.

Source: Laws 1976, LB 434, § 54.

44-2854.01 Rules and regulations.

The Department of Insurance shall adopt and promulgate rules and regulations regarding the administration of the Nebraska Hospital-Medical Liability Act. Such rules and regulations shall relate to issuing notices of payment due and such other matters as may be necessary to promote the efficient operation of the act in accordance with its terms.

Source: Laws 1984, LB 692, § 19.

44-2855 Act, how cited.

Sections 44-2801 to 44-2855 shall be known and may be cited as the Nebraska Hospital-Medical Liability Act.

Source: Laws 1976, LB 434, § 56; Laws 1984, LB 692, § 20; Laws 1990, LB 542, § 5; Laws 2004, LB 998, § 9.

ARTICLE 29

NEBRASKA HOSPITAL AND PHYSICIANS MUTUAL INSURANCE ASSOCIATION ACT

Section

Section

44-2901 Hospitals; mutual insurance association; how incorporated; purpose.

Any three or more hospitals as defined in section 71-419, which are located in this state and licensed by the Department of Health and Human Services, may incorporate a mutual insurance association to insure member hospitals and their officers, directors, employees, and volunteer workers against liability arising from rendering, or failing to render, professional services in the treatment or care of patients by hospitals and their agents and employees or by member physicians.

Source: Laws 1976, LB 809, § 1; Laws 1996, LB 1044, § 243; Laws 2002, LB 1062, § 10; Laws 2007, LB296, § 182.

44-2902 Physicians; mutual insurance association; how incorporated; purpose.

Any ten or more physicians licensed under the Medicine and Surgery Practice Act may incorporate a mutual insurance association to insure member physicians, their professional corporations, partnerships, limited liability companies, agents, and employees against liability arising from rendering or failing to render professional services in the treatment or care of patients.

Source: Laws 1976, LB 809, § 2; Laws 1993, LB 121, § 249; Laws 2007, LB463, § 1137.

Cross References

Medicine and Surgery Practice Act, see section 38-2001.

44-2903 Mutual insurance association; coverages; supplement professional liability insurance.

Any association authorized by section 44-2901 or 44-2902 shall be authorized to insure members against other liability for injury to persons or property caused by agents or employees of the member or by property used in or activities arising from the operations or business of the member or the professional services of member physicians or their agents or employees. Such coverage against other liability may be provided to members only to supplement professional liability insurance from the association.

Source: Laws 1976, LB 809, § 3.

44-2904 Hospital association; qualified to become a member; when; insuring of risks; considerations.

Any hospital, whether within or without the state, shall be qualified to become a member of a hospital association incorporated under sections 44-2901 to 44-2918 if it is licensed either by the Department of Health and Human Services or by the corresponding authority in the state in which the hospital is located, except that no hospital outside of this state may become a

member of such an association until one year after March 31, 1976, nor may any risks outside this state be insured under the provisions of sections 44-2901 to 44-2918 until one year after the issuance of a certificate of authority to transact insurance business by the Department of Insurance. All such risks shall be subject to the prior approval of the Director of Insurance.

In determining whether or not to grant approval for the insuring of risks outside of Nebraska, the Director of Insurance shall consider the following: (1) Limits of indemnity; (2) past and present loss experience of the hospital to be insured; (3) statutes, court decisions, and the insurance climate of the jurisdiction in which the risk is located; and (4) such other information as the director may deem relevant.

Source: Laws 1976, LB 809, § 4; Laws 1996, LB 1044, § 244; Laws 2007, LB296, § 183.

44-2905 Physicians association; qualified to become member; when.

Any physician, licensed to practice medicine in Nebraska, shall be qualified to become a member of a physicians association incorporated under sections 44-2901 to 44-2918 upon acceptance of his application for membership by the association in accordance with the rules and bylaws.

Source: Laws 1976, LB 809, § 5.

44-2906 Association; articles of incorporation; bylaws; contents; filed; where.

(1) Any association to be formed pursuant to the Nebraska Hospital and Physicians Mutual Insurance Association Act shall be formed by submitting executed articles of incorporation to the Department of Insurance for examination, and if approved and found by it to be in accordance with the laws of this state, the department shall so certify. When such articles are thus approved, they shall be filed in the office of the Secretary of State and a copy thereof filed in the office of the department. The articles shall not be considered filed until they have been filed in each such office.

(2) The articles and bylaws shall set forth in detail the association's proposed method of doing business. Such articles and bylaws may include provisions for the following matters:

(a) Reinsurance with a professional reinsurance company;

(b) The extent and method of risk sharing among its members; and

(c) Borrowing money.

Source: Laws 1976, LB 809, § 6; Laws 1999, LB 259, § 8.

44-2907 Association; board of directors; number of directors; make bylaws.

The board of directors of an association formed pursuant to sections 44-2901 to 44-2918 shall be comprised of not fewer than five nor more than twenty-one persons and a majority of them must be residents of the State of Nebraska. A person convicted of a felony may not be a director and all directors must be of good moral character and known professional, administrative or business ability, such business ability to include a practical knowledge of insurance, finance, or investment. Unless otherwise provided in the articles of incorporation, the board of directors shall make all bylaws. If the number of, or qualifications for, directors shall be amended in the articles or bylaws, such

change shall not affect the incumbent directors for the term of office for which they were elected.

Source: Laws 1976, LB 809, § 7.

44-2908 Articles and bylaws; approval or disapproval; procedure.

(1) Within sixty days after the articles and bylaws are filed with the Director of Insurance pursuant to section 44-2906, the director shall make a determination whether the filed documents meet the requirements of sections 44-2901 to 44-2918. Such determination shall be communicated in writing to the organizers of the association.

(2) If the documents so filed are deficient, the director's written findings shall state specifically on what grounds he is disapproving them. The organizers may thereafter amend and refile the articles and bylaws, which amended filing the Director of Insurance shall approve or disapprove within sixty days.

Source: Laws 1976, LB 809, § 8.

44-2909 Association; requirements to transact business.

No association organized under the Nebraska Hospital and Physicians Mutual Insurance Association Act shall transact the business of insurance until:

(1) Its articles and bylaws have been approved by the Director of Insurance and the articles filed as required by section 44-2906;

(2) It has filed with the director acceptable evidence that it has and will maintain a minimum surplus aggregating at least five hundred thousand dollars in cash in the investments authorized under the Insurers Investment Act or a letter of credit issued by a Nebraska banking institution in accordance with loan restrictions prescribed by the laws of this state;

(3) All policies, applications, and other forms together with all manuals and rates to be used have been filed and approved as provided in the Property and Casualty Insurance Rate and Form Act;

(4) A certificate of authority has been issued to the association as provided in section 44-303; and

(5) It has received at least five applications for policies in a hospital association or at least two hundred applications for policies in a physicians association.

Source: Laws 1976, LB 809, § 9; Laws 1991, LB 233, § 47; Laws 1991, LB 237, § 67; Laws 2000, LB 1119, § 38.

Cross References

Insurers Investment Act, see section 44-5101.
Property and Casualty Insurance Rate and Form Act, see section 44-7501.

44-2910 Association; not a member of the Nebraska Property and Liability Insurance Guaranty Association.

The association shall not be a member of the Nebraska Property and Liability Insurance Guaranty Association described in Chapter 44, article 24.

Source: Laws 1976, LB 809, § 10.

44-2911 Association; membership fee; paid into surplus.

The association may collect, at the time a policy is issued, a membership fee of not more than three hundred dollars for each bed owned or operated by the member hospital and, in case of physicians associations, ten thousand dollars for each member physician. Such fee shall be paid into the association's surplus and shall be in addition to any premium charged for insurance.

Source: Laws 1976, LB 809, § 11.

44-2912 Association; members; liable only for membership fee and premiums.

No member of the association shall be liable for any amounts because of such membership, other than the membership fee, prescribed in section 44-2911, and premiums.

Source: Laws 1976, LB 809, § 12.

44-2913 Association; administrative fee; computation; forms; failure to remit fee; rescind license; procedure; appeal.

(1) Every association incorporated pursuant to the Nebraska Hospital and Physicians Mutual Insurance Association Act shall, on or before March 1 of each year, pay an administrative fee to the director in the amount of three-tenths of one percent of the gross amount of direct writing premiums received by it during the preceding calendar year for business done in this state.

(2) The computation of the administrative fee shall be made on forms furnished by the Department of Insurance and shall be forwarded to the department together with a sworn statement by an appropriate officer of the company attesting the accuracy of the fee computation. The department shall furnish such forms prior to the end of the year for which the fees are payable.

(3) The director shall rescind or refuse to reissue the license of any association which fails to remit the administrative fee in conformity with the provisions of this section. Prior to rescinding such license, the director shall issue an order to the association directing the association to show cause why such rescission should not be made. The director shall give not less than ten days' notice of a rescission hearing before the department. Should the company be aggrieved by such determination, an appeal may be taken, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1976, LB 809, § 13; Laws 1988, LB 352, § 67.

Cross References

Administrative Procedure Act, see section 84-920.

44-2914 Association; business; how conducted.

The business of the association shall be conducted so as to preclude any distribution of income, profit, or property of the association to members thereof except in payment of claims, in reduction of premiums, for experience refunds to members, or upon final dissolution.

Source: Laws 1976, LB 809, § 14.

44-2915 Director; determine maximum exposure to loss; approve forms, premium rates, and limits of indemnity; considerations.

For purposes of sections 44-2901 to 44-2918, the director shall have the authority to determine the maximum exposure to loss on any risk to be written by the association. All policy forms, premium rates and limits of indemnity shall be filed with and subject to the approval of the director. In approving premium rates to be charged for malpractice insurance, limits of indemnity and members and risks outside this state, the director shall give due consideration to past and prospective loss and expense experience for medical malpractice insurance written and to be written, trends in the frequency and severity of the loss, the investment income of the association, and such other information as the director may deem relevant.

Source: Laws 1976, LB 809, § 15.

44-2916 Associations; provisions applicable.

To the extent applicable and when not in conflict with the Nebraska Hospital and Physicians Mutual Insurance Association Act, the provisions of the Nebraska Model Business Corporation Act and Chapters 44 and 77 relating to corporations and insurance shall apply to associations incorporated pursuant to the Nebraska Hospital and Physicians Mutual Insurance Association Act.

Source: Laws 1976, LB 809, § 16; Laws 1989, LB 92, § 218; Laws 1995, LB 109, § 222; Laws 2014, LB749, § 288.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

44-2917 Rules and regulations.

The Department of Insurance shall be empowered to adopt and promulgate such reasonable rules and regulations as may be necessary or appropriate to carry out the provisions of sections 44-2901 to 44-2918.

Source: Laws 1976, LB 809, § 17.

44-2918 Act, how cited.

Sections 44-2901 to 44-2918 shall be known and may be cited as the Nebraska Hospital and Physicians Mutual Insurance Association Act.

Source: Laws 1976, LB 809, § 18.

ARTICLE 30

UNCLAIMED LIFE INSURANCE BENEFITS ACT

Section

44-3001 Act, how cited.

Sections 44-3001 to 44-3006 shall be known and may be cited as the Unclaimed Life Insurance Benefits Act.

Source: Laws 2017, LB137, § 1.

44-3002 Terms, defined.

For purposes of the Unclaimed Life Insurance Benefits Act:

(1) Beneficiary means the party entitled or contingently entitled to receive proceeds from a policy or retained asset account;

(2) Death master file means the United States Social Security Administration's Death Master File or any other database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died;

(3) Death master file match means a search of the death master file that results in a match of the social security number or the name and date of birth of an insured, annuity owner, or retained asset account holder;

(4) Policy means any policy or certificate of life insurance that provides a death benefit or any annuity contract, except that such term does not include:

(a) Any policy or certificate of life insurance that provides a death benefit under an employee benefit plan that is (i) subject to the Employee Retirement Income Security Act of 1974 or (ii) part of a federal employee benefit program;

(b) Any policy or certificate of life insurance that is used to fund a pre-need funeral contract or prearrangement;

(c) Any policy or certificate of credit life or accidental death insurance;

(d) Any policy issued to a group master policyholder for which the insurer does not provide record-keeping services; or

(e) An annuity used to fund an employment-based retirement plan or program if (i) the insurer does not perform the record-keeping services or (ii) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants;

(5) Record-keeping services means services provided by an insurer for a group policy customer pursuant to an agreement under which the insurer is responsible for obtaining, maintaining, and administering, in its own or its agent's systems, at least the following information about each individual insured under the group policy or a line of coverage thereunder:

(a) Social security number or name and date of birth;

(b) Beneficiary designation information;

(c) Coverage eligibility;

(d) Benefit amount; and

(e) Premium payment status; and

(6) Retained asset account means any mechanism whereby the settlement of proceeds payable under a policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

Source: Laws 2017, LB137, § 2.

44-3003 Comparison against death master file; match; insurer; duties; group life insurance; insurer duties.

(1) An insurer shall perform a comparison of its insureds' in-force policies and retained asset accounts against a death master file to identify potential

matches of its insureds. The comparison shall be done on at least a semiannual basis by using the full death master file for the initial comparison and thereafter using the death master file update files for subsequent comparisons. For any potential match identified as a death master file match, the insurer shall, within ninety days after the death master file match:

(a) Complete a good faith effort, which shall be documented by the insurer, to confirm the death of the insured or retained asset account holder using other available records and information; and

(b) Determine whether benefits are due in accordance with the applicable policy or retained asset account. If benefits are due under the policy or retained asset account, the insurer shall:

(i) Complete a good faith effort, which shall be documented by the insurer, to locate the beneficiary; and

(ii) Provide the appropriate claim forms or instructions to the beneficiary to make a claim, including the need to provide an official death certificate if applicable under the policy.

(2) With respect to group life insurance, an insurer is required to confirm the possible death of an insured under subdivision (1)(a) of this section if the insurer maintains at least the following information on those covered under the policy:

(a) Social security number or name and date of birth;

(b) Beneficiary designation information;

(c) Coverage eligibility;

(d) Benefit amount; and

(e) Premium payment status.

(3) Every insurer shall implement procedures to account for:

(a) Common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

(b) Compound last names, maiden or married names, and hyphens, blank spaces, or apostrophes in last names;

(c) Transposition of the month and date portions of a date of birth; and

(d) Incomplete social security numbers.

(4) Nothing in this section shall be construed to limit the ability of an insurer to request a valid death certificate as part of any claims validation process.

(5) To the extent permitted by law, an insurer may disclose minimum necessary personal information about an insured, a beneficiary, or the owner of a policy or retained asset account to a person who the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of the claim proceeds.

(6) An insurer or its service provider shall not charge any beneficiary or other authorized representative any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

Source: Laws 2017, LB137, § 3.

44-3004 Benefits; accrued contractual interest; how treated.

(1) If an insurer determines under section 44-3003 that benefits are due to a beneficiary, the benefits from the applicable policy or retained asset account, plus any applicable accrued contractual interest, shall be payable to the designated beneficiary. If such beneficiary cannot be found, the insurer shall comply with section 69-1303 with respect to such benefits and accrued contractual interest. Interest otherwise payable under section 44-3,143 shall not be considered unclaimed funds under section 69-1303.

(2) Once the benefits and accrued contractual interest are presumed abandoned under section 69-1303, the insurer shall notify the State Treasurer, as part of the report sent under section 69-1310, that:

(a) A beneficiary has not submitted a claim with the insurer; and

(b) The insurer has complied with section 44-3003 and has been unable, after good faith efforts documented by the insurer, to contact the beneficiary.

Source: Laws 2017, LB137, § 4.

44-3005 Director of Insurance; powers.

The Director of Insurance may, at his or her discretion, make an order:

(1) Limiting an insurer's death master file comparisons required under section 44-3003 to the insurer's electronic searchable files or approving a plan and timeline for conversion of the insurer's files to electronic files;

(2) Exempting an insurer from death master file comparisons required under section 44-3003 or permitting an insurer to perform such comparisons on only certain policies or retained asset accounts or to perform such comparisons less frequently than semiannually upon a demonstration of hardship by the insurer; or

(3) Phasing in compliance with the Unclaimed Life Insurance Benefits Act according to a plan adopted and published by the director.

Source: Laws 2017, LB137, § 5.

44-3006 Unfair trade practice.

Failure to meet any requirement of the Unclaimed Life Insurance Benefits Act shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 2017, LB137, § 6.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

ARTICLE 31

NEBRASKA PROFESSIONAL ASSOCIATION MUTUAL INSURANCE COMPANY ACT

Section

Section

44-3101 Act, how cited.

Sections 44-3101 to 44-3112 shall be known and may be cited as the Nebraska Professional Association Mutual Insurance Company Act.

Source: Laws 1978, LB 656, § 1.

44-3102 Declaration of intent and purpose.

The intent and purpose of sections 44-3101 to 44-3112 is to establish procedures for organizing and regulating the operations of professional association mutual insurance companies within the State of Nebraska and thereby to promote the general welfare of the people of the State of Nebraska.

Source: Laws 1978, LB 656, § 2.

44-3103 Terms, defined.

As used in the Nebraska Professional Association Mutual Insurance Company Act, unless the context otherwise requires:

(1) Professional association mutual insurance company shall mean any domestic insurance company licensed under the act for the purpose of making insurance as provided in sections 44-3104 and 44-3105. For the purposes of this subdivision, professional association shall mean any organization of individual professional practitioners who are required by this state to obtain a license or other legal authorization prior to performing a professional service, including, but not limited to, certified public accountants, public accountants, dentists, osteopathic physicians, physicians and surgeons, veterinarians, and attorneys at law;

(2) Director shall mean the Director of Insurance; and

(3) Member shall mean an individual belonging to an association as defined in subdivision (1) of this section and whose principal practice is located in this state.

Source: Laws 1978, LB 656, § 3; Laws 1989, LB 342, § 3.

44-3104 Licensed insurance company; limitation on business.

The business of an insurance company licensed pursuant to sections 44-3101 to 44-3112 shall be limited to making insurance, as provided in section 44-3105, on the risks, hazards, and liabilities of members of an association whose principal practice is located in the State of Nebraska for professional practitioners' errors and omissions or malpractice liability.

Source: Laws 1978, LB 656, § 4.

44-3105 Professional association mutual insurance company; certificate of authority; demonstrate need.

Any professional association mutual insurance company applying for a certificate of authority to engage in the insurance business in this state shall demonstrate to the satisfaction of the director that adequate insurance markets in the United States are not reasonably available to cover the risks, hazards, and liabilities of the members to be insured for professional practitioners' errors and omissions or malpractice liability, and that the total insurance coverage necessary to insure such risks, hazards, and liabilities of the members to be insured would develop, in the aggregate, gross annual premiums of at least two hundred fifty thousand dollars.

Source: Laws 1978, LB 656, § 5.

44-3106 Certificate of authority; issued, when; minimum surplus.

No professional association mutual insurance company shall be issued a certificate of authority to do any business in this state until it has filed with the director acceptable evidence that it has and will maintain a minimum surplus aggregating at least five hundred thousand dollars in cash in the investments authorized under the Insurers Investment Act or a letter of credit issued by a Nebraska banking institution in accordance with loan restrictions prescribed by the laws of this state.

Source: Laws 1978, LB 656, § 6; Laws 1991, LB 237, § 68.

Cross References

Insurers Investment Act, see section 44-5101.

44-3107 Certificate of authority; issued, when; minimum number of applications and annual premiums.

No professional association mutual insurance company shall be issued a certificate of authority to do any business in this state until it has received not less than two hundred applications for insurance, and it shall have received in cash one annual premium for each such application.

Source: Laws 1978, LB 656, § 7.

44-3108 Membership in the Nebraska Property and Liability Insurance Guaranty Association; prohibited.

Any professional association mutual insurance company shall not be a member of the Nebraska Property and Liability Insurance Guaranty Association described in Chapter 44, article 24.

Source: Laws 1978, LB 656, § 8.

44-3109 Policy; issued; membership fee.

Any professional association mutual insurance company may collect, at the time a policy is issued, a membership fee. Such fee shall be in addition to any premium charged for insurance and shall be paid into the company's surplus.

Source: Laws 1978, LB 656, § 9.

44-3110 Administrative fee; payment, when; how computed; license; rescission; notice; hearing; appeal.

(1) In addition to the premium tax prescribed in Chapter 77, article 9, every professional association mutual insurance company licensed pursuant to the Nebraska Professional Association Mutual Insurance Company Act shall, on or before March 1 of each year, pay an administrative fee to the director in the amount of three-tenths of one percent of the gross amount of direct writing premiums received by it during the preceding calendar year for business done in this state.

(2) The computation of the administrative fee shall be made on forms furnished by the Department of Insurance, and the fee shall be forwarded to the department together with a sworn statement by an appropriate officer of the company attesting the accuracy of the fee computation. The department shall furnish such forms prior to the end of the year for which the fees are payable.

(3) The director shall rescind or refuse to reissue the license of any company which fails to remit the administrative fee in conformity with this section. Prior to rescinding such license, the director shall issue an order to the company directing the company to show cause why such rescission should not be made. The director shall give not less than ten days' notice of a rescission hearing before the department. Should the company be aggrieved by such determination, an appeal may be taken, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1978, LB 656, § 10; Laws 1986, LB 1114, § 7; Laws 1988, LB 352, § 68.

Cross References

Administrative Procedure Act, see section 84-920.

44-3111 Rules and regulations.

The director may establish and from time to time amend such reasonable rules and regulations as are necessary to enable him to carry out his duties under sections 44-3101 to 44-3112.

Source: Laws 1978, LB 656, § 11.

44-3112 Act; other provisions applicable.

To the extent applicable and when not in conflict with the Nebraska Professional Association Mutual Insurance Company Act, the provisions of the Nebraska Model Business Corporation Act and Chapters 44 and 77 relating to corporations and insurance shall apply to companies incorporated pursuant to the Nebraska Professional Association Mutual Insurance Company Act.

Source: Laws 1978, LB 656, § 12; Laws 1989, LB 92, § 219; Laws 1995, LB 109, § 223; Laws 2014, LB749, § 289.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.

ARTICLE 32

HEALTH MAINTENANCE ORGANIZATIONS

Cross References

Public employees, abortion coverage, limitation, see section 44-1615.01.

Section
44-3201. Repealed. Laws 1990, LB 1136, § 130.
44-3202. Repealed. Laws 1990, LB 1136, § 130.
44-3203. Repealed. Laws 1990, LB 1136, § 130.
44-3204. Repealed. Laws 1990, LB 1136, § 130.
44-3205. Repealed. Laws 1990, LB 1136, § 130.
44-3206. Repealed. Laws 1990, LB 1136, § 130.
44-3207. Repealed. Laws 1990, LB 1136, § 130.
44-3208. Repealed. Laws 1990, LB 1136, § 130.
44-3209. Repealed. Laws 1990, LB 1136, § 130.
44-3210. Repealed. Laws 1990, LB 1136, § 130.
44-3211. Repealed. Laws 1990, LB 1136, § 130.
44-3212. Repealed. Laws 1989, LB 92, § 278; Laws 1989, LB 6, § 13.
44-3213. Repealed. Laws 1990, LB 1136, § 130.
44-3214. Repealed. Laws 1990, LB 1136, § 130.
44-3215. Repealed. Laws 1990, LB 1136, § 130.
44-3216. Repealed. Laws 1990, LB 1136, § 130.
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44-3231. Repealed. Laws 1990, LB 1136, § 130.
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44-3244. Repealed. Laws 1990, LB 1136, § 130.
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44-3252. Repealed. Laws 1990, LB 1136, § 130.
44-3253. Repealed. Laws 1990, LB 1136, § 130.
44-3254. Repealed. Laws 1990, LB 1136, § 130.
44-3255. Repealed. Laws 1987, LB 203, § 1.
44-3256. Repealed. Laws 1987, LB 203, § 1.
44-3257. Repealed. Laws 1987, LB 203, § 1.
44-3258. Repealed. Laws 1990, LB 1136, § 130.
44-3259. Repealed. Laws 1990, LB 1136, § 130.
44-3260. Repealed. Laws 1990, LB 1136, § 130.

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44-3201 Repealed. Laws 1990, LB 1136, § 130.

44-3202 Repealed. Laws 1990, LB 1136, § 130.

44-3203 Repealed. Laws 1990, LB 1136, § 130.

44-3204 Repealed. Laws 1990, LB 1136, § 130.

44-3205 Repealed. Laws 1990, LB 1136, § 130.

44-3206 Repealed. Laws 1990, LB 1136, § 130.

44-3207 Repealed. Laws 1990, LB 1136, § 130.

44-3208 Repealed. Laws 1990, LB 1136, § 130.

44-3209 Repealed. Laws 1990, LB 1136, § 130.

44-3210 Repealed. Laws 1990, LB 1136, § 130.

44-3211 Repealed. Laws 1990, LB 1136, § 130.

44-3212 Repealed. Laws 1989, LB 92, § 278; Laws 1989, LB 6, § 13.

44-3213 Repealed. Laws 1990, LB 1136, § 130.

44-3214 Repealed. Laws 1990, LB 1136, § 130.

44-3215 Repealed. Laws 1990, LB 1136, § 130.

44-3216 Repealed. Laws 1990, LB 1136, § 130.

44-3217 Repealed. Laws 1990, LB 1136, § 130.

44-3218 Repealed. Laws 1990, LB 1136, § 130.

44-3219 Repealed. Laws 1990, LB 1136, § 130.

44-3220 Repealed. Laws 1990, LB 1136, § 130.

44-3221 Repealed. Laws 1990, LB 1136, § 130.

44-3222 Repealed. Laws 1990, LB 1136, § 130.

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44-3225 Repealed. Laws 1990, LB 1136, § 130.

44-3226 Repealed. Laws 1990, LB 1136, § 130.

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44-3231 Repealed. Laws 1990, LB 1136, § 130.

44-3232 Repealed. Laws 1990, LB 1136, § 130.

44-3233 Repealed. Laws 1990, LB 1136, § 130.

44-3234 Repealed. Laws 1990, LB 1136, § 130.

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44-3253 Repealed. Laws 1990, LB 1136, § 130.

44-3254 Repealed. Laws 1990, LB 1136, § 130.

44-3255 Repealed. Laws 1987, LB 203, § 1.

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44-3267 Repealed. Laws 1990, LB 1136, § 130.

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44-3271 Repealed. Laws 1990, LB 1136, § 130.

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44-3282 Repealed. Laws 1990, LB 1136, § 130.

44-3283 Repealed. Laws 1990, LB 1136, § 130.

44-3284 Repealed. Laws 1990, LB 1136, § 130.

44-3285 Repealed. Laws 1990, LB 1136, § 130.

44-3286 Repealed. Laws 1990, LB 1136, § 130.

44-3287 Repealed. Laws 1990, LB 1136, § 130.

44-3288 Repealed. Laws 1990, LB 1136, § 130.

44-3289 Repealed. Laws 1990, LB 1136, § 130.

44-3290 Repealed. Laws 1990, LB 1136, § 130.

44-3291 Repealed. Laws 1990, LB 1136, § 130.

44-3292 Act, how cited.

Sections 44-3292 to 44-32,180 shall be known and may be cited as the Health Maintenance Organization Act.

Source: Laws 1990, LB 1136, § 1.

44-3293 Definitions, where found.

For purposes of the Health Maintenance Organization Act, the definitions found in sections 44-3294 to 44-32,114 shall be used.

Source: Laws 1990, LB 1136, § 2.

44-3294 Basic health care services, defined.

Basic health care services shall include as a minimum the following medically necessary services: Preventive care; emergency care; inpatient and outpatient hospital and physician care; diagnostic laboratory services; diagnostic and therapeutic radiological services; and out-of-area emergency services.

Source: Laws 1990, LB 1136, § 3.

44-3295 Carrier, defined.

Carrier shall mean a health maintenance organization, an insurer, or any other entity responsible for the payment of benefits or the provision of services under a group contract.

Source: Laws 1990, LB 1136, § 4.

44-3296 Copayment, defined.

Copayment shall mean an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

Source: Laws 1990, LB 1136, § 5.

44-3297 Deductible, defined.

Deductible shall mean the amount an enrollee is responsible to pay out of pocket before the health maintenance organization begins to pay the costs associated with treatment.

Source: Laws 1990, LB 1136, § 6.

44-3298 Director, defined.

Director shall mean the Director of Insurance.

Source: Laws 1990, LB 1136, § 7.

44-3299 Enrollee, defined.

Enrollee shall mean an individual who is covered by a health maintenance organization and shall include both subscribers and dependents of subscribers.

Source: Laws 1990, LB 1136, § 8.

44-32,100 Evidence of coverage, defined.

Evidence of coverage shall mean a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder.

Source: Laws 1990, LB 1136, § 9.

44-32,101 Extension of benefits, defined.

Extension of benefits shall mean the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination.

Source: Laws 1990, LB 1136, § 10.

44-32,102 Grievance, defined.

Grievance shall mean a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

Source: Laws 1990, LB 1136, § 11.

44-32,103 Group contract, defined.

Group contract shall mean a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

Source: Laws 1990, LB 1136, § 12.

44-32,104 Group contract holder, defined.

Group contract holder shall mean the person to which a group contract has been issued.

Source: Laws 1990, LB 1136, § 13.

44-32,105 Health maintenance organization, defined.

Health maintenance organization shall mean any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments or deductibles.

Source: Laws 1990, LB 1136, § 14.

44-32,106 Health maintenance organization producer, defined.

Health maintenance organization producer shall mean a person licensed under subdivision (1)(b) of section 44-4054 who solicits, negotiates, effects, procures, delivers, renews, or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself or herself, or who advertises or otherwise holds himself or herself out to the public as such.

Source: Laws 1990, LB 1136, § 15; Laws 2008, LB855, § 20.

44-32,107 Individual contract, defined.

Individual contract shall mean a contract for health care services issued to and covering an individual. The individual contract may include coverage for dependents of the subscriber.

Source: Laws 1990, LB 1136, § 16.

44-32,108 Insolvent or insolvency, defined.

Insolvent or insolvency shall mean that the health maintenance organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction.

Source: Laws 1990, LB 1136, § 17.

44-32,109 Net worth, defined.

Net worth shall mean the excess of total admitted assets over total liabilities. Liabilities shall not include fully subordinated debt.

Source: Laws 1990, LB 1136, § 18.

44-32,110 Participating provider, defined.

Participating provider shall mean a provider who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

Source: Laws 1990, LB 1136, § 19.

44-32,111 Provider, defined.

Provider shall mean any physician, hospital, or other person licensed or otherwise authorized to furnish health care services.

Source: Laws 1990, LB 1136, § 20.

44-32,112 Replacement coverage, defined.

Replacement coverage shall mean the benefits provided by a succeeding carrier.

Source: Laws 1990, LB 1136, § 21.

44-32,113 Subscriber, defined.

Subscriber shall mean an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization or, in the case of an individual contract, the individual in whose name the contract is issued.

Source: Laws 1990, LB 1136, § 22.

44-32,114 Uncovered expenditures, defined.

Uncovered expenditures shall mean the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization for which an enrollee may also be liable in the event

of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the director.

Source: Laws 1990, LB 1136, § 23.

44-32,115 Establishment of health maintenance organization; certificate of authority required.

Any person may apply to the director for a certificate of authority to establish and operate a health maintenance organization in compliance with the Health Maintenance Organization Act. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority under the act. Operating a health maintenance organization without a certificate of authority shall be a violation of the Unauthorized Insurers Act. A foreign corporation may qualify under the Health Maintenance Organization Act if it registers to do business in this state as a foreign corporation under the Nebraska Model Business Corporation Act and complies with the Health Maintenance Organization Act and other applicable state laws.

Source: Laws 1990, LB 1136, § 24; Laws 1993, LB 583, § 88; Laws 1995, LB 109, § 224; Laws 2014, LB749, § 290.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.
Unauthorized Insurers Act, see section 44-2008.

44-32,116 Existing health maintenance organization; application.

Any health maintenance organization which has not received a certificate of authority to operate as a health maintenance organization under prior law as of July 10, 1990, shall submit an application for a certificate of authority within ninety days of such date. Each such applicant may continue to operate until the director acts upon the application. If the application is denied, the applicant shall be treated as a health maintenance organization whose certificate of authority has been revoked.

Source: Laws 1990, LB 1136, § 25.

44-32,117 Certificate of authority; application; contents.

Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the director, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, articles of organization, partnership agreement, trust agreement, or other applicable documents and all amendments thereto;

(2) A copy of the bylaws, rules, and regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions and biographical information, on forms acceptable to the director, of the persons who are to be responsible for the conduct of the affairs and day-to-day operations of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers in the case of a corporation or the partners or members in the case of a partnership, limited liability company, or association;

(4) A copy of any contract made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third-party administrators, marketing consultants, or persons listed in subdivision (3) of this section and the health maintenance organization;

(5) A copy of the form of evidence of coverage to be issued to subscribers;

(6) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support, including a copy of the applicant's most recent, regular, certified financial statement and an unaudited, current financial statement;

(8) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash-flow statements showing any capital expenditures, any purchase and sale of investments, and any deposits with the state, income and expense statements anticipated from the start of operations until the health maintenance organization has had net income for at least one year, and a statement as to the sources of working capital as well as any other sources of funding;

(9) A power of attorney duly executed by such applicant, if not domiciled in this state, appointing the director and his or her successors and duly authorized deputies as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement or map reasonably describing the geographic area to be served;

(11) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(12) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(13) A description of the procedures to be implemented to meet the protection-against-insolvency requirements in section 44-32,143;

(14) A list of the names, addresses, and license numbers, if any, of all providers with which the health maintenance organization has agreements; and

(15) Such other information as the director requires to make the determinations required in section 44-32,120.

Source: Laws 1990, LB 1136, § 26; Laws 1993, LB 121, § 250.

44-32,118 Modification or amendment of application; required; when.

(1) Any modification or amendment to the items described in section 44-32,117 shall be submitted to the director for his or her approval prior to the effectuation of the modification or amendment.

(2) Any modification or amendment shall be deemed approved unless disapproved within thirty days, except that the director may postpone the action for such further time, not exceeding an additional thirty days, as necessary for proper consideration.

Source: Laws 1990, LB 1136, § 27; Laws 1993, LB 583, § 89.

44-32,119 Application; transmittal to Department of Health and Human Services; duties; applicability.

(1) Upon receipt of an application for issuance of a certificate of authority, the Director of Insurance shall forthwith transmit copies of such application and accompanying documents to the Department of Health and Human Services.

(2) The Department of Health and Human Services shall determine whether the applicant has complied with sections 44-32,126 to 44-32,128 with respect to health care services to be furnished.

(3) Within forty-five days of receipt of the application for issuance of a certificate of authority, the Department of Health and Human Services shall certify to the Director of Insurance that the proposed health maintenance organization meets the requirements of such sections or notify the Director of Insurance that the health maintenance organization does not meet such requirements and specify in what respects it is deficient.

(4) This section shall not apply to an application from an applicant that only provides health care benefits pursuant to Title 42, Chapter 7, Subchapter XVIII, Part C or D, of the United States Code, commonly known as Medicare Parts C and D. If a certificate of authority was originally issued to a health maintenance organization only authorizing the provision of health care benefits through Medicare Part C or D and such health maintenance organization expands its operations after receiving such certificate of authority, the expansion shall be treated as a new application to the Department of Insurance and transmitted to the Department of Health and Human Services for review pursuant to this section.

Source: Laws 1990, LB 1136, § 28; Laws 1996, LB 1044, § 245; Laws 2007, LB296, § 184; Laws 2021, LB21, § 3.
Effective date August 28, 2021.

44-32,120 Certificate of authority; issuance; conditions.

The Director of Insurance shall, within forty-five days of receipt of certification or notice of deficiencies pursuant to section 44-32,119, issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and being satisfied that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) Any deficiencies identified by the Department of Health and Human Services have been corrected and the department has certified to the Director of Insurance that the health maintenance organization's proposed plan of operation meets the requirements of sections 44-32,126 to 44-32,128;

(3) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through

insurance or otherwise, except to the extent of reasonable requirements for copayments or deductibles; and

(4) The health maintenance organization is in compliance with sections 44-32,138 to 44-32,148.

A certificate of authority shall be denied only after the Director of Insurance complies with the requirements of section 44-32,153.

Source: Laws 1990, LB 1136, § 29; Laws 1996, LB 1044, § 246; Laws 2007, LB296, § 185.

44-32,121 Certificate of authority; expiration; renewal.

A certificate of authority issued pursuant to sections 44-32,119 and 44-32,120 shall expire on April 30 in each year and shall be renewed annually if the health maintenance organization has continued to comply with the laws of this state and the rules and regulations.

Source: Laws 1990, LB 1136, § 30.

44-32,122 Health maintenance organization; powers.

The powers of a health maintenance organization shall include, but not be limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, and ancillary equipment and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the health maintenance organization;

(2) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts, including provider and subscriber contracts, between affiliates or between the health maintenance organization and its parent;

(3) Furnishing of basic health care services through providers, provider associations, or agents for providers which are under contract with or employed by the health maintenance organization;

(4) Contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;

(5) Contracting with an insurance company licensed in this state for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) Offering of other health care services in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual; and

(7) The joint marketing of products with an insurance company licensed in this state as long as the company that is offering each product is clearly identified.

Source: Laws 1990, LB 1136, § 31.

44-32,123 Health maintenance organization; exercise of powers; approval requirements.

A health maintenance organization shall file notice, with adequate supporting information, with the director prior to the exercise of any power granted in subdivision (1), (2), or (4) of section 44-32,122 which may affect the financial soundness of the health maintenance organization. The director shall disapprove such exercise of power only if it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the director does not disapprove the exercise of the power within thirty days of the filing, it shall be deemed approved. The director may exempt activities having a de minimis effect from the filing requirement.

Source: Laws 1990, LB 1136, § 32.

44-32,124 Health maintenance organization; deemed to transact business of insurance.

Notwithstanding any differences provided by law between a health maintenance organization and an insurer as described in section 44-103, a health maintenance organization shall be deemed to assume, underwrite, and spread risk and otherwise transact the business of insurance.

Source: Laws 1990, LB 1136, § 33.

44-32,125 Fiduciary relationships; bond or insurance required.

Any director, officer, employee, partner, or limited liability company member of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization shall be responsible for such funds in a fiduciary relationship to the health maintenance organization. A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such individuals in an amount not less than two hundred fifty thousand dollars for each health maintenance organization. The requirements of this section may be met for each of two or more health maintenance organizations owned by a common parent if the parent maintains the bond or insurance on behalf of the health maintenance organizations and any other carrier or carriers owned by the parent in an aggregate amount of not less than the lesser of (1) two hundred fifty thousand dollars times the number of such health maintenance organizations and such other carrier or carriers or (2) five million dollars.

Source: Laws 1990, LB 1136, § 34; Laws 1993, LB 121, § 251; Laws 1994, LB 884, § 61.

44-32,126 Quality of care; procedures established.

Each health maintenance organization shall establish procedures to assure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, and continuity of care.

Source: Laws 1990, LB 1136, § 35.

44-32,127 Quality assurance program; requirements.

Each health maintenance organization shall have an ongoing, internal quality assurance program to monitor and evaluate its health care services, including

primary and specialist physician services, and ancillary and preventive health care services across all institutional and noninstitutional settings. The quality assurance program shall include, but not be limited to, the following:

(1) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(2) A written quality assurance plan which describes the following:

(a) The health maintenance organization's scope and purpose in quality assurance;

(b) The organizational structure responsible for quality assurance activities;

(c) Contractual arrangements, when appropriate, for delegation of quality assurance activities;

(d) Confidentiality policies and procedures;

(e) A system of ongoing evaluation activities;

(f) A system of focused evaluation activities;

(g) A system for credentialing providers and performing peer review activities; and

(h) Duties and responsibilities of the designated physician responsible for the quality assurance activities;

(3) A written statement describing the system of ongoing quality assurance activities, including, but not limited to, the following:

(a) Problem assessment, identification, selection, and study;

(b) Corrective action, monitoring, evaluation, and reassessment; and

(c) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(4) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation, and report format; and

(5) A written plan for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

Each health maintenance organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the Department of Health and Human Services. Each health maintenance organization shall also establish a mechanism for periodic reporting of quality assurance program activities to the governing body of the health maintenance organization, the providers, and appropriate staff.

Source: Laws 1990, LB 1136, § 36; Laws 1996, LB 1044, § 247; Laws 2007, LB296, § 186.

44-32,128 Patient record system; requirements.

Each health maintenance organization shall ensure the use and maintenance of an adequate patient record system which facilitates documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assess-

ing the quality of health and medical care provided to enrollees. Enrollee clinical records shall be available to the Department of Health and Human Services or an authorized designee for examination and review to ascertain compliance with section 44-32,127 or as deemed necessary by the department.

Source: Laws 1990, LB 1136, § 37; Laws 1996, LB 1044, § 248; Laws 2007, LB296, § 187.

44-32,129 Group and individual contracts; required provisions.

Every group and individual contract holder shall be entitled to a group or individual contract. The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive or which encourage misrepresentation as described by section 44-1525. The contract shall contain a clear statement of the following:

(1) Name and address of the health maintenance organization;

(2) Eligibility requirements;

(3) Benefits and services within the service area;

(4) Emergency care benefits and services;

(5) Out-of-area benefits and services, if any;

(6) Copayments, deductibles, or other out-of-pocket expenses;

(7) Limitations and exclusions;

(8) Enrollee termination;

(9) Enrollee reinstatement, if any;

(10) Claims procedures;

(11) Enrollee grievance procedures;

(12) Continuation of coverage;

(13) Conversion;

(14) Extension of benefits, if any;

(15) Coordination of benefits, if applicable;

(16) Subrogation, if any;

(17) Description of the service area;

(18) Entire contract provision;

(19) Term of coverage;

(20) Cancellation of group or individual contract holder;

(21) Renewal;

(22) Reinstatement of group or individual contract holder, if any;

(23) Grace period; and

(24) Conformity with state law.

An evidence of coverage may be filed as part of the group contract to describe the provisions required in subdivisions (1) through (17) of this section.

Source: Laws 1990, LB 1136, § 38.

44-32,130 Group and individual contracts; additional required provisions.

(1) An individual contract shall provide a ten-day period to examine and return the contract and have the premium refunded. If services were received

during the ten-day period and the person returns the contract to receive a refund of the premium paid, he or she shall pay for such services.

(2) A group or individual contract shall permit enrollees to voluntarily terminate enrollment for any reason at any time.

(3) A group contract shall permit enrollees to convert to individual enrollment upon termination of enrollment in the group.

(4) A group contract shall not contain provisions that are in conflict with sections 44-3,144 to 44-3,150.

Source: Laws 1990, LB 1136, § 39; Laws 1994, LB 1224, § 80.

44-32,131 Subscriber; receive evidence of coverage; contents.

Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization. The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, or deceptive or which encourage misrepresentation as described by section 44-1525. The evidence of coverage shall contain a clear statement of the provisions required in subdivisions (1) through (17) of section 44-32,129.

Source: Laws 1990, LB 1136, § 40.

44-32,132 Forms; readability standards; filing requirements.

The director may establish readability standards for individual contract, group contract, and evidence of coverage forms. No group or individual contract, evidence of coverage, or amendment thereto shall be delivered or issued for delivery in this state unless its form has been filed with and approved by the director. If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage shall not need to be submitted to the director for approval. The director may require the submission of whatever relevant information he or she deems necessary in determining whether to approve or disapprove a filing.

Source: Laws 1990, LB 1136, § 41.

44-32,133 Forms; filing; when; disapproval or withdrawal of approval; notice; hearing.

(1) Every form required to be filed with the director shall be filed not less than thirty days prior to delivery or issuance for delivery in this state. At any time during the thirty-day period, the director may extend the period for review for an additional thirty days. Notice of an extension shall be in writing. At the end of the review period, the form shall be deemed approved if the director has taken no action. The person filing shall notify the director in writing prior to using a form that is deemed approved. At any time, after thirty days' notice and for cause shown, the director may withdraw approval of any form. The withdrawal shall be effective at the end of the thirty days.

(2) When a filing is disapproved or approval of a form is withdrawn, the director shall give the health maintenance organization written notice of the reasons for disapproval or withdrawal and in the notice shall inform the health maintenance organization that within thirty days of receipt of the notice the

health maintenance organization may request a hearing. A hearing shall be conducted within thirty days after the director has received the request for hearing.

Source: Laws 1990, LB 1136, § 42.

44-32,134 Filings; required.

(1) Every health maintenance organization shall file annually, on or before March 1, an annual financial statement with the Director of Insurance, with a copy to the Department of Health and Human Services, covering the preceding calendar year. The annual financial statement shall be on forms prescribed by the Director of Insurance and shall be prepared in accordance with annual statement instructions and accounting practices and procedures manuals as prescribed by the director which conform substantially to the annual statement instructions and the Accounting Practices and Procedures Manuals of the National Association of Insurance Commissioners.

(2) Every health maintenance organization shall file annually, on or before March 1, with the Director of Insurance, with a copy to the department:

(a) A list of the providers who have executed a contract that complies with section 44-32,141; and

(b) A description of the grievance procedures, the total number of grievances handled through such procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(3) Every health maintenance organization shall file annually, on or before June 1, audited financial statements with the Director of Insurance, with a copy to the department.

(4) The Director of Insurance may require such additional reports as are deemed necessary and appropriate to carry out his or her duties under the Health Maintenance Organization Act.

Source: Laws 1990, LB 1136, § 43; Laws 1996, LB 1044, § 249; Laws 2000, LB 930, § 9; Laws 2007, LB296, § 188.

44-32,135 Information to subscribers and enrollees.

Each health maintenance organization shall provide a list of providers to its subscribers upon enrollment and reenrollment. Each health maintenance organization shall provide notice within thirty days of any material change in the operation of the health maintenance organization to its subscribers if the change affects the subscribers directly. An enrollee shall be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating provider. Each health maintenance organization shall provide to subscribers information on how services may be obtained and where additional information on access to services can be obtained and a toll-free telephone number for calls within the service area.

Source: Laws 1990, LB 1136, § 44.

44-32,136 Grievance procedure.

Each health maintenance organization shall establish and maintain a grievance procedure to provide for the resolution of grievances initiated by enroll-

ees. The procedure shall be approved by the Director of Insurance after consultation with the Department of Health and Human Services. The Director of Insurance or the department may examine the grievance procedure. The health maintenance organization shall maintain records regarding grievances received since the date of the last examination.

Source: Laws 1990, LB 1136, § 45; Laws 1996, LB 1044, § 250; Laws 2007, LB296, § 189.

44-32,137 Investments.

With the exception of investments made in accordance with subdivision (1) of section 44-32,122, the investable funds of a health maintenance organization shall be invested only as authorized under the Insurers Investment Act for a domestic life insurance company.

Source: Laws 1990, LB 1136, § 46; Laws 1991, LB 237, § 69.

Cross References

Insurers Investment Act, see section 44-5101.

44-32,138 Net worth requirements.

(1) Before issuing a certificate of authority, the director shall require that the health maintenance organization have an initial net worth of one million five hundred thousand dollars and maintain the minimum net worth required under this section.

(2) Except as provided in subsection (3) of this section, a health maintenance organization shall maintain a minimum net worth equal to the greater of:

(a) One million dollars; or

(b) Two percent of annual premium revenue as reported on the most recent annual financial statement filed with the director on the first one hundred fifty million dollars of premium revenue and one percent of annual premium revenue on the premium revenue in excess of one hundred fifty million dollars.

(3) A health maintenance organization licensed under prior law before July 10, 1990, shall maintain a minimum net worth of:

(a) Twenty-five percent of the amount required by subsection (2) of this section by December 31, 1990;

(b) Fifty percent of the amount required by subsection (2) of this section by December 31, 1991;

(c) Seventy-five percent of the amount required by subsection (2) of this section by December 31, 1992; and

(d) One hundred percent of the amount required by subsection (2) of this section by December 31, 1993.

(4) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the director. Any interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated. The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses. Any debt incurred by a note meeting the requirements of this subsection and otherwise

acceptable to the director shall not be considered a liability and shall be recorded as equity.

Source: Laws 1990, LB 1136, § 47.

44-32,139 Deposit requirements.

(1) Except as provided in subsection (2) of this section, each health maintenance organization shall deposit with the director, or at the discretion of the director with any organization or trustee acceptable to him or her through which a custodial or controlled account is utilized, cash, securities, or any combination of cash or securities or other measures that are acceptable to the director which at all times have a value of not less than three hundred thousand dollars.

(2) A health maintenance organization that is in operation under prior law on July 10, 1990, shall make a deposit equal to one hundred fifty thousand dollars for the first year and three hundred thousand dollars for the second year.

(3) The deposit made pursuant to this section shall be an admitted asset of the health maintenance organization in the determination of net worth. All income from a deposit shall be an asset of the health maintenance organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of cash or securities or other measures of equal amount and value. Any securities or other measures shall be approved by the director before being deposited or substituted.

(4) The deposit made pursuant to this section shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The director may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

(5) The director may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner, insurance director, insurance superintendent, or equivalent official of the state or jurisdiction of domicile for the protection of all subscribers and enrollees of such health maintenance organization, wherever located, cash, acceptable securities, or surety and delivers to the director a certificate to such effect duly authenticated by the appropriate official holding the deposit.

Source: Laws 1990, LB 1136, § 48.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-32,140 Liabilities; computation.

Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide (1) for any unearned premium, (2) for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid, and for which such organization is or may be liable, and (3) for the expense of adjustment or settlement of such claims. Such liabilities shall be computed in

accordance with rules and regulations adopted and promulgated by the director upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

Source: Laws 1990, LB 1136, § 49.

44-32,141 Provider contracts; requirements.

Every contract between a health maintenance organization and a participating provider shall be in writing and shall provide that, if the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee will not be liable to the provider for any sum owed by the health maintenance organization. If the contract has not been reduced to writing or fails to contain the provision required by this section, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization. No participating provider, or agent, trustee, or assignee of a participating provider, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

Source: Laws 1990, LB 1136, § 50.

44-32,142 Provider agreement; notice of termination.

An agreement to provide health care services between a provider and a health maintenance organization shall require that, if the provider terminates the agreement, the provider will give the health maintenance organization at least sixty days' notice of termination.

Source: Laws 1990, LB 1136, § 51.

44-32,143 Insolvency; plan required.

The director shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The director may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit; and

(5) Any other arrangements to assure that benefits are continued as specified in this section.

Source: Laws 1990, LB 1136, § 52.

44-32,144 Uncovered expenditures insolvency deposit.

(1) If uncovered expenditures exceed ten percent of the total health care expenditures of a health maintenance organization for the previous calendar

quarter, the health maintenance organization shall place an uncovered expenditures insolvency deposit of cash or securities that are acceptable to the director with the director or with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained. Such deposit shall at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims. The fair market value of the deposit shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(2) The deposit required under this section shall be in addition to the deposit required under section 44-32,139 and shall be an admitted asset of the health maintenance organization in the determination of net worth. All income from such deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn quarterly with the approval of the director.

(3) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if (a) a substitute deposit of cash or securities of equal amount and value is made, (b) the fair market value of the deposit exceeds the amount of the required deposit, or (c) the required deposit is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the director.

Source: Laws 1990, LB 1136, § 53.

44-32,145 Uncovered expenditures insolvency deposit; use.

The deposit required under section 44-32,144 shall be in trust and may be used only by the director for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred uncovered expenses. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization. The director may prescribe the time, manner, and form for filing claims under this section.

Source: Laws 1990, LB 1136, § 54.

44-32,146 Uncovered expenditures; reports.

The director may require a health maintenance organization to file annual or quarterly, or more frequent, reports of uncovered expenditures and liability for uncovered expenditures. The director may require that the reports include an audit opinion.

Source: Laws 1990, LB 1136, § 55.

44-32,147 Insolvency; replacement coverage; duty to provide; director; duties.

(1) If a health maintenance organization is determined to be insolvent and ordered liquidated by a court of competent jurisdiction, upon such order, all

other carriers which participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period and which are providing coverage for enrollees on the date of the court order shall offer such group's subscribers of the insolvent health maintenance organization a thirty-day enrollment period commencing on the date of the court order. The subscribers transferring from the insolvent health maintenance organization shall be entitled to coverage on the same terms and at the same rates as they would have obtained had they elected the other carrier at the last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization or if the director determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the director shall allocate equitably the insolvent health maintenance organization's group contracts for such groups among all health maintenance organizations which operate within any portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group is allocated shall offer such group the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(3) The director shall also allocate equitably the insolvent health maintenance organization's individual enrollees who are unable to obtain other coverage among all health maintenance organizations which operate within any portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which individual enrollees are allocated shall offer such individual enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by his or her type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct individual enrollment may aggregate all of the allocated individual enrollees into one group for rating and coverage purposes.

Source: Laws 1990, LB 1136, § 56.

44-32,148 Replacement coverage; requirements.

(1) Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing such hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment, hospital confinement, or pregnancy. Discontinu-

ance shall mean the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization and shall not mean the termination of any agreement between any individual enrollee and the health maintenance organization.

(2) Except to the extent benefits for a condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

Source: Laws 1990, LB 1136, § 57.

44-32,149 Premium rates.

(1) No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the director. A specific schedule of premium rates or a methodology for determining premium rates shall be established in accordance with actuarial principles for various categories of enrollees. The premium applicable to an enrollee shall not be individually determined based on the status of his or her health. The premium rates shall not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the director as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(2) The director shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of this section are met. If the director disapproves such filing, he or she shall notify the health maintenance organization. In the notice, the director shall specify the reasons for his or her disapproval. A hearing shall be conducted within thirty days after a request in writing by the person filing. If the director does not take action on such schedule or methodology within thirty days of the filing of such schedule or methodology, it shall be deemed approved.

Source: Laws 1990, LB 1136, § 58.

44-32,150 Insurance Producers Licensing Act; applicability.

The Insurance Producers Licensing Act shall apply to health maintenance organization producers except to the extent that the director determines that the nature of health maintenance organizations renders application of the act clearly inappropriate.

Source: Laws 1990, LB 1136, § 59.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-32,151 Powers of insurers.

(1) An insurer licensed in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the Health Maintenance Organization Act. Any two or more such

insurers or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance shall include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) An insurer may contract with a health maintenance organization to provide insurance or similar protection against the cost of health care services provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization shall constitute a permissible group under the insurance laws of this state. An insurer may make benefit payments to health maintenance organizations for health care services rendered by providers under such contracts.

Source: Laws 1990, LB 1136, § 60.

44-32,152 Examinations; expenses.

(1) The Director of Insurance may make an examination of the affairs of any health maintenance organization in accordance with the Insurers Examination Act and any provider with whom such health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state. The Department of Health and Human Services may make an examination concerning the quality assurance program of any health maintenance organization and any provider with whom such health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

(2) Every health maintenance organization and provider shall submit its books and records for an examination and in every way facilitate the completion of the examination. For the purpose of an examination, the Director of Insurance and the Department of Health and Human Services may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of a provider concerning the business. An examination shall not involve the confidential communications between physicians and patients.

(3) The expenses of an examination shall be assessed against the health maintenance organization being examined and remitted to the Director of Insurance or the Department of Health and Human Services for whom the examination is being conducted in the manner provided in the Insurers Examination Act.

(4) In lieu of an examination, the Director of Insurance or the Department of Health and Human Services may accept the report of an examination made by the insurance commissioner, insurance director, insurance superintendent, or equivalent official or director of health or equivalent official of another state.

Source: Laws 1990, LB 1136, § 61; Laws 1993, LB 583, § 90; Laws 1996, LB 1044, § 251; Laws 2007, LB296, § 190.

Cross References

Insurers Examination Act, see section 44-5901.

44-32,153 Certificate of authority; suspension, revocation, or denial; grounds.

If the Director of Insurance finds that any of the conditions listed in this section exist, any certificate of authority issued under the Health Maintenance Organization Act may be suspended or revoked or any application for a certificate of authority may be denied:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section 44-32,117 unless amendments to such submissions have been filed with and approved by the director;

(2) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which does not comply with the requirements of sections 44-32,129 to 44-32,133 and 44-32,149;

(3) The health maintenance organization does not provide or arrange for basic health care services;

(4) The Department of Health and Human Services certifies to the Director of Insurance that:

(a) The health maintenance organization does not meet the requirements of subsection (2) of section 44-32,119; or

(b) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to correct, within the time prescribed by section 44-32,154, any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired;

(7) The health maintenance organization has failed to implement grievance procedures in a reasonable manner to resolve valid complaints;

(8) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has otherwise failed substantially to comply with the act.

Source: Laws 1990, LB 1136, § 62; Laws 1996, LB 1044, § 252; Laws 2007, LB296, § 191.

44-32,154 Deficiency in net worth; impaired condition; director; powers.

(1) Whenever the director finds that the net worth maintained by any health maintenance organization is less than the minimum net worth required to be maintained by section 44-32,138, he or she shall give written notice to the health maintenance organization of the amount of the deficiency and require (a) filing of a plan for correction of the deficiency acceptable to the director and (b) correction of the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted

by the director. Such a deficiency shall be an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in supervision, rehabilitation, liquidation, or conservation.

(2) Unless allowed by the director, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue, or deliver any certificate, agreement, or contract of coverage in this state for which a premium is charged or collected when the health maintenance organization writing such coverage is impaired and the impairment is known to the health maintenance organization or such person. The existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement, or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

Source: Laws 1990, LB 1136, § 63.

44-32,155 Certificate of authority; suspension, revocation, or denial; administrative penalty; procedure.

A certificate of authority shall be suspended or revoked, an application for a certificate of authority denied, or an administrative penalty imposed pursuant to section 44-32,164 only after compliance with the requirements of sections 44-32,156 to 44-32,158.

Source: Laws 1990, LB 1136, § 64.

44-32,156 Suspension, revocation, denial, or administrative penalty; order; hearing.

Suspension or revocation of a certificate of authority, the denial of an application for a certificate, or the imposition of an administrative penalty shall be by written order and shall be sent by the Director of Insurance to the health maintenance organization or applicant by certified or registered mail and to the Department of Health and Human Services. The written order shall state the grounds, charges, or conduct on which the suspension, revocation, denial, or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within thirty days from the date of mailing of the order. If no written request is made, such order shall be final upon the expiration of thirty days.

Source: Laws 1990, LB 1136, § 65; Laws 1996, LB 1044, § 253; Laws 2007, LB296, § 192.

44-32,157 Hearing; notice; decision; appeal.

(1) If the health maintenance organization or applicant requests a hearing pursuant to section 44-32,156, the Director of Insurance shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the Department of Health and Human Services stating:

(a) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(b) A specific place for the hearing, which may be either in Lancaster County or in the county where the health maintenance organization's or applicant's principal place of business is located.

(2) If a hearing is requested, the chief executive officer of the Department of Health and Human Services or his or her designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the chief executive officer with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority shall be conclusive and binding upon the Director of Insurance.

(3) After the hearing or upon failure of the health maintenance organization to appear at such hearing, the Director of Insurance shall take whatever action he or she deems necessary based on written findings and shall mail his or her decision to the health maintenance organization or applicant with a copy to the Department of Health and Human Services. The action of the Director of Insurance and the recommendation and findings of the chief executive officer may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act. The act shall apply to proceedings under this section to the extent it is not in conflict with this section.

Source: Laws 1990, LB 1136, § 66; Laws 1996, LB 1044, § 254; Laws 2007, LB296, § 193.

Cross References

Administrative Procedure Act, see section 84-920.

44-32,158 Certificate of authority; suspension or revocation; effect.

(1) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees other than newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

(2) When the certificate of authority of a health maintenance organization is revoked, such health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such health maintenance organization. It shall engage in no further advertising or solicitation whatsoever. The director may, by written order, permit such further operation of the health maintenance organization as he or she finds to be in the best interest of enrollees to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Source: Laws 1990, LB 1136, § 67.

44-32,159 Hazardous operation; violations; director; powers.

Whenever the director determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees or creditors or the general public or that it has violated the Health Maintenance Organization Act, he or she may, after notice and hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including, but not limited to, the following:

(1) Reduce the total amount of present and potential liability for benefits by reinsurance or another method acceptable to the director;

(2) Reduce the volume of new business being accepted;

(3) Reduce expenses by specified methods;

(4) Suspend or limit the writing of new business for a period of time;

(5) Increase the health maintenance organization's capital and surplus by contribution; or

(6) Take such other steps as the director deems appropriate under the circumstances.

The violation by a health maintenance organization of any law of this state to which such health maintenance organization is subject shall be deemed a violation of the act.

Source: Laws 1990, LB 1136, § 68.

44-32,160 Hazardous operation; violations; uniform standards and criteria; remedies not exclusive.

The director may set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees or creditors or the general public and standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in section 44-32,159. The remedies and measures available to the director under such section shall be in addition to, and not in lieu of, the remedies and measures available to the director under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1990, LB 1136, § 69.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-32,161 Supervision, rehabilitation, liquidation, or conservation; grounds and procedure applicable.

(1) Any supervision, rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the supervision, rehabilitation, liquidation, or conservation of an insurance company and shall be conducted pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. The director may apply for an order directing him or her to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in sections 44-4812 and 44-4817 or when in his or her opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by subdivision (2) of section 44-4842 for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a

health care plan shall have the same priority of distribution of the general assets as established by subdivision (5) of section 44-4842.

Source: Laws 1990, LB 1136, § 70; Laws 2002, LB 1139, § 24.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-32,162 Rules and regulations.

The director shall adopt and promulgate rules and regulations to carry out the Health Maintenance Organization Act.

Source: Laws 1990, LB 1136, § 71.

44-32,163 Fees; distribution.

Every health maintenance organization subject to the Health Maintenance Organization Act shall pay to the director the following fees:

(1) For filing an application for a certificate of authority or amendment thereto, three hundred dollars;

(2) For filing an amendment to the organizational documents that requires approval, twenty dollars;

(3) For filing each annual report, two hundred dollars; and

(4) For renewing a certificate of authority, one hundred dollars.

Fees charged under this section shall be distributed one-half to the Director of Insurance and one-half to the Department of Health and Human Services. All fees or other assessments transmitted to the Department of Health and Human Services pursuant to the act shall be remitted to the state treasury for credit to the Health and Human Services Cash Fund. There shall be appropriated from money credited to the fund pursuant to this section such amounts as are available to pay expenses considered incident to the administration of the act.

Source: Laws 1990, LB 1136, § 72; Laws 1991, LB 703, § 12; Laws 1996, LB 1044, § 255; Laws 2007, LB296, § 194.

44-32,164 Administrative penalty.

The director may, in lieu of suspension or revocation of a certificate of authority, levy an administrative penalty in an amount not less than five hundred dollars nor more than ten thousand dollars if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The director may augment a penalty by an amount equal to the sum that he or she calculates to be the damages suffered by enrollees or other members of the public.

Source: Laws 1990, LB 1136, § 73.

44-32,165 Violations; conference; requirements.

If the Director of Insurance or the Department of Health and Human Services has for any reason cause to believe that any violation of the Health Maintenance Organization Act has occurred or is threatened, the Director of Insurance or the Department of Health and Human Services may give notice to the health maintenance organization and to the representatives or other per-

sons who appear to be involved in such suspected violation to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation. Proceedings under this section shall not be governed by any formal procedural requirements and may be conducted in such manner as the Director of Insurance or the Department of Health and Human Services deems appropriate under the circumstances. Unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section are satisfied.

Source: Laws 1990, LB 1136, § 74; Laws 1996, LB 1044, § 256; Laws 2007, LB296, § 195.

44-32,166 Cease and desist order; hearing; appeal; injunction.

The director may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any action or practice in violation of the Health Maintenance Organization Act. Within ten days after service of the cease and desist order, the respondent may request a hearing on the question of whether actions or practices in violation of the act have occurred. Such hearings shall be conducted as provided by the Administrative Procedure Act. The respondent may appeal the decision of the director, and the appeal shall be in accordance with the Administrative Procedure Act. If the director elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order, the director may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lancaster County.

Source: Laws 1990, LB 1136, § 75.

Cross References

Administrative Procedure Act, see section 84-920.

44-32,167 Net worth violation; director; powers.

If a health maintenance organization fails to comply with the net worth requirement of section 44-32,138, the director may take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

Source: Laws 1990, LB 1136, § 76.

44-32,168 Insurance laws; when applicable.

Except as otherwise provided in Chapter 44 or the Health Maintenance Organization Act, the insurance laws shall not be applicable to any health maintenance organization granted a certificate of authority under the act. This section shall not apply to an insurer licensed and regulated pursuant to the insurance laws except with respect to its activities authorized and regulated pursuant to the act.

Source: Laws 1990, LB 1136, § 77.

44-32,169 Solicitation of enrollees; other law; how construed.

Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Source: Laws 1990, LB 1136, § 78.

44-32,170 Practice of medicine; laws not applicable.

Any health maintenance organization authorized under the Health Maintenance Organization Act shall not be deemed to be practicing medicine and shall be exempt from the Medicine and Surgery Practice Act relating to the practice of medicine.

Source: Laws 1990, LB 1136, § 79; Laws 2007, LB463, § 1138.

Cross References

Medicine and Surgery Practice Act, see section 38-2001.

44-32,171 Applications, filings, and reports; public documents; exception.

All applications, filings, and reports required under the Health Maintenance Organization Act shall be treated as public documents except those which are trade secrets or privileged or confidential quality assurance, commercial, or financial information other than any annual financial statement that may be required under section 44-32,134.

Source: Laws 1990, LB 1136, § 80.

44-32,172 Confidential information; disclosure prohibited; exception.

Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except (1) to the extent that it may be necessary to carry out the purposes of the Health Maintenance Organization Act, (2) upon the express consent of the enrollee or applicant, (3) pursuant to statute or court order for the production of evidence or the discovery thereof, or (4) in the event of a claim or litigation between such person and the health maintenance organization in which such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the health maintenance organization is entitled to claim.

Source: Laws 1990, LB 1136, § 81.

44-32,173 Health care review committee; health maintenance organization; exemption from liability.

A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee or who furnishes any records, information, or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the health maintenance organization which established such committee or the officers, directors, employees, or agents of such health maintenance organization be liable for the

activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

Source: Laws 1990, LB 1136, § 82.

44-32,174 Health care review committee; information and records; confidentiality.

(1) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal from the committee's findings or recommendations. No member of a health care review committee, no officer, director, or other member of a health maintenance organization or its staff engaged in assisting such committee, and no person assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(2) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subsection (1) of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as the original information and records in the possession and control of a health care review committee.

Source: Laws 1990, LB 1136, § 83.

44-32,175 Quality assurance; access to records and information.

To fulfill its quality assurance obligations, a health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any enrollee.

Source: Laws 1990, LB 1136, § 84.

44-32,176 Department of Health and Human Services; contracts authorized.

The Department of Health and Human Services, in carrying out obligations under the Health Maintenance Organization Act, may contract with qualified persons to make recommendations concerning the determinations required to be made. Such recommendations may be accepted in full or in part by the department.

Source: Laws 1990, LB 1136, § 85; Laws 1996, LB 1044, § 257; Laws 2007, LB296, § 196.

44-32,177 Health maintenance organization; acquisition, merger, and consolidation; procedure.

No person shall (1) make a tender for or a request or invitation for tenders of, (2) enter into an agreement to exchange securities for, or (3) acquire in the open market or otherwise any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization, and no person shall enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization unless, at the time any

offer, request, or invitation is made or any agreement is entered into or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the director and has sent to the health maintenance organization information required by subsection (4) of section 44-2126 and the offer, request, invitation, agreement, or acquisition has been approved by the director. Approval by the director shall be governed by the Insurance Holding Company System Act.

Source: Laws 1990, LB 1136, § 86; Laws 1991, LB 236, § 34; Laws 2012, LB887, § 20.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-32,178 Coordination of benefits.

A health maintenance organization may, but shall not be required to, adopt coordination-of-benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans. If a health maintenance organization adopts coordination-of-benefits provisions, the provisions shall be consistent with the coordination-of-benefits provisions that are in general use in the state for coordinating coverage between two or more group health insurance or health care plans. To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are received from nonparticipating providers, provided outside their service areas, or not covered under the terms of their group contracts or evidence of coverage.

Source: Laws 1990, LB 1136, § 87.

44-32,179 Unfair trade and claims settlement practices laws; applicability.

The Unfair Insurance Trade Practices Act and the Unfair Insurance Claims Settlement Practices Act shall apply to health maintenance organizations except to the extent that the director determines the nature of health maintenance organizations renders application of either act clearly inappropriate.

Source: Laws 1990, LB 1136, § 88; Laws 1991, LB 234, § 32.

Cross References

Unfair Insurance Claims Settlement Practices Act, see section 44-1536.
Unfair Insurance Trade Practices Act, see section 44-1521.

44-32,180 Taxation.

(1) Any health maintenance organization subject to the Health Maintenance Organization Act shall also be subject to (a) the premium taxation provisions of Chapter 77, article 9, to the extent that the direct writing premiums are not otherwise subject to taxation under such article and (b) the retaliatory taxation provisions of section 44-150.

(2) Any capitation payment made in accordance with the Medical Assistance Act shall be excluded from computation of any tax obligation imposed by subsection (1) of this section.

Source: Laws 1990, LB 1136, § 89; Laws 1996, LB 969, § 2; Laws 2002, Second Spec. Sess., LB 9, § 1; Laws 2006, LB 1248, § 60; Laws 2010, LB698, § 1.

Cross References

Medical Assistance Act, see section 68-901.

ARTICLE 33
LEGAL SERVICE INSURANCE CORPORATIONS

Section

44-3301 Sections; how interpreted.

Sections 44-3301 to 44-3327 shall be interpreted liberally to (1) encourage the development of more effective and economical ways of providing legal services, (2) ease the burden of necessary legal expenses, and (3) aid in maintaining a high level of competence and adherence to professional standards in the performance of legal services.

Source: Laws 1979, LB 52, § 1.

44-3302 Terms, defined.

As used in sections 44-3301 to 44-3327, unless the context otherwise requires:

(1) Director shall mean the Director of Insurance;

(2) Department shall mean the Department of Insurance;

(3) Insurer shall mean any person, as defined in section 49-801, authorized to conduct an insurance business as an insurer in this state, including corporations organized under sections 44-3312 and 44-3313; and

(4) Legal expense insurance shall mean the assumption of a contractual obligation to pay or reimburse for specified legal services or specified legal

expenses, in consideration of a specified payment for an interval of time, regardless of whether the payment is made by the beneficiaries individually or by a third person for them, in such a manner that the total cost incurred by assuming the obligation is to be spread directly or indirectly among a group of persons. Legal expense insurance includes arrangements that create reasonable expectations of enforceable rights, but does not include the provision of or reimbursement for legal services incidental to other insurance coverages. The payment of only an administrative fee to an attorney shall not be considered payment or reimbursement for specified legal services or specified legal expenses for the purposes of this definition.

Source: Laws 1979, LB 52, § 2; Laws 2019, LB26, § 1.

44-3303 Insurance laws; situations; not applicable.

The insurance laws of this state, including sections 44-3301 to 44-3327, do not apply to:

(1) Retainer contracts made by attorneys at law with individual clients with fees based on estimates of the nature and amount of services to be provided to the specific client and similar contracts made with a group of clients involved in the same or closely related legal matters;

(2) Plans providing no benefits other than consultation and advice in connection with or in combination with referral services;

(3) The furnishing of limited legal assistance on an informal basis, involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, education, or similar relationship;

(4) The furnishing of legal assistance by labor unions and other employee organizations to their members in matters relating to employment or occupation;

(5) Employee welfare benefit plans to the extent that state laws are superseded by Section 514 of the Employee Retirement Income Security Act of 1974;

(6) Automobile club service contracts which supply incidental or limited legal services or reimbursement for legal services in automobile related matters; and

(7) Plans that do not include the assumption of risk or obligation to pay or reimburse for specified legal services or specified legal expenses. The payment of only an administrative fee to an attorney shall not be considered payment or reimbursement for specified legal services or a specified legal expense.

Source: Laws 1979, LB 52, § 3; Laws 2019, LB26, § 2.

44-3304 Legal expense insurance business; authorization by director; exceptions.

(1) No person may conduct a legal expense insurance business in this state unless authorized to do so by the director.

(2) Subsection (1) of this section shall not apply to any person issuing group, blanket, or franchise policies if fewer than twenty-five percent of the certificate holders or insureds reside in this state and the person is regulated to a comparable extent by another state in which a larger number of certificate holders or insureds reside.

Source: Laws 1979, LB 52, § 4.

44-3305 Legal expense insurance; policy; certificate of coverage; issuance.

(1) Legal expense insurance may be written as individual, group, blanket, or franchise insurance. Each contractual obligation for legal expense insurance shall be evidenced by a policy. Each person insured under a group policy shall be issued a certificate of coverage.

(2) No policy or certificate of legal expense insurance may be issued in this state unless a copy of the form has been filed with and approved by the director.

Source: Laws 1979, LB 52, § 5.

44-3306 Policy or certificate form; disapproval; grounds.

The director may disapprove a policy or certificate form of an insurer whose purpose according to its articles of incorporation is restricted to transacting legal expense insurance and business reasonably related thereto if he or she finds that it:

(1) Is unfair, unfairly discriminatory, misleading, or encourages misrepresentation or misunderstanding of the contract;

(2) Provides coverage or benefits or contains other provisions that would endanger the solidity of the insurer;

(3) Provides rates which are excessive, inadequate, or unfairly discriminatory; or

(4) Is contrary to law.

Source: Laws 1979, LB 52, § 6.

44-3307 Provider contracts; director approval required; report.

(1) Provider contracts, and changes thereto, made between an insurer, whose purpose is restricted to transacting legal expense insurance and business reasonably related thereto, and providing attorneys or other providers of services covered by the legal expense insurance policy shall be filed with the director and shall not become effective until approved by the director.

(2) Legal expense insurers shall annually report to the director, in such detail as the director reasonably requires, the number and geographical distribution of attorneys and other providers of services covered by the legal expense insurance policy with whom they maintain contractual relations and the nature of the relations. For individual insurers or groups of insurers the directors may require more frequent reports.

Source: Laws 1979, LB 52, § 7.

44-3308 Insurer; transacting legal expense insurance; deposit of securities or surety bond; purpose; release; reduction.

(1) An insurer whose purposes according to its articles of incorporation are restricted to transacting legal expense insurance and business reasonably related thereto shall deposit with the director securities eligible for deposit by an insurance company, which shall have at all times a market value of not less than one hundred fifty thousand dollars, or as provided by subsection (7) of this section. A deposit under this section shall be held to assure the faithful performance of the insurer's obligations to its policyholders.

(2) In lieu of any deposit of securities required under subsection (1) of this section, the insurer may file with the director a surety bond in the amount of one hundred fifty thousand dollars, or as provided by subsection (7) of this section. The bond shall be one issued by an insurance company authorized to do business in the State of Nebraska. The bond shall be for the same purposes as the deposit in lieu of which it is filed, and it shall be subject to the director's approval. No such bond shall be canceled or subject to cancellation unless at least thirty days' advance notice thereof, in writing, is filed with the director.

(3) Securities or bond posted by the insurer pursuant to subsection (1) or (2) of this section shall be for the benefit of and subject to action thereon in the event of insolvency of the insurer by any person or persons sustaining an actionable injury due to the failure of the insurer to faithfully perform its obligations to its policyholders.

(4) The State of Nebraska shall be responsible for the safekeeping of all securities deposited with the director under this section. The securities shall not, on account of being in this state, be subject to taxation.

(5) The depositing insurer shall, during its solvency, have the right to exchange or substitute other securities of a like quality and value for securities on deposit, to receive the interest and other income accruing on such securities, and to inspect the deposit at all reasonable times.

(6) The deposit or bond shall be maintained unimpaired as long as the insurer continues in business in this state. Whenever the insurer ceases to do business and furnishes to the director proof satisfactory to the director that the insurer adequately provided for all of its obligations to its policyholders or contract holders in this state, the director shall release the deposited securities to the parties entitled thereto, on presentation of the director's receipts for such securities, or shall release any bond filed with it in lieu of such deposit.

(7) The director may reduce the minimum market value of securities required under subsection (1) of this section or the amount of the surety bond required under subsection (2) of this section if he or she finds that the reduction is justified by:

(a) The terms and number of existing contracts with subscribers;

(b) Support by financially sound public or private organizations or agencies;

(c) Agreements with lawyers or paralegal personnel for the providing of legal services;

(d) Agreements with other persons for insuring the payment of the cost of legal services or the provision for alternative coverage in the event the insurer is unable to perform its obligations; or

(e) Other reliable financial guarantees.

(8) No part of the securities or bond to be filed under this section shall be supplied directly or indirectly by dues payments made for the purpose of meeting requirements to practice a profession.

Source: Laws 1979, LB 52, § 8.

44-3309 Insurer; acts prohibited.

An insurer shall not contract itself to practice law in any manner, nor shall the insurer control or attempt to control the attorney in the exercise of his or her professional judgment.

Source: Laws 1979, LB 52, § 9.

44-3310 Insurers; contract with others; purposes; approval.

Insurers may contract with other insurers, including insurance companies organized under any of the laws of the State of Nebraska, for partial or total administrative services or for joint participation through contractual agreements or otherwise cede or accept legal expense insurance obligations from such insurers on the whole or any part of such legal expense insurance obligations. Such contract forms, documents, treaties, or agreement forms shall be filed with and approved by the director to be in accordance with the plan of operation of such insurer prior to their effectiveness. The director may adopt and promulgate rules and regulations concerning such participation contracts and agreements with insurers.

Source: Laws 1979, LB 52, § 10; Laws 1989, LB 92, § 231.

44-3311 Legal expense insurance policy; possible violations; director; report.

The director shall report to the Counsel for Discipline of the Nebraska Supreme Court any information of possible instances of overcharging for legal services, incompetence, or violations of the Nebraska Rules of Professional Conduct by lawyers who provide services in connection with a legal expense insurance policy.

Source: Laws 1979, LB 52, § 11; Laws 2004, LB 1207, § 44; Laws 2006, LB 1115, § 35.

44-3312 Legal service insurance corporation; articles of incorporation; contents.

(1) Two or more persons may organize a legal service insurance corporation under this section.

(2) The articles of incorporation of a not-for-profit corporation shall conform to the requirements applicable to not-for-profit corporations under the Nebraska Nonprofit Corporation Act and the articles of incorporation of a corporation for profit shall conform to the requirements applicable to corporations for profit under the Nebraska Model Business Corporation Act, except that:

(a) The name of the corporation shall indicate that legal services or indemnity for legal services is to be provided;

(b) The purposes of the corporation shall be limited to providing legal services or indemnity for legal expenses and business reasonably related thereto;

(c) The articles shall state whether members or other providers of services may be required to share operating deficits, either through assessments or through reductions in the compensation for services rendered. They shall also state the general conditions and procedures for deficit sharing and any limits on the amount of the deficit to be assumed by each individual member or provider;

(d) For corporations having members, the articles shall state the conditions and procedures for acquiring membership and that only members have the right to vote; and

(e) For corporations not having members, the articles shall state how the directors are to be selected.

Source: Laws 1979, LB 52, § 12; Laws 1995, LB 109, § 225; Laws 1996, LB 681, § 195; Laws 2014, LB749, § 291.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.
Nebraska Nonprofit Corporation Act, see section 21-1901.

44-3313 Incorporators; certificate of authority; application; contents.

The incorporators shall file with the director an application for a certificate of authority to do business, which shall include or have attached the following:

(1) The names, addresses, and occupations of all incorporators, proposed directors, and officers;

(2) For corporate incorporators, their articles and bylaws and a list of the names, addresses, and occupations of their directors and principal officers and, for the three most recent years, their annual statements and reports;

(3) The proposed articles and bylaws;

(4) All agreements relating to the corporation to which any incorporator, or proposed director or officer is a party;

(5) The amount and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other persons;

(6) The proposed compensation of directors and officers;

(7) The forms to be used for any contracts between the corporation and its members or other persons concerning the provision of services to insureds;

(8) The proposed minimum amount of surplus;

(9) The plan for conducting the insurance business including all of the following:

(a) The geographical area in which business is intended to be done;

(b) The types of legal expense insurance intended to be written including specification whether and to what extent indemnity rather than service benefits are to be provided;

(c) The proposed marketing methods; and

(d) To the extent required by the director, the proposed method for the establishment of premium rates and other charges to policyholders; and

(10) Such other documents or information as the director reasonably requires.

Source: Laws 1979, LB 52, § 13.

44-3314 Certificate of authority; director; issuance; conditions.

The director shall issue a certificate of authority to a corporation organized under the provisions of sections 44-3312 and 44-3313 if:

(1) He or she finds that all requirements of law have been met;

(2) He or she is satisfied that all natural persons who are incorporators, the directors and principal officers of corporate incorporators, and the proposed directors and officers of the corporation being formed are trustworthy, competent, and collectively have the competence and experience to engage in the particular insurance business proposed; and

(3) He or she is satisfied that the business plan is consistent with the interests of the corporation's potential insureds and of the public.

Source: Laws 1979, LB 52, § 14.

44-3315 Legal service insurance corporation; legal existence; when commenced.

Upon the issuance of the certificate of authority, and upon the issuance of the certificate of incorporation by the Secretary of State, the legal existence of the corporation organized under sections 44-3312 and 44-3313 shall begin, the articles and bylaws shall become effective, the proposed directors and officers shall take office, and the corporation shall be authorized to transact legal service insurance in this state subject to the requirements and restrictions of sections 44-3301 to 44-3327.

Source: Laws 1979, LB 52, § 15.

44-3316 Legal service insurance corporation; funds; investments.

A corporation organized under sections 44-3312 and 44-3313 shall invest its funds as provided by Chapter 44 and its investments shall be valued as provided by Chapter 44. The investments shall exceed its liabilities and reserves except for claim liability covered by contracting attorney guarantees and it shall be a continuing condition of licensing by the director that such solvency be maintained.

Source: Laws 1979, LB 52, § 16.

44-3317 Legal service insurance corporation; reserves.

A corporation organized under sections 44-3312 and 44-3313 shall maintain the reserves necessary for the sound operation of the business, including unearned premium reserves. The amount and manner of calculating such reserves shall be determined by rule of the director.

Source: Laws 1979, LB 52, § 17.

44-3318 Legal expense insurers; acts; not applicable.

An insurer whose purposes according to its articles of incorporation are restricted to transacting legal expense insurance and business reasonably related thereto shall not be a member of the Nebraska Property and Liability Insurance Guaranty Association described in Chapter 44, article 24, or the Nebraska Life and Health Insurance Guaranty Association described in Chapter 44, article 27. The Nebraska Property and Liability Insurance Guaranty Association Act and the Nebraska Life and Health Insurance Guaranty Association Act shall not be applicable to legal expense insurance issued by an insurer whose purposes according to its articles of incorporation are restricted to transacting legal expense insurance and business reasonably related thereto.

Source: Laws 1979, LB 52, § 18.

Cross References

Nebraska Life and Health Insurance Guaranty Association Act, see section 44-2720.
Nebraska Property and Liability Insurance Guaranty Association Act, see section 44-2418.

44-3319 Legal service insurance corporation; advancement of funds; repayment.

Any person may advance to a corporation organized under sections 44-3312 and 44-3313 on a contingent liability basis such funds as are necessary for the purposes of its business or to enable it to comply with any requirements of sections 44-3301 to 44-3327. Such money and interest thereon as may have been agreed upon shall be repayable and shall be repaid only on prior approval by the director. Repayment shall only be made out of operating surplus after reserve requirements have been met. No assessments against insureds may be levied for the purpose of repayment and no dividends may be paid to members as long as interest or repayment installments remain unpaid.

Source: Laws 1979, LB 52, § 19.

44-3320 Legal service insurance corporation; laws applicable.

All corporations organized under sections 44-3312 and 44-3313 shall be governed by such other laws regulating the business of insurance and profit and nonprofit corporations as do not conflict with sections 44-3301 to 44-3327.

Source: Laws 1979, LB 52, § 20.

44-3321 Legal service insurance corporation; agency or management contract; director approval required.

A corporation organized under sections 44-3312 and 44-3313 shall not enter into an exclusive agency contract or management contract, unless the contract is first filed with the director and approved within thirty days of filing or such reasonable extended period as the director may specify by notice given within thirty days. The director may disapprove the contracts submitted if he or she finds that the contract contains provisions which impair the interests of the insurer's participants, creditors, or the public in this state.

Source: Laws 1979, LB 52, § 21.

44-3322 Legal service insurance corporation; affairs; transactions; examination.

The Department of Insurance may appoint any deputy or examiner or other persons who shall have the power of visitation and examination into the affairs of any corporation organized under sections 44-3312 and 44-3313. Such deputy or examiner shall have free access to all the books, papers, and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents, or employees or other persons in relation to the affairs, transactions, and condition of such corporation.

Source: Laws 1979, LB 52, § 22.

44-3323 Legal service insurance corporation; supervision, rehabilitation, conservation, dissolution, or liquidation; procedures.

Any supervision, rehabilitation, conservation, dissolution, or liquidation of a corporation organized under sections 44-3312 and 44-3313 shall be conducted

pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1979, LB 52, § 23; Laws 1989, LB 319, § 76.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-3324 Legal service insurance corporation; annual premium statement; filed.

Each corporation organized under sections 44-3312 and 44-3313 shall annually on March 1 file with the department its statement for the preceding calendar year, and in the form prescribed by the director, showing all premiums received by it for the issuance of legal expense insurance in this state. Such annual statements may use accounting principles common to its business, but such accounting principles must enable the director to ascertain whether the reserve required by section 44-3317 has been maintained.

Source: Laws 1979, LB 52, § 24.

44-3325 Legal service insurance corporation; annual statement; failure to file; penalty.

Any corporation organized under sections 44-3312 and 44-3313 neglecting to file the annual statement in the form and within the time provided by section 44-3324 shall forfeit one hundred dollars for each day during which such neglect continues, and, upon notice by the director to that effect, its authority to do business in this state shall cease while such default continues.

Source: Laws 1979, LB 52, § 25.

44-3326 Director; require additional reports.

In addition to an annual statement, the director may require of licensees, under oath and in the form prescribed by him or her, such additional regular or special reports as he or she may deem necessary to the proper supervision of corporations under sections 44-3312 and 44-3313.

Source: Laws 1979, LB 52, § 26.

44-3327 Legal service insurance corporation; taxation provisions applicable.

Any corporation organized under sections 44-3312 and 44-3313 shall also be subject to the taxation provisions of Chapter 77, article 9, to the extent that direct writing premiums are subject to taxation under such article.

Source: Laws 1979, LB 52, § 27.

ARTICLE 34

POLICY READABILITY

Section

Section
44-3408. Sections; when applicable.

44-3401 Act, how cited.

Sections 44-3401 to 44-3408 shall be known and may be cited as the Nebraska Life, Sickness and Accident Insurance Policy Readability Act.

Source: Laws 1979, LB 415, § 1.

44-3402 Sections, purposes.

The purpose of sections 44-3401 to 44-3408 is to establish minimum standards for readability of language used in policies of life insurance, sickness and accident insurance, credit life insurance, and credit accident and health insurance delivered or issued for delivery in this state. Sections 44-3401 to 44-3408 are not intended to change the risks assumed by insurers subject to the act, nor to change their obligation to comply with the substance of other insurance laws applicable to life, sickness and accident, credit life, or credit accident and health insurance policies. Sections 44-3401 to 44-3408 are not intended to prevent flexibility and innovation in the development of policy forms or content nor to require standard policy forms or content.

Source: Laws 1979, LB 415, § 2.

44-3403 Terms, defined.

For purposes of the Nebraska Life, Sickness and Accident Insurance Policy Readability Act, unless the context otherwise requires:

(1) Director shall mean the Director of Insurance;

(2) Insurer shall mean any company, corporation, exchange, society, or association whether organized on the stock, mutual, assessment, or fraternal plan of insurance, which is authorized under the laws of this state to provide life insurance, sickness and accident insurance, credit life insurance, or credit accident and health insurance, including, but not limited to, fraternal benefit societies and health maintenance organizations; and

(3) Policy shall mean any contract of life insurance, sickness and accident insurance, credit life insurance, or credit accident and health insurance delivered or issued for delivery in this state by any insurer subject to the act.

Source: Laws 1979, LB 415, § 3; Laws 1989, LB 92, § 232.

44-3404 Policies; applicability of sections.

Sections 44-3401 to 44-3408 shall apply to all policies, except:

(1) Any policy which is a security subject to federal jurisdiction;

(2) Any group policy covering a group of one thousand or more lives at date of issue, other than a group credit life insurance policy or a group credit accident and health insurance policy, but this shall not exempt any individual certificate issued under a group policy delivered or issued for delivery in this state;

(3) Any group annuity contract which funds a pension, profit-sharing, or deferred compensation plan;

(4) Any form used in connection with, as a conversion from, as an addition to, or in exchange under, a contractual provision for a policy delivered or

issued for delivery on a form approved or permitted to be issued before the dates such forms must be approved under sections 44-3401 to 44-3408; or

(5) The renewal of a policy delivered or issued for delivery before the dates such forms must be approved under sections 44-3401 to 44-3408.

Source: Laws 1979, LB 415, § 4.

44-3405 Policies; text; style; arrangement; requirements; filings; certificate.

(1) No policy of life insurance, sickness and accident insurance, credit life insurance, or credit accident and health insurance shall be delivered or issued for delivery in this state unless: (a) The text achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test which has been approved by the director; (b) the policy is printed, except for specification pages, schedules, and tables, in not less than ten-point type, one-point leaded; (c) the style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text of the policy or to any endorsements or riders; and (d) a table of contents or an index of the principal sections of the policy is provided with the policy, if the policy has more than three thousand words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

(2) For the purposes of this section, a Flesch reading ease test score shall be measured by the following method: (a) For policies containing ten thousand words or less of text, the entire policy shall be analyzed. For policies containing more than ten thousand words, the readability of two two-hundred-word samples per page may be analyzed instead of the entire policy. The samples shall be separated by at least ten printed lines; (b) the number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015; (c) the total number of syllables shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6; and (d) the sum of the figures computed under subdivisions (b) and (c) of this subsection subtracted from 206.835 equals the Flesch reading ease score for the policy.

(3) For the purposes of subdivisions (2)(b), (2)(c), and (2)(d) of this section, the following procedures shall be used: A contraction, hyphenated word, or numbers and letters, when separated by spaces, shall be counted as one word; a unit of words ending with a period, semicolon, or colon, but excluding headings and captions, shall be counted as a sentence; and, a syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. When the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(4) The term text as used in this section shall include all printed matter except the following: (a) The name and address of the insurer; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules, or tables; and (b) any policy language which is drafted to conform to the requirements of any federal law, regulation, or agency interpretation; any policy language required by any collective-bargaining agreement; any medical terminology; any words which are defined in the policy; and any policy language required by law or regulation, if the insurer identifies the language or terminology excepted by this

subsection, and certifies, in writing, that the language or terminology is entitled to be excepted by subdivision (b) of this subsection.

(5) Filings subject to this section shall be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used, or stating that the score is lower than the minimum required but should be approved in accordance with section 44-3406. To confirm the accuracy of any certification, the director may require the submission of further information to verify the certification in question.

(6) Riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

Source: Laws 1979, LB 415, § 5.

44-3406 Flesch reading ease score; lower score authorized; when.

The director may authorize a lower score than the Flesch reading ease score required in subsection (1) of section 44-3405 whenever, in his or her sole discretion, he or she finds that a lower score: (1) Will provide a more accurate reflection of the readability of a policy form; (2) is warranted by the nature of a particular policy form or type or class of policy forms; or (3) is caused by certain policy language which is drafted to conform to the requirements of any state law, regulation, or agency interpretation.

Source: Laws 1979, LB 415, § 6.

44-3407 Policy; approval.

A policy meeting the requirements of section 44-3405 shall be approved, notwithstanding the provision of any other laws which specify the content of policies, if the policy provides protection not less favorable than that required by such laws.

Source: Laws 1979, LB 415, § 7.

44-3408 Sections; when applicable.

Sections 44-3401 to 44-3408 applies to all policies filed on or after June 30, 1981. No policy shall be delivered or issued for delivery in this state on or after June 30, 1984, unless approved by the director or permitted to be issued under sections 44-3401 to 44-3408. Any policy which has been approved or permitted to be issued before June 30, 1984, and which meets the standards set by sections 44-3401 to 44-3408, need not be refiled for approval, but may continue to be lawfully delivered or issued for delivery in this state upon the filing with the director of a list of such policies identified by policy number and accompanied by a certificate as to each such policy in the manner provided in section 44-3405.

Source: Laws 1979, LB 415, § 8.

ARTICLE 35

SERVICE CONTRACTS

(a) CERTIFICATE OF AUTHORITY

Section
44-3501. Repealed. Laws 1990, LB 1136, § 130.

Section
44-3502. Repealed. Laws 1990, LB 1136, § 130.
44-3503. Repealed. Laws 1990, LB 1136, § 130.
44-3504. Repealed. Laws 1990, LB 1136, § 130.
44-3505. Repealed. Laws 1990, LB 1136, § 130.
44-3506. Repealed. Laws 1990, LB 1136, § 130.
44-3507. Repealed. Laws 1990, LB 1136, § 130.
44-3508. Repealed. Laws 1990, LB 1136, § 130.
44-3509. Repealed. Laws 1990, LB 1136, § 130.
44-3510. Repealed. Laws 1990, LB 1136, § 130.
44-3511. Repealed. Laws 1990, LB 1136, § 130.
44-3512. Repealed. Laws 1990, LB 1136, § 130.
44-3513. Repealed. Laws 1990, LB 1136, § 130.
44-3514. Repealed. Laws 1990, LB 1136, § 130.
44-3515. Repealed. Laws 1990, LB 1136, § 130.
44-3516. Repealed. Laws 1990, LB 1136, § 130.
44-3517. Repealed. Laws 1990, LB 1136, § 130.
44-3518. Repealed. Laws 1990, LB 1136, § 130.
44-3519. Repealed. Laws 1990, LB 1136, § 130.

(b) MOTOR VEHICLES

44-3520. Act, how cited.
44-3521. Terms, defined.
44-3522. Motor vehicle service contract; requirements.
44-3523. Motor vehicle service contract reimbursement insurance policy; requirements; failure to timely provide covered service; effect.
44-3524. Cease and desist order; notice; hearing; injunction.
44-3525. Rules and regulations.
44-3526. Act; exemptions.
44-3527. Motor vehicle service contract; filing; form; requirements; enforcement of act; procedure.

(a) CERTIFICATE OF AUTHORITY

44-3501 Repealed. Laws 1990, LB 1136, § 130.

44-3502 Repealed. Laws 1990, LB 1136, § 130.

44-3503 Repealed. Laws 1990, LB 1136, § 130.

44-3504 Repealed. Laws 1990, LB 1136, § 130.

44-3505 Repealed. Laws 1990, LB 1136, § 130.

44-3506 Repealed. Laws 1990, LB 1136, § 130.

44-3507 Repealed. Laws 1990, LB 1136, § 130.

44-3508 Repealed. Laws 1990, LB 1136, § 130.

44-3509 Repealed. Laws 1990, LB 1136, § 130.

44-3510 Repealed. Laws 1990, LB 1136, § 130.

44-3511 Repealed. Laws 1990, LB 1136, § 130.

44-3512 Repealed. Laws 1990, LB 1136, § 130.

44-3513 Repealed. Laws 1990, LB 1136, § 130.

44-3514 Repealed. Laws 1990, LB 1136, § 130.

44-3515 Repealed. Laws 1990, LB 1136, § 130.

44-3516 Repealed. Laws 1990, LB 1136, § 130.

44-3517 Repealed. Laws 1990, LB 1136, § 130.

44-3518 Repealed. Laws 1990, LB 1136, § 130.

44-3519 Repealed. Laws 1990, LB 1136, § 130.

(b) MOTOR VEHICLES

44-3520 Act, how cited.

Sections 44-3520 to 44-3527 shall be known and may be cited as the Motor Vehicle Service Contract Reimbursement Insurance Act.

Source: Laws 1990, LB 1136, § 92; Laws 2020, LB774, § 5.

44-3521 Terms, defined.

For purposes of the Motor Vehicle Service Contract Reimbursement Insurance Act:

(1) Director means the Director of Insurance;

(2) Incidental costs means expenses specified in a motor vehicle service contract that are incurred by the service contract holder due to the failure of a vehicle protection product to perform as provided in the contract. Incidental costs include, but are not limited to, insurance policy deductibles, rental vehicle charges, the difference between the actual value of the stolen vehicle at the time of theft and the cost of a replacement vehicle, sales taxes, registration fees, transaction fees, and mechanical inspection fees. Incidental costs may be reimbursed in either a fixed amount specified in the motor vehicle service contract or sales agreement or by use of a formula itemizing specific incidental costs incurred by the service contract holder;

(3) Mechanical breakdown insurance means a policy, contract, or agreement that undertakes to perform or provide repair or replacement service, or indemnification for such service, for the operational or structural failure of a motor vehicle due to defect in materials or workmanship or normal wear and tear and that is issued by an insurance company authorized to do business in this state;

(4) Motor vehicle means any motor vehicle as defined in section 60-339;

(5)(a) Motor vehicle service contract means a contract or agreement given for consideration over and above the lease or purchase price of a motor vehicle that undertakes to perform or provide repair or replacement service, or indemnification for such service, for the operational or structural failure of a motor vehicle due to defect in materials or workmanship or normal wear and tear but does not include mechanical breakdown insurance.

(b) Motor vehicle service contract also includes a contract or agreement that is effective for a specified duration and paid for by means other than the purchase of a motor vehicle to perform any one or more of the following:

(i) The repair or replacement of tires or wheels on a motor vehicle damaged as a result of coming into contact with road hazards;

(ii) The removal of dents, dings, or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding, or painting;

(iii) The repair of chips or cracks in or replacement of motor vehicle windshields as a result of damage caused by road hazards;

(iv) The replacement of a motor vehicle key or keyfob in the event the key or keyfob becomes inoperable or is lost;

(v) The payment of specified incidental costs as the result of a failure of a vehicle protection product to perform as specified; and

(vi) Other products and services approved by the director;

(6) Motor vehicle service contract provider means a person who issues, makes, provides, sells, or offers to sell a motor vehicle service contract, except that motor vehicle service contract provider does not include an insurer as defined in section 44-103;

(7) Motor vehicle service contract reimbursement insurance policy means a policy of insurance issued to a motor vehicle service contract provider to either provide reimbursement to the motor vehicle service contract provider under the terms of the insured motor vehicle service contracts issued or sold by the motor vehicle service contract provider or, in the event of the motor vehicle service contract provider's nonperformance, to pay on behalf of the motor vehicle service contract provider all covered contractual obligations incurred by the motor vehicle service contract provider under the terms of the insured motor vehicle service contracts issued or sold by the motor vehicle service contract provider in this state;

(8) Road hazards means hazards that are encountered during normal driving conditions, including, but not limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs, or composite scraps;

(9) Service contract holder means a person who purchases a motor vehicle service contract; and

(10)(a) Vehicle protection product means a vehicle protection device, system, or service that:

(i) Is installed on or applied to a vehicle;

(ii) Is designed to prevent loss or damage to a vehicle from a specific cause; and

(iii) Includes a written warranty.

(b) Vehicle protection product includes, but is not limited to, chemical additives, alarm systems, body part marking products, steering locks, window etch products, pedal and ignition locks, fuel and ignition kill switches, and electronic, radio, and satellite tracking devices.

Source: Laws 1990, LB 1136, § 93; Laws 2005, LB 274, § 230; Laws 2006, LB 875, § 4; Laws 2012, LB1054, § 1; Laws 2020, LB774, § 6.

44-3522 Motor vehicle service contract; requirements.

No motor vehicle service contract shall be issued, sold, or offered for sale in this state unless:

(1) The motor vehicle service contract provider is insured under a motor vehicle service contract reimbursement insurance policy issued by an insurer authorized to do business in this state;

(2) True and correct copies of the motor vehicle service contract and the motor vehicle service contract reimbursement insurance policy have been filed with the director; and

(3) The contract conspicuously states:

(a) That the obligations of the motor vehicle service contract provider to the service contract holder are covered under the motor vehicle service contract reimbursement insurance policy; and

(b) The name and address of the issuer of the motor vehicle service contract reimbursement insurance policy.

Source: Laws 1990, LB 1136, § 94; Laws 2006, LB 875, § 5; Laws 2007, LB188, § 1.

44-3523 Motor vehicle service contract reimbursement insurance policy; requirements; failure to timely provide covered service; effect.

(1) No motor vehicle service contract reimbursement insurance policy shall be issued, sold, or offered for sale in this state unless the policy conspicuously states that the insurer will either reimburse or pay on behalf of the motor vehicle service contract provider any covered sums the motor vehicle service contract provider is legally obligated to pay or, in the event of the provider's nonperformance, will provide the service that the provider is legally obligated to perform according to the provider's contractual obligations under the motor vehicle service contracts issued or sold by the provider in this state.

(2) In the event covered service is not provided by the motor vehicle service contract provider within sixty days of proof of loss by the service contract holder, the service contract holder is entitled to apply directly to the insurer providing the motor vehicle service contract reimbursement insurance policy.

(3) The motor vehicle service contract reimbursement insurance policy shall completely and fully reimburse or pay on behalf of the motor vehicle service contract provider all repair costs incurred under the motor vehicle service contract. All unearned premium reserves and claim reserve funds shall be established as liabilities on the books of the insurer in accordance with statutory accounting practices. This subsection shall not apply to programs directly obligating an automobile dealer to perform under the motor vehicle service contract.

Source: Laws 1990, LB 1136, § 95; Laws 2006, LB 875, § 6; Laws 2020, LB774, § 7.

44-3524 Cease and desist order; notice; hearing; injunction.

(1) The director may issue an order instructing a motor vehicle service contract provider to cease and desist from selling or offering for sale motor vehicle service contracts if the director determines that the provider has failed to comply with the Motor Vehicle Service Contract Reimbursement Insurance Act. At the same time the order is issued, the director shall serve notice to the motor vehicle service provider of the reasons for such order and that the motor vehicle service provider may request a hearing in writing within ten business days after receipt of the order. If a hearing is requested, the director shall

schedule a hearing within ten business days after receipt of the request. The hearing shall be conducted in accordance with the Administrative Procedure Act. If a hearing is not requested and none is ordered by the director, the order shall remain in effect until modified or vacated by the director.

(2) Upon the failure of a motor vehicle service contract provider to obey a cease and desist order issued by the director, the director may give notice in writing of the failure to the Attorney General who may commence an action against the provider to enjoin the provider from selling or offering for sale motor vehicle service contracts until the provider complies with the act. The district court may issue the injunction.

Source: Laws 1990, LB 1136, § 96; Laws 2014, LB700, § 15.

Cross References

Administrative Procedure Act, see section 84-920.

44-3525 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Motor Vehicle Service Contract Reimbursement Insurance Act and to establish minimum standards for disclosure of the coverage limitations and exclusions of motor vehicle service contracts.

Source: Laws 1990, LB 1136, § 97.

44-3526 Act; exemptions.

The Motor Vehicle Service Contract Reimbursement Insurance Act shall not apply to:

(1) Motor vehicle service contracts (a)(i) issued by a motor vehicle manufacturer or importer for the motor vehicles manufactured or imported by that manufacturer or importer and (ii) sold by a franchised motor vehicle dealer licensed pursuant to the Motor Vehicle Industry Regulation Act or (b) issued and sold directly by a motor vehicle manufacturer or importer licensed pursuant to the Motor Vehicle Industry Regulation Act for the motor vehicles manufactured or imported by that manufacturer or importer; or

(2) Product warranties governed by the Magnuson-Moss Warranty - Federal Trade Commission Improvement Act, 15 U.S.C. 2301 et seq., or to any other warranties, indemnity agreement, or guarantees that are not provided incidental to the purchase of a vehicle protection product.

Source: Laws 1990, LB 1136, § 98; Laws 2010, LB816, § 3; Laws 2012, LB1054, § 2.

Cross References

Motor Vehicle Industry Regulation Act, see section 60-1401.

44-3527 Motor vehicle service contract; filing; form; requirements; enforcement of act; procedure.

(1) For purposes of this section, conspicuously means writing, displaying, or presenting a term in such a way that a reasonable person against whom it is to operate shall notice. Conspicuously stated terms include:

(a) A heading in capitals equal to or greater in size than the surrounding text, or in contrasting type, font, or color to the surrounding text of the same or lesser size; and

(b) Language in the body of a record or display in larger type than the surrounding text, or in contrasting type, font, or color to the surrounding text of the same size, or set off from surrounding text of the same size by symbols or other marks that call attention to the language.

(2) It is the responsibility of the motor vehicle service contract provider issuing the motor vehicle service contract to file a true and correct copy of the motor vehicle service contract form, motor vehicle service contract reimbursement insurance policy, and the notice of filing form with the Department of Insurance. Such notice of filing shall be made on a form provided by the department and must contain the name and address of the business entity filing the form as well as a contact person, the names and addresses of entities from which the service contract forms were purchased, the names and addresses of insurers insuring the provider's contractual liability, and the names and addresses of sales personnel. It is the responsibility of the motor vehicle service contract provider to notify the department on a continuing basis of any changes in the filings.

(3) Every motor vehicle service contract shall be written in clear, understandable language and shall be printed or typed in easy-to-read type, size, and style, and shall not be issued, sold, or offered for sale in this state unless the contract:

(a) Identifies the motor vehicle service contract provider and the service contract holder;

(b) Conspicuously states that the obligations of the motor vehicle service contract provider to the service contract holder are guaranteed under a service contract reimbursement insurance policy;

(c) Conspicuously states the name and address of the insurance company issuing the reimbursement insurance policy;

(d) Sets forth the total purchase price and the terms under which it is to be paid;

(e) Sets forth the procedure for making a claim, including an address and telephone number for claim assistance;

(f) Conspicuously states the existence of a deductible amount, if any;

(g) Clearly specifies the merchandise or services, or both, to be provided and any limitations, exceptions, or exclusions;

(h) Sets forth all of the obligations and duties of the service contract holder, including, but not limited to, the duty to prevent any further damage to the vehicle and the obligation to notify the provider in advance of any repair, if any;

(i) Sets forth any terms, restrictions, or conditions governing transferability of a service contract, if any;

(j) Sets forth applicable cancellation requirements; and

(k) States that the service contract holder has the right to file a claim directly with the insurer in the event of nonperformance by the motor vehicle service contract provider in the event covered service is not provided by the motor vehicle service contract provider within sixty days of proof of loss being filed by the service contract holder with the service contract provider, along with the method, requirements, and instructions for making such a claim.

(4) If the director determines that a motor vehicle service contract provider has failed to comply with the Motor Vehicle Service Contract Reimbursement Insurance Act, the director may issue an order to cease and desist from selling

or offering for sale motor vehicle service contracts. Accompanied with that order shall be a notice of hearing setting forth the time, date, place, and issues to be heard. Such hearing shall take place not less than ten days nor more than thirty days from the date from the issuance of the order to cease and desist. Upon the failure of a motor vehicle service contract provider to obey an order to cease and desist issued by the director, the director may give notice in writing of the failure to the Attorney General, who may commence an action against the provider to enjoin that provider from selling or offering for sale motor vehicle service contracts.

(5) If any provision of this section is declared invalid, the remainder shall not be affected.

Source: Laws 2020, LB774, § 8.

ARTICLE 36

MEDICARE SUPPLEMENT INSURANCE STANDARDS

Section

44-3601 Act, how cited.

Sections 44-3601 to 44-3610 shall be known and may be cited as the Medicare Supplement Insurance Minimum Standards Act.

Source: Laws 1980, LB 877, § 1; Laws 1981, LB 329, § 1; Laws 1988, LB 998, § 2; Laws 1992, LB 1006, § 19.

44-3602 Terms, defined.

For purposes of the Medicare Supplement Insurance Minimum Standards Act:

(1) Applicant shall mean:

(a) In the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) In the case of a group medicare supplement policy, the proposed certificate holder;

(2) Certificate shall mean any certificate delivered or issued for delivery in this state under a group medicare supplement policy;

(3) Certificate form shall mean the form on which the certificate is delivered or issued for delivery by the issuer;

(4) Director shall mean the Director of Insurance;

(5) Issuer shall include insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entities delivering or issuing for delivery in this state medicare supplement policies or certificates;

(6) Medicare shall mean the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

(7) Medicare supplement policy shall mean a group or individual policy of sickness and accident insurance or a subscriber contract of health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act, 42 U.S.C. 1395 et seq., or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare; and

(8) Policy form shall mean the form on which the policy is delivered or issued for delivery by the issuer.

Source: Laws 1980, LB 877, § 2; Laws 1981, LB 329, § 2; Laws 1985, LB 209, § 2; Laws 1985, LB 253, § 2; Laws 1988, LB 998, § 3; Laws 1989, LB 92, § 235; Laws 1990, LB 983, § 1; Laws 1992, LB 1006, § 20; Laws 1996, LB 969, § 3.

44-3603 Act; applicability.

(1) The Medicare Supplement Insurance Minimum Standards Act shall apply to:

(a) All medicare supplement policies delivered or issued for delivery in this state on or after April 16, 1992; and

(b) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(2) The act shall not apply to a policy of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(3) Except as otherwise specifically provided in subsection (4) of section 44-3607, the act shall not be intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons, which policies or plans are not marketed or held to be medicare supplement policies or benefit plans.

Source: Laws 1980, LB 877, § 3; Laws 1981, LB 329, § 3; Laws 1986, LB 305, § 1; Laws 1988, LB 998, § 4; Laws 1990, LB 983, § 2; Laws 1992, LB 1006, § 21; Laws 1996, LB 969, § 4.

44-3604 Policies and certificates; director; powers and duties; preexisting condition; coverage.

(1) No medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by medicare.

(2) Notwithstanding any other provision of law, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more

than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(3) The director shall adopt and promulgate reasonable rules and regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state. No requirement of Chapter 44 relating to minimum required policy benefits, other than the minimum standards contained in the Medicare Supplement Insurance Minimum Standards Act, shall apply to medicare supplement policies and certificates. The standards may include, but shall not be limited to:

(a) Terms of renewability;

(b) Initial and subsequent conditions of eligibility;

(c) Nonduplication of coverage;

(d) Probationary periods;

(e) Benefit limitations, exceptions, and reductions;

(f) Elimination periods;

(g) Requirements for replacement;

(h) Recurrent conditions; and

(i) Definitions of terms.

(4) The director shall adopt and promulgate reasonable rules and regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements, and reporting practices for medicare supplement policies and certificates.

(5) The director may adopt and promulgate rules and regulations necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations promulgated under federal law, including:

(a) Requiring refunds or credits if the policies or certificates do not meet loss-ratio requirements;

(b) Establishing a uniform methodology for calculating and reporting loss ratios;

(c) Assuring public access to policies, premiums, and loss-ratio information of issuers of medicare supplement insurance;

(d) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(e) Establishing a policy for holding public hearings prior to approval of premium increases; and

(f) Establishing standards for medicare select policies and certificates.

(6) The director may adopt and promulgate reasonable rules and regulations which specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the director, are unjust, unfair, or unfairly

discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

Source: Laws 1980, LB 877, § 4; Laws 1981, LB 329, § 4; Laws 1986, LB 305, § 2; Laws 1988, LB 998, § 5; Laws 1990, LB 983, § 3; Laws 1992, LB 1006, § 22; Laws 1996, LB 969, § 5.

44-3605 Repealed. Laws 1992, LB 1006, § 99.

44-3606 Benefits to policyholders; loss-ratio standards.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The director shall adopt and promulgate reasonable rules and regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses when coverage is provided by a health maintenance organization on a service basis rather than a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Source: Laws 1980, LB 877, § 6; Laws 1981, LB 329, § 6; Laws 1988, LB 998, § 7; Laws 1990, LB 983, § 5; Laws 1992, LB 1006, § 23.

44-3607 Outline of coverage; informational brochure; disclosure requirements.

(1) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The director shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. As used in this section, format shall mean style, arrangement, and overall appearance, including, but not limited to, the size, color, and prominence of type and arrangement of text and captions. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(c) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) The director may prescribe by rule and regulation a standard form and the contents of an informational brochure for persons eligible for medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct-response insurance policies, the director may require by rule and regulation that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct-response insurance policies, the director may require by rule and regulation that the prescribed brochure be provided upon

request to any prospective insureds eligible for medicare but in no event later than the time of policy delivery.

(4) The director may adopt and promulgate rules and regulations for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages for all sickness and accident insurance policies sold to persons eligible for medicare other than:

(a) Medicare supplement policies; or

(b) Disability income policies.

(5) The director may further adopt and promulgate rules and regulations to govern the full and fair disclosure of the information in connection with the replacement of sickness and accident policies, subscriber contracts, or certificates by persons eligible for medicare.

Source: Laws 1980, LB 877, § 7; Laws 1981, LB 329, § 7; Laws 1988, LB 998, § 8; Laws 1992, LB 1006, § 24; Laws 1996, LB 969, § 6.

44-3608 Return of policy or certificate; notice; refund.

Notwithstanding any other provision of law, medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

Source: Laws 1980, LB 877, § 8; Laws 1988, LB 998, § 9; Laws 1992, LB 1006, § 25.

44-3608.01 Advertisement; director; powers.

Every issuer of medicare supplement policies and certificates in this state shall provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval by him or her to the extent review or approval may be required under state law.

Source: Laws 1989, LB 92, § 236; Laws 1992, LB 1006, § 26.

44-3609 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Medicare Supplement Insurance Minimum Standards Act.

Source: Laws 1980, LB 877, § 9; Laws 1981, LB 329, § 8; Laws 1988, LB 998, § 10; Laws 1992, LB 1006, § 27.

44-3610 Act; violation; provisions applicable.

A violation of any provision of the Medicare Supplement Insurance Minimum Standards Act or any rule and regulation adopted and promulgated pursuant to such act shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

In addition to any other applicable penalties for violations of Chapter 44, the director may require an issuer violating any provision of the Medicare Supplement Insurance Minimum Standards Act or any rule or regulation issued under the act to cease marketing any medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require such issuer to take such actions as are necessary to comply with the act, or both.

Source: Laws 1980, LB 877, § 10; Laws 1988, LB 998, § 11; Laws 1991, LB 234, § 33; Laws 1992, LB 1006, § 28.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-3611 Repealed. Laws 1992, LB 1006, § 99.

ARTICLE 37

MOTOR CLUB SERVICES ACT

Section

44-3701 Act, how cited.

Sections 44-3701 to 44-3721 shall be known and may be cited as the Motor Club Services Act.

Source: Laws 1981, LB 113, § 1.

44-3702 Definitions, sections found.

For the purposes of sections 44-3701 to 44-3721, unless the context otherwise requires, the definitions found in sections 44-3703 to 44-3708 shall apply.

Source: Laws 1981, LB 113, § 2.

44-3703 Club, defined.

Club shall mean any organization or other person presently or hereafter engaged in selling, furnishing, or making available to members, either as principal or agent, motor club services.

Source: Laws 1981, LB 113, § 3.

44-3704 Club representative, defined.

Club representative shall mean any person in this state designated by the club who acts or aids in any manner in the solicitation, negotiation, or renewal of motor club service contracts, except it shall not mean any person performing only work of a clerical nature in the office of a club or providing an application to a potential club member.

Source: Laws 1981, LB 113, § 4.

44-3705 Director, defined.

Director shall mean the Director of Insurance.

Source: Laws 1981, LB 113, § 5.

44-3706 Insurance service, defined.

Insurance service shall mean any act by a club to sell or furnish to a member group insurance benefits covering accidental injury and death or any motor club service, except that such insurance shall be issued only by an insurance company duly authorized to do such business in this state. A club representative shall not be required to be a licensed insurance agent pursuant to Chapter 44 in connection with the sale of group insurance benefits covering accidental injury and death or other insurance covering a motor club service specifically enumerated in section 44-3707, which may be issued in conjunction with and as a part of a motor club service contract.

Source: Laws 1981, LB 113, § 6.

44-3707 Motor club service, defined.

Motor club service shall mean the rendering, furnishing, or procuring of, or reimbursement for any of the services enumerated in this section, which shall include but not be limited to:

(1) Towing service;

(2) Bail and arrest bond service;

(3) Emergency road service;

(4) Claim adjustment service;

(5) Legal service;

(6) Theft service;

(7) Map service;

(8) Emergency travel expense service;

(9) Community traffic safety service;

(10) Merchandise and discount service;

(11) Travel, touring, and travel information service;

(12) Guaranteed hotel or motel rate service;

(13) New car pricing service;

(14) Financial service;

(15) Check cashing service;

(16) Personal property registration service;

(17) Buying and selling service;

(18) License service;

(19) Credit card service; and

(20) Insurance service.

Nothing contained in this section shall prohibit a club from offering services which augment or are incidental to any service offered by the club or any other services which are of assistance and are beneficial to members and are feasible for the club to render.

Source: Laws 1981, LB 113, § 7.

44-3708 Motor club service contract, defined.

Motor club service contract shall mean any written agreement whereby any club, for a consideration, promises to render, furnish, or procure for any member a motor club service.

Source: Laws 1981, LB 113, § 8.

44-3709 Motor club; deposit securities or surety bond.

A club shall not render or agree to render a motor club service without first depositing and thereafter continuously maintaining the amount of fifty thousand dollars in cash or securities approved by the director or, in lieu of such cash or securities, a performance bond in the amount of fifty thousand dollars executed by a surety company authorized by the laws of this state to transact business within this state. The bond shall be executed to the State of Nebraska and shall be for the use of the state and for any members who may have a cause of action against the club.

Source: Laws 1981, LB 113, § 9.

44-3710 Motor club; security; purpose.

The security required in section 44-3709 shall be used for the following:

(1) Protection, use, and benefit of all persons whose applications for membership in a motor club have been accepted by such club or its representative; and

(2) Covering of the following obligations, which are hereby required to be met:

(a) The faithful furnishing and rendering to members by the club of any and all of the motor club services furnished, sold, or offered for sale by it;

(b) The complying with and abiding by all the provisions of sections 44-3701 to 44-3721 by the club, and all the rules and regulations of the director, adopted and promulgated in accordance with sections 44-3701 to 44-3721; and

(c) The paying of all fines and penalties by the club that may become due to the state from the club under and by virtue of the provisions of sections 44-3701 to 44-3721.

Source: Laws 1981, LB 113, § 10.

44-3711 Club member; action on security; aggregate liability.

If any member shall be defrauded or aggrieved by any misconduct, wrongful act, misrepresentation, or failure of the club to render its services or fulfill its contractual obligations, such member may bring suit on the security provided in section 44-3710 in his or her own name, but the aggregate liability of the surety for all such suits shall, in no event, exceed the amount of such bond required in section 44-3709.

Source: Laws 1981, LB 113, § 11.

44-3712 Motor club; certificate of authority required; issuance; requirements; fee.

(1) No club shall offer, issue, or renew a motor club service contract in this state without first obtaining from the director a certificate of authority to act. A certificate of authority shall be issued by the director to the club upon submission of the items in subdivisions (a) to (f) of this subsection in a form satisfactory to the director. The applicant shall submit:

(a) A formal application for the certificate in such form and detail as the director requires, executed under oath by its president and secretary or two other principal officers of the club or such other persons as the director may require;

(b) A certified copy of its charter or articles of incorporation and its bylaws, if any;

(c) If a corporation, a certified copy of the certificate of authority or good standing certificate from the Secretary of State;

(d) A copy of the club's most recent financial statement prepared in accordance with generally accepted accounting principles and certified by two principal officers of the applicant or, in the event the applicant is not a corporation, such other persons as the director may require;

(e) An explanation of its plan of doing business and copies of the following:

(i) Its application for membership;

(ii) The proposed membership certificate or identification card and any proposed addendum to such certificate or card;

(iii) Any individual insurance policy or group certificate to be offered; and

(iv) Any motor club service contract to be issued; and

(f) Any other relevant information requested by the director.

(2) No certificate of authority shall be issued by the director until the club has paid an initial certificate of authority fee of one hundred dollars.

Source: Laws 1981, LB 113, § 12.

44-3713 Certificate of authority; expiration date; renewal requirements; fee.

Certificates of authority issued pursuant to sections 44-3701 to 44-3721 shall expire annually on April 30, unless sooner revoked or suspended. No certificate of authority shall be renewed by the director until the club has:

(1) Paid an annual certificate of authority fee of one hundred dollars; and

(2) Filed a copy of its most recent financial statement prepared in accordance with generally accepted accounting principles and certified by two principal

officers of the club or, in the event the applicant is not a corporation, such other persons as the director may require.

Source: Laws 1981, LB 113, § 13.

44-3714 Motor club; director; issue cease and desist order; revoke or suspend certificate; grounds; hearing.

The director may order the club to cease and desist or may revoke, suspend, or refuse to continue the certificate of authority of a club whenever, after a hearing and for cause shown, he or she determines that any of the following circumstances exist:

(1) The club has violated or failed to comply with any provision of the Motor Club Services Act or any rule or regulation adopted and promulgated under such act;

(2) The club has obtained a certificate of authority through willful misrepresentation or fraud;

(3) The club has engaged in fraudulent or dishonest practices;

(4) The club has willfully, orally or in writing, misrepresented the terms, benefits, privileges, and provisions of any motor club service contract issued or to be issued by it or any other club;

(5) The club is unable to meet its obligations as determined by generally accepted accounting principles; or

(6) The club has refused without just cause to submit relevant information to the director with respect to the motor club services within this state after it has received notice of an alleged occurrence of any of the actions in subdivisions (1) through (5) of this section.

Source: Laws 1981, LB 113, § 14; Laws 1989, LB 92, § 238.

44-3715 Motor club service contract; required contents.

No motor club service contract shall be issued or delivered in this state unless it contains all of the following:

(1) The exact corporate or other name of the club;

(2) The exact location of its home office or any business office to which inquiries may be made;

(3) The motor club services contracted for;

(4) The territory wherein motor club services contracted for are to be rendered; and

(5) The duration of such motor club service contract.

Source: Laws 1981, LB 113, § 15.

44-3716 Motor club representative; registration; qualifications; examination; termination of representative's authority; fees.

(1) No individual shall act as a club representative in Nebraska without the club having registered such individual with the director within thirty days after the date of designation as a club representative. Application for registration as a club representative shall be made to the director upon forms prescribed and furnished by him or her. The director may require a club representative to take a written examination, for a fee, on the services customarily offered by motor

clubs. A club representative licensed as an insurance agent for sickness, accident, and health insurance pursuant to Chapter 44 shall not be required to be examined.

(2) The club representative shall furnish information concerning his or her identity, business address, personal history, business experience, and such other information that the director deems pertinent and germane. A club representative shall (a) be at least eighteen years of age, (b) be a trustworthy person of good repute, and (c) have received training from the club or have otherwise qualified by experience in the business of clubs rendering motor club services.

(3) Any willful misrepresentation of any information required to be disclosed in any application for registration shall be subject to the sanctions provided for in sections 44-3701 to 44-3721.

(4) Upon termination of any club representative's authority to act on behalf of the club, the club shall notify the director in writing within thirty days of such termination.

(5) The fee to be paid to the director at the time registration is made annually on a day specified by the director for the renewal of such registration shall be five dollars.

Source: Laws 1981, LB 113, § 16.

44-3717 Motor club representative; director; issue cease and desist order; revoke or suspend authority; hearing.

Upon satisfactory evidence that a club representative has violated or failed to comply with any provision of the Motor Club Services Act or any rule or regulation adopted and promulgated under such act, the director may issue an order requiring the club representative to cease and desist from engaging in such violation. After a hearing and for good cause shown, the director may revoke or suspend the club representative's authority.

Source: Laws 1981, LB 113, § 17; Laws 1989, LB 92, § 239.

44-3718 Motor club services; laws applicable.

The offering of motor club services shall be subject solely and exclusively to the provisions of sections 44-3701 to 44-3721, and the offering of such services by any duly authorized club shall not be deemed transacting business as an insurance company, association, or exchange, except as otherwise provided in sections 44-3701 to 44-3721.

Source: Laws 1981, LB 113, § 18.

44-3719 Director; duties; rules and regulations.

The director shall administer and enforce the provisions of sections 44-3701 to 44-3721 and may adopt and promulgate rules and regulations in accordance with sections 44-3701 to 44-3721.

Source: Laws 1981, LB 113, § 19; Laws 2014, LB700, § 16.

44-3720 Act; administrative procedures.

Except as otherwise provided in the Motor Club Services Act, all hearings held by and all orders and decisions made or any failure to act by the director

pursuant to the Motor Club Services Act shall be subject to the Administrative Procedure Act. Any order of the director may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1981, LB 113, § 20; Laws 1988, LB 352, § 71.

Cross References

Administrative Procedure Act, see section 84-920.

44-3721 Violations; penalty.

If any person shall willfully violate the provisions of sections 44-3701 to 44-3720, such person shall be deemed guilty of a Class III misdemeanor.

Source: Laws 1981, LB 113, § 21.

ARTICLE 38

DENTAL SERVICES

Section

44-3801 Sections, how construed.

Sections 44-3801 to 44-3826 shall be interpreted liberally to aid in maintaining a high level of competence and adherence to professional standards in the performance of dental services.

Source: Laws 1982, LB 139, § 1.

44-3802 Terms, defined.

As used in sections 44-3801 to 44-3826, unless the context otherwise requires:

(1) Director shall mean the Director of Insurance;

(2) Department shall mean the Department of Insurance;

(3) Prepaid dental service plan or plan shall mean a contractual arrangement to provide specified dental services, in consideration of a specified payment for an interval of time, regardless of whether the payment for such services is made by the beneficiaries individually or by a third person for them, in such a manner that the total cost of such services is to be spread directly or indirectly among a group of persons. A prepaid dental service plan includes arrangements that create reasonable expectations of enforceable rights, but does not include the provision of, or reimbursement for, dental services incidental to other insurance coverages; and

(4) Prepaid dental service corporation shall mean a corporation organized under sections 44-3801 to 44-3826 and offering a prepaid dental service plan in this state.

Source: Laws 1982, LB 139, § 2; Laws 2010, LB813, § 1.

44-3803 Insurance laws; applicability.

The insurance laws of this state including sections 44-3801 to 44-3826 shall not apply to:

(1) Retainer contracts made by dentists with individual patients with fees based on estimates of the nature and amount of services to be provided to the specific patient and similar contracts made with a group of patients involved in the same or closely related dental matters;

(2) Plans providing no benefits other than consultation and advice in connection with or in combination with referral services; and

(3) The furnishing of limited dental assistance on an informal basis, involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, education, or similar relationship.

Source: Laws 1982, LB 139, § 3.

44-3804 Prepaid dental service plan; certificate of authority; exception.

No person may offer a prepaid dental service plan in this state unless authorized to do so by the director. This section shall not apply to any person issuing group policies if fewer than twenty-five percent of the certificate holders or insureds reside in this state and the person is regulated to a comparable extent by another state in which a larger number of certificate holders or insureds reside.

Source: Laws 1982, LB 139, § 4; Laws 1989, LB 92, § 240.

44-3805 Prepaid dental service plan; coverage; contract; certificate; requirements; prohibited acts.

(1) A prepaid dental service plan may be offered on an individual or group basis. Each person covered under a group contract shall be issued a certificate of coverage.

(2) No contract or certificate for dental service may be issued in this state unless a copy of the form has been filed with and approved by the director.

(3) No prepaid dental service plan offered in this state shall limit any fees charged for services that are not covered by the plan.

Source: Laws 1982, LB 139, § 5; Laws 2010, LB813, § 2.

44-3806 Prepaid dental service plan; contract; certificate; disapproved; when.

The director may disapprove a contract or certificate form for dental service under a prepaid dental service plan if the director finds that the form:

(1) Is unfair, unfairly discriminatory, misleading, or encourages misrepresentation or misunderstanding of the contract;

(2) Provides coverage or benefits or contains other provisions that would endanger the solvency of such plan;

(3) Provides payment rates which are excessive, inadequate, or unfairly discriminatory; or

(4) Is contrary to law.

Source: Laws 1982, LB 139, § 6.

44-3807 Corporation; provider contracts; file; report.

(1) Provider contracts, and changes thereto, made between a prepaid dental service corporation and any provider of services covered by any plan shall be filed with the director and shall not become effective until approved by the director.

(2) A prepaid dental service corporation shall annually report to the director, in such detail as the director reasonably requires, the number and geographical distribution of providers of services with whom they maintain contractual relations and the nature of the relations.

Source: Laws 1982, LB 139, § 7.

44-3808 Corporation; deposit securities or surety bond; duties.

(1) A prepaid dental service corporation shall deposit with the director securities eligible for deposit by an insurance company which shall have at all times a market value of not less than fifty thousand dollars or an amount as provided by subsection (7) of this section. A deposit under this section shall be held to assure the faithful performance of the corporation's obligations under its prepaid dental service plan.

(2) In lieu of any deposit of securities required under subsection (1) of this section, a prepaid dental service corporation may file with the director a surety bond in the amount of fifty thousand dollars or an amount as provided by subsection (7) of this section. The bond shall be one issued by an insurance company authorized to do business in the State of Nebraska. The bond shall be for the same purposes as the deposit in lieu of which it is filed and it shall be subject to the director's approval. No such bond shall be canceled or subject to cancellation unless at least thirty days' advance notice thereof, in writing, is filed with the director.

(3) Securities or a bond posted by a prepaid dental service corporation pursuant to subsection (1) or (2) of this section shall be for the benefit of and subject to action thereon in the event of insolvency of the corporation by any person or persons sustaining an actionable injury due to the failure of the corporation to faithfully perform its obligations under its prepaid dental service plan.

(4) The State of Nebraska shall be responsible for the safekeeping of all securities deposited with the director under this section. The securities shall not, on account of being in this state, be subject to taxation.

(5) The depositing corporation shall, during its solvency, have the right to exchange or substitute other securities of a like quality and value for securities on deposit, to receive the interest and other income accruing on such securities, and to inspect the deposit at all reasonable times.

(6) The deposit or bond shall be maintained unimpaired as long as the corporation continues to offer a prepaid dental service plan in this state. Whenever the corporation ceases to offer a prepaid dental service plan and furnishes to the director proof satisfactory to the director that the corporation has adequately provided for all of its obligations under its prepaid dental service plans in this state, the director shall release the deposited securities on presentation of the director's receipts for such securities or shall release any bond filed in lieu of such deposit.

(7) The director may reduce the minimum market value of securities required under subsection (1) of this section or the amount of the surety bond required under subsection (2) of this section if the director finds that the reduction is justified by:

(a) The terms and number of existing contracts under its prepaid dental service plans;

(b) Support by financially sound public or private organizations or agencies;

(c) Agreements with dentists or other providers for the provisions of dental services;

(d) Agreements with other persons for insuring the payment of the cost of dental services or the provision for alternative coverage in the event the corporation is unable to perform its obligations; or

(e) Other reliable financial guarantees.

(8) No part of the securities or bond to be filed under this section shall be supplied directly or indirectly by dues payments made for the purpose of meeting requirements to practice a profession.

Source: Laws 1982, LB 139, § 8.

44-3809 Corporation; contract; limitations.

A prepaid dental service corporation shall not contract itself to practice dentistry in any manner, nor shall the corporation control or attempt to control the dentist in the exercise of professional judgment.

Source: Laws 1982, LB 139, § 9.

44-3810 Corporation; contracts authorized; requirements.

A prepaid dental service corporation may contract with others, including insurance companies organized under any of the laws of the State of Nebraska, for partial or total administrative services or for joint participation or otherwise cede to or accept from others the whole or any part of the corporation's dental service obligations. Such contracts shall be filed with and approved by the director as being in accordance with the plan of the corporation prior to their

effectiveness. The director may adopt and promulgate rules and regulations concerning such contracts.

Source: Laws 1982, LB 139, § 10; Laws 1989, LB 92, § 241.

44-3811 Prepaid dental service plan; code of ethics; violation; director; duties.

The director shall report to the president of the Nebraska Dental Association, or to any person designated by the Nebraska Dental Association to receive grievances concerning dentists from the public, any information of possible violations of the code of ethics by dentists who provide services in connection with a prepaid dental service plan.

Source: Laws 1982, LB 139, § 11.

44-3812 Corporation; articles of incorporation; requirements.

(1) Two or more persons may organize a prepaid dental service corporation under this section.

(2) The articles of incorporation of the corporation shall conform to the requirements of the Nebraska Nonprofit Corporation Act or to the requirements of the Nebraska Model Business Corporation Act, except that:

(a) The name of the corporation shall indicate that dental services are to be provided;

(b) The purposes of the corporation shall be limited to providing dental services and business reasonably related thereto;

(c) The articles shall state whether members, shareholders, or providers of services may be required to share operating deficits, either through assessments or through reductions in compensation for services rendered, the general conditions and procedures for deficit sharing, and any limits on the amount of the deficit to be assumed by each individual member, shareholder, or provider;

(d) For corporations having members, the articles shall state the conditions and procedures for acquiring membership and that only members have the right to vote; and

(e) For corporations not having members, the articles shall state how the directors are to be selected.

Source: Laws 1982, LB 139, § 12; Laws 1995, LB 109, § 226; Laws 1996, LB 681, § 196; Laws 2014, LB749, § 292.

Cross References

Nebraska Model Business Corporation Act, see section 21-201.
Nebraska Nonprofit Corporation Act, see section 21-1901.

44-3813 Certificate of authority; application; contents.

The incorporators shall file with the director an application for a certificate of authority to do business, which shall include or have attached the following:

(1) The names, addresses, and occupations of all incorporators, proposed directors, and officers;

(2) For corporate incorporators, their articles and bylaws and a list of the names, addresses, and occupations of their directors and principal officers and, for the three most recent years, their annual statements and reports;

(3) The proposed articles and bylaws;

(4) All agreements relating to the corporation to which any incorporator or proposed director or officer is a party;

(5) The amount and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other persons;

(6) The proposed compensation of directors and officers;

(7) The forms to be used for any contracts between the corporation and its members or other persons concerning the provision of services;

(8) The proposed minimum amount of surplus;

(9) The plan for conducting its prepaid dental service plans including all of the following:

(a) The geographical area in which any plan is intended to operate;

(b) The types of dental services intended to be offered;

(c) The proposed marketing methods and copies of proposed marketing materials; and

(d) To the extent required by the director, the proposed method for the establishment of payment rates and other charges under the plans; and

(10) Such other documents or information as the director reasonably requires.

Source: Laws 1982, LB 139, § 13.

44-3814 Certificate of authority; issuance; when.

The director shall issue a certificate of authority to a corporation organized under sections 44-3801 to 44-3826 if:

(1) The director finds that all requirements of law have been met;

(2) The director is satisfied that all natural persons who are incorporators, the directors and principal officers of corporate incorporators, and the proposed directors and officers of the corporation being formed are trustworthy, competent, and collectively have the competence and experience to offer the particular plans proposed; and

(3) The director is satisfied that the plan is consistent with the interest of the persons to be served and the public.

Source: Laws 1982, LB 139, § 14.

44-3815 Corporation; existence commenced; effect.

Upon the issuance of the certificate of authority, and upon the issuance of the certificate of incorporation by the Secretary of State, the existence of the corporation organized under sections 44-3801 to 44-3826 shall begin, the articles and bylaws shall become effective, the proposed directors and officers shall take office, and the corporation shall be authorized to offer prepaid dental service plans in this state subject to the requirements and restrictions of sections 44-3801 to 44-3826.

Source: Laws 1982, LB 139, § 15.

44-3816 Corporation; investments; limitation.

A corporation organized under sections 44-3801 to 44-3826 shall invest its funds as provided by Chapter 44 and its investments shall be valued as provided by Chapter 44. The investments shall exceed its liabilities and reserves except for claim liability covered by contracting dentist guarantees, and it shall be a continuing condition of licensing by the director that such solvency be maintained.

Source: Laws 1982, LB 139, § 16.

44-3817 Corporation; reserves.

A corporation organized under sections 44-3801 to 44-3826 shall maintain the reserves necessary for the sound operation of its prepaid dental service plans, including unearned payment reserves. The amount and manner of calculating such reserves shall be determined by rule and regulation of the director.

Source: Laws 1982, LB 139, § 17.

44-3818 Corporation; prohibited memberships; laws not applicable.

A prepaid dental service corporation shall not be a member of the Nebraska Property and Liability Insurance Guaranty Association described in Chapter 44, article 24, or the Nebraska Life and Health Insurance Guaranty Association described in Chapter 44, article 27. The Nebraska Property and Liability Insurance Guaranty Association Act and the Nebraska Life and Health Insurance Guaranty Association Act shall not be applicable to prepaid dental service plans.

Source: Laws 1982, LB 139, § 18.

Cross References

Nebraska Life and Health Insurance Guaranty Association Act, see section 44-2720.
Nebraska Property and Liability Insurance Guaranty Association Act, see section 44-2418.

44-3819 Corporation; advancement of funds; repayment; conditions.

Any person may advance to a corporation organized under sections 44-3801 to 44-3826 on a contingent liability base such funds as are necessary for the purposes of its business or to enable it to comply with any requirements of sections 44-3801 to 44-3826. Such money and interest thereon as may have been agreed upon shall be repayable but shall be repaid only on prior approval by the director. Repayment shall only be made out of operating surplus after reserve requirements have been met. No assessments against members may be levied for the purpose of repayment and no dividends may be paid to members or shareholders as long as interest or repayment installments remain unpaid.

Source: Laws 1982, LB 139, § 19.

44-3820 Corporation; laws governing.

All corporations organized pursuant to sections 44-3801 to 44-3826 shall be governed by such other laws regulating profit and nonprofit corporations as do not conflict with sections 44-3801 to 44-3826.

Source: Laws 1982, LB 139, § 20.

44-3821 Corporation; department; power to examine.

The Department of Insurance may appoint any deputy or examiner or other persons who shall have the power of visitation and examination into the affairs of any corporation organized pursuant to sections 44-3801 to 44-3826. Such deputy or examiner shall have free access to all the books, papers, and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents, or employees or other persons in relation to the affairs, transactions, and condition of such corporation.

Source: Laws 1982, LB 139, § 21.

44-3822 Corporation; supervision, rehabilitation, conservation, dissolution, or liquidation.

Any supervision, rehabilitation, conservation, dissolution, or liquidation of a corporation organized under sections 44-3801 to 44-3826 shall be conducted pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1982, LB 139, § 22; Laws 1989, LB 319, § 78.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-3823 Corporation; annual statement.

Each corporation organized under sections 44-3801 to 44-3826 shall annually on March 1 file with the department its statement for the preceding calendar year, in the form prescribed by the director, showing all payments received for prepaid dental services in this state. Such annual statements may use accounting principles common to its business, but such accounting principles shall enable the director to ascertain whether the reserve required by section 44-3817 has been maintained.

Source: Laws 1982, LB 139, § 23.

44-3824 Corporation; failure to file statement; penalty.

Any corporation organized under sections 44-3801 to 44-3826 neglecting to file the annual statement in the form and within the time provided by section 44-3823 shall forfeit one hundred dollars for each day during which such neglect continues, and, upon notice by the director to that effect, its authority to do business in this state shall cease while such default continues.

Source: Laws 1982, LB 139, § 24.

44-3825 Corporation; additional reports.

In addition to an annual statement, the director may require of corporations, under oath and in the form prescribed by the director, such additional regular or special reports as the director may deem necessary to the proper supervision of corporations under sections 44-3801 to 44-3826.

Source: Laws 1982, LB 139, § 25.

44-3826 Corporation; taxation.

Any corporation organized pursuant to sections 44-3801 to 44-3826 shall be subject to taxation under the provisions of Chapter 77, article 9, to the extent that direct writing premiums are subject to taxation under such article.

Source: Laws 1982, LB 139, § 26.

ARTICLE 39
EDUCATION

(a) CONTINUING EDUCATION FOR INSURANCE LICENSEES

(b) PRELICENSING EDUCATION FOR INSURANCE PRODUCERS

(a) CONTINUING EDUCATION FOR INSURANCE LICENSEES

44-3901 Continuing education; purpose.

The purpose of sections 44-3901 to 44-3908 is to establish requirements for continuing education of insurance producers and consultants who are licensed in order to maintain and improve the quality of insurance services provided to the public.

Source: Laws 1982, LB 274, § 1; Laws 2008, LB855, § 21.

44-3902 Terms, defined.

For purposes of sections 44-3901 to 44-3908, unless the context otherwise requires:

(1) Active participation means either (a) attendance at formal meetings of a professional insurance association where a formal business program is presented, (b) service on the board of directors or a formal committee of a professional insurance association and involvement in the activities of such board or committee, or (c) participation in industry, regulatory, or legislative meetings held by or on behalf of a professional insurance association;

(2) Department means the Department of Insurance;

(3) Director means the Director of Insurance;

(4) Licensee means a natural person who is licensed by the department as a resident insurance producer or consultant;

(5) Professional insurance association means a state or national membership organization that offers courses, lectures, seminars, or other instructional programs certified by the director as approved continuing education activities

pursuant to section 44-3905, is organized as an association or corporation for the express purpose of promoting the interests of insurance licensees in this state or nationally, and is based on paid membership renewable annually or biennially for a membership fee; and

(6) Two-year period means (a) the period commencing on the date of licensing and ending on the date of expiration of the licensee's first license and (b) each succeeding twenty-four-month period beginning on the date of expiration of the licensee's first license regardless of the time period such license is in effect.

Source: Laws 1982, LB 274, § 2; Laws 1989, LB 92, § 242; Laws 1999, LB 260, § 4; Laws 2008, LB855, § 22; Laws 2018, LB486, § 1; Laws 2021, LB21, § 4.
Effective date August 28, 2021.

44-3903 Continuing education requirements; exceptions.

Sections 44-3901 to 44-3908 shall not apply to the following persons:

(1) Licensees for whom an examination is not required under the laws of this state;

(2) Licensees who sell or consult only in the areas of credit life insurance and credit accident and health insurance;

(3) Licensees who sell or consult only in the area of travel insurance;

(4) Licensees who sell or consult only in the area of self-service storage facility insurance pursuant to section 44-4069;

(5) Licensees holding such limited or restricted licenses as the director may exempt; and

(6) Licensees in their first license period if that first license expires less than one year after the date of licensing.

Source: Laws 1982, LB 274, § 3; Laws 1985, LB 48, § 1; Laws 1989, LB 92, § 243; Laws 1990, LB 984, § 1; Laws 2001, LB 51, § 34; Laws 2015, LB458, § 1; Laws 2018, LB1012, § 1; Laws 2021, LB21, § 5.
Effective date August 28, 2021.

44-3904 Licensee; requirements; furnish evidence of continuing education.

(1)(a)(i) Licensees qualified to solicit property and casualty insurance shall be required to complete twenty-one hours of approved continuing education activities in each two-year period commencing before January 1, 2010. Licensees qualified to solicit life, accident and health or sickness, property, casualty, or personal lines property and casualty insurance shall be required to complete six hours of approved continuing education activities for each line of insurance, including each miscellaneous line, in which he or she is licensed in each two-year period commencing before January 1, 2010. Licensees qualified to solicit life, accident and health or sickness, property, casualty, or personal lines property and casualty insurance shall be required to complete twenty-one hours of approved continuing education activities in each two-year period commencing on or after January 1, 2010.

(ii) Licensees qualified to solicit only crop insurance shall be required to complete three hours of approved continuing education activities in each two-year period.

(iii) Licensees qualified to solicit only limited line pre-need funeral insurance shall be required to complete (A) three hours of approved continuing education activities in each two-year period if such licensee holds a license as a funeral director and embalmer under the Funeral Directing and Embalming Practice Act or (B) six hours of approved continuing education activities in each two-year period if such licensee does not hold a license as a funeral director and embalmer under the Funeral Directing and Embalming Practice Act.

(iv) Licensees qualified to solicit any lines of insurance other than those described in subdivisions (i), (ii), and (iii) of subdivision (a) of this subsection shall be required to complete six hours of approved continuing education activities in each two-year period for each line of insurance, including each miscellaneous line, in which he or she is licensed. Licensees qualified to solicit variable life and variable annuity products shall not be required to complete additional continuing education activities because the licensee is qualified to solicit variable life and variable annuity products.

(b) Licensees who are not insurance producers shall be required to complete twenty-one hours of approved continuing education activities in each two-year period commencing on or after January 1, 2000.

(c) In each two-year period, every licensee shall furnish evidence to the director that he or she has satisfactorily completed the hours of approved continuing education activities required under this subsection for each line of insurance in which he or she is licensed as a resident insurance producer, except that no licensee shall be required to complete more than twenty-four cumulative hours required under this subsection in any two-year period commencing on or after January 1, 2000.

(d) A licensee shall not repeat a continuing education activity for credit within a two-year period.

(2) In each two-year period, licensees required to complete approved continuing education activities under subsection (1) of this section shall, in addition to such activities, be required to complete three hours of approved continuing education activities on insurance industry ethics.

(3)(a) Active participation may be approved for up to six hours of continuing education credit to be applied to the twenty-one-hour requirement in subdivision (1)(a)(i) of this section or to the twenty-one-hour requirement in subdivision (1)(b) of this section for life, accident and health or sickness, property, casualty, and personal lines property and casualty insurance for each two-year period for a licensee who is a member of a professional insurance association. A licensee may not use continuing education credit granted for active participation to satisfy other continuing education requirements or the requirement in subsection (2) of this section for three hours of approved continuing education activities on insurance industry ethics. Regardless of the number of associations in which a licensee has demonstrated active participation, a licensee shall not be granted more than six credit hours of continuing education credit for active participation for each two-year period.

(b) Each professional insurance association shall verify active participation separately for each licensee in the form and manner prescribed by the director.

Upon receipt of such verification and payment, the director shall grant continuing education hours.

(4) When the requirements of this section have been met, the licensee shall furnish to the department evidence of completion for the current two-year period.

Source: Laws 1982, LB 274, § 4; Laws 1985, LB 48, § 2; Laws 1988, LB 1114, § 1; Laws 1989, LB 92, § 244; Laws 1989, LB 279, § 4; Laws 1993, LB 583, § 91; Laws 1994, LB 978, § 29; Laws 1999, LB 260, § 5; Laws 2008, LB855, § 23; Laws 2015, LB198, § 1; Laws 2018, LB486, § 2.

Cross References

Funeral Directing and Embalming Practice Act, see section 38-1401.

44-3905 Continuing education activities; director; duties; continuing education sponsor; requirements; fee; administrative penalty.

(1)(a) The director shall certify as approved continuing education activities those courses, lectures, seminars, or other instructional programs which he or she determines would be beneficial in improving the product knowledge or service capability of licensees, except that the director shall refuse to certify as approved any continuing education activity if the sponsors associated with such continuing education activity are not on the list of approved continuing education sponsors maintained pursuant to subdivision (c) of this subsection. The director may require descriptive information about any continuing education activity and refuse approval of any continuing education activity that does not advance the purposes of sections 44-3901 to 44-3908. The director may require a nonrefundable fee as established by the director not to exceed fifty dollars for review of any continuing education activity submitted for approval or renewal.

(b) Beginning January 1, 2019, any certification by the director of an approved continuing education activity shall be for a four-year period. Any continuing education activity approved prior to January 1, 2019, shall expire on January 1, 2020, or four years after the date of approval, whichever is later. Prior to the expiration of any such certification, the approved continuing education sponsor may seek a renewal of such certification from the director, and the director may recertify such continuing education activity as approved if the director determines the courses, lectures, seminars, or other instructional programs continue to benefit the product knowledge or service capabilities of licensees.

(c) The director shall maintain a list of persons or entities that the director has approved as continuing education sponsors. Such persons or entities shall meet the qualifications for continuing education sponsors established by the director. The director may require such information about any continuing education sponsor as is necessary to determine whether the continuing education sponsor has met such qualifications. The director shall require a nonrefundable fee as established by the director not to exceed two hundred dollars for approval of any continuing education sponsor. The director may impose an administrative penalty not to exceed two hundred dollars per violation, and, in addition, may remove a continuing education sponsor from the approved continuing education sponsor list, after notice and hearing, if the director determines that the continuing education sponsor has:

(i) Failed to maintain compliance with qualifications established by the director pursuant to this subsection;

(ii) Advertised, prior to approval, that a continuing education activity is approved;

(iii) Advertised a continuing education activity in a materially misleading manner;

(iv) Submitted a continuing education activity outline with material inaccuracies in topic content;

(v) Presented nonapproved material during the time of an approved continuing education activity;

(vi) Failed to notify continuing education activity registrants of removal or expiration of a continuing education activity approval;

(vii) Changed the program teaching method or program content in a material manner without notice to the director;

(viii) Failed to present a continuing education activity for the total amount of time specified in the certification request forms submitted to the department for a continuing education activity;

(ix) Advertised, after expiration of the certification, that a continuing education activity is approved;

(x) Failed to inform the director of an individual's successful completion of an approved continuing education activity in a manner and timeframe prescribed by the director;

(xi) Committed other acts which reasonably indicated that the continuing education sponsor is incompetent or fails to use reasonable care;

(xii) Failed to maintain records of successful completion;

(xiii) Failed to report disciplinary action taken by another state licensing authority;

(xiv) Committed improprieties in connection with the classification, application for certification, maintenance of records, teaching method, or program content for a continuing education activity; or

(xv) Failed to respond to the department within fifteen working days after receipt of an inquiry from the department.

(2) The director shall certify the number of hours to be awarded for participation in an approved continuing education activity based upon contact or classroom hours.

(3) The director shall certify the number of hours to be awarded for successful completion of a correspondence course or program of independent study based upon the number of hours which would be awarded in an equivalent classroom course or program.

(4) The director shall approve the types of associations that meet the requirements of professional insurance associations upon application of an association and may establish reasonable requirements for active participation. The director may require an approved association to provide additional information

to the director so that the director may determine whether or not the association continues to meet the requirements of a professional insurance association.

Source: Laws 1982, LB 274, § 5; Laws 1989, LB 92, § 245; Laws 1993, LB 583, § 92; Laws 1999, LB 260, § 6; Laws 2018, LB486, § 3; Laws 2018, LB743, § 22.

44-3906 Advisory council; consult with director.

The director may convene an advisory council of representatives of the insurance industry to consult with him or her on the approval and certification of continuing education activities.

Source: Laws 1982, LB 274, § 6.

44-3907 Continuing education requirements; extension of time; failure to comply; effect.

(1) For good cause shown, the director may grant an extension of time during which the requirements imposed by sections 44-3901 to 44-3908 may be completed, but such extension of time shall not exceed the period of one year.

(2) The director shall not renew a license nor issue a new license to any licensee who has failed to comply with the requirements set forth in sections 44-3901 to 44-3908.

Source: Laws 1982, LB 274, § 7.

44-3908 Rules and regulations.

The director may adopt and promulgate rules and regulations for the effective administration of sections 44-3901 to 44-3908 pursuant to the Administrative Procedure Act.

Source: Laws 1982, LB 274, § 8; Laws 2018, LB743, § 23.

Cross References

Administrative Procedure Act, see section 84-920.

(b) PRELICENSING EDUCATION FOR INSURANCE PRODUCERS

44-3909 Repealed. Laws 2018, LB743, § 37.

44-3910 Repealed. Laws 2018, LB743, § 37.

44-3911 Repealed. Laws 2018, LB743, § 37.

44-3912 Repealed. Laws 2018, LB743, § 37.

44-3913 Repealed. Laws 2018, LB743, § 37.

ARTICLE 40

INSURANCE PRODUCERS LICENSING ACT

Section
44-4001. Transferred to section 44-4047.
44-4002. Repealed. Laws 2001, LB 51, § 42.
44-4003. Repealed. Laws 2001, LB 51, § 42.
44-4004. Repealed. Laws 2001, LB 51, § 42.
44-4005. Repealed. Laws 2001, LB 51, § 42.

Section
44-4005.01. Transferred to section 44-3909.
44-4005.02. Transferred to section 44-3910.
44-4005.03. Transferred to section 44-3911.
44-4005.04. Transferred to section 44-3912.
44-4005.05. Transferred to section 44-3913.
44-4006. Repealed. Laws 2001, LB 51, § 42.
44-4007. Repealed. Laws 2001, LB 51, § 42.
44-4008. Repealed. Laws 2001, LB 51, § 42.
44-4009. Repealed. Laws 2001, LB 51, § 42.
44-4010. Repealed. Laws 2001, LB 51, § 42.
44-4011. Repealed. Laws 2001, LB 51, § 42.
44-4012. Repealed. Laws 2001, LB 51, § 42.
44-4013. Repealed. Laws 2001, LB 51, § 42.
44-4014. Repealed. Laws 2001, LB 51, § 42.
44-4015. Repealed. Laws 2001, LB 51, § 42.
44-4016. Repealed. Laws 2001, LB 51, § 42.
44-4017. Repealed. Laws 2001, LB 51, § 42.
44-4018. Repealed. Laws 2001, LB 51, § 42.
44-4019. Repealed. Laws 2001, LB 51, § 42.
44-4020. Repealed. Laws 2001, LB 51, § 42.
44-4021. Repealed. Laws 1989, LB 92, § 278.
44-4022. Repealed. Laws 2001, LB 51, § 42.
44-4023. Repealed. Laws 2001, LB 51, § 42.
44-4024. Repealed. Laws 2001, LB 51, § 42.
44-4025. Repealed. Laws 2001, LB 51, § 42.
44-4026. Repealed. Laws 2001, LB 51, § 42.
44-4027. Repealed. Laws 2001, LB 51, § 42.
44-4028. Repealed. Laws 2001, LB 51, § 42.
44-4029. Repealed. Laws 2001, LB 51, § 42.
44-4030. Repealed. Laws 2001, LB 51, § 42.
44-4031. Repealed. Laws 2001, LB 51, § 42.
44-4032. Repealed. Laws 2001, LB 51, § 42.
44-4033. Repealed. Laws 2001, LB 51, § 42.
44-4034. Repealed. Laws 2001, LB 51, § 42.
44-4035. Repealed. Laws 2001, LB 51, § 42.
44-4036. Repealed. Laws 2001, LB 51, § 42.
44-4037. Repealed. Laws 2001, LB 51, § 42.
44-4038. Repealed. Laws 2001, LB 51, § 42.
44-4039. Repealed. Laws 2001, LB 51, § 42.
44-4040. Repealed. Laws 2001, LB 51, § 42.
44-4041. Repealed. Laws 2001, LB 51, § 42.
44-4042. Repealed. Laws 2001, LB 51, § 42.
44-4043. Repealed. Laws 2001, LB 51, § 42.
44-4044. Repealed. Laws 2001, LB 51, § 42.
44-4045. Repealed. Laws 2001, LB 51, § 42.
44-4046. Transferred to section 44-4067.
44-4047. Act, how cited.
44-4048. Purpose; applicability.
44-4049. Terms, defined.
44-4050. Licensure required; enforcement.
44-4051. Licensure; exceptions.
44-4052. Licensure examination; requirements.
44-4053. Licensure application; approval requirements; program of instruction.
44-4054. License; lines of authority; renewal; procedure; licensee; duties; director; powers.
44-4055. Nonresident license; requirements.
44-4056. Examination; exemptions.
44-4057. Assumed name; duties.
44-4058. Temporary license; requirements; limitations.
44-4059. Disciplinary actions; administrative fine; procedure.
44-4060. Payments; restrictions.

Section

44-4001 Transferred to section 44-4047.

44-4002 Repealed. Laws 2001, LB 51, § 42.

44-4003 Repealed. Laws 2001, LB 51, § 42.

44-4004 Repealed. Laws 2001, LB 51, § 42.

44-4005 Repealed. Laws 2001, LB 51, § 42.

44-4005.01 Transferred to section 44-3909.

44-4005.02 Transferred to section 44-3910.

44-4005.03 Transferred to section 44-3911.

44-4005.04 Transferred to section 44-3912.

44-4005.05 Transferred to section 44-3913.

44-4006 Repealed. Laws 2001, LB 51, § 42.

44-4007 Repealed. Laws 2001, LB 51, § 42.

44-4008 Repealed. Laws 2001, LB 51, § 42.

44-4009 Repealed. Laws 2001, LB 51, § 42.

44-4010 Repealed. Laws 2001, LB 51, § 42.

44-4011 Repealed. Laws 2001, LB 51, § 42.

44-4012 Repealed. Laws 2001, LB 51, § 42.

44-4013 Repealed. Laws 2001, LB 51, § 42.

44-4014 Repealed. Laws 2001, LB 51, § 42.

44-4015 Repealed. Laws 2001, LB 51, § 42.

44-4016 Repealed. Laws 2001, LB 51, § 42.

44-4017 Repealed. Laws 2001, LB 51, § 42.

44-4018 Repealed. Laws 2001, LB 51, § 42.

44-4019 Repealed. Laws 2001, LB 51, § 42.

44-4020 Repealed. Laws 2001, LB 51, § 42.

44-4021 Repealed. Laws 1989, LB 92, § 278.

44-4022 Repealed. Laws 2001, LB 51, § 42.

44-4023 Repealed. Laws 2001, LB 51, § 42.

44-4024 Repealed. Laws 2001, LB 51, § 42.

44-4025 Repealed. Laws 2001, LB 51, § 42.

44-4026 Repealed. Laws 2001, LB 51, § 42.

44-4027 Repealed. Laws 2001, LB 51, § 42.

44-4028 Repealed. Laws 2001, LB 51, § 42.

44-4029 Repealed. Laws 2001, LB 51, § 42.

44-4030 Repealed. Laws 2001, LB 51, § 42.

44-4031 Repealed. Laws 2001, LB 51, § 42.

44-4032 Repealed. Laws 2001, LB 51, § 42.

44-4033 Repealed. Laws 2001, LB 51, § 42.

44-4034 Repealed. Laws 2001, LB 51, § 42.

44-4035 Repealed. Laws 2001, LB 51, § 42.

44-4036 Repealed. Laws 2001, LB 51, § 42.

44-4037 Repealed. Laws 2001, LB 51, § 42.

44-4038 Repealed. Laws 2001, LB 51, § 42.

44-4039 Repealed. Laws 2001, LB 51, § 42.

44-4040 Repealed. Laws 2001, LB 51, § 42.

44-4041 Repealed. Laws 2001, LB 51, § 42.

44-4042 Repealed. Laws 2001, LB 51, § 42.

44-4043 Repealed. Laws 2001, LB 51, § 42.

44-4044 Repealed. Laws 2001, LB 51, § 42.

44-4045 Repealed. Laws 2001, LB 51, § 42.

44-4046 Transferred to section 44-4067.

44-4047 Act, how cited.

Sections 44-4047 to 44-4069 shall be known and may be cited as the Insurance Producers Licensing Act.

Source: Laws 1984, LB 801, § 1; Laws 1991, LB 419, § 2; Laws 1993, LB 583, § 93; Laws 1999, LB 424, § 2; R.S.Supp.,2000, § 44-4001; Laws 2001, LB 51, § 1; Laws 2015, LB458, § 3; Laws 2018, LB1012, § 2.

44-4048 Purpose; applicability.

(1) The Insurance Producers Licensing Act governs the qualifications and procedures for the licensing of insurance producers. The act is intended to improve efficiency, permit the use of new technology, and reduce costs associated with issuing and renewing insurance licenses.

(2) The act does not apply to excess and surplus lines agents and brokers licensed pursuant to the Surplus Lines Insurance Act except as provided in section 44-4054 and subsection (2) of section 44-4063.

Source: Laws 2001, LB 51, § 2.

Cross References

Surplus Lines Insurance Act, see section 44-5501.

44-4049 Terms, defined.

For purposes of the Insurance Producers Licensing Act:

(1) Business entity means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity;

(2) Director means the Director of Insurance;

(3) Home state means the state in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer;

(4) Insurance has the same meaning as in section 44-102;

(5) Insurance producer or producer has the same meaning as in section 44-103;

(6) Insurer has the same meaning as in section 44-103;

(7) License means a document issued by the director authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent, or inherent, in the holder to represent or commit an insurer;

(8) Limited line credit insurance includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the director determines should be designated a form of limited line credit insurance;

(9) Limited line credit insurance producer means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy;

(10) Limited line pre-need funeral insurance means life insurance or a fixed annuity contract purchased by or on behalf of the insured solely to pay the costs

of funeral services or funeral service merchandise to be purchased from a funeral home establishment or cemetery;

(11) Limited line pre-need funeral insurance producer means a person who sells, solicits, or negotiates limited line pre-need funeral insurance coverage to individuals;

(12) Limited lines insurance means any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to subsection (1) of section 44-4054 or any line of insurance that the director may deem it necessary to recognize for the purposes of complying with subsection (5) of section 44-4055;

(13) Limited lines producer means a person authorized by the director to sell, solicit, or negotiate limited lines insurance;

(14) Negotiate means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers;

(15) Person means any individual or business entity;

(16) Sell means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company;

(17) Solicit means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company;

(18) State means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States;

(19) Terminate means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance;

(20) Uniform application means the uniform application as prescribed by the director which conforms substantially to the uniform application for resident and nonresident producer licensing adopted by the National Association of Insurance Commissioners; and

(21) Uniform business entity application means the uniform business entity application as prescribed by the director which conforms substantially to the uniform business entity application for resident and nonresident business entities adopted by the National Association of Insurance Commissioners.

Source: Laws 2001, LB 51, § 3; Laws 2015, LB198, § 3.

44-4050 Licensure required; enforcement.

A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with the Insurance Producers Licensing Act. A person who sells, solicits, or negotiates insurance in this state for any class of insurance who is not licensed for that line of authority may be restrained by temporary and permanent injunctions.

Source: Laws 2001, LB 51, § 4.

44-4051 Licensure; exceptions.

(1) Nothing in the Insurance Producers Licensing Act shall be construed to require an insurer to obtain an insurance producer license. For purposes of this section, the term insurer does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) The following persons need not be licensed as an insurance producer:

(a) An officer, director, or employee of an insurer or of an insurance producer if the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and:

(i) The officer's, director's, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) The officer's, director's, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers when the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(b) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, or group or blanket health insurance or for the purpose of enrolling individuals under insurance plans or issuing certificates thereunder, or otherwise assisting in administering such insurance plans, when no commission is paid for such service;

(c) An employer or his, her, or its officers, directors, or employees or the trustee of any employee trust plan to the extent that such employer, officer, director, employee, or trustee is engaged in the administration or operation of any program of employee benefits for his, her, or its own employees or the employees of a subsidiary or affiliate involving the use of insurance issued by a licensed insurer if such employer, officer, director, employee, or trustee is not in any manner compensated directly or indirectly by the insurer issuing such insurance;

(d) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(e) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state if the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(f) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract if that person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal

place of business and the contract of insurance insures risks located in that state; or

(g) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer if the employee does not sell or solicit insurance or receive a commission.

Source: Laws 2001, LB 51, § 5.

44-4052 Licensure examination; requirements.

(1) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to section 44-4056, 44-4068, or 44-4069. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws, rules, and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations adopted and promulgated by the director.

(2) The director may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable fee set forth in section 44-4064.

(3) Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the director as set forth in section 44-4064.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

Source: Laws 2001, LB 51, § 6; Laws 2015, LB458, § 4; Laws 2018, LB1012, § 3.

44-4053 Licensure application; approval requirements; program of instruction.

(1) A person applying for a resident insurance producer license shall make application to the director on the uniform application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the director shall find that the individual:

(a) Is at least eighteen years of age. Notwithstanding the provisions of section 43-2101, if any person is issued a license pursuant to the Insurance Producers Licensing Act, his or her minority ends;

(b) Has not committed any act that is a ground for denial, suspension, or revocation set forth in section 44-4059;

(c) Has paid the fees set forth in section 44-4064; and

(d) Has successfully passed the examinations for the lines of authority for which the person has applied.

(2) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the director shall find that:

(a) The business entity has paid the fees set forth in section 44-4064; and

(b) The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules, and regulations of this state.

(3) The director may require any documents reasonably necessary to verify the information contained in an application.

(4) Each insurer that sells, solicits, or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting, or negotiating limited line credit insurance a program of instruction that may be approved by the director.

Source: Laws 2001, LB 51, § 7; Laws 2018, LB743, § 24.

44-4054 License; lines of authority; renewal; procedure; licensee; duties; director; powers.

(1) Unless denied licensure pursuant to section 44-4059, a person who has met the requirements of sections 44-4052 and 44-4053 shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority:

(a) Life insurance coverage on human lives, including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(b) Accident and health or sickness, insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income;

(c) Property insurance coverage for the direct or consequential loss or damage to property of every kind;

(d) Casualty insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property;

(e) Variable life and variable annuity products, insurance coverage provided under variable life insurance contracts, and variable annuities;

(f) Limited line credit insurance;

(g) Limited line pre-need funeral insurance;

(h) Personal lines property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes; and

(i) Any other line of insurance permitted under Nebraska laws, rules, or regulations.

(2) An insurance producer license shall remain in effect unless revoked or suspended if the fee set forth in section 44-4064 is paid and education requirements for resident individual producers are met by the due date.

(3) All business entity licenses issued under the Insurance Producers Licensing Act shall expire on April 30 of each year, and all producers licenses shall expire on the last day of the month of the producer's birthday in the first year after issuance in which his or her age is divisible by two. Such producer licenses may be renewed within the ninety-day period before their expiration dates. Business entity and producer licenses also may be renewed within the thirty-day period after their expiration dates upon payment of a late renewal fee as established by the director pursuant to section 44-4064 in addition to the applicable fee otherwise required for renewal of business entity and producer

licenses as established by the director pursuant to such section. All business entity and producer licenses renewed within the thirty-day period after their expiration dates pursuant to this subsection shall be deemed to have been renewed before their expiration dates.

(4) The director may establish procedures for renewal of licenses by rule and regulation adopted and promulgated pursuant to the Administrative Procedure Act.

(5) An individual insurance producer who allows his or her license to lapse may, within twelve months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination. Producer licenses reinstated pursuant to this subsection shall be issued only after payment of a reinstatement fee as established by the director pursuant to section 44-4064 in addition to the applicable fee otherwise required for renewal of producer licenses as established by the director pursuant to such section.

(6) The director may grant a licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, including, but not limited to, a long-term medical disability, a waiver of those procedures. The director may grant a producer a waiver of any examination requirement or any other fine, fee, or sanction imposed for failure to comply with renewal procedures.

(7) The license shall contain the licensee's name, address, and personal identification number, the date of issuance, the lines of authority, the expiration date, and any other information the director deems necessary.

(8) Licensees shall inform the director by any means acceptable to the director of a change of legal name or address within thirty days after the change. Any person failing to provide such notification shall be subject to a fine by the director of not more than five hundred dollars per violation, suspension of the person's license until the change of address is reported to the director, or both.

(9) The director may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the director may deem appropriate.

Source: Laws 2001, LB 51, § 8; Laws 2015, LB198, § 4.

Cross References

Administrative Procedure Act, see section 84-920.

44-4055 Nonresident license; requirements.

(1) Unless denied licensure pursuant to section 44-4059, a nonresident person shall receive a nonresident insurance producer license if:

(a) The person is currently licensed as a resident and in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the fees required by section 44-4064;

(c) The person has submitted or transmitted to the director the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed uniform application; and

(d) The person's home state awards nonresident producer licenses to residents of this state on the same basis.

(2) The director may verify the insurance producer's licensing status through the producer database maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.

(3) A nonresident insurance producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty days of the change of legal residence. No fee or license application is required for the filing of the change of address.

(4) Notwithstanding any other provision of the Insurance Producers Licensing Act, a person licensed as a surplus lines insurance producer in his or her home state shall receive a nonresident surplus lines producer license pursuant to subsection (1) of this section. Except as to subsection (1) of this section, nothing in this section otherwise amends or supersedes any provision of the Surplus Lines Insurance Act.

(5) Notwithstanding any other provisions of the Insurance Producers Licensing Act, a person licensed as a limited line credit insurance producer, a limited line pre-need funeral insurance producer, or other type of limited lines producer in his or her home state shall receive a nonresident limited lines insurance producer license, pursuant to subsection (1) of this section, granting the same scope of authority as granted under the license issued by the producer's home state.

Source: Laws 2001, LB 51, § 9; Laws 2015, LB198, § 5.

Cross References

Surplus Lines Insurance Act, see section 44-5501.

44-4056 Examination; exemptions.

(1) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or that state's producer database records, maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety days of establishing legal residence to become a resident licensee pursuant to section 44-4053. No examination shall be required of that person to obtain any line of authority previously held in the prior state except if the director determines otherwise by rule and regulation.

Source: Laws 2001, LB 51, § 10; Laws 2018, LB743, § 25.

44-4057 Assumed name; duties.

An insurance producer doing business under any name other than the producer's legal name shall notify the director prior to using the assumed name.

Source: Laws 2001, LB 51, § 11.

44-4058 Temporary license; requirements; limitations.

(1) The director may issue a temporary insurance producer license for a period not to exceed one hundred eighty days without requiring an examination if the director deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(a) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to such business or to provide for the training and licensing of new personnel to operate the producer's business;

(b) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(c) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America; or

(d) In any other circumstance in which the director deems that the public interest will best be served by the issuance of the license.

(2) The director may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The director may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The director may by order revoke a temporary license if the interest of insureds or the public are endangered, or for the grounds set forth in section 44-4059. A temporary license may not continue after the owner or the personal representative disposes of the business.

Source: Laws 2001, LB 51, § 12.

44-4059 Disciplinary actions; administrative fine; procedure.

(1) The director may suspend, revoke, or refuse to issue or renew an insurance producer's license or may levy an administrative fine in accordance with subsection (4) of this section, or any combination of actions, for any one or more of the following causes:

(a) Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

(b) Violating any insurance law or violating any rule, regulation, subpoena, or order of the director or of another state's insurance commissioner or director;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating, or converting any money or property received in the course of doing insurance business;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony or a Class I, II, or III misdemeanor;

(g) Having admitted or been found to have committed any insurance unfair trade practice, any unfair claims settlement practice, or fraud;

(h) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere;

(i) Having an insurance producer license, or its equivalent, denied, suspended, placed on probation, or revoked in Nebraska or in any other state, province, district, or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(l) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation pursuant to the License Suspension Act;

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; and

(o) Failing to maintain in good standing a resident license in the insurance producer's home state.

(2) If the director does not renew or denies an application for a license, the director shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the director within thirty days for a hearing before the director to determine the reasonableness of the director's action. The hearing shall be held within thirty days and shall be held pursuant to the Administrative Procedure Act.

(3) The license of a business entity may be suspended, revoked, or refused if the director finds, after notice and hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the business entity and the violation was neither reported to the director nor corrective action taken.

(4) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person violating the Insurance Producers Licensing Act may, after notice and hearing, be subject to an administrative fine of not more than one thousand dollars per violation. Such fine may be enforced in the same manner as civil judgments. Any person charged with a violation of the act may waive his or her right to a hearing and consent to such discipline as the director determines is appropriate. The Administrative Procedure Act shall govern all hearings held pursuant to such act.

(5) The director shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by the Insurance Producers Licensing Act against any person who is under investigation for or charged with a violation of the act even if the person's license or registration has been

surrendered or has lapsed by operation of law. No disciplinary proceeding shall be instituted against any licensed person after the expiration of three years from the termination of such license.

Source: Laws 2001, LB 51, § 13; Laws 2017, LB231, § 1.

Cross References

Administrative Procedure Act, see section 84-920.
License Suspension Act, see section 43-3301.

Under the Insurance Producers Licensing Act, fraud means any act, omission, or concealment which involves a breach of legal or equitable duty, trust, or confidence justly reposed, and injurious to another or by which an undue and unconscientious advantage is taken of another. Diamond v. State, 302 Neb. 892, 926 N.W.2d 71 (2019).

44-4060 Payments; restrictions.

(1) An insurer or insurance producer shall not pay a commission, service fee, brokerage, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under the Insurance Producers Licensing Act and is not so licensed.

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

(3) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under the act at the time of the sale, solicitation, or negotiation and was so licensed at that time.

(4) An insurer or insurance producer may pay or assign commissions, service fees, brokerages, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state unless the payment would violate section 44-361.

Source: Laws 2001, LB 51, § 14.

44-4061 Appointed agent; requirements; fees.

(1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(2) To appoint an insurance producer as its agent, the appointing insurer shall file, in a format approved by the director, a notice of appointment within fifteen days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint an insurance producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(3) An insurer shall pay an appointment fee, in the amount and method of payment set forth in section 44-4064, for each insurance producer appointed by the insurer.

(4) An insurer shall remit, in a manner prescribed by the director, a renewal appointment fee in the amount set forth in section 44-4064.

Source: Laws 2001, LB 51, § 15.

44-4062 Business relationship; termination; requirements; procedure; administrative fine.

(1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with an insurance producer shall notify the director within thirty days following the effective date of the termination, if the reason for termination is one of the reasons set forth in section 44-4059 or the insurer has knowledge the producer was found by a court, government body, or self-regulatory organization authorized by law to have engaged in any of the activities in such section. Upon the written request of the director, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with an insurance producer for any reason not set forth in section 44-4059, shall notify the director within thirty days following the effective date of the termination. Upon written request of the director, the insurer shall provide additional information, documents, records, or other data pertaining to the termination.

(3) If an insurance producer terminates an appointment, employment, contract, or other insurance business relationship with an insurer or authorized representative of the insurer and the insurer or authorized representative has knowledge that the insurance producer has engaged in any of the activities set forth in section 44-4059, the insurer or authorized representative shall notify the director of such activities within thirty days following the effective date of the termination. If an insurance producer terminates an appointment, employment, contract, or other insurance business relationship with an insurer or authorized representative and the insurer or authorized representative has knowledge that the insurance producer was found by a court, government body, or self-regulatory organization to have engaged in any of the activities set forth in section 44-4059, the insurer or authorized representative shall notify the director within thirty days following the effective date of the termination. Upon the written request of the director, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the producer.

(4) The insurer or the authorized representative of the insurer shall promptly notify the director if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the director in accordance with subsection (1) or (2) of this section had the insurer then known of its existence.

(5) Notifications made pursuant to subsection (1), (2), (3), or (4) of this section shall be made in a format acceptable to the director.

(6)(a) Within fifteen days after making the notification required by subsection (1), (2), (3), or (4) of this section, the insurer shall mail a copy of the notification to the insurance producer at his or her last-known address. If the producer is terminated pursuant to subsection (1) or (3) of this section, the insurer shall provide a copy of the notification to the producer at the producer's last-known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(b) Within thirty days after the insurance producer has received the original or additional notification, the producer may file written comments concerning

the substance of the notification with the director. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer. The comments shall become a part of the director's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (8) of this section.

(7)(a) In the absence of actual malice:

(i) No insurer, authorized representative of an insurer, insurance producer, director, or organization of which the director is a member that compiles information and makes it available to other insurance commissioners or regulatory or law enforcement agencies shall be subject to civil liability;

(ii) No civil cause of action of any nature shall arise against the entities set forth in subdivision (7)(a)(i) of this section, or their respective agents or employees, as a result of any statement or information provided pursuant to this section;

(iii) No civil cause of action of any nature shall arise against the entities set forth in subdivision (7)(a)(i) of this section, or their respective agents or employees, as a result of any information relating to any statement provided by an insurer or insurance producer at the written request of the director; and

(iv) No civil cause of action of any nature shall arise against the entities set forth in subdivision (7)(a)(i) of this section, or their respective agents or employees, as a result of any statement by a terminating insurer or insurance producer to an insurer or producer, limited solely and exclusively to whether a termination for cause under subsection (1) of this section or a report made pursuant to subsection (3) of this section was reported to the director if the propriety of any termination for cause under subsection (1) of this section or a report made pursuant to subsection (3) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(b) In any action brought against a person that may have immunity under subdivision (7)(a) of this section, the party bringing the action shall plead specifically in any allegation that subdivision (7)(a) of this section does not apply because such person did so with actual malice.

(c) This subsection shall not abrogate or modify any existing statutory or common-law privileges or immunities.

(8)(a) Any documents, materials, or other information in the control or possession of the director furnished by an insurer, insurance producer, or employee or agent acting on behalf of the insurer or producer, or obtained by the director in an investigation pursuant to this section shall be confidential and privileged. Such documents, materials, or other information shall not be public records subject to public inspection pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action, except that the director is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's duties.

(b) Neither the director nor any person who receives documents, materials, or other information while acting under the authority of the director, shall be permitted or required to testify in any private civil action concerning any

confidential documents, materials, or information subject to subdivision (8)(a) of this section.

(c) In order to assist in the performance of the director's duties under the Insurance Producers Licensing Act, the director:

(i) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subdivision (8)(a) of this section, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and state, federal, and international law enforcement authorities and regulatory agencies if the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information;

(ii) May receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries, and state, federal, and international law enforcement authorities and regulatory agencies. The director shall maintain as confidential and privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the source jurisdiction; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in subdivision (8)(c) of this section.

(e) Nothing in the act shall prohibit the director from releasing final, adjudicated actions, including for cause terminations or reports made pursuant to subsection (3) of this section that are open to public inspection pursuant to sections 84-712 to 84-712.09, to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries.

(9)(a) An insurer or authorized representative of the insurer that fails to report as required under this section, or that is found to have reported with actual malice by a court of competent jurisdiction, may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with section 44-1529.

(b) An insurance producer that fails to report as required by this section, or that is found to have reported with actual malice by a court of competent jurisdiction, may, after notice and hearing, have its license suspended or revoked, or may be subject to an administrative fine in accordance with section 44-4059.

Source: Laws 2001, LB 51, § 16.

44-4063 Licensure requirements; waiver; when.

(1) The director shall waive any requirements for a nonresident insurance producer license applicant with a valid license from his or her home state, except the requirements imposed by section 44-4055, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident producer's satisfaction of his or her home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon insurance producers from this state on the same basis.

Source: Laws 2001, LB 51, § 17.

44-4064 Fees.

(1) Before any license or appointment is issued or renewed under the Insurance Producers Licensing Act or before any appointment is terminated, the person requesting such license shall pay or cause to be paid to the director the following fee or fees, if applicable, as established by the director:

(a) For each insurance producer license, a fee not to exceed one hundred dollars;

(b) For each annual appointment, a fee not to exceed ten dollars;

(c) For each termination of an appointment, a fee not to exceed ten dollars;

(d) A late renewal fee not to exceed one hundred twenty-five dollars;

(e) A reinstatement fee not to exceed one hundred seventy-five dollars; and

(f) For each business entity license, a fee not to exceed fifty dollars.

(2) If a licensed person (a) desires to add a line or lines of insurance to his or her existing license, (b) seeks to change any other information contained in the license for any reason, or (c) applies for a duplicate license, such person shall pay to the director a fee established by the director to cover the expense of replacing the license.

(3) The director shall not prorate fees imposed pursuant to subsection (1) of this section and shall not refund fees to any person in the event of a license denial. The director may refund fees paid pursuant to this section if the payment has been made in error.

Source: Laws 2001, LB 51, § 18; Laws 2008, LB855, § 27.

44-4065 Reports.

(1) An insurance producer shall report to the director any administrative action taken against the producer in another jurisdiction, by a professional self-regulatory organization such as the Financial Industry Regulatory Authority or a similar organization, or by another governmental agency within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(2) An insurance producer shall report to the director any obligation regarding insurance premiums or fiduciary funds owed to a company, including a premium finance company, or a managing general agent within thirty days of the date of discharge or attempt to discharge such obligation in a personal or organizational bankruptcy proceeding.

(3) Within thirty days of the date of arraignment or date of waiver of arraignment, if waived, an insurance producer shall report to the director any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(4) For purposes of this section, administrative action shall include, but not be limited to, any arbitration or mediation award, disciplinary action, civil action, or sanction taken against or involving an insurance producer.

Source: Laws 2001, LB 51, § 19; Laws 2009, LB192, § 3.

Under the Insurance Producers Licensing Act, if an insurance producer fails to report a civil action taken against the producer in another jurisdiction within 30 days of the final disposition of the civil action, the producer violates the reporting requirement. Diamond v. State, 302 Neb. 892, 926 N.W.2d 71 (2019).

44-4066 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Insurance Producers Licensing Act.

Source: Laws 2001, LB 51, § 20.

44-4067 Rental car company; limited license; fee.

(1) The director may issue to a rental car company that has complied with this section a limited license authorizing the limited licensee to act as an insurance producer with reference to the kinds of insurance specified in this section for any insurer authorized to write such kinds of insurance in this state.

(2) For purposes of this section:

(a) Limited licensee means a rental car company authorized to sell certain kinds of insurance relating to the rental of rental vehicles pursuant to this section;

(b) Rental agreement means any written agreement setting forth the terms and conditions governing the use of a rental vehicle;

(c) Rental car company means any person in the business of providing leased or rented rental vehicles to the public. Rental car company includes a franchise of a rental car company;

(d) Rental vehicle means a motor vehicle of the private passenger type, including passenger vans and minivans and trucks up to twenty-six thousand pounds gross vehicle weight; and

(e) Renter means any person obtaining the use of a rental vehicle from a rental car company under the terms of a rental agreement.

(3) An applicant for a limited license shall file with the director:

(a) A written application for a limited license, signed by an officer of the applicant, containing such information as the director prescribes;

(b) A list of all rental locations at which the applicant conducts business in this state;

(c) A list of all employees of the applicant who may act on behalf and under the supervision of the applicant pursuant to this section;

(d) A training program which meets the requirements of subsection (10) of this section;

(e) A copy of the contract entered into between the insurer and the applicant; and

(f) A certificate by the insurer that is to be named in such limited license, stating that the insurer will appoint such applicant to act as the insurance producer in reference to the doing of such kind or kinds of insurance specified in this section if the limited license applied for is issued by the director. Such certificate shall be signed by an officer or managing agent of such insurer.

(4) Before a limited license is issued or renewed, the limited licensee shall pay or cause to be paid to the director an application fee not to exceed one hundred dollars as established by the director or a renewal fee not to exceed one hundred dollars as established by the director per year due on the anniversary date of the issuance of the limited license.

(5) A limited licensee shall provide to the director an updated list of all rental locations and of all employees of the limited licensee who may act on behalf and under the supervision of the limited licensee. Such list shall be provided to the director quarterly.

(6)(a) If any provision of this section or if one or more of the grounds provided under section 44-4059 is violated by a limited licensee, the director may, after notice and hearing:

(i) Revoke or suspend a limited license issued under this section;

(ii) Impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations have occurred, as the director deems to be necessary or convenient to carry out the purposes of this section; and

(iii) Order payment of an administrative fine of not more than one thousand dollars per violation.

(b) An order issued pursuant to this subsection may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

(7) A limited licensee may act as an insurance producer for an authorized insurer only in connection with rental vehicles and only with respect to the following kinds of insurance:

(a) Motor vehicle liability insurance, including uninsured and underinsured motorist coverage, that provides coverage to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(b) Accident and health insurance that provides coverage to renters and other rental vehicle occupants for accidental death or dismemberment and for medical expenses resulting from an accident involving the rental vehicle that occurs during the rental period; and

(c) Personal property insurance that provides coverage to renters and other rental vehicle occupants for the loss of or damage to personal property that occurs during the rental period.

(8) No insurance may be issued pursuant to this section unless:

(a) The rental period of the rental agreement does not exceed forty-five consecutive days;

(b) The limited licensee provides brochures or other written materials to the renter that:

(i) Summarize the material terms of the insurance offered by the limited licensee to renters, including the identity of the insurer;

(ii) Describe the process for filing a claim; and

(iii) Contain information on the price, benefits, exclusions, conditions, or other limitations of such insurance as the director may by rule and regulation prescribe;

(c) The limited licensee makes the following disclosures to the renter:

(i) That the insurance offered by the limited licensee to renters may provide a duplication of coverage already provided by a renter's personal automobile insurance policy or by another source of coverage;

(ii) That if purchased, the insurance offered by the limited licensee to renters is primary over any other coverages applicable to the renter; and

(iii) That the purchase by the renter of any kind of insurance specified in this section is not required in order for the renter to rent a rental vehicle;

(d) Evidence of coverage is stated in the rental agreement; and

(e) Costs for insurance are separately itemized in the rental agreement.

(9) Any limited license issued under this section shall also authorize any employee of the limited licensee who is trained pursuant to subsection (10) of this section to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of insurance specified in this section.

(10) Each limited licensee shall conduct a training program which shall meet the following minimum standards:

(a) Each trainee shall receive basic instruction about the kinds of insurance specified in this section offered for purchase by prospective renters of rental vehicles;

(b) Each trainee shall be instructed to acknowledge to a prospective renter of a rental vehicle that the purchase by the renter of any kind of insurance specified in this section is not required in order for the renter to rent a rental vehicle; and

(c) Each trainee shall be instructed to acknowledge to a prospective renter of a rental vehicle that the renter may have insurance policies that already provide the coverage being offered by the limited licensee pursuant to this section.

(11) All records pertaining to transactions under any limited license shall be kept available and open to the inspection of the director or his or her representatives at any time with notice and during business hours. Records shall be maintained for three years following the completion of transactions under a limited license.

(12) Notwithstanding any other provision of this section or rule or regulation adopted and promulgated by the director, a limited licensee shall not be required to treat money collected from renters purchasing insurance when renting rental vehicles as funds received in a fiduciary capacity, except that the charges for coverage shall be itemized and be ancillary to a rental transaction.

(13) No limited licensee subject to this section shall:

(a) Offer or sell any kind of insurance specified in this section except in conjunction with and incidental to a rental agreement;

(b) Advertise, represent, or otherwise hold itself or any of its employees out as authorized insurers or licensed insurance producers;

(c) Pay any additional compensation, fee, or commission dependent on the placement of insurance under the limited license issued pursuant to this section; or

(d) Require the purchase of any kind of insurance specified in this section as a condition of rental of a rental vehicle.

Source: Laws 1999, LB 424, § 1; R.S.Supp.,2000, § 44-4046; Laws 2001, LB 51, § 21.

Cross References

Administrative Procedure Act, see section 84-920.

44-4068 Travel insurance; limited lines travel insurance producer; license; duties; travel retailer; duties; director; powers.

(1) For purposes of this section:

(a) Limited lines travel insurance producer means a licensed insurance producer, including a limited lines producer, who is designated by an insurer as the travel insurance supervising entity;

(b) Offer and disseminate means to provide general information about travel insurance, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicensable activities permitted by the state;

(c) Travel insurance means insurance coverage for personal risks incident to planned travel, including interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel. Travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting six months or longer, including those working overseas as an expatriate or as deployed military personnel; and

(d) Travel retailer means a business entity that makes, arranges, or offers travel services and that offers and disseminates travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(2)(a) The director may issue a limited lines travel insurance producer license to an individual or business entity that authorizes the limited lines travel insurance producer to sell, solicit, or negotiate travel insurance through a licensed insurer in a form and manner prescribed by the director.

(b) A travel retailer, its employees, and its authorized representatives may offer and disseminate travel insurance as a service to the travel retailer's customers, on behalf of and under the direction of an individual or a business entity that holds a limited lines travel insurance producer license. In doing so, the travel retailer must provide to prospective purchasers of travel insurance:

(i) A description of the material terms or the actual material terms of the insurance coverage;

(ii) A description of the process for filing a claim;

(iii) A description of the review or cancellation process for the travel insurance policy; and

(iv) The identity and contact information of the insurer and limited lines travel insurance producer.

(c) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf on a form prescribed by the director. The limited lines travel insurance producer must maintain and update the register annually and include: The name, address, and contact information of each travel retailer; the name, address, and contact information of an officer or person who directs or controls the travel retailer's operations; and the travel retailer's federal tax identification number. The

limited lines travel insurance producer must submit the register to the director upon request. The limited lines travel insurance producer must also certify that the travel retailer registered is not in violation of 18 U.S.C. 1033.

(d) The limited lines travel insurance producer must designate one of its employees who is a licensed individual producer as the person responsible for the limited lines travel insurance producer's compliance with the travel insurance laws, rules, and regulations of the state.

(e) The limited lines travel insurance producer shall require each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the director. The training material must include, at minimum, instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(3) A limited lines travel insurance producer and those registered under its license are exempt from the examination requirements in section 44-4052 and the continuing education requirements in sections 44-3901 to 44-3908.

(4) Any travel retailer offering or disseminating travel insurance shall make brochures or other written materials available to prospective purchasers that:

(a) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(c) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(5) A travel retailer's employee or authorized representative who is not licensed as an insurance producer may not:

(a) Evaluate or interpret the technical terms, benefits, or conditions of the offered travel insurance coverage;

(b) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(c) Hold himself or herself out as a licensed insurer, licensed producer, or insurance expert.

(6) A travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this section is authorized to receive related compensation for the services upon registration by the limited lines travel insurance producer.

(7) Travel insurance may be provided under an individual policy or under a group or master policy.

(8) The limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure that the travel retailer complies with this section.

(9) The director may take disciplinary action against a limited lines travel insurance producer pursuant to section 44-4059.

Source: Laws 2015, LB458, § 5; Laws 2018, LB743, § 26.

44-4069 Operator of self-service storage facility; limited license; applicant; application fee; renewal fee; director; powers; order; appeal; disclosures; training program; records; prohibited acts.

(1) The director may issue to the operator of a self-service storage facility that has complied with this section a limited license to act as an insurance producer with reference to the kinds of insurance specified in this section for any insurer authorized to write such kinds of insurance in this state.

(2) An applicant for a limited license shall file with the director:

(a) A written application for a limited license, signed by an officer of the applicant, containing such information as the director prescribes;

(b) A list of all self-service storage facilities at which the applicant conducts business in this state;

(c) On request of the director, a list of all employees of the applicant who may act on behalf and under the supervision of the applicant pursuant to this section;

(d) A training program which meets the requirements of subsection (9) of this section; and

(e) A certificate executed by the insurer, stating that the insurer will appoint such applicant to act as the insurance producer in reference to the doing of such kind or kinds of insurance specified in this section if the limited license applied for is issued by the director. Such certificate shall be signed by an officer or managing agent of such insurer.

(3) Before a limited license is issued, the applicant shall pay or cause to be paid to the director an application fee established by the director, not to exceed one hundred dollars. Before a limited license is renewed, the limited licensee shall pay or cause to be paid to the director a renewal fee established by the director, not to exceed one hundred dollars per year. The renewal fee shall be due on the anniversary date of the issuance of the limited license.

(4) A limited licensee shall provide to the director an updated list of all self-service storage facilities and of all employees of the limited licensee who may act on behalf and under the supervision of the limited licensee. Such list shall be provided to the director quarterly.

(5)(a) If any provision of this section or if one or more of the grounds provided under section 44-4059 is violated by a limited licensee, the director may, after notice and hearing:

(i) Revoke or suspend a limited license issued under this section;

(ii) Impose such other penalties, including suspending the transaction of insurance at specific self-service storage facilities where violations have occurred, as the director deems to be necessary or convenient to carry out the purposes of this section; and

(iii) Order payment of an administrative fine of not more than one thousand dollars per violation.

(b) An order issued pursuant to this subsection may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

(6) A limited licensee may act as an insurance producer for an authorized insurer only in connection with insurance providing coverage for the loss of, or damage to, tangible personal property that is contained in storage space or in transit during a rental agreement period, which may be offered on a month-to-month or other periodic basis under an individual policy, or as a group, commercial, or master policy to provide insurance for the self-service storage facility's occupants.

(7) No insurance may be issued pursuant to this section unless:

(a) The limited licensee provides brochures or other written materials to the occupant that:

(i) Summarize the material terms of the insurance offered by the limited licensee to occupants, including the identity of the insurer and any third-party administrator or supervising entity authorized to act on behalf of the insurer;

(ii) Describe the process for filing a claim; and

(iii) Contain information on the price, benefits, exclusions, conditions, or other limitations of such insurance as the director may by rule and regulation prescribe;

(b) The limited licensee makes the following disclosures to the occupant:

(i) That the insurance offered by the limited licensee to occupants may provide a duplication of coverage already provided by an occupant's homeowner's insurance policy or by another source of coverage. This disclosure shall be prominently displayed in the brochure or other written materials provided to the occupant in at least twelve-point bold type;

(ii) That, if purchased, the insurance offered by the limited licensee to occupants is primary over any other coverages applicable to the occupant;

(iii) That the purchase by the occupant of any kind of insurance specified in this section from the limited licensee is not required in order for the occupant to lease space at a self-service storage facility;

(iv) That, if purchased, the insurance offered by the limited licensee to occupants is not an automobile liability policy and would not provide compliance with the Motor Vehicle Safety Responsibility Act; and

(v) That a limited licensee's employee who is not licensed as an insurance producer may not evaluate or interpret the technical terms, benefits, or conditions of the kinds of insurance specified in this section and may not evaluate or provide advice concerning an occupant's existing insurance coverage;

(c) Evidence of coverage is issued at the time the insurance is purchased; and

(d) Costs for insurance are separately itemized in the rental agreement or an invoice issued to the occupant.

(8) Any limited license issued under this section shall also authorize any employee of the limited licensee who is trained pursuant to subsection (9) of this section to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of insurance specified in this section.

(9) Each limited licensee shall conduct a training program which shall meet the following minimum standards:

(a) Each trainee shall be instructed about the kinds of insurance specified in this section offered for purchase by occupants;

(b) Each trainee shall be instructed that an occupant may have an insurance policy that already provides the coverage being offered by the limited licensee pursuant to this section and may not need to purchase from the limited licensee the insurance specified in this section; and

(c) The training program shall be submitted and approved by the director and shall contain, at a minimum, instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective occupants.

(10) All records pertaining to transactions under any limited license shall be kept available and open to the inspection of the director or his or her representatives at any time with notice and during business hours. Records shall be maintained for three years following the completion of transactions under a limited license.

(11) Notwithstanding any other provision of this section or rule or regulation adopted and promulgated by the director, a limited licensee shall not be required to treat money collected from occupants purchasing insurance as funds received in a fiduciary capacity, except that the charges for coverage shall be itemized and be ancillary to a rental agreement.

(12) No limited licensee subject to this section shall:

(a) Offer or sell any kind of insurance specified in this section except in conjunction with and incidental to a rental agreement;

(b) Advertise, represent, or otherwise hold itself or any of its employees out as authorized insurers or licensed insurance producers;

(c) Pay its employees any additional compensation, fee, or commission dependent on the placement of insurance under the limited license issued pursuant to this section; or

(d) Require the purchase of any kind of insurance specified in this section from the limited licensee as a condition of rental of leased space at a self-service storage facility.

(13) A limited licensee is exempt from the continuing education requirements in sections 44-3901 to 44-3908 and the examination requirements in section 44-4052.

(14) For purposes of this section:

(a) Leased space means the individual storage space at a self-service storage facility which is rented to an occupant pursuant to a rental agreement;

(b) Limited licensee means an operator of a self-service storage facility authorized to sell certain kinds of insurance relating to the use and occupancy of leased space at a self-service storage facility pursuant to this section;

(c) Occupant means a person entitled to the use of leased space at a self-service storage facility under a rental agreement or his or her successors or assigns;

(d) Operator means the owner, operator, lessor, or sublessor of a self-service storage facility or an agent or any other person authorized to manage the facility. Operator does not include a warehouseman if the warehouseman issues a warehouse receipt, bill of lading, or other document of title for the personal property stored;

(e) Personal property means movable property that is not affixed to land and includes: (i) Goods, wares, merchandise, household items, and furnishings; (ii)

vehicles, motor vehicles, trailers, and semitrailers; and (iii) watercraft and motorized watercraft; and

(f) Rental agreement means any written agreement or lease that establishes or modifies the terms, conditions, or rules concerning the use and occupancy of leased space at a self-service storage facility.

Source: Laws 2018, LB1012, § 4.

Cross References

Administrative Procedure Act, see section 84-920.
Motor Vehicle Safety Responsibility Act, see section 60-569.

ARTICLE 41
PREFERRED PROVIDERS

Section

44-4101 Definitions, where found.

For the purposes of sections 44-4101 to 44-4113, unless the context otherwise requires, the definitions found in sections 44-4102 to 44-4107 shall be used.

Source: Laws 1984, LB 902, § 1; Laws 1995, LB 473, § 5.

44-4102 Insured, defined.

Insured shall mean any individual resident of Nebraska eligible to receive benefits from any insurer or insurance arrangement.

Source: Laws 1984, LB 902, § 2.

44-4103 Insurer, defined.

Insurer shall mean any insurance company as defined in section 44-103, fraternal benefit society as described in section 44-1072, prepaid dental service plan as defined in section 44-3802, or health maintenance organization as defined in section 44-32,105 authorized to transact health insurance business in the State of Nebraska.

Source: Laws 1984, LB 902, § 3; Laws 1985, LB 508, § 39; Laws 1989, LB 92, § 265; Laws 1990, LB 1136, § 100.

44-4104 Insurance arrangement, defined.

Insurance arrangement shall mean any plan, program, contract, or combination thereof, or other arrangement under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust, third-party administrator, or group health insurance plan with an insurer, or any combination thereof, health care services or benefits.

Source: Laws 1984, LB 902, § 4.

44-4105 Participant or participant in an insurance arrangement, defined.

Participant or participant in an insurance arrangement shall mean any employer, union, or other organization providing health care services or benefits to its employees or members through an insurance arrangement.

Source: Laws 1984, LB 902, § 5.

44-4106 Preferred providers, defined.

Preferred providers shall mean providers of health services who agree to furnish services in a manner reasonably expected to contain or lower costs by contracting with insurers and participants in insurance arrangements or an insurer or participant organized as a provider of health services providing such services under a preferred provider contract.

Source: Laws 1984, LB 902, § 6.

44-4107 Prospective reimbursement, defined.

Prospective reimbursement shall mean a system whereby provider rates are established prior to the period to which they apply and the provider incurs financial risk for costs in excess of the predetermined rates.

Source: Laws 1984, LB 902, § 7.

44-4108 Legislative findings.

The Legislature hereby finds that health care services should be provided at the most favorable prices and that competition for health services should be promoted while ensuring the quality of health services provided to the patient.

Source: Laws 1984, LB 902, § 8.

44-4109 Preferred provider insurance arrangements; authorized.

An insurer or a participant in an insurance arrangement may enter into contracts to purchase health services on a bid or negotiated basis with health providers at alternative rates of reimbursement and offer such benefit to insureds. Such insurers and participants in insurance arrangements may offer or administer a health benefit plan including preferred provider policies or contracts which limit the number and types of providers of health services eligible for payment as preferred providers under such policies or contracts. Insurers and participants in insurance arrangements may establish terms and conditions which shall be met by a provider of health services in order to qualify for payment as a preferred provider under such policies or contracts. Such terms and conditions may include provisions which identify the method of

payment for services, including, but not limited to, development of prospective reimbursement systems.

Source: Laws 1984, LB 902, § 9.

44-4109.01 Policies or contracts; requirements.

Policies or contracts authorized by sections 44-4109 and 44-4110 are subject to the following requirements:

(1) A prospective insured shall be provided information about the terms and conditions of the insurance arrangement to enable him or her to make an informed decision about accepting a system of health care delivery. If the insurance arrangement is described orally to a prospective insured, the description shall use easily understood, truthful, and objective terms. All written descriptions shall be in a readable and understandable format. Specific items that shall be included are:

(a) Coverage provisions, benefits, and any exclusions by category of service, provider, or physician and, if applicable, by specific service;

(b) Any prior authorization or other review requirements, including preauthorization review, concurrent review, postservice review, and postpayment review, the manner in which an insured may obtain review of a denial of coverage, and the nature of any liability an insured may incur if the insured does not comply with the authorization requirements of the policy, contract, certificate, or other materials; and

(c) Information on the insured's financial responsibility for payment for deductibles, coinsurance, or other noncovered services;

(2) If an insurer conducts customer satisfaction surveys concerning an insurance arrangement, the results of such surveys shall be made available upon request to existing and prospective participants in insurance arrangements;

(3) The policy, contract, certificate, or other materials shall establish a mechanism by which a committee of preferred providers will be involved in reviewing and advising the insurance arrangement about medical policy, including coverage of new technology and procedures, quality and credentialing criteria, and medical management procedures;

(4) All policies or contracts shall have a system for credentialing participating preferred providers and shall allow all providers within the insurance arrangement's geographic service area to apply for such credentials periodically and not less than annually. The credentialing process:

(a) Shall begin upon application of a provider for inclusion in the policy or contract; and

(b) Shall be based solely on quality, accessibility, or economic considerations and shall be applied in accordance with reasonable business judgment.

Credentialing standards or criteria shall be made available, upon request, to providers and insureds;

(5) If the policy or contract is with an organized delivery system formed by insurers, hospitals, physicians, or allied health professionals, or a combination of such entities, participation by a provider may be limited to a participant in the organized delivery system or to providers having staff privileges at a particular health care facility;

(6) If an insurer or a participant in an insurance arrangement refuses to contract with a provider, the provider shall be permitted to appeal the adverse decision. A person conducting the provider-appeal procedure may be employed by the insurer or participant in an insurance arrangement if the person does not initially participate in the decision to take adverse action against the provider. The provider-appeal procedure shall include, but not be limited to, notice of the date and time of the hearing, a statement of the criteria or standards on which the decision was based, an opportunity for the provider to review information upon which the adverse decision was based, an opportunity for the provider to appear personally at the hearing and present any additional information, and a timely decision on the appeal;

(7) If the insurer or participant in an insurance arrangement excludes or fails to retain a provider previously contracted with to provide health care services, the provider shall be permitted to appeal the adverse decision in the same manner as set forth in subdivision (6) of this section. If the provider disagrees with the decision, the provider shall be permitted to appeal to an appeals committee consisting of one person selected by each party to the appeal and one person mutually agreeable to both parties. The parties to the appeal shall pay to the appeal committee any costs associated with the person they select and shall share the costs of the person mutually agreeable to both parties, which costs shall not be recoverable by the other party;

(8) Prior to initiation of a proceeding to terminate a provider's participation, the provider shall be given an opportunity to enter into and complete a corrective action plan, except in cases of fraud or imminent harm to patient health or when the provider's ability to provide services has been restricted by an action, including probation or any compliance agreements, by the Department of Health and Human Services or other governmental agency; and

(9) Policies and contracts shall not exclude providers with practices containing a substantial number of patients having severe or expensive medical conditions, except that this section shall not prohibit plans from excluding providers who fail to meet the insurance arrangement's criteria for quality, accessibility, or economic considerations.

Source: Laws 1995, LB 473, § 4; Laws 1996, LB 1044, § 258; Laws 2007, LB296, § 197.

44-4110 Development of preferred provider organizations; conditions.

All providers of health services in Nebraska may develop preferred provider organizations and contract with insurers and participants in insurance arrangements if such providers have met all licensure and certification requirements necessary to practice a specific profession or to operate a specific health care facility pursuant to the Health Care Facility Licensure Act and the Uniform Credentialing Act. An organization of preferred providers may limit itself to one or more specific professions or specialties within a profession, as defined in the Uniform Credentialing Act, and may limit the number of participating providers to that required to adequately meet the need for its particular program and the purpose of sections 44-4101 to 44-4113 to furnish health services in a manner reasonably expected to contain or lower costs.

Source: Laws 1984, LB 902, § 10; Laws 1995, LB 473, § 6; Laws 2007, LB463, § 1139.

Cross References

Health Care Facility Licensure Act, see section 71-401.
Uniform Credentialing Act, see section 38-101.

44-4110.01 Confidential information; disclosure prohibited; exception.

Any data or information pertaining to the diagnosis, treatment, or health of any insured or applicant obtained from such person or from any provider by any preferred provider organization shall be held in confidence and shall not be disclosed to any person except (1) upon the express consent of the insured or applicant, (2) pursuant to statute or court order for the production of evidence or the discovery thereof, or (3) in the event of a claim or litigation between such person and the preferred provider organization in which such data or information is pertinent. A preferred provider organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished such information to the preferred provider organization is entitled to claim.

Source: Laws 1990, LB 1136, § 101.

44-4110.02 Health care review committee; preferred provider organization; exemption from liability.

A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent, or employee of a health care review committee or who furnishes any records, information, or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of such action, nor shall the preferred provider organization which established the committee or the officers, directors, employees, or agents of the preferred provider organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

Source: Laws 1990, LB 1136, § 102.

44-4110.03 Health care review committee; information and records; confidentiality.

(1) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal from the committee's findings or recommendations. No member of a health care review committee, no officer, director, or other member of a preferred provider organization or its staff engaged in assisting such committee, and no person assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if such subpoena is based solely on such activities.

(2) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subsection (1) of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as the original information and records in the possession and control of a health care review committee.

Source: Laws 1990, LB 1136, § 103.

44-4111 Contracts with preferred providers; procedure; discrimination prohibited.

(1) Insurers and participants may contract for health services with preferred providers through a process of competitive bidding or through individual negotiations with preferred providers. After completion of such bidding process or individual negotiations, an insurer or participant may offer to providers the terms and conditions of a preferred provider contract. Providers willing and qualified to meet the terms and conditions of a preferred provider contract offered by an insurer or participant may agree to provide health services pursuant to such contract.

(2) The terms and conditions of the policies or contracts specified in section 44-4109 shall not discriminate against or among health providers. Differences in prices among providers based on individual negotiations with such providers, market conditions, patient mix, method of payment, or price differences among providers in different geographical areas shall not be deemed discrimination.

Source: Laws 1984, LB 902, § 11.

44-4112 Mandated providers; opportunity to bid, contract, provide services.

Mandated types of providers whose services are required to be made available to insureds pursuant to section 44-513 shall, to the extent required by such section, have the same opportunity to bid and negotiate contracts for health services as a preferred provider or to provide health services as a nonpreferred provider.

Source: Laws 1984, LB 902, § 12.

44-4113 Use of nonpreferred providers; effect.

Insurers and participants in insurance arrangements shall provide for payment for services rendered by nonpreferred providers or providers who have not negotiated a contract with the insurer or participants in the insurance arrangement. Insureds under an insurance arrangement shall use the preferred providers who have contracted with the group to obtain coverage under the plan at the least direct expense to the insured. Insureds selecting nonpreferred providers may be held financially responsible for the difference between the benefits available under a preferred provider contract and the charges of the nonpreferred provider and may be subject to larger coinsurance or deductible provisions. Under a prepaid dental service plan as defined in section 44-3802, a participant's premium contribution for health services provided by nonpreferred providers to an insured shall be an amount equal to the participant's contribution pursuant to a preferred provider contract.

Source: Laws 1984, LB 902, § 13.

ARTICLE 42

COMPREHENSIVE HEALTH INSURANCE POOL ACT

Section

Section

44-4201 Act, how cited.

Sections 44-4201 to 44-4235 shall be known and may be cited as the Comprehensive Health Insurance Pool Act.

Source: Laws 1985, LB 391, § 1; Laws 1997, LB 862, § 20; Laws 2001, LB 360, § 20; Laws 2004, LB 1047, § 9; Laws 2009, LB358, § 1.

44-4202 Legislative purpose and intent.

It is the purpose and intent of the Legislature to provide access to health insurance coverage at an affordable premium to all residents of Nebraska, including those individuals denied coverage due to a preexisting medical condition or whose policy includes a restrictive rider limiting coverage for such a condition. The purpose of the Comprehensive Health Insurance Pool Act is to provide a mechanism to ensure the availability of health insurance coverage to

individuals unable to purchase such coverage for a preexisting medical condition either on an individual or group basis directly from an insurer. It is the intent of the Legislature that adequate levels of health insurance coverage be made available to residents of Nebraska who are otherwise considered uninsurable or who are underinsured due to a medical condition creating a high risk. It is the intent of the Comprehensive Health Insurance Pool Act to provide affordable insurance for individuals with such medical conditions by making such health insurance coverage available.

Source: Laws 1985, LB 391, § 2; Laws 2000, LB 1253, § 2.

44-4203 Definitions, where found.

For the purposes of the Comprehensive Health Insurance Pool Act, the definitions found in sections 44-4204 to 44-4215.02 shall be used.

Source: Laws 1985, LB 391, § 3; Laws 1997, LB 862, § 21; Laws 2000, LB 1253, § 3; Laws 2001, LB 360, § 21; Laws 2004, LB 1047, § 10.

44-4204 Agent or insurance agent, defined.

Agent or insurance agent means any person licensed as an insurance agent by the department and duly appointed and authorized by an insurer to solicit applications for insurance and to discharge such other duties as may be vested in or required of the agent by the insurer.

Source: Laws 1985, LB 391, § 4; Laws 2000, LB 1253, § 4.

44-4205 Benefits plan, defined.

Benefits plan means the coverages to be offered by the pool to eligible individuals meeting the requirements of section 44-4221.

Source: Laws 1985, LB 391, § 5; Laws 2000, LB 1253, § 5.

44-4206 Board, defined.

Board means the Board of Directors of the pool.

Source: Laws 1985, LB 391, § 6; Laws 1992, LB 1006, § 29; Laws 2000, LB 1253, § 6.

44-4206.01 Church plan, defined.

Church plan means a plan as defined under 29 U.S.C. 1002.

Source: Laws 1997, LB 862, § 22; Laws 2000, LB 1253, § 7.

44-4206.02 Creditable coverage, defined.

(1) Creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Medicare;

(d) Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., other than coverage consisting solely of benefits under section 1928 of the act, 42 U.S.C. 1396s;

(e) 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003;

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under 5 U.S.C. 8901 et seq.;

(i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage does not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage means any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on April 19, 1998.

Source: Laws 1997, LB 862, § 23; Laws 1998, LB 1035, § 6; Laws 2000, LB 1253, § 8; Laws 2003, LB 6, § 1.

44-4207 Department, defined.

Department means the Department of Insurance.

Source: Laws 1985, LB 391, § 7; Laws 2000, LB 1253, § 9.

44-4208 Director, defined.

Director means the Director of Insurance.

Source: Laws 1985, LB 391, § 8; Laws 2000, LB 1253, § 10.

44-4208.01 Governmental plan, defined.

Governmental plan means a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

Source: Laws 1997, LB 862, § 24; Laws 2000, LB 1253, § 11.

44-4208.02 Group health plan, defined.

Group health plan means an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

Source: Laws 1997, LB 862, § 25; Laws 2000, LB 1253, § 12.

44-4209 Health insurance, defined.

Health insurance means any hospital, surgical, or medical expense-incurred policy or health maintenance organization contract. Health insurance does not include (1) accident-only, disability income, hospital confinement indemnity,

dental, or credit insurance, (2) coverage issued as a supplement to liability insurance, (3) medicare or insurance provided as a supplement to medicare, (4) insurance arising from workers' compensation provisions, (5) automobile medical payment insurance, (6) any other specific limited coverage, or (7) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy.

Source: Laws 1985, LB 391, § 9; Laws 1989, LB 92, § 266; Laws 2000, LB 1253, § 13.

44-4210 Insurer, defined.

Insurer means any insurance company as defined in section 44-103 or health maintenance organization as defined in section 44-32,105 authorized to transact health insurance business in the State of Nebraska.

Source: Laws 1985, LB 391, § 10; Laws 1989, LB 92, § 267; Laws 1990, LB 1136, § 104; Laws 2000, LB 1253, § 14.

44-4211 Medicare, defined.

Medicare means coverage under parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

Source: Laws 1985, LB 391, § 11; Laws 2000, LB 1253, § 15.

44-4212 Member, defined.

Member means any insurer participating in the pool.

Source: Laws 1985, LB 391, § 12; Laws 2000, LB 1253, § 16.

44-4213 Net loss, defined.

Net loss means the excess of incurred claims plus expenses over the sum of written and renewed premiums and other appropriate revenue.

Source: Laws 1985, LB 391, § 13; Laws 2000, LB 1253, § 17.

44-4214 Plan of operation, defined.

Plan of operation means the plan of operation of the pool, including articles, bylaws, and operating rules, submitted by the board pursuant to section 44-4218.

Source: Laws 1985, LB 391, § 14; Laws 2000, LB 1253, § 18.

44-4215 Pool, defined.

Pool means the Comprehensive Health Insurance Pool.

Source: Laws 1985, LB 391, § 15; Laws 2000, LB 1253, § 19.

44-4215.01 Resident, defined.

Resident means an individual who is legally domiciled in this state.

Source: Laws 2001, LB 360, § 22.

44-4215.02 Qualified trade adjustment assistance eligible individual, defined.

Qualified trade adjustment assistance eligible individual shall mean an individual who is eligible for the credit for health insurance costs under section 35 of the Internal Revenue Code.

Source: Laws 2004, LB 1047, § 11.

44-4216 Comprehensive Health Insurance Pool; created; membership; board of directors.

(1) There is hereby created a nonprofit entity to be known as the Comprehensive Health Insurance Pool. All insurers authorized to issue or provide health insurance in this state shall be members of the pool.

(2)(a) Prior to January 1, 2001, the pool shall be managed by a board of directors composed of nine directors whose terms shall expire on December 31, 2000. The board shall at all times, to the extent possible, include at least two representatives of domestic insurance companies, one representative of a health maintenance organization, one representative of a health agency which is involved in advocating for individuals with special health care needs, and one representative of the general public. The director shall adopt and promulgate rules and regulations to establish eligibility and selection criteria for the representative of the general public and for the representative of the health agency.

(b)(i) On and after January 1, 2001, the pool shall be managed by a board of directors composed of seven directors. Such board shall be selected by the director and shall be composed of four representatives of domestic insurers, one representative of health agencies which are involved in advocating for individuals with special health care needs, one representative of individuals eligible for pool coverage, and one representative of the general public.

(ii) With regard to the board as it is composed on and after January 1, 2001:

(A) The representative of health agencies shall not be a member of the board of directors, an officer, or an employee of an insurer;

(B) The representative of individuals eligible for pool coverage (I) shall not be a member of the board of directors, an officer, or an employee of an insurer and (II) shall be an individual who is eligible for pool coverage or who would be eligible for pool coverage if he or she were not otherwise eligible for other health coverage, or the spouse, parent, adult child, or guardian of such individual; and

(C) The representative of the general public (I) shall not be a member of the board of directors, an officer, or an employee of an insurer or of a health agency which is involved in advocating for individuals with special health care needs and (II) shall not be an individual who is qualified for selection as the representative of individuals eligible for pool coverage as provided in subdivision (2)(b)(ii)(B) of this section.

(iii) Recommendations of individuals for selection to the board as it is composed on and after January 1, 2001, may be submitted to the director:

(A) From domestic insurers in the case of the representatives of domestic insurers;

(B) From health agencies which are involved in advocating for individuals with special health care needs in the case of the representative of health agencies; and

(C) From individuals eligible for pool coverage and from organizations which are involved in advocating for individuals eligible for pool coverage in the case of the representative of individuals eligible for pool coverage.

Source: Laws 1985, LB 391, § 16; Laws 1987, LB 319, § 1; Laws 1989, LB 279, § 5; Laws 1992, LB 1006, § 30; Laws 2000, LB 1253, § 20.

44-4217 Board; pool administrator; selection.

The director shall select the board. The board shall select a pool administrator pursuant to section 44-4223.

Source: Laws 1985, LB 391, § 17; Laws 1989, LB 279, § 6; Laws 1992, LB 1006, § 31; Laws 2000, LB 1253, § 21; Laws 2011, LB73, § 1.

44-4218 Administration of pool; submit plan of operation; procedure.

The board shall submit to the department a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The director shall, after notice and hearing, approve the plan of operation if the plan assures the fair, reasonable, and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the director consistent with the date on which the coverage under the Comprehensive Health Insurance Pool Act is required to be made available. If the board fails to submit an acceptable plan of operation or fails to submit acceptable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the Comprehensive Health Insurance Pool Act pursuant to the Administrative Procedure Act. Such rules and regulations shall continue in force until modified by the director or superseded by a plan submitted by the board and approved by the director.

Source: Laws 1985, LB 391, § 18; Laws 1992, LB 1006, § 32.

Cross References

Administrative Procedure Act, see section 84-920.

44-4219 Plan of operation; contents.

In its plan of operation, the board shall:

(1) Establish procedures for the handling and accounting of assets and funds of the pool;

(2) Select a pool administrator in accordance with section 44-4223;

(3) Establish procedures for the selection, replacement, term of office, and qualifications of the directors of the board and rules of procedures for the operation of the board; and

(4) Develop and implement a program to publicize the existence of the pool, the eligibility requirements, and the procedures for enrollment and to maintain public awareness of the pool.

Source: Laws 1985, LB 391, § 19; Laws 1992, LB 1006, § 33; Laws 2000, LB 1253, § 22; Laws 2011, LB73, § 2.

44-4220 Board; powers; enumerated.

The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the business of health insurance and, in addition thereto, the power to carry out the provisions and purposes of the Comprehensive Health Insurance Pool Act, including the specific authority to:

(1)(a) Enter into contracts as are necessary or proper, including the authority, with the approval of the director, to enter into contracts with similar pools from other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions; and

(b) Enter into contracts, with the approval of the director, with any physician, hospital, or other person licensed or otherwise authorized in this state to furnish health care services for participating in an insurance arrangement as defined in section 44-4104;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members;

(3) Take such legal action as necessary to avoid the improper issuance of pool coverage;

(4) Subject to the requirements of section 44-4227, establish appropriate rates and rate schedules, expense allowances, agents' solicitation and referral fees, claim reserves and formulas, and any other actuarial functions appropriate to the operation of the pool;

(5) Issue policies of insurance in accordance with the requirements of the plan of operation and the act and, with the approval of the director, refuse to renew all policy forms for a class of contract and offer a conversion privilege to any covered individual;

(6) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, the policy and other contract design, and any other function within the authority of the pool;

(7) Borrow money to effectuate the purposes of the act. Any notes or other evidence of indebtedness of the pool not in default shall be legal investment for insurers and may be carried as admitted assets; and

(8) Enter into reinsurance agreements and establish rules, conditions, and procedures for reinsuring risks under the act.

Source: Laws 1985, LB 391, § 20; Laws 1989, LB 279, § 7; Laws 1990, LB 1136, § 105; Laws 1992, LB 1006, § 34; Laws 2000, LB 1253, § 23.

44-4220.01 Review of operation; report.

Following the close of each calendar year, the board shall conduct a review of the operation of the pool and report to the director the board's recommendations for cost savings in the operation of the pool.

Source: Laws 2009, LB358, § 2.

44-4220.02 Review of health care provider reimbursement rates; report; health care provider; reimbursement; other payments.

(1)(a) In addition to the requirements of section 44-4220.01, following the close of each calendar year, the board shall conduct a review of health care provider reimbursement rates for benefits payable under pool coverage for covered services. The board shall report to the director the results of the review within thirty days after the completion of the review.

(b) The review required by this section shall include a determination of whether (i) health care provider reimbursement rates for benefits payable under pool coverage for covered services are in excess of reasonable amounts and (ii) cost savings in the operation of the pool could be achieved by establishing the level of health care provider reimbursement rates for benefits payable under pool coverage for covered services as a multiplier of an objective standard.

(c) In the determination pursuant to subdivision (1)(b)(i) of this section, the board shall consider:

(i) The success of any efforts by the pool administrator to negotiate reduced health care provider reimbursement rates for benefits payable under pool coverage for covered services on a voluntary basis;

(ii) The effect of health care provider reimbursement rates for benefits payable under pool coverage for covered services on the number and geographic distribution of health care providers providing covered services to covered individuals;

(iii) The administrative cost of implementing a level of health care provider reimbursement rates for benefits payable under pool coverage for covered services; and

(iv) A filing by the pool administrator which shows the difference, if any, between the aggregate amounts set for health care provider reimbursement rates for benefits payable under pool coverage for covered services by existing contracts between the pool administrator and health care providers and the amounts generally charged to reimburse health care providers prevailing in the commercial market. No such filing shall require the pool administrator to disclose proprietary information regarding health care provider reimbursement rates for specific covered services under pool coverage.

(d) If the board determines that cost savings in the operation of the pool could be achieved, the board shall set forth specific findings supporting the determination and may establish the level of health care provider reimbursement rates for benefits payable under pool coverage for covered services as a multiplier of an objective standard.

(2) A health care provider who provides covered services to a covered individual under pool coverage and requests payment is deemed to have agreed to reimbursement according to the health care provider reimbursement rates for benefits payable under pool coverage for covered services established pursuant to this section. Any reimbursement paid to a health care provider for providing covered services to a covered person under pool coverage is limited to the lesser of billed charges or the health care provider reimbursement rates for benefits payable under pool coverage for covered services established pursuant to this section. A health care provider shall not collect or attempt to collect from a covered individual any money owed to the health care provider by the pool. A health care provider shall not have any recourse against a covered individual for any covered services under pool coverage in excess of

the copayment, coinsurance, or deductible amounts specified in the pool coverage.

(3) Nothing in this section shall prohibit a health care provider from billing a covered individual under pool coverage for services which are not covered services under pool coverage.

Source: Laws 2009, LB358, § 3; Laws 2011, LB73, § 3.

44-4221 Purchase pool coverage; eligibility.

(1) To be eligible to purchase pool coverage, an individual shall:

(a) Be a resident of the state for a period of at least six months and shall be an individual:

(i) Who is not eligible for coverage under a group health plan comparable to pool coverage, medicare by reason of age, or medical assistance pursuant to the Medical Assistance Act or section 43-522, or any successor program, and who does not have any other health insurance coverage comparable to pool coverage;

(ii) Who, if such individual was offered the option of continuation coverage under COBRA or under a similar program, both elected such continuation coverage and exhausted such continuation coverage; and

(iii)(A) Who has received, within six months prior to application to the pool, a rejection in writing, for reasons of health, from an insurer for health insurance coverage comparable to pool coverage;

(B) Who currently has, or has been offered within six months prior to application to the pool, health insurance coverage comparable to pool coverage by an insurer which includes a restrictive rider which limits health insurance coverage for a preexisting medical condition; or

(C) Who has been refused health insurance coverage comparable to pool coverage, or has been offered health insurance coverage at a rate exceeding the premium rate for pool coverage, within six months prior to application to the pool;

(b) Be a resident of the state for any length of time and be an individual:

(i) For whom, as of the date the individual seeks pool coverage under this section, the aggregate of the periods of creditable coverage is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(ii) Who is not eligible for coverage under a group health plan, medicare, or medical assistance pursuant to the Medical Assistance Act or section 43-522, or any successor program, and who does not have any other health insurance coverage;

(iii) With respect to whom the most recent prior creditable coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(iv) Who, if such individual was offered the option of continuation coverage under COBRA or under a similar program, both elected such continuation coverage and exhausted such continuation coverage; or

(c) Be a resident of the state for any length of time and be a qualified trade adjustment assistance eligible individual.

(2) The board may adopt and promulgate a list of medical or health conditions for which an individual would be eligible for pool coverage without applying for health insurance coverage pursuant to subdivision (1)(a) of this section. Individuals who can demonstrate the existence or history of any medical or health conditions on the list adopted and promulgated by the board shall be eligible to apply directly to the pool for pool coverage.

Source: Laws 1985, LB 391, § 21; Laws 1992, LB 1006, § 35; Laws 1997, LB 862, § 26; Laws 1998, LB 1035, § 7; Laws 1998, LB 1063, § 2; Laws 2000, LB 1253, § 24; Laws 2004, LB 1047, § 12; Laws 2006, LB 1248, § 61; Laws 2009, LB358, § 4.

Cross References

Medical Assistance Act, see section 68-901.

44-4222 Purchase of pool coverage; ineligibility.

(1) An individual shall not be eligible for initial or continued pool coverage if:

(a) He or she is eligible for medicare benefits by reason of age or medical assistance established pursuant to the Medical Assistance Act;

(b) He or she is a resident or inmate of a correctional facility, except that this subdivision shall not apply if such individual is eligible for pool coverage under subdivision (1)(b) of section 44-4221;

(c) He or she has terminated pool coverage unless twelve months have elapsed since such termination, except that this subdivision shall not apply if such individual has received and become ineligible for medical assistance pursuant to the Medical Assistance Act during the immediately preceding twelve months, if such individual is eligible for pool coverage under subdivision (1)(b) of section 44-4221, or if such individual is eligible for waiver of any waiting period or preexisting condition exclusions pursuant to section 44-4228;

(d) The pool has paid out one million dollars in claims for the individual;

(e) He or she is no longer a resident of Nebraska; or

(f) The premium for his or her pool coverage is paid for by a person other than the following:

(i) The individual;

(ii) An individual related to the individual by blood, marriage, or adoption; or

(iii) An entity operating under the federal Ryan White HIV/AIDS Treatment Modernization Act of 2006, Public Law 109-415, as such act existed on August 30, 2009.

(2) Pool coverage shall terminate for any individual on the date the individual becomes ineligible under subsection (1) of this section.

Source: Laws 1985, LB 391, § 22; Laws 1987, LB 319, § 2; Laws 1989, LB 279, § 8; Laws 1990, LB 1136, § 106; Laws 1992, LB 1006, § 36; Laws 1997, LB 862, § 27; Laws 1998, LB 1035, § 8; Laws 2000, LB 1253, § 25; Laws 2006, LB 1248, § 62; Laws 2009, LB358, § 5.

Cross References

Medical Assistance Act, see section 68-901.

44-4222.01 Insurer, agent, broker, or third-party administrator; prohibited acts; violation; unfair trade practice.

(1) No insurer, agent, broker, or third-party administrator shall refer an individual employee to the pool or arrange for an individual employee to apply for pool coverage for the purpose of separating that individual employee from group health insurance coverage in connection with the individual employee's employment.

(2) Any violation of this section shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 2009, LB358, § 6.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-4223 Selection of pool administrator; procedure.

(1) The board shall select a pool administrator through a competitive bidding process to administer the pool. The pool administrator may be an insurer or a third-party administrator authorized to transact business in this state. The board shall evaluate bids submitted on the basis of criteria established by the board which shall include:

(a) The applicant's proven ability to handle individual sickness and accident insurance;

(b) The efficiency of the applicant's claim-paying procedures;

(c) The applicant's estimate of total charges for administering the pool;

(d) The applicant's ability to administer the pool in a cost-effective manner; and

(e) The applicant's ability to negotiate reduced health care provider reimbursement rates for benefits payable under pool coverage for covered services.

(2) The pool administrator shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by a pool administrator, the board shall invite all insurers and third-party administrators authorized to transact business in this state, including the current pool administrator, to submit bids to serve as the pool administrator for the succeeding three-year period. Selection of the pool administrator for the succeeding period shall be made at least six months prior to the end of the current three-year period.

Source: Laws 1985, LB 391, § 23; Laws 1992, LB 1006, § 37; Laws 2011, LB73, § 4.

44-4224 Pool administrator; duties.

The pool administrator shall:

(1) Perform all eligibility verification functions relating to the pool;

(2) Establish a premium billing procedure for collection of premiums from covered individuals on a periodic basis as determined by the board;

(3) Perform all necessary functions to assure timely payment of benefits to covered individuals, including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made; and

(b) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the reports shall be determined by the board;

(5) Following the close of each calendar year, report such income and expense items as directed by the board to the board and the department on a form prescribed by the director; and

(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services to the pool.

Source: Laws 1985, LB 391, § 24; Laws 2000, LB 1253, § 26; Laws 2011, LB73, § 5.

44-4225 Board; report; Comprehensive Health Insurance Pool Distributive Fund; created; use; investment; director; funding powers.

(1) Following the close of each calendar year, the board shall report the board's determination of the paid and incurred losses for the year, taking into account investment income and other appropriate gains and losses. The board shall distribute copies of the report to the director, the Governor, and each member of the Legislature. The report submitted to each member of the Legislature shall be submitted electronically.

(2) The Comprehensive Health Insurance Pool Distributive Fund is created. Commencing with the premium and related retaliatory taxes for the taxable year ending December 31, 2001, and for each taxable year thereafter, any premium and related retaliatory taxes imposed by section 44-150 or 77-908 paid by insurers writing health insurance in this state, except as otherwise set forth in subdivisions (1) and (2) of section 77-912, shall be remitted to the State Treasurer for credit to the fund. The fund shall be used for the operation of and payment of claims made against the pool. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

(3) The board shall make periodic estimates of the amount needed from the fund for payment of losses resulting from claims, including a reasonable reserve, and administrative, organizational, and interim operating expenses and shall notify the director of the amount needed and the justification of the board for the request.

(4) The director shall approve all withdrawals from the fund and may determine when and in what amount any additional withdrawals may be necessary from the fund to assure the continuing financial stability of the pool.

(5) No later than May 1, 2002, and each May 1 thereafter, after funding of the net loss from operation of the pool for the prior premium and related retaliatory tax year, taking into account the policyholder premiums, account investment income, claims, costs of operation, and other appropriate gains and losses, the director shall transmit any money remaining in the fund as directed by section 77-912, disregarding the provisions of subdivisions (1) through (3) of such section. Interest earned on money in the fund shall be credited proportionately

in the same manner as premium and related retaliatory taxes set forth in section 77-912.

Source: Laws 1985, LB 391, § 25; Laws 1991, LB 419, § 3; Laws 1992, LB 1006, § 38; Laws 2000, LB 1253, § 27; Laws 2011, LB73, § 6; Laws 2012, LB782, § 54.

Cross References

Nebraska Capital Expansion Act, see section 72-1269.
Nebraska State Funds Investment Act, see section 72-1260.

44-4226 Major medical expense coverage required; considerations.

(1) The pool shall offer major medical expense coverage to every eligible individual. The pool coverage, its schedule of benefits, and exclusions and other limitations shall be established through rules and regulations adopted and promulgated by the director taking into consideration the advice and recommendations of the members.

(2) In establishing the pool coverage, the director shall take into consideration the levels of individual health insurance coverage provided in the state and such medical economic factors as may be deemed appropriate and shall determine benefit levels, deductibles, coinsurance and stop-loss factors, exclusions, and limitations determined to be generally reflective of and commensurate with individual health insurance coverage provided by the ten insurers writing the largest amount of individual health insurance coverage in the state.

(3) Pool coverage established under this section shall provide both an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance and stop-loss factors may be adjusted annually according to the medical component of the Consumer Price Index.

Source: Laws 1985, LB 391, § 26; Laws 1992, LB 1006, § 39; Laws 2000, LB 1253, § 28; Laws 2009, LB358, § 7.

44-4227 Premium and standard risk rates; how determined.

(1)(a) For calendar years prior to January 1, 2010, rates and rate schedules may be adjusted for appropriate risk factors such as age, sex, and area variation in claim costs in accordance with established actuarial and underwriting practices. Special rates shall be provided for children under eighteen years of age.

(b) For calendar years prior to January 1, 2010, the pool, with the assistance of an independent actuary, shall determine the standard risk rate by calculating the average individual rate charged by the five insurers writing the largest amount of individual health insurance coverage in the state actuarially adjusted to be comparable with the pool coverage, except that such five insurers shall not include any insurer which has not been writing individual health insurance coverage in this state in at least the three preceding calendar years. The selection of the independent actuary shall be subject to the approval of the director. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated risk experience and expenses for such coverage. The annual premium rate established for pool coverage shall be one hundred thirty-five percent of rates established as applicable for individual standard risks, except that the annual premium rate established for pool coverage for

children under eighteen years of age shall be sixty-seven and five-tenths percent of rates established as applicable for individual standard risks.

(2)(a) For calendar years beginning on and after January 1, 2010, rates and rate schedules may be adjusted for appropriate risk factors such as age, sex, and area variation in claim costs in accordance with established actuarial and underwriting practices.

(b)(i) For calendar years beginning on and after January 1, 2010, the pool, with the assistance of an independent actuary, shall determine the standard risk rate by calculating the average individual rate charged by the ten insurers writing the largest amount of individual health insurance coverage in the state actuarially adjusted to be comparable with the pool coverage, except that such ten insurers shall not include any insurer which has not been writing individual health insurance coverage in this state in at least the three preceding calendar years. The selection of the independent actuary shall be subject to the approval of the director. In the event ten insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated risk experience and expenses for such coverage.

(ii)(A) The annual premium rate established for pool coverage for calendar year 2010 (I) shall be one hundred forty percent of rates established as applicable for individual standard risks or (II) shall be the rates established as applicable for individual standard risks for the previous calendar year adjusted by a trend factor reflecting medical economic factors as the board deems appropriate, whichever is greater.

(B) The annual premium rate established for pool coverage for calendar year 2011 (I) shall be one hundred forty-five percent of rates established as applicable for individual standard risks or (II) shall be the rates established as applicable for individual standard risks for the previous calendar year adjusted by a trend factor reflecting medical economic factors as the board deems appropriate, whichever is greater.

(C) The annual premium rate established for pool coverage for calendar year 2012 and each calendar year thereafter (I) shall be one hundred fifty percent of rates established as applicable for individual standard risks or (II) shall be the rates established as applicable for individual standard risks for the previous calendar year adjusted by a trend factor reflecting medical economic factors as the board deems appropriate, whichever is greater.

(3) The board shall not adjust or increase pool rates more than one time during any calendar year. All rates and rate schedules shall be submitted to the director for approval. The director shall hold a public hearing pursuant to the Administrative Procedure Act prior to approving an adjustment to or increase in pool rates.

Source: Laws 1985, LB 391, § 27; Laws 1989, LB 279, § 9; Laws 1990, LB 1136, § 107; Laws 1991, LB 419, § 4; Laws 1992, LB 1006, § 40; Laws 1998, LB 1063, § 3; Laws 2000, LB 1253, § 29; Laws 2009, LB358, § 8.

Cross References

Administrative Procedure Act, see section 84-920.

44-4228 Pool coverage; exclusions; application for coverage; requirements.

(1) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of pool coverage as to any condition (a) which had manifested itself during the six-month period immediately preceding the effective date of pool coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment or (b) for which medical advice, care, or treatment was recommended or received during the six-month period immediately preceding the effective date of pool coverage.

(2) Any individual whose health coverage is involuntarily terminated on or after January 1, 1992, and who is not eligible for a conversion policy or a continuation-of-coverage policy or contract available under state or federal law may apply for pool coverage but shall submit proof of eligibility pursuant to subdivision (1)(a) of section 44-4221. If such proof is supplied and if pool coverage is applied for under the Comprehensive Health Insurance Pool Act within sixty days after the involuntary termination and if premiums are paid to the pool for the entire coverage period, any waiting period or preexisting condition exclusions provided for under the pool coverage shall be waived to the extent similar exclusions, if any, under the previous health coverage have been satisfied and the effective date of the pool coverage shall be the day following termination of the previous health coverage. The board may assess an additional premium for pool coverage provided pursuant to this subsection notwithstanding the premium limitations stated in section 44-4227. For purposes of this section, an individual whose health coverage is involuntarily terminated means an individual whose health insurance or health plan is terminated by reason of the withdrawal by the insurer from this state, bankruptcy or insolvency of the employer or employer trust fund, or cessation by the employer of providing any group health plan for all of its employees.

(3) Any individual whose health coverage under a continuation-of-coverage policy or contract available under state or federal law terminates or is involuntarily terminated on or after July 1, 1993, for any reasons other than nonpayment of premium may apply for pool coverage but shall submit proof of eligibility applied for within ninety days after the termination or involuntary termination. If premiums are paid to the pool for the entire coverage period, the effective date of the pool coverage shall be the day following termination of the previous coverage under the continuation-of-coverage policy or contract. Any waiting period or preexisting condition exclusions provided for under the pool shall be waived to the extent similar exclusions, if any, under any prior health coverage have been satisfied.

(4) Subsection (1) of this section shall not apply to an individual who has received medical assistance pursuant to the Medical Assistance Act or section 43-522 or an organ transplant recipient terminated from coverage under medicare during the six-month period immediately preceding the effective date of coverage.

(5) All waiting periods and preexisting conditions shall be waived for an individual eligible for pool coverage under subdivision (1)(b) of section 44-4221.

(6) The waiting period and preexisting condition exclusions are waived for a qualified trade adjustment assistance eligible individual under subdivision (1)(c) of section 44-4221 if the individual maintained creditable coverage for an aggregate period of three months as of the date on which the individual seeks to

enroll in pool coverage, not counting any period prior to a sixty-three-day break in coverage.

Source: Laws 1985, LB 391, § 28; Laws 1989, LB 279, § 10; Laws 1990, LB 1136, § 108; Laws 1991, LB 419, § 5; Laws 1992, LB 835, § 1; Laws 1994, LB 1222, § 60; Laws 1997, LB 862, § 28; Laws 1998, LB 1035, § 9; Laws 2000, LB 1253, § 30; Laws 2004, LB 1047, § 13; Laws 2006, LB 1248, § 63.

Cross References

Medical Assistance Act, see section 68-901.

44-4229 Reduction of benefits; when.

Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, or any state or federal law or program.

Source: Laws 1985, LB 391, § 29.

44-4230 Recovery of noncovered expenses; cause of action; subrogation.

The pool shall have a cause of action against a covered individual for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this section. The pool shall have a right of subrogation to any payments made to a covered individual by another person or his or her insurer on account of an injury caused by such other person's wrongful act or negligence.

Source: Laws 1985, LB 391, § 30; Laws 1990, LB 1136, § 109; Laws 2000, LB 1253, § 31.

44-4231 Pool; limitation on liability.

Participation in the pool as members, the establishment of rates, forms, or procedures, or any other joint or collective action required by the Comprehensive Health Insurance Pool Act shall not be the basis of any cause of action, criminal or civil liability, or penalty against the pool or any of its members or the board.

Source: Laws 1985, LB 391, § 31; Laws 1992, LB 1006, § 41.

44-4232 Pool; exempt from taxation.

The pool shall be exempt from any and all taxes assessed by the State of Nebraska.

Source: Laws 1985, LB 391, § 32.

44-4233 Member; offset tax liability.

(1) Any member subject to premium and related retaliatory tax liability imposed by section 44-150 or 77-908 may offset assessments paid to the pool by such member against its tax liability in the year of payment or subsequent years. The member may offset such paid assessments against (a) subsequent

premium tax prepayments imposed by section 77-918, (b) subsequent premium tax payments imposed by section 77-908, and (c) related retaliatory tax liability imposed by section 44-150. Prior to January 1, 2004, no individual member shall be subject to any liability of the pool in excess of its premium and related retaliatory tax liability which may be offset under this section.

(2) Commencing with assessments imposed or paid in 1991 and for all subsequent years prior to January 1, 2004, whenever it reasonably appears to the satisfaction of the board that a member has during a calendar year paid assessments that exceed that member's premium and related retaliatory tax liability for that calendar year, the board shall, upon request from such member, order the refund to that member of the amount of the assessment that exceeded that member's premium and related retaliatory tax liability. A member's request for a refund shall be filed with the board not later than thirty days after the due date of the member's premium tax return filed with the department. If the refund is not made by the board within thirty days after receipt of the refund request, the member may within thirty days thereafter initiate a suit in district court for the amount claimed. The suit shall be heard by the district court de novo. In the event that an assessment against a member is limited by reason of that member's premium and related retaliatory tax liability, the amount by which the assessment is limited may be assessed against the other members in a manner consistent with the basis for assessments specified in subsection (3) of section 44-4225.

Source: Laws 1985, LB 391, § 33; Laws 1986, LB 1114, § 8; Laws 1987, LB 302, § 7; Laws 1992, LB 835, § 2; Laws 1992, LB 1006, § 42; Laws 1993, LB 10, § 1; Laws 1995, LB 837, § 1; Laws 1997, LB 55, § 3; Laws 1997, LB 862, § 29; Laws 1999, LB 355, § 6; Laws 2000, LB 1253, § 32.

44-4234 Repealed. Laws 1992, LB 1006, § 99.

44-4235 Insurer; notice required.

Every insurer shall include a notice of the existence of the pool in (1) any rejection of an application for health insurance coverage for reasons of the health of the applicant and (2) any restrictive health insurance rider issued on or after January 1, 1999.

Source: Laws 1985, LB 391, § 35; Laws 1992, LB 1006, § 43; Laws 1998, LB 1063, § 4.

ARTICLE 43

INTERGOVERNMENTAL RISK MANAGEMENT

Section
44-4301. Act, how cited.
44-4302. Legislative findings.
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Section

44-4301 Act, how cited.

Sections 44-4301 to 44-4339 shall be known and may be cited as the Intergovernmental Risk Management Act.

Source: Laws 1987, LB 398, § 1.

44-4302 Legislative findings.

The Legislature hereby finds and declares that protection against losses due to liability and damage or loss of property and provision of employee benefit plans is essential to the proper functioning of state and local government. The resources of state and local governmental agencies are often burdened by the securing of necessary insurance protection and employee benefits through standard insurance carriers. In addition, the Legislature finds that benefits can be derived through pooling of purchasing by state and local government. Proper risk management requires the spreading of risk so as to minimize fluctuation in insurance needs. The Legislature further finds that all contributions of financial and administrative resources made by state and local governmental agencies pursuant to an agreement authorized by the Intergovernmental Risk Management Act are made for a public and governmental purpose.

Source: Laws 1987, LB 398, § 2; Laws 2001, LB 664, § 1.

44-4303 Terms, defined.

For purposes of the Intergovernmental Risk Management Act, unless the context otherwise requires:

(1) Accident insurance means insurance against loss of expense resulting from the sickness of the insured, from the bodily injury or death of the insured by accident, or both;

(2) Dental insurance means a contractual arrangement to provide specified dental services, in consideration of a specified payment for an interval of time, regardless of whether the payment is made by the beneficiaries individually or by a third person for them, in such a manner that the total cost of such services is to be spread directly or indirectly among a group of persons;

(3) Errors and omissions liability means liability to which a member of a governing body of a public agency, an elected or appointed officer of a public agency, or an employee of a public agency may be subject in an individual capacity by reason of any error, misstatement, misleading statement, act, omission, neglect of duty, or breach of duty, including misfeasance or nonfeasance, in the performance of duties for the public agency;

(4) General liability means any liability, other than workers' compensation liability, to which a public agency may be subject (a) directly, (b) by reason of liability arising out of an act or omission of its employee, agent, or officer in the course and scope of employment, (c) by reason of liability arising out of an act or omission of its student in the course and scope of education or training, or (d) by reason of liability it has assumed by contract. It includes, but is not limited to, liability commonly protected against by casualty insurance, general liability insurance, professional liability insurance, automobile insurance, motor vehicle liability insurance, and surety and fidelity insurance;

(5) Group self-insurance means the pooling of public money by a risk management pool from contributions by its members for the purpose of payment of losses incurred by members which are protected against by the pool;

(6) Health insurance means any hospital, surgical, or medical expense-incurred policy or health maintenance organization contract. Health insurance does not include (a) accident-only, disability income, hospital confinement indemnity, dental, or credit insurance, (b) coverage issued as a supplement to liability insurance, (c) medicare or insurance provided as a supplement to medicare, (d) insurance arising from workers' compensation provisions, (e) automobile medical payment insurance, (f) any other specific limited coverage, or (g) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy;

(7) Life insurance means insurance upon lives of persons, including endowments and annuities, and every insurance pertaining thereto and disability benefits;

(8) Member means a public agency which is a party to an agreement providing for the establishment and operation of a risk management pool;

(9) Public agency means any county, city, village, school district, public power district, rural fire district, or other political subdivision of this state, the State of Nebraska, the University of Nebraska, and any corporation whose primary function is to act as an instrumentality or agency of the State of Nebraska;

(10) Risk management pool or pool means an association formed by two or more public agencies by an agreement pursuant to the Intergovernmental Risk

Management Act providing for joint and cooperative action in the use of their financial or administrative resources in order to accomplish any of the public and governmental purposes authorized by the act;

(11) Standard insurance means any policy of insurance issued by a company licensed to transact insurance business in the State of Nebraska or any policy of insurance issued in accordance with the requirements for a lawful surplus lines insurance transaction;

(12) State of Nebraska includes any department, agency, board, bureau, commission, or council of the State of Nebraska authorized to participate in a risk management pool by the Risk Manager pursuant to section 81-8,239.01; and

(13) Workers' compensation liability means liability to which a public agency may be subject as an employer under the Nebraska Workers' Compensation Act.

Source: Laws 1987, LB 398, § 3; Laws 1988, LB 1220, § 2; Laws 2001, LB 664, § 2.

Cross References

Nebraska Workers' Compensation Act, see section 48-1,110.

44-4304 Risk management pool; agreements authorized.

(1) Any two or more public agencies may make and execute an agreement providing for joint and cooperative action in accordance with the Intergovernmental Risk Management Act to form, become members of, and operate a risk management pool for the purpose of providing to members risk management services and insurance coverages in the form of group self-insurance or standard insurance, including any combination of group self-insurance and standard insurance, to protect members against losses arising from any of the following:

(a) General liability;

(b) Damage, destruction, or loss of real or personal property, including, but not limited to, loss of use or occupancy, and loss of income or extra expense resulting from loss of use or occupancy;

(c) Errors and omissions liability; and

(d) Workers' compensation liability.

(2) Any two or more public agencies, other than school districts and educational service units, may make and execute an agreement providing for joint and cooperative action in accordance with the act to form, become members of, and operate a risk management pool for the purpose of providing to members risk management services and insurance coverages in the form of group self-insurance or standard insurance, including any combination of group self-insurance and standard insurance, to provide health, dental, accident, and life insurance to member's employees and officers.

Source: Laws 1987, LB 398, § 4; Laws 2001, LB 664, § 3.

44-4305 Risk management pool; powers.

(1) Any risk management pool organized pursuant to the Intergovernmental Risk Management Act, whether or not a body corporate, shall have the power to sue and be sued, make contracts, hold and dispose of real and personal

property, borrow money, contract debt, and pledge any pool assets in the name of the pool.

(2) The power to make contracts prescribed in subsection (1) of this section shall specifically include the power to establish the risk management pool as a separate legal or administrative entity.

Source: Laws 1987, LB 398, § 5.

44-4306 Risk management pool; agreement; contents.

Any agreement entered into for the purpose of establishing and operating a risk management pool shall provide:

(1) A financial plan setting forth in general terms the:

(a) Types of insurance coverage to be offered by the pool, applicable deductible levels, and maximum level of claims which the pool will self-insure;

(b) Amount of cash reserves to be set aside for the payment of claims;

(c) Amount of standard insurance to be purchased by the pool to provide coverage over and above the claims which are not to be satisfied directly from the pool's resources; and

(d) Amount of aggregate excess insurance coverage and specific excess insurance coverage to be purchased in a given fiscal period; and

(2) A plan of management setting forth:

(a) The means of establishing the governing authority of the pool. (i) The governing authority shall be a board of directors who are elected or appointed officials of member public agencies. (ii) The number of members of the board who are either elected or appointed officials of member public agencies shall not be less than the requisite number of members needed to transact all the business of the pool;

(b) The responsibility of the board of directors with regard to fixing annual contributions to the pool from members, maintaining reserves, levying and collecting from members assessments for deficiencies, disposing of surpluses, and administering the pool in the event of termination or insolvency;

(c) A procedure by which new members may be admitted to and existing members may leave the pool. The procedure shall permit members to withdraw from participation in a pool. Withdrawal shall not affect the obligations of the withdrawing member under any contract or agreement with the pool or impair the payment of any outstanding bonds or any interest on such bonds;

(d) The identification of funds and reserves by exposure area;

(e) A provision requiring that all claims shall be paid promptly;

(f) A provision requiring that no part of the net earnings or assets of the pool shall inure to the benefit of any private person;

(g) A provision requiring that, upon dissolution of the pool, all of the assets of the pool will vest in member public agencies in the manner set forth in the plan of management;

(h) A system or program of loss control; and

(i) Any other standards, procedures, or practices necessary or desirable for the continued operation of the pool.

Source: Laws 1987, LB 398, § 6.

44-4307 Certificate of authority; issuance; fee.

(1) A risk management pool shall not provide any form of group self-insurance to its members until it has received a certificate of authority to do so from the Department of Insurance. Such certificate shall expire on the last day of April in each year and shall be renewed annually thereafter if the risk management pool has continued to comply with the Intergovernmental Risk Management Act and the rules and regulations of the Department of Insurance adopted and promulgated thereunder.

(2) The Department of Insurance shall issue a certificate of authority to a risk management pool if the Director of Insurance determines:

(a) That the pool's financial plan and plan of management and any amendments thereto satisfy the requirements of section 44-4306;

(b) That the pool has adequate surplus and reserves and will receive adequate financial contributions from its members in order to operate in a manner which is not hazardous to the public; and

(c) That any individual, corporation, partnership, limited liability company, or other entity engaged by the pool to provide services in connection with its management or operation is capable of running the affairs of the pool, is of good character and known business ability, and has a practical knowledge of the executive duties of conducting a risk management pool.

(3) The filing fee for a certificate of authority issued pursuant to the Intergovernmental Risk Management Act shall be one thousand dollars.

Source: Laws 1987, LB 398, § 7; Laws 1989, LB 92, § 268; Laws 1993, LB 121, § 253.

44-4308 Rules and regulations.

The Department of Insurance may adopt and promulgate reasonable rules and regulations (1) requiring a risk management pool to maintain reserves similar to those required of a domestic insurance company offering the same coverage as the group self-insurance coverage offered by a pool to its members, (2) requiring prior approval by the Director of Insurance before a risk management pool distributes dividends to its members in order to ensure that adequate reserves will be maintained, (3) requiring a risk management pool to process and act upon claims in accordance with the guidelines applicable for domestic insurance companies, and (4) requiring the pool to notify the Department of Insurance thirty days in advance of any change in the contribution level of the members, of any change in the coverages offered by the pool, and of any amendments to the agreement establishing the pool.

Source: Laws 1987, LB 398, § 8.

44-4309 Risk management pool; termination of participation; effect.

(1) A member of a risk management pool may voluntarily terminate its participation in the pool by giving written notice to the other members of the pool and the Director of Insurance at least ninety days prior to the desired termination date. Such voluntary termination shall be approved by the Director of Insurance if he or she finds that the terminating member and the remaining members of the pool are in good standing and have met all requirements of the laws of this state, any rules or regulations adopted and promulgated by the

Department of Insurance pursuant to the Intergovernmental Risk Management Act, and any bylaws of the risk management pool.

(2) A member of a risk management pool may be involuntarily terminated as a member of the pool if the Director of Insurance finds, after due notice and hearing, that the member (a) has failed to pay any contribution or assessment due to the pool, (b) has failed to discharge any other obligation it owes to the pool, or (c) has failed to comply with any laws of this state, any rules or regulations adopted and promulgated by the Department of Insurance pursuant to the Intergovernmental Risk Management Act, or any bylaw of the risk management pool. Such hearing may be initiated by the Director of Insurance on his or her own initiative or at the request of the pool's board of directors.

(3) Any member of a risk management pool which voluntarily terminates its membership in the pool or which is involuntarily terminated as a member of the pool shall nevertheless remain liable subsequent to the date of termination for all contractual obligations it has entered into with the pool on or before the date of termination.

Source: Laws 1987, LB 398, § 9.

44-4310 Risk management pool; report; examination.

(1) On or before March 1 of each year after a risk management pool has received a certificate of authority as prescribed in section 44-4307, it shall make and file with the Department of Insurance a report of its affairs and operations during the last preceding calendar year. Such report shall be made in such form and shall contain such information as the Director of Insurance may by rule or regulation prescribe in order to protect the public interest and the interests of the members of the pool. Upon application to and approval by the director, an individual pool may make and file the report on or before a date other than March 1 for a different twelve-month period in order to correspond with the applicable fiscal year established by the pool. The director may require any individual pool to file additional periodic reports as he or she may find to be reasonably necessary and appropriate to protect and inform members of the pool and the public, to insure solvency of the pool, and to insure fair dealings in the investments of the pool.

(2) The department shall examine the business affairs, records, and assets of each pool once every four years to assure that the pool is financially sound. The department may examine a pool sooner than four years from the preceding examination if the director has reason to believe that the pool is not financially sound. Any examination conducted by the department pursuant to this subsection shall be at the expense of the pool being examined.

Source: Laws 1987, LB 398, § 10; Laws 1997, LB 170, § 1.

44-4311 Risk management pool; dissolution.

A risk management pool shall not be voluntarily dissolved or otherwise cease to function without written approval by the Director of Insurance after he or she has determined that all claims and other legal obligations of the pool have been paid or that adequate provisions for such payment have been made.

Source: Laws 1987, LB 398, § 11.

44-4312 Risk management pool; deficiency; assessment required.

(1) If the assets of a risk management pool are at any time insufficient to enable the pool to discharge its liabilities and other obligations and to maintain adequate reserves and surpluses in accordance with reasonable determinations by the Department of Insurance, the pool shall make up the deficiency or the Director of Insurance shall order the pool to levy an assessment upon its members in an amount necessary to make up the deficiency.

(2) If the risk management pool fails to make up a deficiency or to make the required assessment of its members pursuant to subsection (1) of this section within thirty days after the Director of Insurance orders it to do so or if the deficiency is not fully made up within sixty days after the date on which such assessment is made or within such longer period of time as may be specified by the Director of Insurance, the pool shall be proceeded against in the same manner as provided for domestic insurers. The Director of Insurance shall have the same powers, duties, and limitations in such proceeding as are provided for in a proceeding against a domestic insurer.

(3) If the liquidation of a risk management pool is ordered, an assessment shall be levied upon its members for such amount as the Director of Insurance determines is necessary to discharge all liabilities of the pool, including the reasonable costs of liquidation.

Source: Laws 1987, LB 398, § 12.

44-4313 Risk management pool; investment of funds.

The capital, surplus, and other funds, or any part thereof, of any risk management pool may be invested as authorized under the Insurers Investment Act for an insurer.

Source: Laws 1987, LB 398, § 13; Laws 1988, LB 1220, § 3; Laws 1991, LB 237, § 70; Laws 2001, LB 664, § 4.

Cross References

Insurers Investment Act, see section 44-5101.

44-4314 Rules and regulations.

The Department of Insurance may, after notice and hearing, adopt and promulgate such reasonable rules and regulations as may be necessary or proper to carry out the provisions of sections 44-4306 to 44-4314, 44-4319, and 44-4320.

Source: Laws 1987, LB 398, § 14.

44-4315 Risk management pool; applicability of insurance laws.

Notwithstanding any other provision of law to the contrary, (1) any risk management pool organized pursuant to the Intergovernmental Risk Management Act shall not be considered an insurance company or insurer under the laws of this state, (2) any agreement forming a risk management pool or providing group self-insurance coverages to its members shall not constitute insurance or the conduct of an insurance business, and (3) no risk management pool organized pursuant to the Intergovernmental Risk Management Act shall be a member of the Nebraska Life and Health Insurance Guaranty Association or the Nebraska Property and Liability Insurance Guaranty Association.

Source: Laws 1987, LB 398, § 15; Laws 2001, LB 664, § 5.

Cross References

Nebraska Life and Health Insurance Guaranty Association, see section 44-2705.
Nebraska Property and Liability Insurance Guaranty Association, see section 44-2404.

44-4316 Funds, how construed.

Funds set aside by any public agency for a risk management pool shall not be construed to be a cash reserve or a sinking fund.

Source: Laws 1987, LB 398, § 16.

44-4317 Public agency; tax levy; agreements; authorized.

(1)(a) Any public agency which has the authority to levy a tax shall be authorized to levy a tax, to contract indebtedness, and to issue general obligation bonds payable from such a tax levy to pay the premium costs of general liability insurance, property insurance, workers' compensation insurance, health, dental, or accident insurance, life insurance, and any other insurance to protect against any of the losses described in section 44-4304 and to pay all costs and expenses associated with membership in a risk management pool, including, but not limited to, standard insurance coverages, group self-insurance coverages, assessments levied by the pool, retirement of debt incurred by the pool, and operating expenses of the pool.

(b) A member of a risk management pool which has the authority to levy a tax shall be authorized to enter into agreements obligating the member to make payments beyond its current budget year for any of such purposes.

(c) Taxes levied by a public agency other than an educational service unit or school district for the payment of the principal of, premium of, or interest on such a general obligation bond of such public agency, the payment of such insurance premium costs, and the payment of all costs and expenses associated with membership in a risk management pool may be levied in excess of any tax limitation imposed by statute.

(d) Except as permitted in subdivision (1)(e) of this section, taxes levied by an educational service unit or school district on or after April 3, 2008, for the payment of the principal of, premium of, or interest on such a general obligation bond of such public agency, the payment of such insurance premium costs, and the payment of all costs and expenses associated with membership in a risk management pool shall be subject to the levy limit applicable to such public agency under section 77-3442.

(e) Taxes levied by an educational service unit or school district for the payment of the principal of, premium of, or interest on such a general obligation bond of such educational service unit or school district issued prior to April 3, 2008, shall be excluded from the levy limit applicable to such public agency under section 77-3442.

(2) Nothing in the Intergovernmental Risk Management Act shall be construed or interpreted as permitting the State of Nebraska, represented by the Risk Manager, to enter into any agreement or contract or do any act in contravention of the Constitution of the State of Nebraska.

Source: Laws 1987, LB 398, § 17; Laws 2001, LB 664, § 6; Laws 2008, LB988, § 1.

44-4318 Funds or reserve; disclosure; discovery.

Information regarding that portion of the funds or liability reserve of a risk management pool established for the purpose of satisfying a specific claim or cause of action shall be exempt from disclosure under sections 84-712 to 84-712.09. Notwithstanding any other provision of law to the contrary, a party to a claim or action against a public agency or any risk management pool shall not be entitled to discover that portion of the funds or liability reserve established by the pool for purposes of satisfying the claim or cause of action, except that such information shall be discoverable in any supplemental or ancillary proceeding to enforce a judgment against a public agency or risk management pool.

Source: Laws 1987, LB 398, § 18.

44-4319 Workers' compensation coverage; requirements; court; powers.

(1) All risk management pools shall comply with the Nebraska Workers' Compensation Act and all rules of the Nebraska Workers' Compensation Court.

(2) The Nebraska Workers' Compensation Court may, as provided by section 48-146.02, revoke or suspend the authority of a risk management pool to provide group self-insurance coverage of workers' compensation liability pursuant to the Intergovernmental Risk Management Act.

Source: Laws 1987, LB 398, § 19.

Cross References

Nebraska Workers' Compensation Act, see section 48-1,110.

44-4320 Payment to director; computation.

Every risk management pool shall pay to the Director of Insurance, on or before March 1 of each year, an amount equal to five-tenths of one percent of annual contributions received by the pool less any amount paid for excess or aggregate insurance during the immediately preceding calendar year for health, dental, and accident coverage and one percent of annual contributions received by the pool less any amount paid for excess or aggregate insurance during the immediately preceding calendar year for coverage of all other risks included within the pool's group self-insurance program. A pool which has a scheme of operations that contemplates a return of a portion of the contributions of pool members without such members being claimants under the pool's insuring agreements may deduct such return contributions and any dividends paid during the immediately preceding calendar year from the pool's contributions for the purpose of calculating the amount due. The computation of such amount shall be made on forms furnished by the Department of Insurance which shall be filed with the department together with a sworn statement by the pool's chief operating officer attesting to the accuracy of the computation. The department shall furnish such forms to each pool prior to the end of the year for which such amount is payable together with any information relative to computation of the amount as may be necessary. Upon receipt of payment, the director shall audit and examine the computations and satisfy himself or herself that the amount paid is in conformity with this section. The director shall transmit such payments to the State Treasurer. One-half of the payments shall be handled in the manner prescribed in section 77-913, and the remaining one-half of such payments shall be deposited in the General Fund promptly upon

completion of the director's audit and examination and in no event later than May 1 of each year.

Source: Laws 1987, LB 398, § 20; Laws 1988, LB 1220, § 4; Laws 1999, LB 259, § 9; Laws 2001, LB 664, § 7.

44-4321 Bonds; issuance.

Subject only to any agreement with the holders of outstanding bonds, a risk management pool may issue such types of bonds as its board may determine, including bonds as to which the principal and interest are payable exclusively from all or a portion of the revenue from one or more revenue-producing contracts made by the risk management pool with any person, or from its revenue generally, or which may be additionally secured by a pledge of any grant, subsidy, or contribution from any person, by a pledge of any income, revenue, funds, or money of the risk management pool from any source whatsoever, or by a mortgage or security interest in any real or personal property, commodity, or product or any service or interest therein.

Source: Laws 1987, LB 398, § 21.

44-4322 Bonds; amount.

A risk management pool may from time to time issue its bonds in such principal amounts as its board of directors deems necessary to provide sufficient funds to carry out any of the risk management pool's purposes and powers, including the establishment or increase of reserves and the payment of all other costs or expenses of the risk management pool incident to and necessary or convenient to carry out its purposes and powers.

Source: Laws 1987, LB 398, § 22.

44-4323 Liability for bonds.

(1) Neither the members of a risk management pool's board of directors nor any person executing the bonds shall be liable personally on such bonds by reason of the issuance thereof.

(2) The bonds shall not be a debt, liability, or general obligation of any member of a risk management pool or of this state, and neither this state nor any member of a risk management pool shall be liable thereon. Neither the faith and credit nor the taxing power of any member of a risk management pool or of the state shall be pledged to the payment of the principal or interest on the bonds. Bonds shall be payable only out of any funds or properties of the issuing risk management pool. Such limitations shall be plainly stated upon the face of the bonds.

Source: Laws 1987, LB 398, § 23.

44-4324 Bonds; issuance; terms.

Bonds shall be authorized by resolution of the issuing risk management pool's board of directors, may be issued under a resolution or under a trust indenture or other security instrument in one or more series, and shall bear such date or dates, mature at such time or times, bear interest at such rate or rates, be in such denomination or denominations, be in such form, either coupon or registered, carry such conversion or registration privileges, have such rank or priority, be executed in such manner, be payable in such medium

of payment and at such place or places, and be subject to such terms of redemption, with or without premium, as such resolution, trust indenture, or other security instrument may provide and without limitation by the provisions of any other law limiting amounts, maturities, or interest rates. Any officer authorized or designated to sign, countersign, execute, or attest any bond or any coupon may utilize a facsimile signature in lieu of his or her manual signature.

Source: Laws 1987, LB 398, § 24.

44-4325 Bonds; negotiable; sale.

(1) Except as the issuing risk management pool's board of directors may otherwise provide, any bond and any interest coupons thereto attached shall be fully negotiable within the meaning and for all purposes of article 8, Uniform Commercial Code.

(2) The bonds may be sold at public or private sale as the issuing risk management pool's board of directors may provide and at such price or prices as such board shall determine.

Source: Laws 1987, LB 398, § 25.

44-4326 Signatures; validity.

In case any officers whose signatures appear on any bonds or coupons cease to be such officers before the delivery of such obligations, such signatures shall nevertheless be valid and sufficient for all purposes to the same extent as if such officers had remained in office until such delivery.

Source: Laws 1987, LB 398, § 26.

44-4327 Bonds; risk management pool; powers.

A risk management pool shall have power in connection with the issuance of its bonds:

(1) To covenant as to the use of any or all of its property, real or personal;

(2) To redeem the bonds, to covenant for their redemption, and to provide the terms and conditions thereof;

(3) To covenant to charge or seek necessary approval to charge fees and charges sufficient to meet operating and maintenance expenses of the risk management pool, interest and principal payments, whether at maturity or upon sinking fund redemption, on any outstanding bonds or other indebtedness of the risk management pool, and creation and maintenance of any reasonable reserves therefor and to provide for any margins or coverages over and above debt service on the bonds deemed desirable for the marketability or security of the bonds;

(4) To covenant and prescribe as to events of default and terms and conditions upon which any or all of its bonds shall become or may be declared due before maturity, as to the terms and conditions upon which such declaration and its consequences may be waived, and as to the consequences of default and the remedies of bondholders;

(5) To covenant as to the mortgage or pledge of or the grant of any other security interest in any real or personal property and all or any part of the revenue from any revenue-producing contract or contracts made by the risk

management pool with any person to secure the payment of bonds, subject to such agreements with the holders of outstanding bonds as may then exist;

(6) To covenant as to the custody, collection, securing, investment, and payment of any revenue, assets, money, funds, or property with respect to which the risk management pool may have any rights or interest;

(7) To covenant as to the purposes to which the proceeds from the sale of any bonds then or thereafter to be issued may be applied and the pledge of such proceeds to secure the payment of the bonds;

(8) To covenant as to limitations on the issuance of any additional bonds, the terms upon which additional bonds may be issued and secured, and the refunding of outstanding bonds;

(9) To covenant as to the rank or priority of any bonds with respect to any lien or security;

(10) To covenant as to the procedure by which the terms of any contract with or for the benefit of the holders of bonds may be amended or abrogated, the amount of bonds the holders of which must consent thereto, and the manner in which such consent may be given;

(11) To covenant as to the custody of any of its properties or investments, the safekeeping thereof, the insurance to be carried thereon, and the use and disposition of insurance proceeds;

(12) To covenant as to the vesting in a trustee or trustees, within or outside the state, of such properties, rights, powers, and duties in trust as the risk management pool may determine;

(13) To covenant as to the appointing and providing for the duties and obligations of a paying agent or paying agents or other fiduciaries within or outside the state;

(14) To make all other covenants and to do any and all such acts and things as may be necessary, convenient, or desirable in order to secure its bonds or in the absolute discretion of the risk management pool as may tend to make the bonds more marketable, notwithstanding that such covenants, acts, or things may not be enumerated in this section; and

(15) To execute all instruments necessary or convenient in the exercise of the powers granted in the Intergovernmental Risk Management Act or in the performance of covenants or duties, which instruments may contain such covenants and provisions as any purchaser of bonds may reasonably require.

Source: Laws 1987, LB 398, § 27.

44-4328 Refunding bonds; issuance; terms.

A risk management pool may issue and sell refunding bonds for the purpose of paying or providing for the payment of any of its bonds at or prior to maturity or upon acceleration or redemption. Refunding bonds may be issued at any time prior to or at the maturity or redemption of the refunded bonds as the risk management pool's board of directors deems appropriate. The refunding bonds may be issued in a principal amount not exceeding an amount sufficient to pay or to provide for the payment of (1) the principal of the bonds being refunded, (2) any redemption premium thereon, (3) interest accrued or to accrue to the first or any subsequent redemption date or dates selected by the risk management pool's board of directors in its discretion, or to the date or

dates of maturity, whichever is determined to be most advantageous or convenient for the risk management pool, (4) the expenses of issuing the refunding bonds, including bond discount, and redeeming the bonds being refunded, and (5) such reserves for debt service or other capital or current expenses from the proceeds of such refunding bonds as may be deemed necessary or convenient by the board of directors of the issuing risk management pool. A determination by the board of directors that any refinancing is advantageous or necessary to the risk management pool, that any of the amounts provided in this section should be included in such refinancing, or that any of the bonds to be refinanced should be called for redemption on the first or any subsequent redemption date or permitted to remain outstanding until their respective dates of maturity shall be conclusive.

Source: Laws 1987, LB 398, § 28.

44-4329 Refunding bonds; use.

Refunding bonds may be exchanged for and in payment and discharge of any of the outstanding obligations being refunded. The refunding bonds may be exchanged for a like, greater, or smaller principal amount of the bonds being refunded as the issuing risk management pool's board of directors may determine in its discretion. The holder or holders of the bonds being refunded need not pay accrued interest on the refunding bonds if and to the extent that interest is due or accrued and unpaid on the bonds being refunded and to be surrendered.

Source: Laws 1987, LB 398, § 29.

44-4330 Refunding bond proceeds; use.

To the extent not required for the immediate payment and retirement of the obligations being refunded or for the payment of expenses incurred in connection with such refunding and subject to any agreement with the holders of any outstanding bonds, principal proceeds from the sale of any refunding bonds shall be deposited in trust to provide for the payment and retirement of the bonds being refunded, payment of interest and any redemption premiums, and payment of any expenses incurred in connection with such refunding, but provision may be made for the pledging and disposition of any surplus, including, without limitation, provision for the pledging of any such surplus to the payment of the principal of and interest on any issue or series of refunding bonds. Money in any such trust fund may be invested in direct obligations of or obligations the principal of and interest on which are guaranteed by the United States Government, in obligations of any agency or instrumentality of the United States Government, or in certificates of deposit issued by a bank or trust company if such certificates are secured by a pledge of any of such obligations having an aggregate market value, exclusive of accrued interest, equal at least to the principal amount of the certificates so secured. Nothing in this section shall be construed as a limitation on the duration of any deposit in trust for the retirement of obligations being refunded but which shall not have matured and which are not presently redeemable or, if presently redeemable, have not been called for redemption.

Source: Laws 1987, LB 398, § 30.

44-4331 Refunding bonds; procedures applicable.

The issue of refunding bonds, the manner of sale, maturities, interest rates, form, and other details thereof, the security therefor, the rights of the holders thereof, and the rights, duties, and obligations of the risk management pool in respect of the same shall be governed by the Intergovernmental Risk Management Act relating to the issue of bonds other than refunding bonds insofar as the same may be applicable.

Source: Laws 1987, LB 398, § 31.

44-4332 Bonds; issuance; consent not required.

Bonds may be issued under the Intergovernmental Risk Management Act without obtaining the consent of any department, division, commission, board, bureau, or instrumentality of this state and without any other proceedings or the happening of any other conditions or things than those proceedings, conditions, or things which are specifically required by the Intergovernmental Risk Management Act, and the validity of and security for any bonds shall not be affected by the existence or nonexistence of any such consent or other proceedings, conditions, or things.

Source: Laws 1987, LB 398, § 32.

44-4333 Bonds; publication; when required.

The board of directors of a risk management pool may provide for the publication of any resolution or other proceeding adopted by it pursuant to the Intergovernmental Risk Management Act or, in lieu thereof, a notice of intention to issue bonds in a newspaper of general circulation published in the county where the principal office or place of business of the risk management pool is located or, if no newspaper is so published, then in a newspaper qualified to carry legal notices having general circulation in such county.

Source: Laws 1987, LB 398, § 33.

44-4334 Notice of intention to issue bonds; contents.

In the case of a resolution or other proceeding providing for the issuance of bonds pursuant to the Intergovernmental Risk Management Act, the board of directors of the risk management pool may, either before or after the adoption of such resolution or other proceeding, in lieu of publishing the entire resolution or other proceeding, publish a notice of intention to issue bonds under the Intergovernmental Risk Management Act, titled as such, containing:

(1) The name of the risk management pool;

(2) The purpose of the issue, including a brief description of the project and the names of the public agencies to be serviced by the project;

(3) The maximum principal amount of bonds to be issued;

(4) The maturity date or dates and maximum amount maturing on such dates;

(5) The maximum rate of interest payable on the bonds; and

(6) The time and place where a copy of the form of the resolution or other proceeding providing for the issuance of the bonds may be examined, which copy shall be at an office of the risk management pool identified in the notice,

during regular business hours of the risk management pool as described in the notice, for a period of at least thirty days after the publication of the notice.

Source: Laws 1987, LB 398, § 34.

44-4335 Bonds; issuance; right to contest.

For a period of thirty days after such publication, any person in interest shall have the right to contest the legality of such resolution or proceeding or any bonds which may be authorized thereby, any provisions made for the security and payment of such bonds, any contract of purchase, sale, or lease, or any insurance policy contract, and after such time no one shall have any cause of action to contest the regularity, formality, or legality thereof for any cause whatsoever.

Source: Laws 1987, LB 398, § 35.

44-4336 Bonds; authorized as investments.

Bonds issued pursuant to the Intergovernmental Risk Management Act are hereby made securities in which all public officers and instrumentalities of the state and all political subdivisions, insurance companies, trust companies, banks, savings and loan associations, investment companies, personal representatives, administrators, trustees, and other fiduciaries may properly and legally invest funds, including capital in their control or belonging to them. Such bonds are hereby made securities which may properly and legally be deposited with and received by any officer or instrumentality of this state or any political subdivision for any purpose for which the deposit of bonds or obligations of this state or any political subdivision thereof is now or may hereafter be authorized by law.

Source: Laws 1987, LB 398, § 36.

44-4337 Bonds; risk management pool property; tax exempt.

(1) All bonds of a risk management pool are declared to be issued for an essential public and governmental purpose and, together with interest thereon and income therefrom, shall be exempt from all taxes.

(2) The property of a risk management pool, including any pro rata share of any property owned by a risk management pool in conjunction with any other person, is declared to be public property of a public agency used for essential public and governmental purposes. Such property and the income of a risk management pool shall be exempt from all taxes of the state or any member of a risk management pool or other public agency and shall be exempt from all special assessments of any participating member of a risk management pool.

Source: Laws 1987, LB 398, § 37.

44-4338 State of Nebraska; agreement with bond holders.

The State of Nebraska does hereby pledge to and agree with the holders of any bonds and with those parties who may enter into contracts with any risk management pool or member of a risk management pool under the Intergovernmental Risk Management Act that the state will not alter, impair, or limit the rights thereby vested until the bonds, together with applicable interest, are fully met and discharged and such contracts are fully performed. Nothing contained in the act shall preclude such alteration, impairment, or limitation if

and when adequate provisions have been made by law for the protection of the holders of the bonds or persons entering into contracts with any risk management pool or member of a risk management pool. Each risk management pool and member of a risk management pool may include this pledge and undertaking for the state in such bonds or contracts.

Source: Laws 1987, LB 398, § 38.

44-4339 Act, how construed.

The Intergovernmental Risk Management Act, being necessary for the welfare of the state and its inhabitants, shall be construed liberally to effect its purpose.

Source: Laws 1987, LB 398, § 39.

ARTICLE 44

RISK RETENTION ACT

Section

44-4401 Act, how cited.

Sections 44-4401 to 44-4423 shall be known and may be cited as the Risk Retention Act.

Source: Laws 1987, LB 514, § 1; Laws 1991, LB 236, § 45.

44-4402 Purpose of act.

The purpose of the Risk Retention Act is to regulate the formation and operation of risk retention groups in this state formed under the federal Liability Risk Retention Act of 1986 and to regulate the operation of purchasing groups in this state formed under the federal Liability Risk Retention Act of 1986.

Source: Laws 1987, LB 514, § 2.

44-4403 Terms, defined.

For purposes of the Risk Retention Act, unless the context otherwise requires:

(1) Commissioner shall mean the commissioner, director, or superintendent of insurance in any other state;

(2) Completed operations liability shall mean liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by (a) any person who performs the work or (b) any person who hires an independent contractor to perform the work. The term shall include liability for activities completed or abandoned before the date of the occurrence giving rise to the liability;

(3) Department shall mean the Department of Insurance;

(4) Director shall mean the Director of Insurance;

(5) Domicile, for purposes of determining the state in which a purchasing group is domiciled, shall mean (a) for a corporation, the state in which the purchasing group is incorporated and (b) for an unincorporated entity, the state of its principal place of business;

(6) Hazardous financial condition shall mean that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to (a) meet obligations to policyholders with respect to known claims and reasonably anticipated claims or (b) pay other obligations in the normal course of business;

(7) Insurance shall mean primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state;

(8) Liability shall mean legal liability for damages, including the cost of defense, legal costs and fees, and other claim expenses, for injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of (a) any profit or nonprofit business, trade, product, services, including professional services, premises, or operations or (b) any activity of any state or local government or any agency or political subdivision thereof. The term shall not include personal risk liability, workers' compensation, and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act, 45 U.S.C. 51 et seq.;

(9) Personal risk liability shall mean liability for damages for injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in subdivision (8) of this section;

(10) Plan of operation or a feasibility study shall mean an analysis which presents the expected activities and results of a risk retention group including at a minimum:

(a) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

(b) The coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(c) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that such experience is reasonably available;

(d) Pro forma financial statements and projections;

(e) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(f) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies, and reinsurance agreements;

(g) Identification of each state in which the risk retention group has obtained or sought to obtain a charter and license and a description of its status in each such state; and

(h) Such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered and licensed for liability insurance companies authorized by the insurance laws of that state;

(11) Product liability shall mean liability for damages for any personal injury, death, emotional harm, consequential economic damage, or property damage, including damages resulting from loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product but shall not include the liability of any person for such damages if the product involved was in the possession of the person when the incident giving rise to the claim occurred;

(12) Purchasing group shall mean any group which:

(a) Has as one of its purposes the purchase of liability insurance on a group basis;

(b) Purchases such insurance only for its members and only to cover their similar or related liability exposure as described in subdivision (c) of this subdivision;

(c) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(d) Is domiciled in any state;

(13) Risk retention group shall mean a corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands:

(a) Whose primary activity consists of assuming and spreading all or part of the liability exposure of its members;

(b) That is organized for the primary purpose of conducting the activity described under subdivision (a) of this subdivision;

(c) That (i) is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state or (ii) before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been

engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as such terms were defined in the federal Product Liability Risk Retention Act of 1981 before the date of the enactment of the Risk Retention Act of 1986;

(d) That does not exclude any person from membership in a group solely to provide members of such group a competitive advantage over such person;

(e) That (i) has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group or (ii) has as its sole owner an organization which has as (A) its members only persons who comprise the membership of the risk retention group and (B) its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(f) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations;

(g) Whose activities do not include the provision of insurance other than (i) liability insurance for assuming and spreading all or any portion of the liability of its group members and (ii) reinsurance with respect to the liability of any other risk retention group or any members of such other group that is engaged in businesses or activities so that such group or member meets the requirement described in subdivision (f) of this subdivision from membership in the risk retention group which provides such reinsurance; and

(h) The name of which includes the phrase Risk Retention Group; and

(14) State shall mean any state of the United States or the District of Columbia.

Source: Laws 1987, LB 514, § 3; Laws 1991, LB 236, § 46.

44-4404 Risk retention group; charter and license requirements; governance standards; material service provider contract; term; audit committee; written charter; waiver of requirement; code of business conduct and ethics.

(1) A risk retention group seeking to be chartered and licensed in this state shall be chartered and licensed as a liability insurance company under Chapter 44 and, except as provided elsewhere in the Risk Retention Act, shall comply with all of the laws, rules, and regulations applicable to such insurers chartered and licensed in this state and with sections 44-4405 to 44-4413 to the extent such requirements are not a limitation on laws, rules, or regulations of this state.

(2) Before a risk retention group may offer insurance in any state, it shall submit for approval to the director a plan of operation and revisions of such plan if the group intends to offer any additional lines of liability insurance.

(3) At the time of filing its application for a charter and license, the risk retention group shall provide to the director in summary form the following information: The identity of the initial members of the group; the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group; the amount and nature of initial capitalization; the coverages to be afforded; and the states in which the group intends to operate. Upon receipt of this informa-

tion, the director shall forward such information to the National Association of Insurance Commissioners. Providing notification to the National Association of Insurance Commissioners shall be in addition to and shall not be sufficient to satisfy the requirements of section 44-4405 or any other sections of the act.

(4) Subsections (5) through (11) of this section provide governance standards for risk retention groups licensed and chartered in this state. Any risk retention group in existence on January 1, 2017, shall be in compliance with such standards by January 1, 2018. Any risk retention group that is initially licensed on or after January 1, 2017, shall be in compliance with such standards at the time of licensure.

(5)(a) For purposes of this subsection:

(i) Board of directors or board means the governing body of the risk retention group elected by the shareholders or members to establish policy, elect or appoint officers and committees, and make other governing decisions; and

(ii) Director means a natural person designated in the articles of the risk retention group or designated, elected, or appointed by any other manner, name, or title to act as a director.

(b) The board of directors of the risk retention group shall have a majority of independent directors. If the risk retention group is a reciprocal, then the attorney in fact would be required to adhere to the same standards regarding independence of operation and governance as imposed on the risk retention group's board of directors or subscribers advisory committee under this subsection. To the extent permissible under state law, service providers of a reciprocal risk retention group should contract with the risk retention group and not the attorney in fact.

(c) No director qualifies as independent unless the board of directors affirmatively determines that the director has no material relationship with the risk retention group. Each risk retention group shall disclose these determinations to its domestic regulator at least annually. For this purpose, any person that is a direct or indirect owner of or subscriber in the risk retention group, or is an officer, director, or employee of such an owner and insured unless some other position of such officer, director, or employee constitutes a material relationship, as contemplated by section 3901(a)(4)(E)(ii) of the federal Liability Risk Retention Act of 1986, is considered to be independent.

(d) Material relationship of a person with the risk retention group includes, but is not limited to:

(i) The receipt in any one twelve-month period of compensation or payment of any other item of value by such person, a member of such person's immediate family, or any business with which such person is affiliated from the risk retention group or a consultant or service provider to the risk retention group is greater than or equal to five percent of the risk retention group's gross written premium for such twelve-month period or two percent of its surplus, whichever is greater, as measured at the end of any fiscal quarter falling in such a twelve-month period. Such person or immediate family member of such person is not independent until one year after his or her compensation from the risk retention group falls below the threshold;

(ii) A relationship with an auditor as follows: A director or an immediate family member of a director who is affiliated with or employed in a professional capacity by a present or former internal or external auditor of the risk retention

group is not independent until one year after the end of the affiliation, employment, or auditing relationship; and

(iii) A relationship with a related entity as follows: A director or immediate family member of a director who is employed as an executive officer of another company where any of the risk retention group's present executives serve on that other company's board of directors is not independent until one year after the end of such service or the employment relationship.

(6)(a) The term of any material service provider contract with the risk retention group shall not exceed five years. Any such contract, or its renewal, shall require the approval of the majority of the risk retention group's independent directors. The risk retention group's board of directors shall have the right to terminate any service provider, audit, or actuarial contracts at any time for cause after providing adequate notice as defined in the contract. The service provider contract is deemed material if the amount to be paid for such contract is greater than or equal to five percent of the risk retention group's annual gross written premium or two percent of its surplus, whichever is greater.

(b) For purposes of this subsection, service providers shall include captive managers, auditors, accountants, actuaries, investment advisors, lawyers, managing general underwriters, or other parties responsible for underwriting, determination of rates, collection of premiums, adjusting and settling claims, or the preparation of financial statements. Any reference to lawyers in this subdivision does not include defense counsel retained by the risk retention group to defend claims, unless the amount of fees paid to such lawyers are material as referenced in subdivision (5)(d) of this section.

(c) No service provider contract meeting the definition of material relationship contained in subdivision (5)(d) of this section shall be entered into unless the risk retention group has notified the director in writing of its intention to enter into such transaction at least thirty days prior thereto and the director has not disapproved it within such period.

(7) The risk retention group's board of directors shall adopt a written policy in the plan of operation as approved by the board that requires the board to:

(a) Assure that all owners or insureds of the risk retention group receive evidence of ownership interest;

(b) Develop a set of governance standards applicable to the risk retention group;

(c) Oversee the evaluation of the risk retention group's management, including, but not limited to, the performance of the captive manager, managing general underwriter, or other party or parties responsible for underwriting, determination of rates, collection of premiums, adjusting or settling claims, or the preparation of financial statements;

(d) Review and approve the amount to be paid for all material service providers; and

(e) Review and approve, at least annually:

(i) The risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(ii) The officers' and service providers' performance in light of those goals and objectives; and

(iii) The continued engagement of the officers and material service providers.

(8)(a) The risk retention group shall have an audit committee composed of at least three independent board members as described in subsection (5) of this section. A nonindependent board member may participate in the activities of the audit committee, if invited by the members, but cannot be a member of such committee.

(b) The audit committee shall have a written charter that defines the committee's purpose, which, at a minimum, must be to:

(i) Assist board oversight of (A) the integrity of the financial statements, (B) the compliance with legal and regulatory requirements, and (C) the qualifications, independence, and performance of the independent auditor and actuary;

(ii) Discuss the annual audited financial statements and quarterly financial statements with management;

(iii) Discuss the annual audited financial statements with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor;

(iv) Discuss policies with respect to risk assessment and risk management;

(v) Meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(vi) Review with the independent auditor any audit problems or difficulties and management's response;

(vii) Set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(viii) Require the external auditor to rotate the lead or coordinating audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing that audit so that neither individual performs audit services for more than five consecutive fiscal years; and

(ix) Report regularly to the board of directors.

(c) The domestic regulator may waive the requirement to establish an audit committee composed of independent board members if the risk retention group is able to demonstrate to the domestic regulator that it is impracticable to do so and the risk retention group's board of directors itself is otherwise able to accomplish the purposes of an audit committee as described in subdivision (8)(b) of this section.

(9) The board of directors shall adopt and disclose governance standards, where disclose means making such information available through electronic or other means, including the posting of such information on the risk retention group's website, and providing such information to members or insureds upon request, which shall include:

(a) A process by which the directors are elected by the owners or insureds;

(b) Director qualification standards;

(c) Director responsibilities;

(d) Director access to management and, as necessary and appropriate, independent advisors;

(e) Director compensation;

(f) Director orientation and continuing education;

(g) The policies and procedures that are followed for management succession; and

(h) The policies and procedures that are followed for annual performance evaluation of the board.

(10) The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers, and employees and promptly disclose to the board of directors any waivers of the code for directors or executive officers, which should include the following topics:

(a) Conflicts of interest;

(b) Matters covered under the corporate opportunities doctrine under the state of domicile;

(c) Confidentiality;

(d) Fair dealing;

(e) Protection and proper use of risk retention group assets;

(f) Compliance with all applicable laws, rules, and regulations; and

(g) Requiring the reporting of any illegal or unethical behavior which affects the operation of the risk retention group.

(11) The captive manager, president, or chief executive officer of the risk retention group shall promptly notify the domestic regulator in writing if he or she becomes aware of any material noncompliance with any of the governance standards provided in subsections (5) through (11) of this section.

Source: Laws 1987, LB 514, § 4; Laws 1991, LB 236, § 47; Laws 2016, LB772, § 15.

44-4405 Foreign risk retention groups; requirements.

Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall observe and abide by the laws of this state as follows:

(1) Before offering insurance in this state, a risk retention group shall submit to the director:

(a) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, the date of chartering and licensing, its principal place of business, and such other information, including information on its membership, as the director may require to verify that the risk retention group is qualified under subdivision (13) of section 44-4403. The identity and location of specific group members shall not be considered public record, except that such information may be provided to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the documents, material, or other information. The director may receive such information regarding the identity and location of specific group members from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subdivision with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information

shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section;

(b) A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed, except that the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance which (i) was defined in the federal Product Liability Risk Retention Act of 1981 before October 27, 1986, and (ii) was offered before such date by any risk retention group which had been chartered and licensed and operating for not less than three years before such date. The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by subsection (2) of section 44-4404 at the same time that such revision is submitted to the state in which the risk retention group is chartered and licensed; and

(c) A statement of registration which designates the director as its agent for the purpose of receiving service of legal documents or process; and

(2) Any risk retention group doing business in this state shall submit to the director:

(a) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist under criteria established by the National Association of Insurance Commissioners;

(b) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(c) Upon request by the director, a copy of any audit performed with respect to the risk retention group; and

(d) Such information as may be required to verify its continuing qualification as a risk retention group under subdivision (13) of section 44-4403.

Source: Laws 1987, LB 514, § 5; Laws 1991, LB 236, § 48; Laws 2001, LB 52, § 48.

44-4406 Premiums; taxable.

All premiums paid for coverage within this state to risk retention groups shall be subject to taxation at the same rate and subject to the same interest, fines, and penalties for nonpayment as that applicable to foreign admitted insurers, and it shall be the responsibility of each risk retention group to report and pay

such taxes whether or not the group is licensed as an insurance company in this state and whether or not agents or brokers are utilized.

Source: Laws 1987, LB 514, § 6.

44-4407 Unfair trade and claims settlement practices laws; applicability.

Any risk retention group shall comply with and be subject to the Unfair Insurance Trade Practices Act and any rule or regulation issued under the act. Any risk retention group and its agents and representatives shall comply with and be subject to the Unfair Insurance Claims Settlement Practices Act and any rule or regulation issued under the act. If the director seeks an injunction regarding such conduct, the injunction shall be obtained from a court of competent jurisdiction.

Source: Laws 1987, LB 514, § 7; Laws 1991, LB 236, § 49; Laws 1991, LB 234, § 36.

Cross References

Unfair Insurance Claims Settlement Practices Act, see section 44-1536.
Unfair Insurance Trade Practices Act, see section 44-1521.

44-4408 Examination of financial condition; required.

Any risk retention group shall submit to an examination by the director to determine its financial condition if the commissioner of the state in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty days after a request by the director. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioner's Examiner Handbook.

Source: Laws 1987, LB 514, § 8; Laws 1991, LB 236, § 50.

44-4409 Notice; required.

Any application form for insurance from a risk retention group and any policy issued by a risk retention group shall contain, in ten-point type on the front page and the declaration page, the following notice:

NOTICE

THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

Source: Laws 1987, LB 514, § 9; Laws 1991, LB 236, § 51.

44-4410 Prohibited acts.

A risk retention group shall not:

(1) Solicit or sell insurance to any person who is not eligible for membership in such group; or

(2) Solicit or sell insurance or operate in a hazardous financial condition or financially impaired condition.

Source: Laws 1987, LB 514, § 10.

44-4411 Member or owner; prohibitions.

A risk retention group shall not do business in this state if an insurance company is directly or indirectly a member or owner of such group, other than in the case of a risk retention group all of whose members are insurance companies.

Source: Laws 1987, LB 514, § 11.

44-4412 Insurance coverage; prohibitions.

A risk retention group may not offer insurance coverage prohibited by Chapter 44 or declared unlawful by the Supreme Court.

Source: Laws 1987, LB 514, § 12.

44-4413 Financial impairment; compliance with order.

A risk retention group which is not chartered and licensed in this state and which is doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the director or the commissioner of any other state if there has been a finding of financial impairment after an examination under section 44-4408.

Source: Laws 1987, LB 514, § 13; Laws 1991, LB 236, § 52.

44-4414 Guaranty fund; membership; coverage.

(1) A risk retention group shall not join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state nor shall any risk retention group or its insureds receive any benefit from any such fund for claims arising out of operations of such risk retention group.

(2) When a purchasing group obtains insurance covering its members' risks from an insurer not admitted in this state or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance insolvency guaranty fund or similar mechanism in this state.

(3) When a purchasing group obtains insurance covering its members' risks from an insurer admitted in this state, only risks resident or located in this state shall be covered by the Nebraska Property and Liability Insurance Guaranty Association Act.

Source: Laws 1987, LB 514, § 14; Laws 1991, LB 236, § 53.

Cross References

Nebraska Property and Liability Insurance Guaranty Association Act, see section 44-2418.

44-4415 Repealed. Laws 1999, LB 260, § 17.

44-4416 Purchasing group; exemption from insurance laws; when.

Any purchasing group meeting the criteria established under the federal Liability Risk Retention Act of 1986 shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance or to the prohibition of group purchasing or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state which prohibits providing or offering to provide to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms,

coverages, or other matters. A purchasing group shall be subject to all other applicable laws of this state.

Source: Laws 1987, LB 514, § 16.

44-4417 Purchasing group; notice; requirements; registration fees.

(1) A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the director which shall:

(a) Identify the state in which the purchasing group is domiciled;

(b) Identify all other states in which the purchasing group intends to do business;

(c) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(d) Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company;

(e) Specify the method by which and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(f) Identify the principal place of business of the group; and

(g) Provide such other information as may be required by the director to verify that the purchasing group is qualified under subdivision (12) of section 44-4403.

(2) A purchasing group which intends to do business in this state shall include an initial registration fee of one hundred dollars at the time it furnishes notice to the director pursuant to subsection (1) of this section. A purchasing group shall pay an additional fee of one hundred dollars to the director on October 1 of each year thereafter so long as such registration continues. The fees required by this subsection shall be payable to the department and shall be remitted to the State Treasurer for credit to the Department of Insurance Cash Fund.

(3) A purchasing group shall, within ten days, notify the director of any changes in the items set forth in subsection (1) of this section.

(4) A purchasing group shall register with and designate the director as its agent solely for the purpose of receiving service of legal documents or process, except that such requirement shall not apply in the case of a purchasing group that:

(a) Was domiciled before April 1, 1986, and is domiciled on and after October 27, 1986, in any state of the United States;

(b) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state;

(c) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state;

(d) Was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(e) Does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981 as in effect before October 27, 1986.

(5) Each purchasing group that is required to give notice pursuant to subsection (1) of this section shall also furnish such information as may be required by the director to:

(a) Verify that the entity qualifies as a purchasing group;

(b) Determine where the purchasing group is located; and

(c) Determine appropriate tax treatment.

Source: Laws 1987, LB 514, § 17; Laws 1991, LB 236, § 54; Laws 1994, LB 978, § 30.

44-4418 Purchasing group; purchase of insurance; authorized; when.

(1) A purchasing group shall not purchase insurance from a risk retention group that is not chartered and licensed in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws, rules, and regulations of such state, except that such licensed agent or broker need not be a resident of this state.

(2) A purchasing group which obtains liability insurance from an insurer not admitted in this state or from a risk retention group shall inform each of the members of the purchasing group which have a risk resident or located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state and that such risk retention group or such insurer may not be subject to all insurance laws, rules, and regulations of this state.

(3) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole, but coverage may provide for a deductible or self-insured retention applicable to individual members.

(4) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

Source: Laws 1987, LB 514, § 18; Laws 1991, LB 236, § 55.

44-4418.01 Purchasing group; premium taxes.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing group shall be:

(1) Imposed at the same rate and subject to the same interest, fines, and penalties as applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(2) Paid first by such insurance source if an insurer admitted in this state and, if not an insurer admitted in this state, by the surplus lines licensee acting as agent or broker for the purchasing group.

Source: Laws 1991, LB 236, § 56.

44-4419 Director; administrative powers.

The director may make use of any of the powers established under Chapter 44 to enforce the laws of this state if those powers are not specifically preempted by the federal Product Liability Risk Retention Act of 1981 as amended by the Risk Retention Amendments of 1986. Such powers shall

include, but not be limited to, administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and impose penalties. With regard to any investigation, administrative proceedings, or litigation, the director may rely on the procedural law, rules, and regulations of this state. The injunctive authority of the director in regard to risk retention groups shall be restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

Source: Laws 1987, LB 514, § 19.

44-4420 Violations; penalties.

A risk retention group which violates any provision of the Risk Retention Act shall be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license to do business in this state.

Source: Laws 1987, LB 514, § 20.

44-4421 Sale or purchase of insurance; requirements.

(1) Any person other than a licensed surplus lines licensee acting or offering to act as an insurance producer for a risk retention group or purchasing group which solicits members, sells insurance coverage, purchases coverage for its members located within this state, or otherwise does business in this state shall, before commencing any such activity, obtain a license from the director pursuant to the Insurance Producers Licensing Act.

(2) Every person, firm, association, or corporation licensed pursuant to the Insurance Producers Licensing Act, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by section 44-4409 in the case of a risk retention group and subsection (2) of section 44-4418 in the case of a purchasing group.

Source: Laws 1987, LB 514, § 21; Laws 1989, LB 92, § 269; Laws 1991, LB 236, § 57; Laws 2001, LB 51, § 35.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-4422 Federal order; enforceable.

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state, in all states, or in any territory or possession of the United States upon a finding that such group is in a hazardous financial condition shall be enforceable in the courts of this state.

Source: Laws 1987, LB 514, § 22.

44-4423 Rules and regulations.

The director shall adopt and promulgate rules and regulations relating to risk retention groups necessary to carry out the Risk Retention Act.

Source: Laws 1987, LB 514, § 23.

ARTICLE 45
LONG-TERM CARE INSURANCE ACT

44-4501 Act, how cited.

Sections 44-4501 to 44-4521 shall be known and may be cited as the Long-Term Care Insurance Act.

Source: Laws 1987, LB 416, § 1; Laws 1992, LB 1006, § 44; Laws 1999, LB 323, § 1; Laws 2007, LB117, § 9.

44-4502 Purpose of act.

The purposes of the Long-Term Care Insurance Act are to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

Source: Laws 1987, LB 416, § 2.

44-4503 Long-term care insurance; applicability of acts.

The Long-Term Care Insurance Act shall apply to policies delivered or issued for delivery in this state on or after May 30, 1987, and shall not supersede the obligations of entities subject to the act to comply with the provisions of Chapter 44 insofar as such provisions do not conflict with the Long-Term Care Insurance Act, except that the Medicare Supplement Insurance Minimum Standards Act shall not apply to long-term care insurance. Any product adver-

tised, marketed, or offered as long-term care insurance shall be subject to the Long-Term Care Insurance Act.

Source: Laws 1987, LB 416, § 3; Laws 1988, LB 998, § 13; Laws 1992, LB 1006, § 45.

Cross References

Medicare Supplement Insurance Minimum Standards Act, see section 44-3601.

44-4504 Definitions, sections found.

As used in the Long-Term Care Insurance Act, unless the context otherwise requires, the definitions found in sections 44-4505 to 44-4510 shall be used.

Source: Laws 1987, LB 416, § 4.

44-4505 Applicant, defined.

Applicant shall mean (1) in the case of an individual policy, the person who seeks to contract for such benefits and (2) in the case of a group policy, the proposed certificate holder.

Source: Laws 1987, LB 416, § 5.

44-4506 Certificate, defined.

Certificate shall mean any certificate issued under a group policy, which policy has been delivered or issued for delivery in this state.

Source: Laws 1987, LB 416, § 6.

44-4507 Director, defined.

Director shall mean the Director of Insurance.

Source: Laws 1987, LB 416, § 7.

44-4508 Group policy, defined.

Group policy shall mean a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(1) One or more employers or labor organizations or a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations;

(2) Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if such association:

(a) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(b) Has been maintained in good faith for purposes other than obtaining insurance;

(3) An association or a trust or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations. Prior to advertising, marketing, or offering such policy within this state, the association or associations or the insurer of the association or associations shall file evidence with the director that the association or associations have at the outset a minimum of one hundred members, have been organized and maintained in

good faith for purposes other than that of obtaining insurance, have been in active existence for at least one year, and have a constitution and bylaws which provide that (a) the association or associations hold regular meetings not less than annually to further purposes of the members, (b) except for credit unions, the association or associations collect dues or solicit contributions from members, and (c) the members have voting privileges and representation on the governing board and committees. Thirty days after such filing, the association or associations shall be deemed to satisfy such organizational requirements unless the director makes a finding that the association or associations do not satisfy those organizational requirements; or

(4) A group other than as described in subdivision (1), (2), or (3) of this section, subject to a finding by the director that:

(a) The issuance of the group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged.

Source: Laws 1987, LB 416, § 8; Laws 1989, LB 92, § 270.

44-4509 Long-term care insurance, defined.

Long-term care insurance shall mean any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance shall include group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Long-term care insurance shall also include a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers, fraternal benefit societies, prepaid health plans, health maintenance organizations, or any similar organizations to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited-benefit health coverage. Long-term care insurance shall not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

Source: Laws 1987, LB 416, § 9; Laws 1989, LB 92, § 271; Laws 1992, LB 1006, § 46.

44-4510 Policy, defined.

Policy shall mean any individual or group policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, prepaid health plan, health maintenance organization, or any similar organization.

Source: Laws 1987, LB 416, § 10; Laws 1989, LB 92, § 272.

44-4511 Insurance; offer; restrictions.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in subdivision (4) of section 44-4508 unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

Source: Laws 1987, LB 416, § 11.

44-4512 Rules and regulations for disclosure.

The director may adopt and promulgate reasonable rules and regulations in accordance with the Administrative Procedure Act that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions of terms.

Source: Laws 1987, LB 416, § 12; Laws 1989, LB 92, § 273.

Cross References

Administrative Procedure Act, see section 84-920.

44-4513 Policy; certificate; restrictions.

(1) No long-term care insurance policy may:

(a) Be canceled, refused renewal, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(2) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as defined in subdivision (1) of section 44-4508, shall use a definition of preexisting condition which is more restrictive than the following: Preexisting condition shall mean a condition for which medical advice or treatment was recommended by or received from a provider of health care services within six months preceding the effective date of coverage of an insured person.

(3) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as defined in subdivision (1) of section 44-4508, may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(4) The director may extend the limitation periods set forth in subsections (2) and (3) of this section as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(5) The definition of preexisting condition shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with such insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (3) of this section expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (3) of this section.

(6) No long-term care insurance policy may be delivered or issued for delivery in this state if such policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care, or recuperative benefits on a prior institutionalization requirement.

(7)(a) A long-term care insurance policy containing postconfinement, postacute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled Limitations or Conditions on Eligibility for Benefits such limitations or conditions, including any required number of days of confinement.

(b) A long-term care insurance policy which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

Source: Laws 1987, LB 416, § 13; Laws 1989, LB 295, § 1; Laws 1992, LB 1006, § 47.

44-4514 Rules and regulations for loss-ratio standards.

The director may adopt and promulgate rules and regulations establishing loss-ratio standards for long-term care insurance policies if a specific reference to long-term care insurance policies is contained in such rules or regulations.

Source: Laws 1987, LB 416, § 14.

44-4515 Applicants; rights.

Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium

refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate other than a certificate issued to a group as defined in subdivision (1) of section 44-4508, the applicant is not satisfied for any reason.

Source: Laws 1987, LB 416, § 15; Laws 1989, LB 295, § 2; Laws 1992, LB 1006, § 48.

44-4516 Outline of coverage; required; contents.

(1)(a) An outline of coverage shall be delivered to a prospective applicant at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(b) The director shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

(c) In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(d) In the case of direct-response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of group coverage shall be specifically described;

(d) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(f) A brief description of the relationship of cost of care and benefits.

(3) A certificate issued pursuant to a group policy that is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the group master policy contains governing contractual provisions.

(4) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct-response solicitations, the insurer

shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. The summary shall include:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

(c) Any exclusions, reductions, and limitations on benefits of long-term care; and

(d) If applicable to the policy type:

(i) A disclosure of the effects of exercising other rights under the policy;

(ii) A disclosure of guarantees related to long-term care costs of insurance charges; and

(iii) Current and projected maximum lifetime benefits.

(5) Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit-payment status, a monthly report shall be provided to the policyholder. Such report shall include:

(a) Any long-term care benefits paid out during the month;

(b) An explanation of any changes in the policy, such as death benefits or cash values, due to long-term care benefits being paid out; and

(c) The amount of long-term care benefits existing or remaining.

Source: Laws 1987, LB 416, § 16; Laws 1992, LB 1006, § 49.

44-4517 Compliance with act.

Any policy or rider advertised, marketed, or offered as long-term care insurance or nursing home insurance shall comply with the Long-Term Care Insurance Act.

Source: Laws 1987, LB 416, § 17; Laws 1992, LB 1006, § 50.

44-4517.01 Policy or certificate; claim denial; grounds; exception; issuance restriction.

(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

(3) After a policy or certificate has been in force for two years it is not contestable upon the grounds of misrepresentation alone. Such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(4)(a) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(b) For purposes of this section, field issued means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third-party administrator by an insurer.

(5) If an insurer has paid benefits under a long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(6) In the event of the death of the insured, this section shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the remaining death benefits under these policies shall be governed by section 44-502. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

Source: Laws 1999, LB 323, § 2.

44-4517.02 Policy or certificate; nonforfeiture benefits.

(1) Except as provided in subsection (2) of this section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.

(2) When a group long-term care insurance policy is issued, the offer required in subsection (1) of this section shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

(3) The director shall adopt and promulgate rules and regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates and the standards for nonforfeiture benefits.

Source: Laws 1999, LB 323, § 3.

44-4518 Director; duties.

The director shall adopt and promulgate rules and regulations to promote premium adequacy, to protect the policyholder in the event of substantial rate increases, and to establish minimum standards for marketing practices, agent compensation, agent testing, penalties, and reporting practices for long-term care insurance.

Source: Laws 1992, LB 1006, § 51; Laws 1999, LB 323, § 4.

44-4519 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Long-Term Care Insurance Act, including minimum standards for insurance producer training.

Source: Laws 1992, LB 1006, § 53; Laws 2007, LB117, § 11.

44-4520 Violations; administrative penalty.

In addition to any other penalties provided by the laws of this state, any insurer or agent found by the director to have violated the Long-Term Care Insurance Act or any rule or regulation shall be subject to an administrative penalty of up to three times the amount of any commissions paid for each

policy involved in the violation or up to ten thousand dollars, whichever is greater.

Source: Laws 1992, LB 1006, § 52.

44-4521 Sale, solicitation, or negotiation of long-term care insurance; license required; training course; insurer; duties; records.

(1) On or after August 1, 2008, an individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for health or sickness and accident insurance and has completed a one-time training course and ongoing training every twenty-four months thereafter. All training shall meet the requirements of subsection (2) of this section.

(2) The one-time training course required by subsection (1) of this section shall be no less than eight hours in length, and the required ongoing training shall be no less than four hours in length. All training required under subsection (1) of this section shall consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term insurance partnership programs, including, but not limited to:

(a) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(b) Available long-term care services and providers;

(c) Changes or improvements in long-term care services or providers;

(d) Alternatives to the purchase of private long-term care insurance;

(e) The effect of inflation on benefits and the importance of inflation protection; and

(f) Consumer suitability standards and guidelines.

Training required by subsection (1) of this section shall not include any sales or marketing information, materials, or training other than those required by state or federal law.

(3)(a) Insurers subject to the Long-Term Care Insurance Act shall obtain verification that the insurance producer receives training required by subsection (1) of this section before a producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products. Records shall be maintained in accordance with section 44-5905 and shall be made available to the director upon request.

(b) Insurers subject to the act shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the director to provide assurance to the Department of Health and Human Services that producers have received the training required by subsection (1) of this section and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care, including medicaid, in this state. These records shall be maintained in accordance with section 44-5905 and shall be made available to the director upon request.

(4) The satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements of the State of Nebraska.

(5) The training requirements of subsection (1) of this section may be approved as continuing education activities pursuant to sections 44-3901 to 44-3908.

Source: Laws 2007, LB117, § 10; Laws 2008, LB855, § 28; Laws 2018, LB743, § 27.

ARTICLE 46

DATA REPORTING

Section
44-4601. Repealed. Laws 2000, LB 1119, § 46.
44-4602. Repealed. Laws 2000, LB 1119, § 46.
44-4603. Repealed. Laws 2000, LB 1119, § 46.
44-4604. Repealed. Laws 2000, LB 1119, § 46.
44-4605. Repealed. Laws 2000, LB 1119, § 46.
44-4606. Repealed. Laws 2000, LB 1119, § 46.
44-4607. Repealed. Laws 2000, LB 1119, § 46.

44-4601 Repealed. Laws 2000, LB 1119, § 46.

44-4602 Repealed. Laws 2000, LB 1119, § 46.

44-4603 Repealed. Laws 2000, LB 1119, § 46.

44-4604 Repealed. Laws 2000, LB 1119, § 46.

44-4605 Repealed. Laws 2000, LB 1119, § 46.

44-4606 Repealed. Laws 2000, LB 1119, § 46.

44-4607 Repealed. Laws 2000, LB 1119, § 46.

ARTICLE 47

PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS

Section
44-4701. Act, how cited.
44-4702. Terms, defined.
44-4703. Certificate of authority; required.
44-4704. Application for certificate of authority; contents.
44-4705. Issuance of certificate of authority; conditions; denial.
44-4706. Effect on organizations operating without a certificate of authority.
44-4707. Filing requirements for authorized entities; disapproval.
44-4708. Changes in rates or benefits; material modifications; addition of a limited health service; notices; hearing.
44-4709. Evidence of coverage.
44-4710. Rates and charges.
44-4711. Construction with other laws.
44-4712. Nonduplication of coverage.
44-4713. Complaint system.
44-4714. Examination of organization.
44-4715. Investments.
44-4716. Agents.
44-4717. Provider agreements.
44-4718. Equity requirements.
44-4719. Officers and employees; fidelity bond or deposit.
44-4720. Reports required; contents; fine.
44-4721. Suspension or revocation of certificate of authority.
44-4722. Violations; cease and desist order; penalty.

44-4701 Act, how cited.

Sections 44-4701 to 44-4727 shall be known and may be cited as the Prepaid Limited Health Service Organization Act.

Source: Laws 1989, LB 320, § 1.

44-4702 Terms, defined.

For purposes of the Prepaid Limited Health Service Organization Act:

(1) Director shall mean the Director of Insurance;

(2) Enrollee shall mean an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under the act;

(3) Evidence of coverage shall mean any certificate, agreement, or contract issued pursuant to section 44-4709 setting forth the coverage to which an enrollee is entitled;

(4) Limited health services shall mean dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the director to be limited health services. Limited health services shall not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health services set forth in this subdivision;

(5) Prepaid limited health service organization shall mean any corporation, partnership, limited liability company, or other entity which, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Prepaid limited health service organization shall not include (a) an entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service, (b) an entity that meets the requirements of section 44-4707, or (c) a provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in subdivision (5)(a) or (b) of this section;

(6) Provider shall mean any physician, dentist, health facility, or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services; and

(7) Subscriber shall mean the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under the act.

Source: Laws 1989, LB 320, § 2; Laws 1993, LB 121, § 254.

44-4703 Certificate of authority; required.

No person, corporation, partnership, limited liability company, or other entity may operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the director pursuant to the Prepaid Limited Health Service Organization Act.

Source: Laws 1989, LB 320, § 3; Laws 1993, LB 121, § 255.

44-4704 Application for certificate of authority; contents.

An application for a certificate of authority to operate as a prepaid limited health service organization shall be filed with the director on a form prescribed by the director. Such application shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by the following:

(1) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, articles of organization, partnership agreement, trust agreement, or other applicable documents and all amendments to such documents;

(2) A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant, and the partners or members in the case of a partnership, limited liability company, or association;

(4) A statement generally describing the applicant, its facilities and personnel, and the limited health services to be offered;

(5) A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) A copy of the form of any contract made or to be made between the applicant and any person listed in subdivision (3) of this section;

(7) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, limited liability company, or other entity for the performance on the applicant's behalf of any functions, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of limited health services to enrollees;

(8) A copy of the form of any group contract which is to be issued to employers, unions, trustees, or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) A copy of the most recent financial statements of the applicant audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the director

determines that additional or more recent financial information is required for the proper administration of the Prepaid Limited Health Service Organization Act;

(10) A financial plan which includes a three-year projection of anticipated operating results, a statement of the sources of working capital, any other sources of funding, and provisions for contingencies;

(11) A schedule of rates and charges;

(12) A description of the proposed method of marketing;

(13) A description of the complaint procedures to be utilized as required under section 44-4713;

(14) A description of the quality assessment and utilization review procedures to be utilized by the applicant;

(15) A description of how the applicant will comply with section 44-4718;

(16) The fee for issuance of a certificate of authority provided in section 44-4724; and

(17) Such other information as the director may reasonably require to make the determinations required by the act.

Source: Laws 1989, LB 320, § 4; Laws 1993, LB 121, § 256.

44-4705 Issuance of certificate of authority; conditions; denial.

(1) Following receipt of an application filed pursuant to section 44-4704, the director shall review such application and notify the applicant of deficiencies therein. The director shall issue a certificate of authority if the following conditions are met:

(a) The requirements of section 44-4704 have been fulfilled;

(b) The individuals responsible for the conduct of the affairs of the applicant are competent and trustworthy, possess good reputations, and have had appropriate experience, training, or education;

(c) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the director may consider:

(i) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith;

(ii) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(iii) Any agreement providing for payment of the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization; and

(iv) The manner in which the requirements of section 44-4718 have been fulfilled;

(d) The agreements with providers for the provision of limited health services contain the provisions required by section 44-4717; and

(e) Any deficiencies identified by the director have been corrected.

(2) If the certificate of authority is denied, the director shall notify the applicant by certified mail and shall specify the reasons for denial in the notice.

The prepaid limited health service organization shall have ten days from the date of receipt of the notice to request a hearing before the director pursuant to the Administrative Procedure Act.

Source: Laws 1989, LB 320, § 5.

Cross References

Administrative Procedure Act, see section 84-920.

44-4706 Effect on organizations operating without a certificate of authority.

Within one hundred eighty days after August 25, 1989, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the director. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant shall then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

Source: Laws 1989, LB 320, § 6.

44-4707 Filing requirements for authorized entities; disapproval.

(1) Any entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, or a fraternal benefit society and which is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the director the information described in subdivisions (4), (5), (7), (8), (10), (11), (12), and (14) of section 44-4704 and any subsequent material modification or addition thereto.

(2) If the director disapproves the filing, the procedures set forth in subsection (2) of section 44-4705 shall be followed.

Source: Laws 1989, LB 320, § 7.

44-4708 Changes in rates or benefits; material modifications; addition of a limited health service; notices; hearing.

(1) A prepaid limited health service organization shall file with the director prior to use a notice of any change in rates, charges, or benefits and of any material modification of any matter or document furnished pursuant to section 44-4704, together with such supporting documents as are necessary to fully explain the change or modification. If the director does not disapprove such filing within thirty days of its filing, such filing shall be deemed approved.

(2) If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the director and, at the same time, shall submit the information required by section 44-4704 if different from that filed with the prepaid limited health service organization's application and shall demonstrate compliance with sections 44-4717, 44-4718, and 44-4724. If the director does not disapprove such filing within thirty days of its filing, such filing shall be deemed approved.

(3) If the director does not approve the change, modification, or addition of a limited health service, the director shall notify the prepaid limited health service organization by certified mail and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization shall have

ten days from the date of receipt of the notice to request a hearing before the director pursuant to the Administrative Procedure Act.

Source: Laws 1989, LB 320, § 8.

Cross References

Administrative Procedure Act, see section 84-920.

44-4709 Evidence of coverage.

(1) Every subscriber shall be issued an evidence of coverage which shall contain a clear and complete statement of:

(a) The services to which each enrollee is entitled;

(b) Any limitation of the services, kind of services, or benefits to be provided and exclusions, including any deductible, copayment, or other charges;

(c) Where and in what manner information is available as to where and how services may be obtained; and

(d) The method for resolving complaints.

(2) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

Source: Laws 1989, LB 320, § 9.

44-4710 Rates and charges.

The rates and charges shall be reasonable in relation to the services provided. The director may request a statement from the prepaid limited health service organization describing the appropriateness of the rates and charges.

Source: Laws 1989, LB 320, § 10.

44-4711 Construction with other laws.

(1) A prepaid limited health service organization shall be subject to the Unfair Insurance Trade Practices Act and the Unfair Insurance Claims Settlement Practices Act. No other provision of Chapter 44 shall apply unless specifically mentioned in the Prepaid Limited Health Service Organization Act or unless prepaid limited health service organizations are specifically mentioned in the provisions of Chapter 44.

(2) The provision of limited health services by a prepaid limited health service organization or other entity pursuant to the Prepaid Limited Health Service Organization Act shall not be deemed to be the practice of medicine or other healing arts.

(3) Solicitation to arrange for or provide limited health services in accordance with the Prepaid Limited Health Service Organization Act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(4) A prepaid limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of the Insurance Holding Company System Act unless specifically exempted in writing from one or more of the provisions of the act by the director.

Source: Laws 1989, LB 320, § 11; Laws 1991, LB 236, § 58; Laws 1991, LB 234, § 38.

Cross References

Insurance Holding Company System Act, see section 44-2120.
Unfair Insurance Claims Settlement Practices Act, see section 44-1536.
Unfair Insurance Trade Practices Act, see section 44-1521.

44-4712 Nonduplication of coverage.

Notwithstanding any other law of this state, no prepaid limited health service organization, health maintenance organization, accident and health insurance company, or fraternal benefit society shall be required to include, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, which is provided in accordance with the Prepaid Limited Health Service Organization Act under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, or a fraternal benefit society.

Source: Laws 1989, LB 320, § 12.

44-4713 Complaint system.

Every prepaid limited health service organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by enrollees or providers. This section shall not be construed to preclude an enrollee or a provider from filing a complaint with the director or as limiting the director's ability to investigate such complaints.

Source: Laws 1989, LB 320, § 13.

44-4714 Examination of organization.

(1) The director may make an examination of the affairs of any prepaid limited health service organization as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every four years.

(2) Every prepaid limited health service organization shall make its relevant books and records available for such examination and in every way cooperate with the director to facilitate such examination.

(3) The expenses of examinations under this section shall be charged to the prepaid limited health service organization being examined, and the prepaid limited health service organization shall remit the charges to the director.

(4) In lieu of such examination, the director may accept the report of an examination made by the chief administrative officer of an insurance department of another state.

Source: Laws 1989, LB 320, § 14.

44-4715 Investments.

The funds of a prepaid limited health service organization shall be invested only in cash, certificates of deposit, or obligations of a state or of the United States.

Source: Laws 1989, LB 320, § 15.

44-4716 Agents.

No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license pursuant to the Insurance Producers Licensing Act to sell accident and health insurance policies or health maintenance organization contracts.

Source: Laws 1989, LB 320, § 16.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-4717 Provider agreements.

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

(1) In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including, but not limited to, insolvency or breach of this contract, the enrollees shall not be liable to the provider for any sums owed to the provider under this contract;

(2) No provider or an agent, trustee, or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization;

(3) These provisions shall not prohibit collection of copayments from enrollees;

(4) These provisions shall survive the termination of this contract, regardless of the reason giving rise to the termination;

(5) Termination of this contract shall not release the provider from the obligations and duties imposed by this contract to complete procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed thirty days at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of this contract; and

(6) Any amendment to the provisions of this contract shall be submitted to and be approved by the director prior to becoming effective.

Source: Laws 1989, LB 320, § 17.

44-4718 Equity requirements.

(1) Each prepaid limited health service organization shall, at all times, have and maintain a tangible net equity at least equal to the greater of (a) fifty thousand dollars or (b) two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

(2) A prepaid limited health service organization that has uncovered expenses in excess of fifty thousand dollars, as reported on the most recent annual financial statement filed with the director, shall maintain tangible net equity equal to twenty-five percent of the uncovered expense in excess of fifty thousand dollars in addition to the tangible net equity required by subsection (1) of this section.

(3) For the purpose of this section: (a) Net equity shall mean the excess of total assets over total liabilities, excluding liabilities which have been subordi-

nated in a manner acceptable to the director; and (b) tangible net equity shall mean net equity reduced by the value assigned to intangible assets, including, but not limited to: (i) Goodwill; (ii) going-concern value; (iii) organizational expense; (iv) starting-up costs; (v) obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due; (vi) long-term prepayments of deferred charges; and (vii) nonreturnable deposits.

(4)(a) Each prepaid limited health service organization shall deposit, with the director or with any organization or trustee acceptable to the director through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the director in an amount equal to twenty-five thousand dollars plus twenty-five percent of the tangible net equity required in subsection (1) of this section not to exceed one hundred thousand dollars.

(b) The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.

(c) All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the director before being substituted.

(d) The deposit shall be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to the liquidation laws of the state.

(e) The director may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the director a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

(5) Upon application by a prepaid limited health service organization, the director may waive some or all of the requirements of subsection (1) of this section for any period of time the director deems proper upon a finding that either (a) the prepaid limited health service organization has a net equity of five million dollars or more or (b) an entity having a net equity of five million dollars or more furnishes to the director a written commitment which is acceptable to the director to provide for the uncovered expenses of the prepaid limited health service organization. For the purposes of this subsection, uncovered expense shall mean the cost of limited health services that are the obligation of a prepaid limited health service organization (i) for which an enrollee may be liable in the event of the insolvency of the organization and (ii) for which alternative arrangements acceptable to the director have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, shall be considered covered expenses.

Source: Laws 1989, LB 320, § 18.

44-4719 Officers and employees; fidelity bond or deposit.

(1) A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than fifty thousand dollars or in any other amount prescribed by the director. Except as otherwise provided by subsection (2) of this section, the bond shall be issued by an insurance company that is licensed to do business in this state, or if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a surplus lines licensee resident in this state in compliance with section 44-5504 shall satisfy the requirements of this subsection.

(2) In lieu of the bond specified in subsection (1) of this section, a prepaid limited health service organization may deposit with the director fifty thousand dollars in cash or securities or other investments of the types set forth in section 44-4715. Such a deposit shall be maintained in joint custody with the director in the amount and subject to the same conditions required for a bond under this section.

Source: Laws 1989, LB 320, § 19; Laws 1992, LB 1006, § 54.

44-4720 Reports required; contents; fine.

(1) Every prepaid limited health service organization shall file with the director annually, on or before March 1, a report verified by at least two principal officers covering the preceding calendar year.

(2) Such report shall be on forms prescribed by the director and shall include:

(a) A financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, audited by an independent certified public accountant, or the director may in lieu of such statement accept a consolidated audited financial statement of its parent company audited by an independent certified public accountant, attached to which shall be consolidating financial statements of the prepaid limited health service organization;

(b) Any material changes in the information submitted pursuant to section 44-4704;

(c) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(d) Such other information relating to the performance of the prepaid limited health service organization as is necessary to enable the director to carry out his or her duties under the Prepaid Limited Health Service Organization Act.

(3) The director may require more frequent reports containing such information as is necessary to enable the director to carry out his or her duties under the act.

(4) The director may assess a fine of up to one hundred dollars per day for each day any required report is late, and the director may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Source: Laws 1989, LB 320, § 20.

44-4721 Suspension or revocation of certificate of authority.

(1) The director may suspend or revoke any certificate of authority issued to a prepaid limited health service organization pursuant to the Prepaid Limited Health Service Organization Act upon determining that any of the following conditions exists:

(a) The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to section 44-4704 unless amendments to such submissions have been filed with and approved by the director;

(b) The prepaid limited health service organization issues an evidence of coverage or uses rates or charges which do not comply with the requirements of section 44-4709 or 44-4710;

(c) The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services;

(d) The prepaid limited health service organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(e) The prepaid limited health service organization has failed to implement the complaint system required by section 44-4713 in a reasonable manner to resolve valid complaints;

(f) The continued operation of the prepaid limited health service organization would be hazardous to its enrollees;

(g) The tangible net equity of the prepaid limited health service organization is less than that required by section 44-4718 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the director; and

(h) The prepaid limited health service organization has otherwise failed to substantially comply with the act.

(2) If the director has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the prepaid limited health service organization in writing by certified mail specifically stating the grounds for suspension or revocation and fixing a time not more than sixty days thereafter for a hearing on the matter. Any decision of the director may be appealed. The appeal shall be in accordance with the Administrative Procedure Act.

(3) When the certificate of authority of a prepaid limited health service organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The director may, by written order, permit such further operation of the organization as he or she may find to be in the best interest of enrollees to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Source: Laws 1989, LB 320, § 21.

Cross References

Administrative Procedure Act, see section 84-920.

44-4722 Violations; cease and desist order; penalty.

In lieu of any penalty specified elsewhere in the Prepaid Limited Health Service Organization Act or when no penalty is specifically provided, whenever any prepaid limited health service organization or other person, corporation, partnership, limited liability company, or entity subject to the act has been found, pursuant to the Administrative Procedure Act, to have violated any provision of the Prepaid Limited Health Service Organization Act, the director may:

(1) Issue and cause to be served upon the organization, person, or other entity charged with the violation a copy of such findings and an order requiring such organization, person, or other entity to cease and desist from engaging in the act or practice which constitutes the violation; and

(2) Impose a monetary penalty of not more than one thousand dollars for each violation but not to exceed an aggregate penalty of ten thousand dollars.

Source: Laws 1989, LB 320, § 22; Laws 1993, LB 121, § 257.

Cross References

Administrative Procedure Act, see section 84-920.

44-4723 Supervision, rehabilitation, conservation, or liquidation; proceedings authorized.

Any supervision, rehabilitation, conservation, or liquidation of a prepaid limited health service organization shall be deemed to be the supervision, rehabilitation, conservation, or liquidation of an insurance company and shall be conducted pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. No prepaid limited health service organization shall be subject to the insurance laws, rules, and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to any individuals entitled to receive limited health services from a prepaid limited health service organization.

Source: Laws 1989, LB 320, § 23; Laws 1989, LB 319, § 79.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-4724 Fees.

Every prepaid limited health service organization subject to the Prepaid Limited Health Service Organization Act shall pay to the director the following fees:

(1) For filing an application for certificate of authority or amendment thereto, one hundred dollars;

(2) For filing a change in rates, charges, or benefits, material modification of any matter or document, or addition of a limited health service, fifty dollars;

(3) For filing each annual report, fifty dollars; and

(4) For filing periodic reports as required by the director, fifty dollars.

Source: Laws 1989, LB 320, § 24.

44-4725 Confidentiality; exceptions.

(1) Any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person or from any provider by any prepaid limited health service organization and any contract submitted pursuant to the requirements of the Prepaid Limited Health Service Organization Act shall be held in confidence and shall not be disclosed to any person except:

(a) To the extent that it may be necessary to carry out the purposes of the act;

(b) Upon the express consent of the enrollee, applicant, provider, or prepaid limited health service organization, whichever is applicable;

(c) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) In the event of claim or litigation in which such data or information is relevant.

(2) With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization shall be entitled to claim any statutory privileges against disclosure which the provider who furnished such information to the prepaid limited health service organization is entitled to claim.

(3) Any information provided to the director which constitutes a trade secret, is privileged information, or is part of an investigation or examination by the director shall be held in confidence.

Source: Laws 1989, LB 320, § 25.

44-4726 Taxes.

(1) The same taxes provided for in section 44-32,180 shall be imposed upon each prepaid limited health service organization, and such organizations also shall be entitled to the same tax deductions, reductions, abatements, and credits that health maintenance organizations are entitled to receive.

(2) Any capitation payment made in accordance with the Medical Assistance Act shall be excluded from computation of any tax obligation imposed by subsection (1) of this section.

Source: Laws 1989, LB 320, § 26; Laws 1990, LB 1136, § 110; Laws 1996, LB 969, § 8; Laws 2002, Second Spec. Sess., LB 9, § 2; Laws 2006, LB 1248, § 64; Laws 2010, LB698, § 2.

Cross References

Medical Assistance Act, see section 68-901.

44-4727 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Prepaid Limited Health Service Organization Act.

Source: Laws 1989, LB 320, § 27.

ARTICLE 48

INSURERS SUPERVISION, REHABILITATION, AND LIQUIDATION

Section

44-4801 Purpose of act.

The purpose of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act is to protect the interests of insureds, claimants, creditors, and the public with minimum interference with the normal prerogatives of the owners and managers of insurers through:

(1) Early detection of any potentially dangerous condition in an insurer and prompt application of appropriate corrective measures;

(2) Improved methods for rehabilitating insurers involving the cooperation and management expertise of the insurance industry;

(3) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(4) Equitable apportionment of any unavoidable loss;

(5) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

(6) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business; and

(7) Providing for a comprehensive scheme for the supervision, rehabilitation, and liquidation of insurers and those subject to the act as part of the regulation of the business of insurance, insurance industry, and insurers in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

The act shall be liberally construed to effect the purposes enumerated in this section and shall not be interpreted to limit the powers granted the director by other provisions of the law.

Source: Laws 1989, LB 319, § 1; Laws 1991, LB 236, § 59.

Proceedings under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act are equitable in nature, and therefore, the liquidation court's determinations of claims disputes are reviewed de novo on the record. State ex rel. Wagner v. Amwest Sur. Ins. Co., 274 Neb. 121, 738 N.W.2d 813 (2007).

44-4802 Act; applicability.

The proceedings authorized by the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act may be applied to:

(1) All insurers who are doing or have done an insurance business in this state and against whom claims arising from that business may exist now or in the future;

(2) All insurers who purport to do an insurance business in this state;

(3) All insurers who have insureds who are residents of this state;

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(5) All fraternal benefit societies subject to Chapter 44, article 10;

(6) All title insurers subject to the Title Insurers Act;

(7) All health maintenance organizations subject to the Health Maintenance Organization Act;

(8) All legal service insurance corporations subject to Chapter 44, article 33;

(9) All prepaid dental service corporations subject to Chapter 44, article 38; and

(10) All prepaid limited health service organizations subject to the Prepaid Limited Health Service Organization Act.

Source: Laws 1989, LB 319, § 2; Laws 1990, LB 984, § 3; Laws 1990, LB 1136, § 111; Laws 1991, LB 235, § 57; Laws 1997, LB 53, § 49.

Cross References

Health Maintenance Organization Act, see section 44-3292.
Prepaid Limited Health Service Organization Act, see section 44-4701.
Title Insurers Act, see section 44-1978.

44-4803 Terms, defined.

For purposes of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act:

(1) Ancillary state means any state other than a domiciliary state;

(2) Creditor means a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, or absolute, fixed, or contingent;

(3) Delinquency proceeding means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer and any summary proceeding under section 44-4809 or 44-4810;

(4) Department means the Department of Insurance;

(5) Director means the Director of Insurance;

(6) Doing business includes any of the following acts, whether effected by mail or otherwise:

(a) The issuance or delivery of contracts of insurance to persons who are residents of this state;

(b) The solicitation of applications for such contracts or other negotiations preliminary to the execution of such contracts;

(c) The collection of premiums, membership fees, assessments, or other consideration for such contracts;

(d) The transaction of matters subsequent to execution of such contracts and arising out of them; or

(e) Operating as an insurer under a license or certificate of authority issued by the department;

(7) Domiciliary state means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry;

(8) Fair consideration is given for property or an obligation:

(a) When in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, (i) property is conveyed, (ii) services are rendered, (iii) an obligation is incurred, or (iv) an antecedent debt is satisfied; or

(b) When such property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained;

(9) Foreign country means any other jurisdiction not in any state;

(10) Foreign guaranty association means a guaranty association now in existence in or hereafter created by the legislature of another state;

(11) Formal delinquency proceeding means any liquidation or rehabilitation proceeding;

(12) General assets means all property, real, personal, or otherwise not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, general assets includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all insureds or all insureds and creditors, in more than a single state, are treated as general assets;

(13) Guaranty association means the Nebraska Property and Liability Insurance Guaranty Association, the Nebraska Life and Health Insurance Guaranty Association, and any other similar entity now or hereafter created by the Legislature for the payment of claims of insolvent insurers;

(14) Insolvency or insolvent means:

(a) For an insurer formed under Chapter 44, article 8:

(i) The inability to pay any obligation within thirty days after it becomes payable; or

(ii) If an assessment is made within thirty days after such date, the inability to pay such obligation thirty days following the date specified in the first assessment notice issued after the date of loss;

(b) For any other insurer, that it is unable to pay its obligations when they are due or when its admitted assets do not exceed its liabilities plus the greater of:

(i) Any capital and surplus required by law to be maintained; or

(ii) The total par or stated value of its authorized and issued capital stock; and

(c) For purposes of this subdivision, liabilities includes, but is not limited to, reserves required by statute or by rules and regulations adopted and promulgated or specific requirements imposed by the director upon a subject company at the time of admission or subsequent thereto;

(15) Insurer means any person who has done, purports to do, is doing, or is licensed to do an insurance business and is or has been subject to the authority of or to liquidation, rehabilitation, reorganization, supervision, or conservation by the director or the director, commissioner, or equivalent official of another state. Any other persons included under section 44-4802 are deemed to be insurers;

(16) Netting agreement means an agreement and any terms and conditions incorporated by reference therein, including a master agreement that, together with all schedules, confirmations, definitions, and addenda thereto and transactions under any thereof, shall be treated as one netting agreement:

(a) That documents one or more transactions between parties to the agreement for or involving one or more qualified financial contracts; and

(b) That provides for the netting or liquidation of qualified financial contracts or present or future payment obligations or payment entitlements thereunder, including liquidation or closeout values relating to such obligations or entitlements among the parties to the netting agreement;

(17) Person includes any individual, corporation, partnership, limited liability company, association, trust, or other entity;

(18) Qualified financial contract means a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the director determines by rule and regulation, resolution, or order to be a qualified financial contract for the purposes of the act;

(19) Receiver means receiver, liquidator, rehabilitator, or conservator as the context requires;

(20) Reciprocal state means any state other than this state in which in substance and effect sections 44-4818, 44-4852, 44-4853, and 44-4855 to 44-4857 are in force, in which provisions are in force requiring that the director, commissioner, or equivalent official of such state be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers;

(21) Secured claim means any claim secured by mortgage, trust deed, pledge, or deposit as security, escrow, or otherwise but does not include a special deposit claim or a claim against general assets. The term includes claims which have become liens upon specific assets by reason of judicial process;

(22) Special deposit claim means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons but does not include any claim secured by general assets;

(23) State means any state, district, or territory of the United States and the Panama Canal Zone; and

(24) Transfer includes the sale of property or an interest therein and every other and different mode, direct or indirect, of disposing of or of parting with property, an interest therein, or the possession thereof or of fixing a lien upon property or an interest therein, absolutely or conditionally, voluntarily, or by or without judicial proceedings. The retention of a security title to property delivered to a debtor is deemed a transfer suffered by the debtor.

Source: Laws 1989, LB 319, § 3; Laws 1990, LB 984, § 4; Laws 1991, LB 236, § 60; Laws 1993, LB 121, § 258; Laws 2011, LB72, § 6.

Cross References

Nebraska Life and Health Insurance Guaranty Association, see section 44-2705.
Nebraska Property and Liability Insurance Guaranty Association, see section 44-2404.

44-4804 Jurisdiction; venue.

(1) No delinquency proceeding shall be commenced under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act by anyone other than the director, and no court shall have jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

(2) No court of this state shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with the act.

(3) In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to sections 25-505.01 to 25-530.08 or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(a) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(b) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract;

(c) If the person served is or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, in any action resulting from such a relationship with the insurer;

(d) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(e) If the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

(4) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

(5) All actions authorized by the act shall be brought in the district court of Lancaster County.

Source: Laws 1989, LB 319, § 4; Laws 1991, LB 236, § 61.

44-4805 Injunctions and orders.

(1) Except as provided in subsection (3) of this section, any receiver appointed in a proceeding under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act may at any time apply for, and the court may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(a) The transaction of further business;

(b) The transfer of property;

(c) Interference with the receiver or with a proceeding under the act;

(d) Waste of the insurer's assets;

(e) Dissipation and transfer of bank accounts;

(f) The institution or further prosecution of any actions or proceedings;

(g) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its insureds;

(h) The levying of execution against the insurer, its assets, or its insureds;

(i) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(j) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(k) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of insureds, creditors, or shareholders or the administration of any proceeding under the act.

(2) Except as provided in subsection (3) of this section, the receiver may apply to any court outside of the state for the relief described in subsection (1) of this section.

(3) A Federal Home Loan Bank shall not be stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action regarding collateral pledged under any security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement.

Source: Laws 1989, LB 319, § 5; Laws 1991, LB 236, § 62; Laws 2013, LB337, § 1.

44-4806 Cooperation of officers, owners, and employees; violation; penalty.

(1) Any officer, manager, director, trustee, owner, employee, or agent of any insurer or any other persons with authority over or in charge of any segment of the insurer's affairs shall cooperate with the director in any proceeding under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act or any investigation preliminary to the proceeding. For purposes of this section, the term person shall include any person who exercises control directly or indirectly over activities of the insurer through a management contract or any holding company or other affiliate of the insurer. To cooperate shall include, but shall not be limited to, the following:

(a) To reply promptly in writing to any inquiry from the director requesting such a reply; and

(b) To make available to the director any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his or her possession, custody, or control.

(2) No person shall obstruct or interfere with the director in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(4) Any person included within subsection (1) of this section who fails to cooperate with the director or any person who obstructs or interferes with the director in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto or who violates any order the director issued validly under the act shall be guilty of a Class I misdemeanor or may, after a hearing, be subject to the imposition by the director of a civil penalty not to

exceed ten thousand dollars and shall be subject further to the revocation or suspension of any insurance licenses issued by the director.

Source: Laws 1989, LB 319, § 6; Laws 1990, LB 984, § 5.

44-4807 Bonds.

In any proceeding under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, the director and his or her deputies shall be responsible on their official bonds for the faithful performance of their duties. If the court deems it desirable for the protection of the assets, it may at any time require an additional bond from the director or his or her deputies, and such bond shall be paid for out of the assets of the insurer as a cost of administration.

Source: Laws 1989, LB 319, § 7.

44-4808 Insurer subject to delinquency proceedings; restrictions.

No insurer that is subject to any delinquency proceedings, whether formal, informal, administrative, or judicial, shall (1) be released from such proceeding unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding, (2) be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority, (3) be returned to the control of its shareholders or private management, or (4) have any of its assets returned to the control of its shareholders or private management, until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the insurer has been approved by the guaranty association.

Source: Laws 1989, LB 319, § 8; Laws 1991, LB 236, § 63.

44-4809 Director's orders; supervision proceedings; hearings; violation; civil penalty; court orders.

(1) Whenever the director has reasonable cause to believe and determines, after a hearing held under subsection (5) of this section, that any domestic insurer has committed or engaged in or is about to commit or engage in any act, practice, or transaction that would subject it to delinquency proceedings under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, he or she may make and serve upon the insurer and any other persons involved such orders as are reasonably necessary to correct, eliminate, or remedy such conduct, condition, or ground.

(2)(a) Whenever the director has reasonable cause to believe and determines, upon examination of any domestic insurer or at any other time, that (i) the insurer's condition renders the continuance of its business hazardous to the public or to its insureds, (ii) the insurer has or appears to have exceeded its powers granted under its certificate of authority and applicable law, (iii) the insurer has failed to comply with the applicable provisions of the insurance laws of this state, (iv) the insurer's business is being conducted fraudulently, or (v) the insurer gives its consent, the director shall by order notify the insurer of his or her determination and furnish to the insurer a written list of the requirements to abate the determination.

(b) For purposes of subdivision (2)(a)(ii) of this section, an insurer has exceeded its powers if it:

(i) Has refused to permit examination of its books, papers, accounts, records, or affairs by the director or his or her deputies, employees, or examiners;

(ii) Has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer;

(iii) Has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto;

(iv) Has neglected or refused to observe an order of the director to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock, or surplus;

(v) Has continued doing business after its license or certificate of authority has been revoked or suspended by the director;

(vi) By contract or otherwise, has unlawfully, in violation of an order of the director, or without first having obtained written approval of the director if approval is required by law:

(A) Totally reinsured its entire outstanding business; or

(B) Merged or consolidated substantially its entire property or business with another insurer;

(vii) Has engaged in any transaction in which it is not authorized to engage under the laws of this state; or

(viii) Has refused to comply with a lawful order of the director.

(3) If the director makes a determination to supervise an insurer subject to an order under subsection (1) or (2) of this section, he or she shall notify the insurer that it is under the supervision of the director. During the period of supervision, the director may appoint a supervisor to supervise such insurer. The order appointing a supervisor shall direct the supervisor to enforce orders issued under subsection (1) or (2) of this section and may also require that the insurer not do any of the following things during the period of supervision without the prior approval of the director or the supervisor:

(a) Dispose of, convey, or encumber any of its assets or its business in force;

(b) Withdraw any funds from any of its bank accounts;

(c) Lend any of its funds;

(d) Invest any of its funds;

(e) Transfer any of its property;

(f) Incur any debt, obligation, or liability;

(g) Merge or consolidate with another company;

(h) Enter into any new reinsurance contract or treaty;

(i) Write or renew any insurance business;

(j) Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract except for nonpayment of premiums due;

(k) Release, pay, or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate, or contract;

(l) Make any material change in management; or

(m) Increase salaries and benefits of officers or directors or make any preferential payment of bonuses, dividends, or other payments deemed preferential.

(4) Any insurer subject to an order under this section shall comply with the lawful requirements of the director and, if placed under supervision, shall have sixty days from the date the supervision order is served within which to comply with the requirements of the director. In the event of such insurer's failure to comply within such period, the director may institute proceedings under section 44-4812 or 44-4817 to have a rehabilitator or liquidator appointed or may extend the period of supervision.

(5) A notice of hearing under subsection (1) or (2) of this section and any order issued pursuant to either subsection shall be served upon the insurer pursuant to the Administrative Procedure Act. The notice of hearing shall state the time and place of hearing and the conduct, condition, or ground upon which the director would base his or her order. Unless mutually agreed between the director and the insurer, the hearing shall occur not less than ten days nor more than thirty days after notice is served and shall be either in the offices of the department or in some other place convenient to the parties to be designated by the director. Such hearings and any notices, orders, correspondence, records, or reports relating thereto shall be considered public unless the director deems it to be in the best interests of the insurer, its insureds or creditors, or the public that such hearings shall be held privately and such notices, orders, correspondence, records, or reports shall be considered confidential.

(6)(a) Any insurer subject to an order under subsection (2) of this section may request a hearing to review the order, but the request for a hearing shall not stay the effect of the order.

(b) If the director issues an order under subsection (2) of this section, the insurer may, at any time, waive a director's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies. Subsequent to a hearing, any party to the proceedings whose interests are substantially affected shall be entitled to judicial review of any order issued by the director.

(c) If the director issues an order under subsection (2) of this section and subsequently determines that a rehabilitation or liquidation is appropriate, the director may at any time institute such proceedings under section 44-4812 or 44-4817.

(7) During the period of supervision, the insurer may request the director to review an action taken or proposed to be taken by the supervisor, specifying why the action complained of is believed not to be in the best interest of the insurer.

(8) If any person has violated any supervision order issued under this section which as to him or her was then still in effect, he or she shall be liable to pay a civil penalty imposed by the district court of Lancaster County not to exceed ten thousand dollars.

(9) The director may apply for and the court may grant such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to enforce a supervision order.

(10) In the event that any person subject to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, including those persons described in subsection (1) of section 44-4806, knowingly violates any valid order of the director issued under this section and, as a result of such violation, the net worth of the insurer is reduced or the insurer suffers loss it would not otherwise have suffered, such person shall become personally liable to the insurer for the amount of any such reduction or loss. The director or supervisor may bring an action on behalf of the insurer in the district court of Lancaster County to recover the amount of the reduction or loss together with any costs.

Source: Laws 1989, LB 319, § 9; Laws 1990, LB 984, § 6; Laws 1991, LB 236, § 64; Laws 2004, LB 1047, § 14.

Cross References

Administrative Procedure Act, see section 84-920.

44-4810 Court; seizure order.

(1) The director may file in the district court of Lancaster County a petition alleging, with respect to a domestic insurer:

(a) That there exist any grounds that would justify a court order for a formal delinquency proceeding against an insurer under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act;

(b) That the interests of insureds, creditors, or the public will be endangered by delay; and

(c) The contents of an order deemed necessary by the director.

(2) Upon a filing under subsection (1) of this section, the court may issue, forthwith, ex parte, and without a hearing, the requested order which shall direct the director to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer and of the premises occupied by it for transaction of its business and until further order of the court enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the director.

(3) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the director to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the director fails to commence a formal delinquency proceeding under the act after having had a reasonable opportunity to do so. An order of the court pursuant to a formal delinquency proceeding under the act shall ipso facto vacate the seizure order.

(4) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(5) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than fifteen days after the request. A hearing under this subsection may be held privately in chambers, and it shall be so held if the insurer proceeded against so requests.

(6) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order

did not appear at the hearing and has not been served, the court may order that notice be given to such person. An order that notice be given shall not stay the effect of any order previously issued by the court.

Source: Laws 1989, LB 319, § 10; Laws 1990, LB 984, § 7; Laws 1991, LB 236, § 65.

44-4811 Confidentiality of hearings.

(1) In all proceedings and judicial review thereof under section 44-4810, all records of the insurer, other documents, all department files, and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith unless and until the court, after hearing arguments from the parties in chambers, orders otherwise or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the district court shall be held by him or her in a confidential file.

(2)(a) The records described in subsection (1) of this section may be provided to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the records.

(b) The director may receive supervision, rehabilitation, and liquidation records from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged records received pursuant to this subdivision with notice or the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

Source: Laws 1989, LB 319, § 11; Laws 1991, LB 236, § 66; Laws 2001, LB 52, § 49.

44-4812 Grounds for rehabilitation.

The director may apply by petition to the district court of Lancaster County for an order authorizing him or her to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(1) The insurer is in such condition that the further transaction of business would be hazardous financially to its insureds or creditors or the public;

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer;

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the director to be dishonest or untrustworthy in a way affecting the insurer's business;

(4) Control of the insurer, whether by stock ownership or otherwise and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy;

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director, trustee, employee, or other person, has refused to be examined under oath or affirmation by the director concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all his or her influence on management;

(6) After demand by the director under the Insurers Examination Act or under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer;

(7) Without first obtaining the written consent of the director, the insurer has transferred or attempted to transfer, in a manner contrary to the Insurance Holding Company System Act or sections 44-224.01 to 44-224.10, substantially its entire property or business or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person;

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act;

(9) Within the previous four years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the director under section 44-4809;

(10) The insurer has failed to pay within sixty days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state if the court in which such judgment was entered had jurisdiction over such subject matter, except that such nonpayment shall not be a ground until sixty days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the director or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously

agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full;

(11) The insurer has failed to file its annual report or other financial report required by statute or by rule or regulation within the time allowed by law and, after written demand by the director, has failed to give an adequate explanation immediately; or

(12) The board of directors or the holders of a majority of the shares entitled to vote or a majority of those individuals entitled to the control of those entities listed in section 44-4802 requests or consents to rehabilitation under the act.

Source: Laws 1989, LB 319, § 12; Laws 1990, LB 984, § 8; Laws 1991, LB 236, § 67; Laws 1993, LB 583, § 106.

Cross References

Insurance Holding Company System Act, see section 44-2120.
Insurers Examination Act, see section 44-5901.

44-4813 Rehabilitation orders.

(1) An order to rehabilitate the business of a domestic insurer or an alien insurer domiciled in this state shall appoint the director and his or her successors in office the rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the district court of Lancaster County or register of deeds of the county in which the principal business of the company is conducted or in which its principal office or place of business is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) Any order issued under this section shall require accounting to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in the order but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under subsection (4) of section 44-4814 will be prepared by the rehabilitator and the timetable for doing so.

(3) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer and shall not be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer unless such revocation or cancellation is done by the rehabilitator pursuant to section 44-4814.

Source: Laws 1989, LB 319, § 13; Laws 1991, LB 236, § 68.

44-4814 Director; powers and duties.

(1) The director as rehabilitator may appoint one or more special deputies who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the director may employ such counsel, clerks, and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the director, with the approval of the court, and shall be paid out of the funds or assets of the

insurer. The persons appointed under this section shall serve at the pleasure of the director. The director, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, should such a committee be deemed necessary. Such committee shall serve at the pleasure of the director and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the director or the court in rehabilitation proceedings conducted under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

(2) The rehabilitator may take such action as he or she deems necessary or appropriate to reform and revitalize the insurer. He or she shall have all the powers of the directors, officers, and managers of the insurer, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He or she shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(3) If it appears to the rehabilitator that there has been criminal or tortious conduct or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, he or she may pursue all appropriate legal remedies on behalf of the insurer.

(4)(a)(i) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he or she shall prepare a plan to effect such changes.

(ii) Such plan may include the establishment of a trust to be treated as an insurer with the trustee serving as liquidator under the act retaining all liabilities and assets except the charter and licenses and shall include provisions requiring the rehabilitator to petition the court to convert the rehabilitation proceedings to a liquidation. Such trust shall be considered an insurer for the purposes of the act. Such plan may include provisions for cancellation of all outstanding stock and other securities of, and other equity interests in, the insurer and court approval of the issuance and sale of new stock or other securities for the purpose of transferring to one or more buyers control and ownership of the insurer together with any or all of its licenses and certificates to do business and such other assets as the rehabilitator deems appropriate to the transaction. The proceeds of such sale shall be assets of the trust. The order of the court approving such a sale may provide that the sale is free and clear of all claims and interests of the insurer's insureds, creditors, shareholders, and members and all other persons interested in the insurer and may discharge the insurer and all property which is the subject of the sale from all claims and interests of the insurer's insureds, creditors, shareholders, and members and all other persons interested in the insurer, except that such a discharge shall not affect the rights of the insurer's insureds, creditors, shareholders, and members and all other persons interested in the insurer's estate to participate in distributions from the trust as otherwise provided in the act.

(b) Upon application of the rehabilitator for approval of the plan and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan

proposed may include the imposition of liens upon the policies of the company if all rights of shareholders are first relinquished. A plan for a life insurer may also propose the imposition of a moratorium upon loan and cash surrender rights under policies for such period and to such an extent as may be necessary.

(5) The rehabilitator shall have the power under sections 44-4826 and 44-4827 to avoid fraudulent transfers.

Source: Laws 1989, LB 319, § 14; Laws 1991, LB 236, § 69; Laws 2005, LB 119, § 12.

44-4815 Actions; effect of rehabilitation.

(1) Except as provided in subsection (4) of this section, any court in this state before which any action or proceeding in which the insurer is a party or is obligated to defend a party is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for ninety days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he or she deems necessary in the interests of justice and for the protection of insureds, creditors, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

(3) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

(4) A Federal Home Loan Bank shall not be stayed, enjoined, or prohibited from exercising or enforcing any right or cause of action regarding collateral pledged under any security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement.

Source: Laws 1989, LB 319, § 15; Laws 1991, LB 236, § 70; Laws 2013, LB337, § 2.

44-4816 Liquidation; termination of rehabilitation.

(1) Whenever the director believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to insureds, creditors, or the public or would be futile, the director may petition the district court of Lancaster County for an order of liquidation. A petition under this subsection shall have

the same effect as a petition under section 44-4817. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(2) The protection of the interests of insureds, claimants, and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of six months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under subsection (4) of section 44-4814, the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(3) The rehabilitator may at any time petition the district court of Lancaster County for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If upon the petition of the rehabilitator or the directors of the insurer or upon its own motion at any time the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 44-4812 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business.

Source: Laws 1989, LB 319, § 16; Laws 1991, LB 236, § 71.

44-4817 Grounds for liquidation.

The director may petition the district court of Lancaster County for an order directing him or her to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(1) Of any ground for an order of rehabilitation as specified in section 44-4812 whether or not there has been a prior order directing the rehabilitation of the insurer;

(2) That the insurer is insolvent; or

(3) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its insureds or creditors or the public.

Source: Laws 1989, LB 319, § 17; Laws 1991, LB 236, § 72.

44-4818 Liquidation order; effect; appeal-pendency plan.

(1) An order to liquidate the business of a domestic insurer shall appoint the director and his or her successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the district court and the register of deeds of the county in which its principal office or place of business is located or, in the case of real estate, with the register of deeds of the county where the property is located shall impart the same notice as a deed, bill of

sale, or other evidence of title duly filed or recorded with that register of deeds would have imparted.

(2) Upon issuance of the order, the rights and liabilities of any such insurer and of its insureds, creditors, shareholders, and members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation except as provided in sections 44-4819 and 44-4837.

(3) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(4) At the time of petitioning for an order of liquidation or at any time thereafter, the director, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

(5) Any order issued under this section shall require financial reports to the court by the liquidator. Financial reports shall include at a minimum the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within one year of the liquidation order and at least annually thereafter.

(6)(a) Within five days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the director shall present for the court's approval a plan for the continued performance of the insurer's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. For appeals pending on March 12, 1991, the plan shall be filed within five days after such date. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. In the event the insurer's financial condition will not, in the judgment of the director, support the full performance of all policy claims obligations during the appeal-pendency period, the plan may prefer the claims of certain insureds and claimants over creditors and interested parties as well as other insureds and claimants, as the director finds to be fair and equitable considering the relative circumstances of such insureds and claimants. The court shall examine the plan submitted by the director, and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the director or any of his or her deputies, agents, clerks, assistants, or attorneys by any party based on preference in an appeal-pendency plan approved by the court.

(b) The appeal-pendency plan shall not supersede or affect the obligations of any guaranty association.

(c) An appeal-pendency plan shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations in the event that the liquidator pays claims from assets of the estate which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. In the event an order of liquidation is set aside upon any appeal, the insurer shall not be released from delinquency proceedings unless all funds advanced by any guaranty association,

including reasonable administrative expenses in connection therewith relating to obligations of the insurer, are repaid in full, together with interest at the judgment rate of interest, or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty associations.

Source: Laws 1989, LB 319, § 18; Laws 1991, LB 236, § 73.

44-4819 Termination and continuation of coverage.

(1) All policies including bonds and other noncancelable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force until the earliest of:

(a) Thirty days from the date of entry of the liquidation order;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The liquidator has effected a transfer of the policy obligation pursuant to subdivision (1)(j) of section 44-4821; or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order of liquidation under section 44-4818 shall terminate coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2) of this section.

Source: Laws 1989, LB 319, § 19; Laws 1991, LB 236, § 74.

44-4820 Dissolution of insurer; court-ordered transfer of control and ownership.

(1) The director may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he or she applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the director upon or after the granting of a liquidation order. If the dissolution has not previously been ordered and if control and ownership of the insurer has not been transferred pursuant to subsection (2) of this section, dissolution shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

(2) Notwithstanding the entry of a liquidation order, on the motion of the liquidator and following such notice and hearing and on such terms as the court deems appropriate, the court may approve the liquidator's cancellation of all outstanding stock and other securities of, and other equity interests in, the insurer and the court may approve the issuance and sale of new stock or other securities for the purpose of transferring to one or more buyers control and ownership of the insurer together with any or all of its licenses and certificates

to do business and such other assets as the liquidator deems appropriate to the transaction. The proceeds of such sale shall be assets of the liquidation estate of the insurer. The order of the court approving such a sale may provide that the sale is free and clear of all claims and interests of the insurer's insureds, creditors, shareholders, and members and all other persons interested in the insurer's estate and may discharge the insurer and all property which is the subject of the sale from all claims and interests of the insurer's insureds, creditors, shareholders, and members and all other persons interested in the insurer's estate, except that such a discharge shall not affect the rights of the insurer's insureds, creditors, shareholders, and members and all other persons interested in the insurer's estate to participate in distributions from the estate as otherwise provided in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1989, LB 319, § 20; Laws 1995, LB 616, § 1.

44-4821 Powers of liquidator.

(1) The liquidator shall have the power:

(a) To appoint a special deputy to act for him or her under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act and to determine his or her reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator;

(b) To employ employees, agents, legal counsel, actuaries, accountants, appraisers, consultants, and such other personnel as he or she may deem necessary to assist in the liquidation;

(c) To appoint, with the approval of the court, an advisory committee of policyholders, claimants, or other creditors, including guaranty associations, should such a committee be deemed necessary. Such committee shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the director or the court in liquidation proceedings conducted under the act;

(d) To fix the reasonable compensation of employees, agents, legal counsel, actuaries, accountants, appraisers, and consultants with the approval of the court;

(e) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer;

(f) To hold hearings, to subpoena witnesses, to compel their attendance, to administer oaths and affirmations, to examine any person under oath or affirmation, and to compel any person to subscribe to his or her testimony after it has been correctly reduced to writing and, in connection therewith, to require the production of any books, papers, records, or other documents which he or she deems relevant to the inquiry;

(g) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer;

(h) To collect all debts and money due and claims belonging to the insurer, wherever located, and for this purpose:

(i) To institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

(ii) To do such other acts as are necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon such terms and conditions as he or she deems best; and

(iii) To pursue any creditor's remedies available to enforce his or her claims;

(i) To conduct public and private sales of the property of the insurer;

(j) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer if the transfer can be arranged without prejudice to applicable priorities under section 44-4842;

(k) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He or she shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

(l) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and shall have priority over any other claims under subdivision (1) of section 44-4842;

(m) To enter into such contracts as are necessary to carry out the order to liquidate and to affirm or disavow any contracts to which the insurer is a party, except that a liquidator shall not have power to disavow, reject, or repudiate any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement;

(n) To continue to prosecute and to institute in the name of the insurer or in his or her own name any and all suits and other legal proceedings in this state or elsewhere and to abandon the prosecution of claims he or she deems unprofitable to pursue further. If the insurer is dissolved under section 44-4820, the liquidator shall have the power to apply to any court in this state or elsewhere for leave to substitute himself or herself for the insurer as plaintiff;

(o) To prosecute any action which may exist on behalf of the insureds, creditors, members, or shareholders of the insurer against any officer of the insurer or any other person;

(p) To remove any or all records and property of the insurer to the offices of the director or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations;

(q) To deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions;

(r) To invest all sums not currently needed unless the court orders otherwise;

(s) To file any necessary documents for record in the office of any register of deeds or record office in this state or elsewhere where property of the insurer is located;

(t) To assert all defenses available to the insurer as against third persons, including statutes of limitations, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations;

(u) To exercise and enforce all the rights, remedies, and powers of any insured, creditor, shareholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with sections 44-4826 to 44-4828, except that a liquidator shall not have power to disavow, reject, or repudiate any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement;

(v) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee and to act as the receiver or trustee whenever the appointment is offered;

(w) To enter into agreements with any receiver or the director, commissioner, or equivalent official of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states; and

(x) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of the act.

(2)(a) If a company placed in liquidation has issued liability policies on a claims-made basis, which policies provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period to report claims as stated in this subsection. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or eighteen months from the order of liquidation.

(b) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within sixty days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. Such offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within ninety days after the order of liquidation. No commissions, premium taxes, assessments, or other fees shall be due on the charge pertaining to the extended period to report claims.

(3) The enumeration in this section of the powers and authority of the liquidator shall not be construed as a limitation upon him or her nor shall it exclude in any manner his or her right to do such other acts not in this section specifically enumerated or otherwise provided for as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(4) Notwithstanding the powers of the liquidator as stated in subsections (1) and (2) of this section, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

Source: Laws 1989, LB 319, § 21; Laws 1991, LB 236, § 75; Laws 2013, LB337, § 3.

The liquidator did not seek to enforce the arbitration agreements in question but disavowed them according to the express powers granted under subsection (1)(m) of this section. State ex rel. Wagner v. Kay, 15 Neb. App. 85, 722 N.W.2d 348 (2006).

44-4822 Notice to creditors and others.

(1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) By first-class mail and by telegram, electronic mail, facsimile, or telephone to the director, commissioner, or equivalent official of each jurisdiction in which the insurer is doing business;

(b) By first-class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(c) By first-class mail to all insurance agents of the insurer;

(d) By first-class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders at their last-known address as indicated by the records of the insurer; and

(e) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(2) Notice to potential claimants under subsection (1) of this section shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 44-4836 on or before a date the liquidator shall specify in the notice. Although an earlier date may be set by the liquidator, the last day to file claims shall be no later than eighteen months following the order of liquidation. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(3)(a) Notice under subsection (1) of this section to agents of the insurer and to potential claimants who are policyholders shall include, when applicable, notice that coverage by a guaranty association may be available for all or part of policy benefits in accordance with applicable state insurance guaranty laws.

(b) The liquidator shall promptly provide to any guaranty association such information concerning the identities and addresses of such policyholders and their policy coverages as may be within the liquidator's possession or control and shall otherwise cooperate with a guaranty association to assist in providing to such policyholders timely notice of the guaranty association's coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

(4) If notice is given in accordance with this section, the distribution of assets of the insurer under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act shall be conclusive with respect to all claimants whether or not they receive actual notice.

Source: Laws 1989, LB 319, § 22; Laws 1991, LB 236, § 76.

If the liquidator's file reflects the potential claimant's direct address, the mailing of a notice to attorneys listed in correspondence between the claimant and the insurance company from several years previous does not satisfy the notice requirements of this section. State ex rel. Wagner v. Amwest Sur. Ins. Co., 274 Neb. 121, 738 N.W.2d 813 (2007).

When notice is not properly given in accordance with this section, a claimant should not be penalized for failing to timely file a claim in the liquidation proceeding of which the claimant was unaware. State ex rel. Wagner v. Amwest Sur. Ins. Co., 274 Neb. 121, 738 N.W.2d 813 (2007).

44-4823 Duties of agents; violation; penalty.

(1) Every person who receives notice in the form prescribed in section 44-4822 that an insurer which he or she represents as an agent is the subject of a liquidation order shall, within fifteen days of such notice, give notice of the liquidation order. The notice shall be sent by first-class mail to the last address contained in the agent's records to each policyholder or other person named in any policy issued through the agent by the insurer if he or she has a record of the address of the policyholder or other person. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy or if the agent has had in his or her possession a copy of the declarations of the policy at any time during the life of the policy except when the ownership of the expiration of the policy has been transferred to another. The written notice shall include the name and address of the insurer, the name and address of the agent, identification of the policy impaired, and the nature of the impairment, including termination of coverage as described in section 44-4819. Notice by a general agent satisfies the notice requirement for any agents under contract to him or her. Each agent obligated to give notice under this section shall file a report of compliance with the liquidator.

(2) Any agent failing to give notice or file a report of compliance as required in subsection (1) of this section may be subject to payment of a civil penalty of not more than one thousand dollars and may have his or her license suspended. The penalty shall be imposed after a hearing held by the director.

(3) The liquidator may waive the duties imposed by this section if he or she determines that other notice to the policyholders of the insurer under liquidation is adequate.

Source: Laws 1989, LB 319, § 23.

44-4824 Actions by and against liquidator.

(1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he or she may intervene in the action. The liquidator may defend any action in which he or she intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within two years or such time in addition to two years as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law

has not expired at the time of the filing of the petition upon which such order is entered. In any agreement, when a period of limitation is fixed for instituting a suit or proceeding upon any claim or for filing any claim, proof of claim, proof of loss, demand, notice, or the like or in any proceeding, judicial or otherwise, when a period of limitation is fixed either in the proceeding or by applicable law for taking any action, filing any claim or pleading, or doing any act, and when in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any such action or do any such act required of or permitted to the insurer within a period of one hundred eighty days subsequent to the entry of an order for liquidation or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) No statute of limitations or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

(4) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

Source: Laws 1989, LB 319, § 24; Laws 1991, LB 236, § 77.

44-4825 Collection and list of assets.

(1) As soon as practicable after the liquidation order but not later than one hundred twenty days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the district court of Lancaster County and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) The submission of an application to the court for disbursement of assets in accordance with section 44-4834 shall fulfill the requirements of subsection (1) of this section.

Source: Laws 1989, LB 319, § 25.

44-4826 Fraudulent transfers and obligations incurred prior to petition.

(1) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act shall be fraudulent as to then existing and future creditors if made or incurred without fair consideration or with actual intent to hinder, delay, or defraud either existing or future creditors. Except as provided in subsection (5) of this section, a transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under the act which is fraudulent under this section may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair

equivalent value, and except that any purchaser, lienor, or obligee who in good faith has given a consideration less than fair for such transfer, lien, or obligation may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under subsection (3) of section 44-4828.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection shall apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(3) Except as provided in subsection (5) of this section, any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (1) of this section if:

(a) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions unless the reinsurer gives a present fair equivalent value for the release; and

(b) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

(4) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(5) A receiver may not avoid any transfer of, or any obligation to transfer, money or any other property arising under or in connection with any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement. However, a transfer may be avoided under this subsection if it was made with actual intent to hinder, delay, or defraud either existing or future creditors.

Source: Laws 1989, LB 319, § 26; Laws 1991, LB 236, § 78; Laws 2013, LB337, § 4.

44-4827 Fraudulent transfer after petition.

(1) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value or,

if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the register of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(a) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred;

(b) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property or any part thereof to the insurer or upon his or her order with the same effect as if the petition were not pending;

(c) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith; and

(d) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(3) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) of this section shall be liable therefor and shall be bound to account to the liquidator.

(4) Nothing in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act shall impair the negotiability of currency or negotiable instruments.

(5) A receiver may not avoid any transfer of, or any obligation to transfer, money or any other property arising under or in connection with any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement. However, a transfer may be avoided under this subsection if it was made with actual intent to hinder, delay, or defraud either existing or future creditors.

Source: Laws 1989, LB 319, § 27; Laws 1991, LB 236, § 79; Laws 2013, LB337, § 5.

44-4828 Preferences and liens.

(1)(a) A preference shall mean a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act the effect of which transfer may be to enable the

creditor to obtain a greater percentage of such debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) Except as provided in subdivision (1)(d) of this section, any preference may be avoided by the liquidator if:

(i) The insurer was insolvent at the time of the transfer;

(ii) The transfer was made within four months before the filing of the petition;

(iii) The creditor receiving it or to be benefited thereby or his or her agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(iv) The creditor receiving it was: An officer; any employee, attorney, or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he or she held such position; any shareholder holding directly or indirectly more than five percent of any class of any equity security issued by the insurer; or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) When the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except when a bona fide purchaser or lienor has given less than fair equivalent value, he or she shall have a lien upon the property to the extent of the consideration actually given by him or her. When a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(d) A liquidator or receiver shall not avoid any preference arising under or in connection with any Federal Home Loan Bank security agreement, or any pledge, security, collateral or guarantee agreement or any other similar arrangement or credit enhancement relating to such Federal Home Loan Bank security agreement.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection shall apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(3)(a) A lien obtainable by legal or equitable proceedings upon a simple contract shall be one arising in the ordinary course of such proceedings upon the entry or recording of a judgment or decree or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It shall not include liens which under applicable law are given a special priority over other liens which are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (2) of this section if such consequences would follow only from the lien or purchase itself or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (2) of this section through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(4) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (2) of this section to be made or suffered after the transfer because of delay in perfecting shall not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(5) If any lien deemed voidable under subdivision (1)(b) of this section has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under the act which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(6) The property affected by any lien deemed voidable under subsections (1) and (5) of this section shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(7) The district court of Lancaster County shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. When an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or

lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator within such reasonable times as the court shall fix.

(8) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator or, when the property is retained under subsection (7) of this section, to the extent of the amount paid to the liquidator.

(9) If a creditor has been preferred and afterward in good faith gives the insurer further credit without security of any kind for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him or her.

(10) If an insurer, directly or indirectly, within four months before the filing of a successful petition for liquidation under the act or at any time in contemplation of a proceeding to liquidate, pays money or transfers property to an attorney for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefit of the estate, except that if the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney for services rendered or to be rendered shall be governed by subdivision (1)(b)(iv) of this section.

(11)(a) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he or she has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It shall be permissible to infer that there is a reasonable cause to so believe if the transfer was made within four months before the date of filing of the successful petition for liquidation.

(b) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (1) of this section shall be personally liable therefor and shall be bound to account to the liquidator.

(c) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

Source: Laws 1989, LB 319, § 28; Laws 1995, LB 616, § 2; Laws 2013, LB337, § 6; Laws 2018, LB193, § 83.

Payments made in the ordinary course of business constitute voidable preferences under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, which contains no exception for such payments. State ex rel. Wagner v. Gilbane Bldg. Co., 276 Neb. 686, 757 N.W.2d 194 (2008).

Without expert evidence properly in the record, an appellate court cannot conclude as a matter of law that a debtor was insolvent at the time of a transfer which occurred prior to the statutory 4-month period during which a liquidator may avoid transfers without proving insolvency at the time of the transfer. State ex rel. Wagner v. Gilbane Bldg. Co., 276 Neb. 686, 757 N.W.2d 194 (2008).

44-4829 Claims of holders of void or voidable rights.

(1) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under the Nebras-

ka Insurers Supervision, Rehabilitation, and Liquidation Act shall be allowed unless he or she surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) of this section by reason of the avoidance, whether voluntary or involuntary, of a preference, lien, conveyance, transfer, assignment, or encumbrance may be filed as an excused late filing under section 44-4835 if filed within thirty days from the date of the avoidance or within the further time allowed by the court under subsection (1) of this section.

Source: Laws 1989, LB 319, § 29.

44-4830 Setoffs.

(1) Mutual debts or mutual credits whether arising out of one or more contracts between the insurer and another person in connection with any action or proceeding under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act shall be set off and the balance only shall be allowed or paid except as provided in subsections (2) and (3) of this section and in section 44-4833.

(2) No setoff shall be allowed in favor of any person when:

(a) The obligation of the insurer to the person would not at the date of the filing of a petition for rehabilitation or liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(c) The obligation of the insurer is owed to an affiliate of such person or any other entity or association other than the person;

(d) The obligation of the person is owed to an affiliate of the insurer or any other entity or association other than the insurer;

(e) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(f) The obligations between the person and the insurer arise out of transactions by which either the person or the insurer has assumed risks and obligations from the other party and then has ceded back to that party substantially the same risks and obligations. Notwithstanding the provisions of this subdivision, the rehabilitator or liquidator may permit setoffs if in his or her discretion a setoff is appropriate because of specific circumstances relating to a transaction.

(3) The rehabilitator or liquidator shall provide persons with accounting statements identifying debts which are currently due and payable. When a person owes to the insurer amounts which are currently due and payable, against which the person asserts setoff of mutual credits which may become due and payable from the insurer in the future, the person shall promptly pay

to the rehabilitator or liquidator the amounts currently due and payable, except that, notwithstanding section 44-4842, the rehabilitator or liquidator shall promptly and fully refund, to the extent of the person's prior payments, any mutual credits that become due and payable to the person by the insurer.

(4) The provisions of subdivision (2)(f) and subsection (3) of this section shall apply to all contracts entered into, renewed, extended, or amended on or after October 1, 1995, and to debts or credits arising from any business written after such date pursuant to any such contract. For purposes of this subsection, any change in the terms of or consideration for any such contract shall be deemed an amendment of the contract.

Source: Laws 1989, LB 319, § 30; Laws 1991, LB 236, § 80; Laws 1991, LB 237, § 71; Laws 1995, LB 616, § 3.

44-4830.01 Netting agreement; qualified financial contract; net or settlement amount; treatment; receiver; powers; duties; notice; claim of counterparty; rights of counterparty.

(1) Notwithstanding any other provision of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act to the contrary, including any other provision of the act that permits the modification of contracts, or another law of this state, a person shall not be stayed or prohibited from exercising any of the following:

(a) A contractual right to terminate, liquidate, or close out any netting agreement or qualified financial contract with an insurer because of one of the following:

(i) The insolvency, financial condition, or default of the insurer at any time, if the right is enforceable under applicable law other than the act; or

(ii) The commencement of a formal delinquency proceeding under the act;

(b) Any right under a pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract; or

(c) Subject to any provision of subsection (2) of section 44-4830, any right to setoff or net out any termination value, payment amount, or other transfer obligation arising under or in connection with a netting agreement or qualified financial contract if the counterparty or its guarantor is organized under the laws of the United States or a state or foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting.

(2) Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under the act shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any provision in the netting agreement or qualified financial contract that may provide that the defaulting party is not required to pay any net or settlement amount due to the defaulting party upon termination. Any limited two-way payment provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full two-way payment provision as against the defaulting insurer. Any such amount, except to the extent it is subject to one or more secondary liens or encumbrances, shall be a general asset of the insurer.

(3) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under the act, the receiver shall do one of the following:

(a) Transfer to one party, other than an insurer subject to a proceeding under the act, all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including all of the following:

(i) All rights and obligations of each party under each netting agreement and qualified financial contract; and

(ii) All property, including any guarantees or credit support documents, securing any claims of each party under each such netting agreement and qualified financial contract; or

(b) Transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in subdivision (a) of this subsection with respect to the counterparty and any affiliate of the counterparty.

(4) If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, the receiver shall use his or her best efforts to notify any person who is party to the netting agreement or qualified financial contract of the transfer by noon of the receiver's local time on the business day following the transfer. For purposes of this subsection, business day means a day other than a Saturday, Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

(5) Notwithstanding any other provision of the act to the contrary, a receiver shall not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract or any pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract that is made before the commencement of a formal delinquency proceeding under the act. However, a transfer may be avoided under section 44-4828 if the transfer was made with actual intent to hinder, delay, or defraud the insurer, a receiver appointed for the insurer, or an existing or future creditor.

(6)(a) In exercising any of its powers under the act to disaffirm or repudiate a netting agreement or qualified financial contract, the receiver shall take action with respect to each netting agreement or qualified financial contract and all transactions entered into in connection therewith in its entirety.

(b) Notwithstanding any other provision of the act to the contrary, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or in the immediately preceding rehabilitation case shall be determined and allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. For purposes of this subdivision, actual direct compensatory damages does not include punitive or exemplary damages, damages for lost profit or lost opportunity, or damages for pain and

suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives market for the contract and agreement claims.

(7) For purposes of this section, contractual right includes any right, whether or not evidenced in writing, arising under (a) statutory or common law, (b) a rule or bylaw of a national securities exchange, a national securities clearing organization, or a securities clearing agency, (c) a rule or bylaw or a resolution of the governing body of a contract market or its clearing organization, or (d) law merchant.

(8) This section does not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

(9) All rights of a counterparty under the act shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts, if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

Source: Laws 2011, LB72, § 7.

44-4831 Assessments.

(1) As soon as practicable, but not more than two years from the date of an order of liquidation under section 44-4818 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(a) The reasonable value of the assets of the insurer;

(b) The insurer's probable total liabilities;

(c) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(d) A recommendation as to whether or not an assessment should be made and in what amount.

(2)(a) Upon the basis of the report provided in subsection (1) of this section, including any supplements and amendments thereto, the district court of Lancaster County may levy one or more assessments against all members of the insurer who are subject to assessment.

(b) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2) of this section, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment therefor.

(4) The liquidator shall give notice of the order to show cause by publication and by first-class mail to each member liable thereunder mailed to his or her last-known address as it appears on the insurer's records at least twenty days before the return day of the order to show cause.

(5)(a) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under

subsection (3) of this section, the court shall make an order adjudging the member liable for the amount of the assessment against him or her pursuant to subsection (3) of this section, together with costs, and the liquidator shall have a judgment against the member therefor.

(b) If on or before such return day the member appears and serves duly verified objections upon the liquidator, the director may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the director determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) of this section by any lawful means.

Source: Laws 1989, LB 319, § 31.

44-4832 Reinsurer's liability.

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

Source: Laws 1989, LB 319, § 32.

44-4833 Recovery of premiums owed; violation; penalty; appeal.

(1)(a) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned commission of such person. An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall not be obligated to pay the unpaid unearned premium due the insurer at the time of the declaration of insolvency as shown on the records of the insurer, and any such unearned premium in the possession of such agent, broker, premium finance company, or other person at such time shall be returned promptly by such agent, broker, premium finance company, or other person to the insured or other person from whom it was received. Credits or setoffs or both shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(b) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency as shown on the records of the insurer.

(2) Upon satisfactory evidence of a violation of this section, the director may pursue either one or both of the following courses of action:

(a) Suspend, revoke, or refuse to renew the licenses of such offending party or parties; or

(b) Impose a civil penalty of not more than one thousand dollars for each and every act in violation of this section by the party or parties.

(3) Before the director takes any action as set forth in subsection (2) of this section, he or she shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held. After such hearing or upon failure of the accused to appear at such hearing, the director, if he or she finds such violation, shall impose the penalties under subsection (2) of this section as he or she deems advisable.

(4) When the director takes action in any or all of the ways set out in subsection (2) of this section, the party aggrieved may appeal from the action to the district court of Lancaster County.

Source: Laws 1989, LB 319, § 33.

44-4834 Liquidator's proposal to distribute assets.

(1) Within one hundred twenty days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors to the extent of the value of the security held and claims falling within the priority established in subdivision (1) of section 44-4842;

(b) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(c) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(d) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in section 44-4842 in accordance with such priorities. No bond shall be required of any such association; and

(e) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(3) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments

made or to be made by the association, then disbursements shall be in the amount of available assets.

(4) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the laws creating such associations.

(5) Notice of such application shall be given to the association in and to the director, commissioner, or equivalent official of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mail, first-class postage prepaid, at least thirty days prior to submission of such application to the court. Action on the application may be taken by the court if the required notice has been given and the liquidator's proposal complies with subdivisions (2)(a) and (b) of this section.

Source: Laws 1989, LB 319, § 34; Laws 2002, LB 1139, § 25.

44-4835 Filing of claims.

(1) Proof of all claims shall be filed with the liquidator in the form required by section 44-4836 on or before the last day for filing specified in the notice required under section 44-4822, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he or she were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) The existence of the claim was not known to the claimant and he or she filed his or her claim as promptly thereafter as reasonably possible after learning of it;

(b) A transfer to a creditor was avoided under sections 44-4826 to 44-4828 or was voluntarily surrendered under section 44-4829 and the filing satisfies the conditions of such section; or

(c) The valuation under section 44-4841 of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation.

(3) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing when such payments were made and expenses incurred as provided by law.

(4) The liquidator may consider any claim filed late which is not covered by subsection (2) of this section and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive at each distribution the same percentage of the amount allowed on his or her claim as is then being paid to claimants of any lower priority. This shall continue until his or her claim has been paid in full.

Source: Laws 1989, LB 319, § 35.

44-4836 Proof of claim.

(1) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(a) The particulars of the claim, including the consideration given for it;

(b) The identity and amount of the security on the claim;

(c) The payments made on the debt, if any;

(d) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

(e) Any right of priority of payment or other specific right asserted by the claimants;

(f) A copy of the written instrument which is the foundation of the claim; and

(g) The name and address of the claimant and the attorney who represents him or her, if any.

(2) No claim need be considered or allowed if it does not contain all the information in subsection (1) of this section which may be applicable. The liquidator may require that a prescribed form be used and may require that other information and documents be included.

(3) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (1) of this section and may take testimony under oath or affirmation, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

Source: Laws 1989, LB 319, § 36.

44-4837 Special claims.

(1) The claim of a third party which is contingent only on his or her first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(2) A claim may be allowed even if contingent if it is filed in accordance with section 44-4835. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers shall

be limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under section 44-4813 or 44-4818.

Source: Laws 1989, LB 319, § 37.

44-4838 Third-party claims.

(1) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on his or her own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 44-4822, whichever is later, he or she is an unexcused late filer.

(3) The liquidator shall make his or her recommendations to the court under section 44-4842 for the allowance of an insured's claim under subsection (2) of this section after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, the liquidator shall reconsider the claim on the basis of additional information and amend his or her recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property based on the lesser of (a) the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expenses of defense or (b) the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (3) of this section. If any insured's claim is subsequently reduced under subsection (3) of this section, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(5) No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

Source: Laws 1989, LB 319, § 38.

44-4839 Disputed claims.

(1) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his or her attorney

by first-class mail at the address shown in the proof of claim. Within sixty days from the mailing of the notice, the claimant may file his or her objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(2) Whenever objections are filed with the liquidator and the liquidator does not alter his or her denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or his or her attorney and to any other persons directly affected not less than ten or more than thirty days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his or her recommendation.

Source: Laws 1989, LB 319, § 39.

44-4840 Claims of surety.

Whenever a creditor whose claim against an insurer is secured in whole or in part by the undertaking of another person fails to prove and file the claim, the other person may do so in the creditor's name and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he or she discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him or her in trust for such other person. The term other person as used in this section shall not apply to a guaranty association or foreign guaranty association.

Source: Laws 1989, LB 319, § 40.

44-4841 Secured creditor's claims.

(1) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(a) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(b) By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(2) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant surrenders his or her security to the liquidator, the entire claim shall be allowed as if unsecured.

Source: Laws 1989, LB 319, § 41.

44-4842 Priority of distribution.

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this section. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any

payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including, but not limited to, the following:

(a) The actual and necessary costs of preserving or recovering the assets of the insurer;

(b) Compensation for all properly authorized services rendered in the rehabilitation and liquidation;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Authorized reasonable attorney's fees and fees for other professional services rendered in the rehabilitation and liquidation;

(f) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses; and

(g) The expenses of examinations conducted pursuant to the Insurers Examination Act;

(2) Class 2. All claims under policies, including such claims of the federal or any state or local government, for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, funding agreements, guaranteed interest contracts, guaranteed investment contracts, synthetic guaranteed investment contracts, and deposit administration contracts, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance or as gratuities. No payment by an employer to his or her employee shall be treated as a gratuity;

(3) Class 3. Claims of the federal government other than those claims included in subdivision (2) of this section;

(4) Class 4. Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors of the insurer shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees;

(5) Class 5. Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors, including claims of ceding and assuming insurers in their capacity as such;

(6) Class 6. Claims of any state or local government except those under subdivision (2) of this section. Claims, including those of a governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the

pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subdivision (9) of this section;

(7) Class 7. Claims filed late or any other claims other than claims under subdivisions (8) and (9) of this section;

(8) Class 8. Surplus or contribution notes or similar obligations and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law; and

(9) Class 9. The claims of shareholders or other owners in their capacity as shareholders.

Source: Laws 1989, LB 319, § 42; Laws 1991, LB 236, § 81; Laws 1993, LB 583, § 107; Laws 2002, LB 1139, § 26; Laws 2004, LB 1047, § 15.

Cross References

Insurers Examination Act, see section 44-5901.

44-4842.01 Claims allowed under separate account policies, contracts, or agreements; how treated.

(1) Every claim allowed under a separate account policy, contract, or agreement providing, in effect, that the assets allocated to the separate account are not chargeable with liabilities arising out of any other business of the life insurer, shall be satisfied out of the assets properly allocated to and maintained in the separate account, equal to the reserves maintained in the separate account for the policies, contracts, or agreements. No liabilities of the insurer arising out of any other business of the insurer shall be satisfied from assets properly allocated to and maintained in a separate account except from any assets allocated to the separate account that exceed the reserves under the separate account policies, contracts, or agreements. Any valid and allowed claim for contractual benefits that cannot be satisfied out of the assets properly allocated to and maintained in a separate account shall be included as a claim against the general account as set forth in subdivision (2) of section 44-4842.

(2) Notwithstanding any other provision of law, to the extent that any assets of a life insurer, other than those assets properly allocated to, and maintained in, a separate account, have been used to fund or pay any expenses, taxes, or policyholder benefits that are attributable to a separate account policy, contract, or agreement that should have been paid by a separate account prior to the commencement of delinquency proceedings, then upon the commencement of delinquency proceedings, the separate accounts that benefited from this payment or funding shall first be used to repay or reimburse the insurer's general assets or account for any unreimbursed net sums due at the commencement of delinquency proceedings prior to the application of the separate account assets to the satisfaction of liabilities of the corresponding separate account policies, contracts, and agreements.

(3) For purposes of this section, separate account policies, contracts, or agreements means any policies, contracts, or agreements that provide for separate accounts as contemplated by sections 44-402.01 to 44-402.05 or section 44-708.

Source: Laws 2004, LB 1047, § 16.

44-4843 Liquidator's recommendations to the court.

(1) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he or she deems necessary. He or she may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court except when the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under section 44-4839. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer with his or her recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove, or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to section 44-4839. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

Source: Laws 1989, LB 319, § 43.

44-4844 Distribution of assets.

Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third-party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

Source: Laws 1989, LB 319, § 44.

44-4845 Unclaimed and withheld funds.

(1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he or she is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, shall be deposited with the district court and shall be paid without interest, except in accordance with section 44-4842, to the person entitled thereto or his or her legal representative upon proof satisfactory to the district court of his or her right thereto. Any amount on deposit not claimed within three years from the date such amount was paid to the district court shall be presumed abandoned and shall be subject to the Uniform Disposition of Unclaimed Property Act.

(2) All funds withheld under section 44-4838 and not distributed shall, upon discharge of the liquidator, be deposited with the district court and paid by the district court in accordance with section 44-4842. Any sums remaining which

under section 44-4842 would revert to the undistributed assets of the insurer shall be presumed abandoned and shall be subject to the act.

Source: Laws 1989, LB 319, § 45.

Cross References

Uniform Disposition of Unclaimed Property Act, see section 69-1329.

44-4846 Termination of proceedings.

(1) When all assets justifying the expense of collection and distribution have been collected and distributed under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomical to distribute, as may be deemed appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1) of this section. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including reasonable attorney's fees.

Source: Laws 1989, LB 319, § 46.

44-4847 Reopening liquidation.

After the liquidation proceeding has been terminated and the liquidator discharged, the director or other interested party may at any time petition the district court of Lancaster County to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

Source: Laws 1989, LB 319, § 47.

44-4848 Records; disposition.

Whenever it appears to the director that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he or she may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

Source: Laws 1989, LB 319, § 48.

44-4849 Receiver; audit.

The district court of Lancaster County may cause audits to be made of the books of the director relating to any receivership established under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, and a report of each audit shall be filed with the director and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

Source: Laws 1989, LB 319, § 49.

44-4850 Conservation of property of foreign or alien insurers.

(1) If a domiciliary liquidator has not been appointed, the director may apply to the district court of Lancaster County by verified petition for an order directing him or her to act as conservator to conserve the property of an alien

insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(a) Any of the grounds in section 44-4812;

(b) That any of its property has been sequestered by official action in its domiciliary state or in any other state;

(c) That enough of its property has been sequestered in a foreign country to give reasonable cause to believe that the insurer is or may become insolvent; or

(d)(i) That its certificate of authority to do business in this state has been revoked or that none was ever issued; and

(ii) That there are residents of this state with outstanding claims against or outstanding policies issued by such insurer.

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it deems appropriate. The filing or recording of the order with the clerk of the district court or the register of deeds of the county in which the principal business of the company is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds would have imparted.

(4) The conservator may at any time petition for and the court may grant an order under section 44-4851 to liquidate assets of a foreign or alien insurer under conservation or, if appropriate, for an order under section 44-4853 to be appointed ancillary receiver.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against such party.

Source: Laws 1989, LB 319, § 50.

44-4851 Liquidation of property of foreign or alien insurers.

(1) If no domiciliary receiver has been appointed, the director may apply to the district court of Lancaster County by verified petition for an order directing him or her to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state on any of the following grounds:

(a) Any of the grounds in section 44-4812 or 44-4817; or

(b) Any of the grounds specified in subdivisions (1)(b) through (d) of section 44-4850.

(2) When an order is sought under subsection (1) of this section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) If it appears to the court that the best interests of insureds, creditors, and the public require, the court may issue an order to liquidate in whatever terms it deems appropriate. The filing or recording of the order with the clerk of the district court or the register of deeds of the county in which the principal business of the company is located or the county in which its principal office or place of business is located shall impart the same notice as a deed, bill of sale,

or other evidence of title duly filed or recorded with that register of deeds would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 44-4853. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 44-4853.

(5) On the same grounds as are specified in subsection (1) of this section, the director may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction or any lesser part thereof that the director deems desirable for the protection of the insureds and creditors in this state.

(6) The court may order the director, when he or she has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act as are otherwise compatible with the provisions of this section.

Source: Laws 1989, LB 319, § 51; Laws 1991, LB 236, § 82.

44-4852 Domiciliary liquidators in other states; claims of residents.

(1) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under subsection (3) of section 44-4853, be vested by operation of law with the title to all of the assets, property, contracts, and rights of action, agents' balances, and all of the books, accounts, and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state. He or she also shall have the right to recover all other assets of the insurer located in this state subject to section 44-4853.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the director shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books, accounts, and other records of the insurer located in this state at the same time that the domiciliary liquidator is vested with title in the domicile. The director may petition for a conservation or liquidation order under section 44-4850 or 44-4851 or for an ancillary receivership under section 44-4853 or, after approval by the district court of Lancaster County, may transfer title to the domiciliary liquidator as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator if the domiciliary law permits. The claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

Source: Laws 1989, LB 319, § 52.

44-4853 Ancillary formal proceedings.

(1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the director may file a petition with the district court of Lancaster County requesting appointment as ancillary receiver in this state:

(a) If he or she finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver; or

(b) If the protection of insureds or creditors in this state so requires.

(2) The court may issue an order appointing an ancillary receiver in whatever terms it deems appropriate. The filing or recording of the order with the register of deeds in this state imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that register of deeds.

(3) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state and shall pay the necessary expenses of the proceedings. He or she shall promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his or her deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties, and powers to those provided in subsection (3) of this section for ancillary receivers appointed in this state.

Source: Laws 1989, LB 319, § 53; Laws 1991, LB 236, § 83.

44-4854 Ancillary summary proceedings.

The director may institute proceedings under sections 44-4809 to 44-4811 at the request of the director, commissioner, or equivalent official of the domiciliary state of any foreign or alien insurer having property located in this state.

Source: Laws 1989, LB 319, § 54; Laws 1990, LB 984, § 9.

44-4855 Claims of nonresidents against insurers domiciled in this state.

(1) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states which are not reciprocal states shall file claims in this state and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states or with the domiciliary liquidator. Claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in subsection (2) of section 44-4856 with respect to ancillary proceed-

ings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states but shall not be conclusive with respect to priorities against general assets under section 44-4842.

Source: Laws 1989, LB 319, § 55.

44-4856 Claims of residents against insurers domiciled in reciprocal states.

(1) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state or with the domiciliary liquidator. Claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state or in ancillary proceedings, if any, in this state. If a claimant elects to prove his or her claim in this state, he or she shall file his or her claim with the liquidator in the manner provided in sections 44-4835 and 44-4836. The ancillary receiver shall make his or her recommendation to the court as under section 44-4843. He or she shall also arrange a date for hearing if necessary under section 44-4839 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service, at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his or her intention to contest the claim, he or she shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

Source: Laws 1989, LB 319, § 56.

44-4857 Attachment, garnishment, and levy of execution.

During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

Source: Laws 1989, LB 319, § 57.

44-4858 Interstate priorities.

(1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that the

claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors and also claimants against other special deposits who have received smaller percentages from their respective special deposits have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his or her security and file his or her claim as a general creditor or the claim may be discharged by resort to the security in accordance with section 44-4841, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

Source: Laws 1989, LB 319, § 58.

44-4859 Subordination of claims for noncooperation.

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his or her control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under subdivision (8) of section 44-4842.

Source: Laws 1989, LB 319, § 59; Laws 2002, LB 1139, § 27.

44-4860 Continuation of proceedings under prior law.

Every proceeding commenced under the laws in effect before May 26, 1989, shall be deemed to have commenced under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act for the purpose of conducting the proceeding henceforth, except that in the discretion of the director the proceeding may be continued, in whole or in part, as it would have been continued had the act not been enacted.

Source: Laws 1989, LB 319, § 60.

44-4861 Rules and regulations.

The director shall adopt and promulgate rules and regulations to carry out the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1989, LB 319, § 61; Laws 1991, LB 236, § 84.

44-4862 Act, how cited.

Sections 44-4801 to 44-4862 shall be known and may be cited as the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 1991, LB 236, § 85; Laws 2004, LB 1047, § 17; Laws 2011, LB72, § 8.

ARTICLE 49

MANAGING GENERAL AGENTS

Section
44-4901. Act, how cited.
44-4902. Terms, defined.
44-4903. License; requirements.
44-4904. Contract; requirements.

Section
44-4905. Managing general agent; prohibited acts.
44-4906. Insurer; duties.
44-4907. Acts of agent; how treated; examination authority.
44-4908. Violations; penalties; action for damages; construction of act.
44-4909. Rules and regulations.
44-4910. Compliance with act; when.

44-4901 Act, how cited.

Sections 44-4901 to 44-4910 shall be known and may be cited as the Managing General Agents Act.

Source: Laws 1990, LB 1136, § 112.

44-4902 Terms, defined.

For purposes of the Managing General Agents Act:

(1) Actuary means a person who is a member in good standing of the American Academy of Actuaries;

(2) Business entity means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity;

(3) Director means the Director of Insurance;

(4) Insurer means any person duly licensed in this state as an insurance company pursuant to Chapter 44;

(5) Managing general agent means any person who manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office, and acts as an agent for such insurer, whether known as a managing general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites in any one quarter or year an amount of gross direct written premium equal to or more than five percent of the policyholders surplus as reported in the last annual statement of the insurer in any one quarter or year and who (a) adjusts or pays claims in excess of ten thousand dollars or (b) negotiates reinsurance on behalf of the insurer. Managing general agent does not include an attorney in fact for a reciprocal or interinsurance exchange under a power of attorney, an employee of the insurer, a United States manager of the United States branch of an alien insurer, or an underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, and is subject to the Insurance Holding Company System Act and whose compensation is not based on the volume of premiums written;

(6) Person means an individual or a business entity; and

(7) Underwrite means the authority to accept or reject risk on behalf of the insurer.

Source: Laws 1990, LB 1136, § 113; Laws 1991, LB 236, § 86; Laws 1993, LB 583, § 108; Laws 2006, LB 875, § 7.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-4903 License; requirements.

No person shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer licensed in this state unless such person is licensed in accordance with the Insurance Producers Licensing Act. No person shall act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed in accordance with such act.

Source: Laws 1990, LB 1136, § 114; Laws 2006, LB 875, § 8.

Cross References

Insurance Producers Licensing Act, see section 44-4047.

44-4904 Contract; requirements.

No person acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and, if both parties share responsibility for a particular function, specifies the division of such responsibilities and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;

(3) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in an institution that is insured by the Federal Deposit Insurance Corporation. The account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months' estimated claims payments and allocated loss adjustment expenses;

(4) Separate records of business written by the managing general agent will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer, and the director shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the director. Such records shall be retained as determined by the director;

(5) The contract may not be assigned in whole or in part by the managing general agent;

(6) Appropriate underwriting guidelines, including:

(a) The maximum annual premium volume;

(b) The basis of the rates to be charged;

(c) The types of risks which may be written;

(d) Maximum limits of liability;

(e) Applicable exclusions;

(f) Territorial limitations;

(g) Policy cancellation provisions; and

(h) The maximum policy period. The insurer shall have the right to cancel or nonrenew any policy of insurance subject to applicable insurance statutes and regulations;

(7) The insurer shall require the managing general agent to obtain and maintain a surety bond for the protection of the insurer. The bond amount shall be at least one hundred thousand dollars or ten percent of the managing general agent's total annual written premium nationwide produced by the managing general agent for the insurer in the prior calendar year, whichever is greater, but not greater than five hundred thousand dollars;

(8) The insurer may require the managing general agent to maintain an errors and omissions policy;

(9) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(a) All claims must be reported to the insurer in a timely manner;

(b) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount determined by the director or exceeds the limit set by the insurer, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of an amount set by the director or an amount set by the insurer, whichever is less;

(c) All claim files will be the joint property of the insurer and the managing general agent. Upon an order of liquidation of the insurer, such files shall become the sole property of the insurer or its estate, and the managing general agent shall have reasonable access to and the right to copy the files on a timely basis; and

(d) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination;

(10) If electronic claims files are in existence, the contract must address the timely transmission of the data;

(11) The managing general agent shall use only advertising material pertaining to the business issued by an insurer that has been approved in writing by the insurer in advance of its use; and

(12) If the contract provides for a sharing of interim profits by the managing general agent and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments or in any other manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to section 44-4906.

Source: Laws 1990, LB 1136, § 115; Laws 2006, LB 875, § 9.

44-4905 Managing general agent; prohibited acts.

The managing general agent shall not:

(1) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(2) Commit the insurer to participate in insurance or reinsurance syndicates;

(3) Appoint any agent or broker without assuring that the agent or broker is lawfully licensed to transact the type of insurance for which he or she is appointed;

(4) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent of the insurer's policyholders surplus as of December 31 of the last-completed calendar year;

(5) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer;

(6) Permit subagents or subbrokers of the insurer appointed by the managing general agent to serve on the insurer's board of directors;

(7) Jointly employ an individual who is employed by the insurer; or

(8) Appoint a submanaging general agent.

Source: Laws 1990, LB 1136, § 116; Laws 1993, LB 583, § 109.

44-4906 Insurer; duties.

(1) The insurer shall have on file an independent audited financial examination or reports for the two most recent fiscal years that prove that the managing general agent has a positive net worth. If the managing general agent has been in existence for less than two fiscal years, the managing general agent shall include financial statements or reports, certified by an officer of the managing general agent and prepared in accordance with generally accepted accounting principles, for any completed fiscal years and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited financial/annual report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following: (a) Amounts shown on the consolidated audited financial/annual report shall be shown on the worksheet; (b) amounts for each entity shall be stated separately; and (c) explanations of consolidating and eliminating entries.

(2) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. The opinion shall be in addition to any other required loss reserve certification.

(3) The insurer shall periodically, at least semiannually, conduct an onsite review of the underwriting and claims-processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer who is not affiliated with the managing general agent.

(5) Within thirty days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of such appointment or termination to the director. Notices of appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the director may request.

(6) An insurer shall each quarter review its books and records to determine if any producer has become a managing general agent. If the insurer determines that a producer has become a managing general agent, the insurer shall promptly notify the producer and the director of such determination and the insurer and producer shall fully comply with the Managing General Agents Act within thirty days.

(7) No officer, director, employee, subproducer, or controlling shareholder of the insurer's managing general agent shall be appointed to its board of directors. This subsection shall not apply to relationships governed by the Insurance Holding Company System Act.

(8) The insurer shall keep the bond required by subdivision (7) of section 44-4904 on file for review by any applicable state insurance director, superintendent, or commissioner.

Source: Laws 1990, LB 1136, § 117; Laws 1991, LB 236, § 87; Laws 2006, LB 875, § 10.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-4907 Acts of agent; how treated; examination authority.

The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined by the department as if it were the insurer.

Source: Laws 1990, LB 1136, § 118; Laws 2006, LB 875, § 11.

44-4908 Violations; penalties; action for damages; construction of act.

(1) If the director determines that the managing general agent or any other person has not materially complied with the Managing General Agents Act, any rule or regulation adopted or promulgated thereunder, or any order issued thereunder, after notice and opportunity to be heard in accordance with the Administrative Procedure Act, the director may:

(a) For each separate violation, order a penalty in an amount not exceeding five thousand dollars;

(b) Order revocation or suspension of the agent's or broker's license; and

(c) If it was found that because of such material noncompliance that the insurer has suffered any loss or damage, maintain a civil action brought by or on behalf of the insurer and its policyholders and creditors for recovery of damages for the benefit of the insurer and its policyholders and creditors and other appropriate relief.

(2) If an order of rehabilitation or liquidation of the insurer has been entered pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, and the receiver appointed under the order determines that the managing general agent or any other person has not materially complied with the Managing General Agents Act, any rule or regulation adopted and promulgated thereunder, or any order issued thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages and other appropriate relief for the benefit of the insurer.

(3) This section shall not affect the right of the director to impose any other penalties provided for in Chapter 44.

(4) The Managing General Agents Act is not intended to and shall not in any manner limit or restrict the rights of policyholders, claimants, and auditors.

Source: Laws 1990, LB 1136, § 119; Laws 1993, LB 583, § 110.

Cross References

Administrative Procedure Act, see section 84-920.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-4909 Rules and regulations.

The director shall adopt and promulgate reasonable rules and regulations for the implementation and administration of the Managing General Agents Act.

Source: Laws 1990, LB 1136, § 120.

44-4910 Compliance with act; when.

No insurer may continue to utilize the services of a managing general agent on and after January 1, 1991, unless such utilization is in compliance with the Managing General Agents Act.

Source: Laws 1990, LB 1136, § 121.

ARTICLE 50

CHILDREN OF NEBRASKA HEARING AID ACT

Section
44-5001. Act, how cited.
44-5002. Legislative findings and declarations.
44-5003. Terms, defined.
44-5004. Health insurance plan; coverage required; items and services; exemption from act.
44-5005. Rules and regulations.

44-5001 Act, how cited.

Sections 44-5001 to 44-5005 shall be known and may be cited as the Children of Nebraska Hearing Aid Act.

Source: Laws 2019, LB15, § 1.

44-5002 Legislative findings and declarations.

The Legislature finds and declares that:

(1) For a child impacted by hearing loss, his or her ability to develop language can be improved by the consistent use of a hearing aid;

(2) Private insurance benefits for children's hearing aids will ultimately provide long-term savings to the State of Nebraska by decreasing the need for

special education services and increasing the academic success of children impacted by hearing loss; and

(3) In the long-term, implementation of the Children of Nebraska Hearing Aid Act will allow those impacted by the act to be more competitive in the workforce and less dependent on assistance from the state and federal governments.

Source: Laws 2019, LB15, § 2.

44-5003 Terms, defined.

For purposes of the Children of Nebraska Hearing Aid Act:

(1) Health insurance plan means a plan which includes dependent coverage for an insured child and which is delivered, issued for delivery, renewed, extended, or modified in this state. Health insurance plan includes any such group or individual sickness and accident insurance policy, health maintenance organization contract, subscriber contract, employee medical, surgical, or hospital care benefit plan, or self-funded employee benefit plan to the extent not preempted by federal law. Health insurance plan also includes any policy, contract, or plan offered or administered by the state or its political subdivisions. Health insurance plan does not include a group health plan offered by a small employer as defined in section 44-5260 or a policy providing coverage for a specified disease, accident-only coverage, hospital indemnity coverage, disability income coverage, Medicare supplement coverage, long-term care coverage, or other limited-benefit coverage;

(2) Hearing aid means an ear level or bone conduction hearing device intended to aid or improve the sense of hearing for a person with a hearing impairment. The term includes all parts, replacement parts, parts for repair, tubing, and ear molds;

(3) Hearing impairment means a hearing impairment diagnosed by an otolaryngologist with an auditory assessment completed by a licensed audiologist; and

(4) Insured child means an individual who is covered by a health insurance plan and less than nineteen years of age.

Source: Laws 2019, LB15, § 3.

44-5004 Health insurance plan; coverage required; items and services; exemption from act.

(1) Beginning January 1, 2020, except as provided in subsection (4) of this section and notwithstanding section 44-3,131, any health insurance plan delivered, issued for delivery, renewed, extended, or modified in this state shall provide coverage pursuant to the Children of Nebraska Hearing Aid Act to each insured child. Such coverage shall be subject to subsection (2) of this section and shall include, for each ear affected by a hearing impairment, the following items and services:

(a) A hearing aid purchased from a licensed audiologist with the medical clearance from an otolaryngologist and costs related to dispensing such hearing aid;

(b) Evaluation for a hearing aid;

(c) Fitting of a hearing aid;

(d) Programming of a hearing aid;

(e) Probe microphone measurements for verification that hearing aid gain and output meet the prescribed targets;

(f) Hearing aid repairs;

(g) Follow-up adjustments, servicing, and maintenance of a hearing aid;

(h) Ear mold impressions;

(i) Ear molds; and

(j) Auditory rehabilitation and training.

(2)(a) Except as otherwise provided in this subsection, the items and services listed in subsection (1) of this section shall be covered on a continual basis to the extent that benefits paid for such items and services during the immediately preceding forty-eight-month period have not exceeded three thousand dollars.

(b) Coverage pursuant to the act shall allow for the replacement of a hearing aid and the associated services within three months of the dispensing date if the hearing aid gain and output fail to meet prescribed targets or the hearing aid is unable to be repaired or adjusted. If an insured child uses a hearing aid on September 1, 2019, and the hearing aid has been deemed unrepairable or obsolete by the manufacturer of the device, the insured child shall be eligible to use the benefits required by the act towards the acquisition of a new hearing aid, parts, and associated services.

(c) Coverage provided to an insured child pursuant to the act shall be subject to the same deductible, copayment, and coinsurance as similar covered items and services under the health insurance plan.

(3) A health insurance plan shall not refuse or deny coverage, refuse to renew or reissue coverage, or terminate coverage for an individual with a hearing impairment who is less than nineteen years of age based on such hearing impairment.

(4) A health insurance plan shall be exempt from the act for a plan year if, using a calculation method approved by the Department of Insurance, the cost of coverage would likely exceed one percent of all premiums collected under such plan for such plan year.

Source: Laws 2019, LB15, § 4.

44-5005 Rules and regulations.

The Department of Insurance may adopt and promulgate rules and regulations necessary to implement the Children of Nebraska Hearing Aid Act.

Source: Laws 2019, LB15, § 5.

ARTICLE 51

INVESTMENTS

Section

Section

44-5101 Act, how cited.

Sections 44-5101 to 44-5154 shall be known and may be cited as the Insurers Investment Act.

Source: Laws 1991, LB 237, § 1; Laws 2003, LB 216, § 12.

44-5102 Purpose of act.

The purpose of the Insurers Investment Act is to protect and further the interests of policyholders, claimants, creditors, and the general public by

establishing standards, requirements, and limitations for the investments of insurers doing business in this state. Such standards, requirements, and limitations are intended to promote solvency, investment yield and growth, investment diversification, investment value stability, and liquidity to meet business needs.

Source: Laws 1991, LB 237, § 2.

44-5103 Terms, defined.

For purposes of the Insurers Investment Act:

(1) Admitted assets means the investments authorized under the act and stated at values at which they are permitted to be reported in the insurer's financial statement filed under section 44-322, except that admitted assets does not include assets of separate accounts, the investments of which are not subject to the act;

(2) Agent means a national bank, state bank, trust company, or broker-dealer that maintains an account in its name in a clearing corporation or that is a member of the Federal Reserve System and through which a custodian participates in a clearing corporation including the Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, agent may include a corporation that is organized or existing under the laws of a foreign country and that is legally qualified under those laws to accept custody of securities;

(3) Business entity means a sole proprietorship, corporation, limited liability company, association, partnership, limited liability partnership, joint-stock company, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, whether organized for profit or not for profit;

(4) Clearing corporation means a clearing corporation as defined in subdivision (a)(5) of section 8-102, Uniform Commercial Code, that is organized for the purpose of effecting transactions in securities by computerized book-entry, except that with respect to securities issued by institutions organized or existing under the laws of a foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, clearing corporation may include a corporation that is organized or existing under the laws of a foreign country and which is legally qualified under those laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system;

(5) Custodian means:

(a) A national bank, state bank, Federal Home Loan Bank, or trust company that shall at all times during which it acts as a custodian pursuant to the Insurers Investment Act be no less than adequately capitalized as determined by the standards adopted by the regulator charged with establishing such standards and assessing the solvency of such institutions and that is regulated by federal or state banking laws or the Federal Home Loan Bank Act or is a member of the Federal Reserve System and that is legally qualified to accept custody of securities in accordance with the standards set forth below, except

that with respect to securities issued by institutions organized or existing under the laws of a foreign country, or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, custodian may include a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as such by that country's government or an agency thereof that shall at all times during which it acts as a custodian pursuant to the Insurers Investment Act be no less than adequately capitalized as determined by the standards adopted by international banking authorities and that is legally qualified to accept custody of securities; or

(b) A broker-dealer that shall be registered with and subject to jurisdiction of the Securities and Exchange Commission, maintains membership in the Securities Investor Protection Corporation, and has a tangible net worth equal to or greater than two hundred fifty million dollars;

(6) Custodied securities means securities held by the custodian or its agent or in a clearing corporation, including the Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system;

(7) Direct when used in connection with the term obligation means that the designated obligor is primarily liable on the instrument representing the obligation;

(8) Director means the Director of Insurance;

(9) Insurer is defined as provided in section 44-103, and unless the context otherwise requires, insurer means domestic insurer;

(10) Mortgage means a consensual interest created by a real estate mortgage, a trust deed on real estate, or a similar instrument;

(11) Obligation means a bond, debenture, note, or other evidence of indebtedness or a participation, certificate, or other evidence of an interest in any of the foregoing;

(12) Policyholders surplus means the amount obtained by subtracting from the admitted assets (a) actual liabilities and (b) any and all reserves which by law must be maintained. In the case of a stock insurer, the policyholders surplus also includes the paid-up and issued capital stock;

(13) Securities Valuation Office means the Securities Valuation Office of the National Association of Insurance Commissioners or any successor office established by the National Association of Insurance Commissioners;

(14) Security certificate has the same meaning as defined in subdivision (a)(16) of section 8-102, Uniform Commercial Code;

(15) State means any state of the United States, the District of Columbia, or any territory organized by Congress;

(16) Tangible net worth means shareholders equity, less intangible assets, as reported in the broker-dealer's most recent Annual or Transition Report pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934, S.E.C. Form 10-K, filed with the Securities and Exchange Commission; and

(17) Treasury/Reserve Automated Debt Entry Securities System and Treasury Direct system mean the book-entry securities systems established pursuant to 5

U.S.C. 301, 12 U.S.C. 391, and 31 U.S.C. 3101 et seq. The operation of the systems are subject to 31 C.F.R. part 357 et seq.

Source: Laws 1991, LB 237, § 3; Laws 1997, LB 273, § 2; Laws 1999, LB 259, § 11; Laws 2005, LB 119, § 13; Laws 2007, LB117, § 12; Laws 2009, LB192, § 4.

44-5104 Applicability of act.

(1) A domestic insurer holding a certificate of authority to do business in this state shall be subject to the Insurers Investment Act. Except as otherwise provided by law, only investments determined to be authorized investments under the act shall be considered admitted assets for purposes of a domestic insurer's financial statements filed with the director pursuant to section 44-322.

(2) A foreign or alien insurer holding a certificate of authority to do business in this state shall not be subject to the act unless the director notifies such insurer that any of its investments will not be recognized by him or her as an authorized investment for purposes of the act.

Source: Laws 1991, LB 237, § 4; Laws 1997, LB 273, § 3.

44-5105 Authorization and approval; investment records; board of directors; duties.

(1) An insurer shall not make any investment, sale, loan, or exchange, except loans on its own policies or contracts, unless authorized, approved, or ratified by a majority of the members of the board of directors or by a committee of its members charged by the board of directors or bylaws with the duty of making such investment, sale, loan, or exchange. The board of directors shall further determine by formal resolution at least annually whether all investments have been made in accordance with the delegations, standards, limitations, and investment objectives prescribed by the board of directors or a committee of the board of directors charged with the responsibility to direct its investments.

(2) The board of directors, after reviewing and assessing the insurer's technical investment and administrative capabilities and expertise, shall adopt a written plan for making investments and for engaging in investment practices. The plan shall specify, unless otherwise authorized by the Director of Insurance, the quality, maturity, and diversification of investments, including investment strategies intended to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus.

(3) On no less than a quarterly basis, and more often if deemed appropriate, the board of directors or committee of the board of directors shall:

(a) Receive and review a summary report on the insurer's investment portfolio, investment activities, and investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan; and

(b) Review and revise, as appropriate, the written plan.

(4) The board of directors shall require that records of authorizations, approvals or other documentation as the board of directors may require, and reports of any action taken under authority delegated under the written plan shall be made available on a regular basis to the board of directors.

(5) The board of directors shall perform its duties in good faith and with that degree of care that ordinarily prudent individuals in like positions would use under similar circumstances.

(6) Each insurer shall maintain a record of its investments in a form and manner as prescribed by the Director of Insurance. Such record shall include an indication by the insurer of the provision of law under which an investment is held.

(7) For purposes of this section, board of directors includes the governing body of an insurer having authority equivalent to that of a board of directors.

Source: Laws 1991, LB 237, § 5; Laws 1997, LB 273, § 4.

44-5106 Policy loans.

An insurer may make loans on any of its policies in an amount not exceeding the reserve thereon.

Source: Laws 1991, LB 237, § 6.

44-5107 Separate accounts.

A life insurer may allocate amounts to separate accounts established pursuant to sections 44-402.01 to 44-402.05.

Source: Laws 1991, LB 237, § 7.

44-5108 Convertible securities.

An insurer may invest in securities which are convertible into other securities if:

(1) The convertible securities are authorized under the Insurers Investment Act at the time of acquisition; and

(2) The securities into which such securities are convertible are authorized under the act at the time of conversion.

Source: Laws 1991, LB 237, § 8.

44-5109 Investments in name of insurer.

An insurer's investments shall be held in its own name or the name of its nominee, except that:

(1) Investments may be held in the name of a clearing corporation, a custodian, or the nominee of either on the following conditions:

(a) The clearing corporation, custodian, or nominee shall be legally authorized to hold the particular investment for the account of others;

(b) Security certificates held by the custodian shall be held separate from the security certificates of the custodian and of all its other customers; and

(c) Securities held indirectly by the custodian and securities in a clearing corporation shall be separately identified on the custodian's official records as being owned by the insurer. The records shall identify which securities are held by the custodian or by its agent and which securities are in a clearing corporation. If the securities are in a clearing corporation, the records shall also identify where the securities are and if in a clearing corporation, the name of the clearing corporation, and if through an agent, the name of the agent; and

(2) An insurer may participate through a member bank in the Federal Reserve book-entry system. The records of the member bank shall at all times show that the investments are held for the insurer or for specific accounts of the insurer.

Source: Laws 1991, LB 237, § 9; Laws 2005, LB 119, § 14.

44-5110 Participation.

(1) An insurer may invest in an individual interest of a pool of obligations or a fractional interest of a single obligation if:

(a) The certificate of participation or interest or the confirmation of participation or interest in the investment is issued in the name of the insurer, a custodian bank, or the nominee of either; and

(b) The certificate or confirmation, if held by a custodian bank, is kept separate and apart from the investment of others so that at all times the participation or interest may be identified as belonging solely to the insurer making the investment.

(2) If an investment is not evidenced by a certificate, adequate evidence of the insurer's investment shall be obtained from the issuer or its transfer or recording agent and retained by the insurer, custodian bank, or clearing corporation except as provided in subdivision (2) of section 44-5109. For purposes of this subsection, adequate evidence shall mean a written receipt or other verification issued by the depository, issuer, or custodian bank which shows that the investment is held for the insurer. Transfers of ownership or investments held as described in subdivisions (1)(c) and (2) of section 44-5109 and this section may be evidenced by a bookkeeping entry on the books of the issuer of the investment, its transfer or recording agent, or the clearing corporation without physical delivery of certificates, if any, evidencing the insurer's investment.

(3) Any investment made pursuant to this section shall also conform with the following:

(a) The investment in which the interest is purchased shall be authorized under the Insurers Investment Act; and

(b) The insurer's pro rata interest in the investment shall be in the same percentage as the par amount of its interest bears to the outstanding par amount of the investment at the time of purchase.

(4) An investment may be authorized under this section although its interest does not include the right to exercise the investor's rights or enforce the investor's remedies according to the provisions of the issue.

(5) Any investment made pursuant to this section shall be purchased pursuant to a written participation agreement.

Source: Laws 1991, LB 237, § 10; Laws 1997, LB 273, § 5; Laws 2003, LB 216, § 13; Laws 2007, LB117, § 13.

44-5111 Computation of investment limitations.

Any investment limitation in the Insurers Investment Act based upon the amount of the insurer's admitted assets or policyholders surplus shall relate to admitted assets or policyholders surplus as shown by the most recent financial statement filed by the insurer pursuant to section 44-322 unless the insurer's

admitted assets or policyholders surplus is revised as a result of an examination conducted pursuant to the Insurers Examination Act, in which case the results of the examination shall control. Except as otherwise provided by law, an investment shall be measured by the lesser of actual cost or admitted value at the time of acquisition. If there is no actual cost at the time of acquisition, the investment shall be measured at the lesser of fair value or admitted value.

For purposes of this section, actual cost means the total amount invested, expended, or which should be reasonably anticipated to be invested or expended in the acquisition or organization of any investment, insurer, or subsidiary, including all organizational expenses or contributions to capital and surplus whether or not represented by the purchase of capital stock or issuance of other securities.

Source: Laws 1991, LB 237, § 11; Laws 1993, LB 583, § 111; Laws 2007, LB117, § 14.

Cross References

Insurers Examination Act, see section 44-5901.

44-5112 Minimum quality ratings.

Any investment required to meet minimum quality ratings by the Insurers Investment Act shall be subject to the following categories:

(1) Category 1. Any investment subject to this subdivision shall have a 1 designation from the Securities Valuation Office. If the Securities Valuation Office does not rate the investment in question but does rate an obligation of the obligor having a priority equal to or lower than the investment in question, the insurer may apply such rating to the investment. If the Securities Valuation Office does not rate the investment in question or an outstanding obligation of the obligor having a priority equal to or lower than the investment in question, the investment shall have a minimum quality rating of A3 by Moody's Investors Services, Inc., A- by Standard and Poor's Corporation, or the corresponding investment grade rating from any nationally recognized statistical rating organization recognized by the Securities Valuation Office; and

(2) Category 2. Any investment subject to this subdivision shall have a 1 or 2 designation from the Securities Valuation Office. If the Securities Valuation Office does not rate the investment in question but does rate an obligation of the obligor having a priority equal to or lower than the investment in question, the insurer may apply such rating to the investment. If the Securities Valuation Office does not rate the investment in question or an outstanding obligation of the obligor having a priority equal to or lower than the investment in question, the investment shall have a minimum quality rating of Baa3 by Moody's Investors Services, Inc., BBB- by Standard and Poor's Corporation, or the corresponding investment grade rating from any nationally recognized statistical rating organization recognized by the Securities Valuation Office. If the obligor of an investment is authorized by, established by, or incorporated under the laws of Canada or any province thereof and the Securities Valuation Office does not rate the investment in question, the minimum quality rating shall be BBB (low) by the Dominion Bond Rating Service, B++ by the Canadian Bond Rating Service, or the corresponding rating of any successor organization approved by the director.

Source: Laws 1991, LB 237, § 12; Laws 1997, LB 273, § 6.

44-5113 Valuation of investments.

For purposes of the Insurers Investment Act, investments shall be valued in accordance with the valuation procedures established by the National Association of Insurance Commissioners unless the director requires a different valuation method or finds another valuation method reasonable under the circumstances.

Source: Laws 1991, LB 237, § 13.

44-5114 Prohibited investments.

An insurer shall not invest in:

(1) Issued shares of its own capital stock except with the written permission of the director. Such permission may be granted if the purpose of the acquisition is:

(a) In connection with the lawful plan for mutualization of the insurer;

(b) In furtherance of a retirement, pension, or incentive program for officers or employees of the insurer which has been approved by the shareholders; or

(c) Shown to be for the benefit of all shareholders.

Any share acquired pursuant to this subdivision shall not be considered an admitted asset; and

(2) Any investment which is found by the director to be designed to evade any provision of the Insurers Investment Act.

Source: Laws 1991, LB 237, § 14.

44-5115 Limitation in any one person.

(1) Except as provided in subsections (2) through (4) of this section, an insurer's investments authorized under the Insurers Investment Act in any one person shall not exceed five percent of the insurer's admitted assets.

(2) Subsection (1) of this section shall not apply to:

(a) Investments authorized under sections 44-5123, 44-5125, 44-5142, and 44-5153;

(b) Investments authorized under sections 44-5124, 44-5126 to 44-5129, and 44-5132 if collateralized by obligations or mortgages for which the full faith and credit of the United States or Canada is pledged for the payment of all principal and interest;

(c) Loans made pursuant to section 44-5106; and

(d) Real estate held pursuant to subsection (2) or (3) of section 44-5144.

(3)(a) An insurer's investments authorized under section 44-5124 or 44-5126 in any one agency or instrumentality of the United States or Canada shall not exceed twenty-five percent of the insurer's admitted assets, and (b) an insurer's investments authorized under section 44-5132 in any one person if collateralized by mortgages for which the full faith and credit of an agency or instrumentality of the United States or Canada is pledged for the payment of all principal and interest shall not exceed twenty-five percent of the insurer's admitted assets. An insurer's investments authorized under section 44-5124 or 44-5126 in any one agency or instrumentality of the United States or Canada and the insurer's investments authorized under section 44-5132 collateralized by mortgages for which the full faith and credit of such agency or instrumentality of the

United States or Canada is pledged for the payment of all principal and interest, in the aggregate, shall not exceed twenty-five percent of the insurer's admitted assets.

(4)(a) An insurer's investments in any one person whose senior obligations have a 3 designation from the Securities Valuation Office, in the aggregate, shall not exceed three percent of the insurer's admitted assets.

(b) An insurer's investments in any one person whose senior obligations have a 4 designation from the Securities Valuation Office, in the aggregate, shall not exceed two percent of the insurer's admitted assets.

(c) An insurer's investments in any one person whose senior obligations have a 5 designation from the Securities Valuation Office, in the aggregate, shall not exceed one percent of the insurer's admitted assets.

(d) An insurer's investments in any one person whose senior obligations have a 6 designation from the Securities Valuation Office, in the aggregate, shall not exceed one-half percent of the insurer's admitted assets.

(5) For purposes of this section, person shall mean an individual or entity or group of individuals or entities so related as in fact to constitute a single venture, institution, corporation, association, company, partnership, limited liability company, syndicate, trust, society, or other legal entity.

Source: Laws 1991, LB 237, § 15; Laws 1993, LB 121, § 259; Laws 1997, LB 273, § 7; Laws 1998, LB 1035, § 10.

44-5116 Several obligors.

The amount of any obligation issued, assumed, or guaranteed by more than one obligor and authorized under more than one provision of the Insurers Investment Act shall be allocated to those provisions on a basis proportional to the obligations of each obligor.

Source: Laws 1991, LB 237, § 16.

44-5117 Investments authorized under more than one provision.

An insurer may hold an investment authorized under more than one provision of the Insurers Investment Act under the provision of its choice except as otherwise expressly provided by law. Nothing in the act shall prevent an insurer from holding an investment under a provision different from the one under which it previously held the investment except as otherwise expressly provided by law.

Source: Laws 1991, LB 237, § 17; Laws 1997, LB 273, § 8.

44-5118 Legal tender.

All cash payments of principal, interest, premiums, dividends, and other cash consideration received on any investment authorized under the Insurers Investment Act shall be payable in lawful money of the United States except as provided in section 44-5137.

Source: Laws 1991, LB 237, § 18; Laws 1997, LB 273, § 9.

44-5119 Director's authority.

(1) The director may impose reasonable and temporary restrictions upon the investments of an insurer, including prohibition or divestment of a particular

investment, if the director finds that the interests of insureds, creditors, or the general public are or may be endangered.

(2) If any insurer desires to exceed any investment limitation contained in the Insurers Investment Act, the insurer shall file an application with the director requesting written approval to exceed the investment limitation. The application shall set out all pertinent information regarding the proposed investment, including a full description of the investment, its actual cost, its market value, any appraisals, any encumbrances, the interest rate, the maturity dates, as appropriate, and any other relevant information requested by the director. The application shall be a public record open to public inspection from the date of filing. If the application is not approved or disapproved by the director within thirty days from the date of filing, the application shall be deemed disapproved. The disapproval in whole or in part shall be in the sole discretion of the director and shall not be subject to judicial review.

In determining whether to approve or disapprove the application, the director shall consider the following factors:

(a) The credit risk quality of the proposed investment;

(b) The liquidity of the proposed investment and of the insurer's entire investment portfolio;

(c) The extent of the diversification of the insurer's investment portfolio;

(d) The yield of the proposed investment;

(e) The reasonableness of the insurer's policyholders surplus in relation to the insurer's outstanding liabilities and financial needs as evaluated in accordance with the factors set forth in section 44-2136; and

(f) Any other relevant considerations.

If the director approves the application in whole or in part, the proposed investment shall be deemed to be an authorized investment to the extent of the director's approval. Whenever an insurer makes application pursuant to this subsection, the director may retain, at the insurer's expense, such attorneys, actuaries, accountants, and other experts not otherwise a part of the director's staff as are reasonably necessary to assist the director in determining whether such application should be approved. Any individual or organization so retained shall be under the direction and control of the director and shall serve in a purely advisory capacity.

Source: Laws 1991, LB 237, § 19.

44-5120 Lending of securities.

(1) An insurer may lend its securities if:

(a) The securities are created or existing under the laws of the United States and, simultaneously with the delivery of the loaned securities, the insurer receives collateral from the borrower consisting of cash or securities backed by the full faith and credit of the United States or an agency or instrumentality of the United States, except that any securities provided as collateral shall not be of lesser quality than the quality of the loaned securities. Any investment made by an insurer with cash received as collateral for loaned securities shall be made in the same kinds, classes, and investment grades as those authorized under the Insurers Investment Act and in a manner that recognizes the liquidity needs of the transaction or is used by the insurer for its general corporate

purposes. The securities provided as collateral shall have a market value when the loan is made of at least one hundred two percent of the market value of the loaned securities;

(b) The securities are created or existing under the laws of Canada or are securities described in section 44-5137 and, simultaneously with the delivery of the loaned securities, the insurer receives collateral from the borrower consisting of cash or securities backed by the full faith and credit of the foreign country, except that any securities provided as collateral shall not be of lesser quality than the quality of the loaned securities. Any investment made by an insurer with cash received as collateral for loaned securities shall be made in the same kinds, classes, and investment grades as those authorized under the Insurers Investment Act and in a manner that recognizes the liquidity needs of the transaction or is used by the insurer for its general corporate purposes. The securities provided as collateral shall have a market value when the loan is made of at least one hundred two percent of the market value of the loaned securities;

(c) Prior to the loan, the borrower or any indemnifying party furnishes the insurer with or the insurer otherwise obtains the most recent financial statement of the borrower or any indemnifying party;

(d) The insurer receives a reasonable fee related to the market value of the loaned securities and to the term of the loan;

(e) The loan is made pursuant to a written loan agreement; and

(f) The borrower is required to furnish by the close of each business day during the term of the loan a report of the market value of all collateral and the market value of all loaned securities as of the close of trading on the previous business day. If at the close of any business day the market value of the collateral for any loan outstanding to a borrower is less than one hundred percent of the market value of the loaned securities, the borrower shall deliver by the close of the next business day an additional amount of cash or securities. The market value of the additional securities, together with the market value of all previously delivered collateral, shall equal at least one hundred two percent of the market value of the loaned securities for that loan.

(2) For purposes of this section, market value includes accrued interest.

(3) An insurer shall effect securities lending only through the services of a custodian bank or similar entity as approved by the director.

(4) An insurer's investments authorized under this section shall not exceed ten percent of its admitted assets.

Source: Laws 1991, LB 237, § 20; Laws 1997, LB 273, § 10; Laws 2002, LB 1139, § 28; Laws 2003, LB 216, § 15; Laws 2007, LB117, § 15.

44-5120.01 Repurchase and reverse repurchase transactions.

(1) For purposes of this section:

(a) Acceptable collateral means:

(i) As to repurchase transactions, cash, cash equivalents, and direct obligations of, or securities that are fully guaranteed as to principal and interest by, the government of the United States or an agency of the government of the

United States or the Federal National Mortgage Association or the Federal Home Loan Mortgage Corporation; and

(ii) As to reverse repurchase transactions, cash and cash equivalents;

(b) Cash equivalents means short-term, highly rated investments or securities readily convertible to known amounts of cash without penalty and so near maturity that they present insignificant risk of change in value. Cash equivalents includes government money market mutual funds and class one money market mutual funds. For purposes of this definition:

(i) Short-term means investments with a remaining term to maturity of ninety days or less; and

(ii) Highly rated means an investment rated at least P-1 by Moody's Investors Service, Inc., A-1 by Standard and Poor's division of The McGraw Hill Companies, Inc., or its equivalent rating by a nationally recognized statistical rating organization recognized by the Securities Valuation Office;

(c) Repurchase transaction means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand; and

(d) Reverse repurchase transaction means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(2) An insurer may engage in repurchase and reverse repurchase transactions as set forth in this section. The insurer shall enter into a written agreement for transactions entered under this section. Such agreements shall require that each transaction terminate no more than one year from its inception.

(3) Cash received in a transaction under this section shall be invested in accordance with the Insurers Investment Act and in a manner that recognizes the liquidity needs of the transaction or is used by the insurer for its general corporate purposes.

(4) So long as the transaction remains outstanding, the insurer, or its agent or custodian, shall maintain as acceptable collateral received in a transaction under this section, either physically or through the book entry systems of the federal reserve, depository trust company, participants' trust company, or other securities depositories approved by the director:

(a) Possession of the acceptable collateral;

(b) A perfected security interest in the acceptable collateral; or

(c) In the case of a jurisdiction outside of the United States, title to, or rights of a secured creditor to, the acceptable collateral.

(5) The limitations of sections 44-5115 and 44-5137 shall not apply to the business entity counterparty exposure created by transactions under this section. An insurer shall not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(a) The aggregate amount of securities then sold to or purchased from any one business entity counterparty under this section would exceed five percent of its admitted assets; and in calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transac-

tions, effect may be given to netting provisions under a master written agreement; or

(b) The aggregate amount of all securities then sold to or purchased from all business entities under this section would exceed twenty percent of its admitted assets.

(6)(a) In a reverse repurchase transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to ninety-five percent of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than ninety-five percent of the market value of the securities so transferred, the business entity counterparty shall be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals ninety-five percent of the market value of the transferred securities.

(b) In a repurchase transaction, the insurer shall receive acceptable collateral having a market value at least equal to one hundred two percent of the purchase price paid by the insurer. If at any time the market value of the acceptable collateral is less than one hundred percent of the purchase price paid by the insurer, the business entity counterparty shall be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, at least equals one hundred two percent of the purchase price. Securities acquired by an insurer in a repurchase transaction shall not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

Source: Laws 2003, LB 216, § 14.

44-5121 Applicability of act.

An insurer's investments shall be subject to the Insurers Investment Act notwithstanding anything in 15 U.S.C. 77r-1 to the contrary.

Source: Laws 1991, LB 237, § 21.

44-5122 Investments held on September 13, 1997.

Any investment held by an insurer on September 13, 1997, which was an authorized investment immediately prior to such date shall be deemed an authorized investment under the Insurers Investment Act.

Source: Laws 1991, LB 237, § 22; Laws 1997, LB 273, § 11.

44-5123 United States Government and government-guaranteed obligations.

An insurer may invest in direct obligations of the United States or obligations for which the full faith and credit of the United States is pledged for the payment of all principal and interest.

Source: Laws 1991, LB 237, § 23.

44-5124 United States agency and instrumentality obligations.

An insurer may invest in direct obligations of any agency or instrumentality of the United States or obligations for which the full faith and credit of any

agency or instrumentality of the United States is pledged for the payment of all principal and interest.

Source: Laws 1991, LB 237, § 24.

44-5125 Canadian Government and government-guaranteed obligations.

An insurer may invest in direct obligations of the government of Canada or obligations for which the full faith and credit of the government of Canada is pledged for the payment of all principal and interest.

Source: Laws 1991, LB 237, § 25.

44-5126 Canadian agency and instrumentality obligations.

An insurer may invest in direct obligations of any agency or instrumentality of the government of Canada or obligations for which the full faith and credit of any agency or instrumentality of the government of Canada is pledged for the payment of all principal and interest.

Source: Laws 1991, LB 237, § 26.

44-5127 Canadian provincial and municipal obligations.

An insurer may invest in direct obligations of any province or municipality of Canada or obligations for which the full faith and credit of any province or municipality of Canada is pledged for the payment of all principal and interest. Any investment authorized under this section shall have a minimum quality rating as described in subdivision (2) of section 44-5112.

Source: Laws 1991, LB 237, § 27; Laws 1997, LB 273, § 12.

44-5128 Other governmental and related obligations.

An insurer may invest in obligations issued, assumed, or guaranteed by the United States, an agency or instrumentality of the United States, a state, a municipality, a political subdivision, the government of Canada, an agency or instrumentality of the government of Canada, any province or municipality of Canada, or any municipal utility, corporate authority, nonprofit corporation, or institution authorized or established by an act of Congress or by the laws of any state, Canada, or any province of Canada if, by statutory or other legal requirements applicable to those obligations, they are payable as to both principal and interest:

(1) From taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of the borrowing entity;

(2) From adequate special revenue pledged or otherwise appropriated or required by law to be provided for the purpose of the payment, excluding any obligation payable solely out of special assessments on properties benefited by local improvements;

(3) From and secured by a pledge of rentals from leases or subleases on property owned or leased by the obligor if:

(a) Such underlying lease has an unexpired term of not less than the term of the lease or sublease whose rentals are pledged by the issuer; and

(b) The fixed rentals reserved under such lease or sublease will be sufficient to pay all of the expenses of the lessor in connection with the lease or sublease and the operation of the property and to pay principal and interest so as to

retire the bonds during the fixed term of such lease or sublease or, if such fixed rentals are not sufficient, a governmental subdivision agrees to pay such required amounts;

(4) From revenue specifically pledged therefor of a public service operated by the borrowing entity if the entity is legally authorized and does obligate itself that rates of service will be fixed, maintained, and collected so as to produce revenue or earnings sufficient to pay all operating and maintenance charges and all principal and interest of such obligations in accordance with their terms; or

(5) From revenue specifically pledged therefor from excise taxes levied.

Any investment authorized under this section shall have a minimum quality rating as described in subdivision (2) of section 44-5112.

Source: Laws 1991, LB 237, § 28; Laws 1997, LB 273, § 13.

44-5129 Business entity obligations.

An insurer may invest in obligations of a business entity created or existing under the laws of the United States or Canada or any state or province thereof. Any investment authorized under this section shall have a minimum quality rating as described in subdivision (2) of section 44-5112.

Source: Laws 1991, LB 237, § 29; Laws 1997, LB 273, § 14.

44-5130 Repealed. Laws 1997, LB 273, § 27.

44-5131 International development bank obligations.

An insurer may invest in obligations of an international development bank of which the United States is a member. Any investment authorized under this section shall have a minimum quality rating as described in subdivision (1) of section 44-5112. An insurer's investments authorized under this section shall not exceed twenty percent of its admitted assets.

Source: Laws 1991, LB 237, § 31; Laws 1997, LB 273, § 15.

44-5132 Bankruptcy-remote business entity securities.

(1) An insurer may invest in a security or other instrument, excluding a mutual fund, evidencing an interest in or the right to receive payments from, or payable from distributions on, an asset, a pool of assets, or specifically divisible cash flows which are legally transferred to a special purpose bankruptcy-remote business entity created or existing under the laws of the United States or Canada or any state or province thereof, on the following conditions:

(a) The business entity is established solely for the purpose of acquiring specific types of assets or rights to cash flows, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the business entity; and

(b) The assets of the business entity consist solely of interest-bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights. However, the existence of credit enhancements, such as letters of credit or guarantees, or other support

features, shall not cause a security or other instrument to be an unauthorized investment under this section.

(2) Investments in interest-only securities or other instruments shall not be authorized under this section.

(3) Any investment authorized under this section shall have a minimum quality rating as described in subdivision (2) of section 44-5112.

Source: Laws 1991, LB 237, § 32; Laws 1997, LB 273, § 16.

44-5133 Repealed. Laws 1997, LB 273, § 27.

44-5134 Collateral loans.

(1) An insurer may, in addition to any investment authorized under section 44-5132, invest in obligations secured by pledged securities if:

(a) The market value of such pledged securities or the fair value if the securities have no recognized market value will at all times of holding the investment be equal to at least one hundred ten percent of the investment in the notes or other evidence of indebtedness; and

(b) The pledged securities are of the kind authorized for investment under the Insurers Investment Act.

(2) For purposes of this section, pledged securities shall mean notes, mortgages, bonds, debentures, and preferred or common stock. Pledged securities shall not be valued at an amount greater than the value at which they could be shown on the insurer's financial statements filed with the director pursuant to section 44-322 if owned directly by the insurer.

(3) An insurer's investments authorized under this section shall not exceed twenty percent of its admitted assets.

Source: Laws 1991, LB 237, § 34; Laws 1997, LB 273, § 17.

44-5135 Leased property.

An insurer may invest in obligations secured by an assignment of a lease to or for the benefit of the insurer and the rents payable under the lease if:

(1) The lessee or ultimate guarantor of any lease securing the obligation is an entity the obligations of which are authorized for investment under sections 44-5123 to 44-5131;

(2) The rentals assigned are sufficient to repay not less than ninety percent of the obligation within the unexpired term of the lease excluding any term that may be provided by an enforceable option of renewal; and

(3) A first lien on the lessor's interest in the unencumbered leased property is obtained as additional security for the obligation for which the rentals described in subdivision (2) of this section are not sufficient to repay the obligation.

Source: Laws 1991, LB 237, § 35.

44-5136 Repealed. Laws 1997, LB 273, § 27.

44-5137 Foreign securities.

(1) An insurer may invest in securities or other investments (a) issued in, (b) located in, (c) denominated in the currency of, (d) whose ultimate payment

amounts of principal or interest are subject to fluctuations in the currency of, or (e) whose obligors are domiciled in countries other than the United States or Canada, which are substantially of the same kinds and classes as those authorized for investment under the Insurers Investment Act.

(2) Subject to the limitations in subsection (3) of this section:

(a) An insurer's investments authorized under subsection (1) of this section in any one foreign jurisdiction whose sovereign debt has a 1 designation from the Securities Valuation Office shall not exceed ten percent of the insurer's admitted assets;

(b) An insurer's investments authorized under subsection (1) of this section in any one foreign jurisdiction whose sovereign debt has a 2 or 3 designation from the Securities Valuation Office shall not exceed five percent of the insurer's admitted assets;

(c) An insurer's investments authorized under subsection (1) of this section in any one foreign jurisdiction whose sovereign debt has a 4, 5, or 6 designation from the Securities Valuation Office shall not exceed three percent of the insurer's admitted assets;

(d) An insurer's investments authorized under subsection (1) of this section denominated in any one foreign currency shall not exceed two percent of the insurer's admitted assets;

(e) An insurer's investments authorized under subsection (1) of this section denominated in foreign currencies, in the aggregate, shall not exceed five percent of the insurer's admitted assets; and

(f) An insurer's investments authorized under subsection (1) of this section shall not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under section 44-5149 to exchange all payments made on the foreign currency denominated investments for United States currency at a rate which effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

(3) An insurer's investments authorized under subsection (1) of this section shall not exceed, in the aggregate, twenty percent of its admitted assets.

(4) An insurer which is authorized to do business in a foreign country or which has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in a foreign country may, in addition to the investments authorized by subsection (1) of this section, invest in securities and investments (a) issued in, (b) located in, (c) denominated in the currency of, (d) whose ultimate payment amounts of principal and interest are subject to fluctuations in the currency of, or (e) whose obligors are domiciled in such foreign countries, which are substantially of the same kinds and classes as those authorized for investment under the act.

(5) An insurer's investments authorized under subsection (4) of this section and cash in the currency of such country which is at any time held by such insurer, in the aggregate, shall not exceed the greater of (a) one and one-half times the amount of its reserves and other obligations under such contracts or (b) the amount which such insurer is required by law to invest in such country.

(6) Any investment in debt obligations authorized under this section shall have a minimum quality rating as described in subdivision (2) of section 44-5112.

(7) An insurer's investments made under this section shall be aggregated with investments of the same kinds and classes made under the Insurers Investment Act except section 44-5153 for purposes of determining compliance with the limitations contained in other sections.

Source: Laws 1991, LB 237, § 37; Laws 1997, LB 273, § 18; Laws 2007, LB117, § 16.

44-5138 Short-term investments.

(1) An insurer may invest in:

(a) Bank certificates of deposit, banker's acceptances, or corporate promissory notes with a remaining term of no more than one year; and

(b) Shares, interests, or participation certificates in any management type of investment trust, corporate or otherwise, registered under the Investment Company Act of 1940, as amended, as a diversified open-end investment company, that invests solely in such investments as described in subdivision (1)(a) of this section.

(2) Any investment in corporate promissory notes authorized under subdivision (1)(a) of this section shall have a 1 or 2 designation from the Securities Valuation Office. If the Securities Valuation Office does not rate the investment in question but does rate an obligation of the obligor having a priority equal to or lower than the investment in question, the insurer may apply such rating to the investment. If the Securities Valuation Office does not rate the investment in question or an outstanding obligation of the obligor having a priority equal to or lower than the investment in question, the investment shall have a minimum short-term quality rating of P-2 by Moody's Investors Service, Inc., A-2 by Standard and Poor's Corporation, or the corresponding investment grade rating from any nationally recognized statistical rating organization recognized by the Securities Valuation Office. If the obligor of an investment is authorized by, established by, or incorporated under the laws of Canada or any province thereof and the Securities Valuation Office does not rate the investment in question, the minimum quality rating shall be R-2 by the Dominion Bond Rating Service, A-1 by the Canadian Bond Rating Service, or the corresponding rating of any successor organization approved by the director.

Source: Laws 1991, LB 237, § 38; Laws 1997, LB 273, § 19; Laws 2003, LB 216, § 16.

44-5139 Investment trusts and investment companies.

(1) An insurer may invest in shares of a fund registered under the Investment Company Act of 1940, as amended, as a diversified open-end investment company and in shares, interests, or participation certificates in any management type of investment trust, corporate or otherwise, subject to the following restrictions:

(a) The investment restrictions and policies relating to the investment of the assets of the trust and its activities shall be limited to the same kinds, classes, and investment grades as those authorized for investment under the Insurers Investment Act; and

(b) The assets of such investment trust shall not be less than twenty million dollars at the date of purchase.

An insurer's investments authorized under this subsection shall not exceed ten percent of its admitted assets. Shares, interests, or participation certificates in trusts described in this subsection shall also be subject to the overall limitation of subsection (3) of section 44-5141.

(2) An insurer may invest in the shares of a fund registered under the Investment Company Act of 1940, as amended, as a diversified open-end investment company when the investment restrictions and policies relating to the investment of the assets of the fund and its activities are limited solely to (a) obligations, (b) commitments to purchase obligations, or (c) assignments of interest in obligations issued or guaranteed by the United States or its agencies or instrumentalities. An insurer's investments authorized under this subsection shall not exceed twenty-five percent of its admitted assets.

Source: Laws 1991, LB 237, § 39.

44-5140 Preferred stock.

(1) An insurer may invest in the preferred stock of any corporation which:

(a) Has retained earnings of not less than one million dollars;

(b) Has earned and paid regular dividends at the regular prescribed rate each year upon its preferred stock, if any is or has been outstanding, for not less than five years immediately preceding the purchase of such preferred stock or during such part of such five-year period as it has had preferred stock outstanding; and

(c) Has had no material defaults in principal payments of or interest on any obligations of such corporation and its subsidiaries having a priority equal to or higher than those purchased during the period of five years immediately preceding the date of acquisition or, if outstanding for less than five years, at any time since such obligations were issued.

The earnings of and the regular dividends paid by all predecessor, merged, consolidated, or purchased corporations may be included through the use of consolidated or pro forma statements.

(2) Except as authorized under the Insurance Holding Company System Act, an insurer shall not own more than five percent of the total issued shares of stock of any corporation other than an insurer.

(3) A life insurer's investments authorized under this section shall not exceed the greater of twenty-five percent of its admitted assets or one hundred percent of its policyholders surplus, nor shall a life insurer's investments authorized under this section that are not rated P-1 or P-2 by the Securities Valuation Office exceed ten percent of its admitted assets.

Source: Laws 1991, LB 237, § 40; Laws 2007, LB117, § 17.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-5141 Common stock; equity interests.

(1) An insurer may invest in the common stock or rights to purchase or sell common stock of any corporation which has retained earnings of not less than one million dollars, except that an investment may be made in any corporation having a majority of its operations in this state which has retained earnings of not less than two hundred fifty thousand dollars. The earnings of all predeces-

sor, merged, consolidated, or purchased corporations shall be included through the use of consolidated or pro forma statements.

(2)(a) An insurer may invest in equity interests or rights to purchase or sell equity interests in business entities other than general partnerships.

(b)(i) A life insurer's investments authorized under this subsection shall not exceed fifty percent of its policyholders surplus.

(ii) A life insurer shall not invest under this subsection in any investment which the life insurer may invest in under section 44-5140 or 44-5144 or subsection (1) of this section.

(3) Except as authorized under the Insurance Holding Company System Act, an insurer shall not invest in more than ten percent of the total equity interests in any business entity other than an insurer.

(4) A life insurer's investments authorized under this section shall not exceed one hundred percent of its policyholders surplus.

Source: Laws 1991, LB 237, § 41; Laws 1997, LB 273, § 20; Laws 2007, LB117, § 18.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-5142 Insurance company stock.

(1) Stock insurers which maintain capital stock required by section 44-214 and nonstock insurers which maintain surplus required by section 44-219 may invest in the common and preferred stock of other insurers.

(2) An insurer's investments authorized under this section shall not exceed the lesser of (a) the amount by which such insurer's admitted assets exceed its required capital and liabilities if a stock insurer or its required surplus and liabilities if a nonstock insurer or (b) fifty percent of its policyholders surplus.

(3) In calculating the admitted assets of the insurer acquiring the stock of another insurer pursuant to this section, the value of any investment in such common or preferred stock shall be the cost of such stock to the acquiring insurer.

Source: Laws 1991, LB 237, § 42.

44-5143 Real estate mortgages.

(1) An insurer may invest in bonds or notes secured by a first mortgage on real estate in the United States or Canada if the amount loaned by the insurer, together with any amount secured by an equal security interest, does not exceed eighty percent of the appraised value of the real estate and improvements at the time of making the investment, or if the funds are used for a construction loan, the amount does not exceed eighty percent of the market value of the real estate together with the actual costs of improvements constructed thereon at the time of final funding by the insurer. The limitation in this subsection shall not:

(a) Apply to investments authorized under section 44-5132;

(b) Prohibit an insurer from renewing or extending a loan for the original amount when the value of such real estate has depreciated;

(c) Prohibit an insurer from accepting, as part payment for real estate sold by it, a mortgage thereon for more than eighty percent of the purchase price of such real estate; or

(d) Prohibit an insurer from advancing additional loan funds to protect its real estate security.

(2) An insurer may invest in bonds or notes secured by a first mortgage on leasehold estates in improved real estate located in the United States or Canada if:

(a) Such underlying real estate is unencumbered except by rentals to accrue therefrom to the owner of the real estate;

(b) There is no condition or right of reentry or forfeiture under which such lien can be cut off, subordinated, or otherwise disturbed so long as the lessee is not in default;

(c) The amount loaned by the insurer, together with any amount secured by an equal security interest, does not exceed eighty percent of the appraised value of such leasehold with improvements at the time of making the loan; and

(d) Such mortgage loan will be completely amortized during the unexpired portion of the lease or leasehold estate.

(3) Nothing in this section shall prevent any amount invested under this section that exceeds eighty percent of the appraised value of the real estate or leasehold and improvements, as the case may be, from being authorized under section 44-5153.

(4) All buildings and other real estate improvements which constitute a material part of the value of the mortgaged premises, whether estates in fee or leasehold estates or combination thereof, shall be (a)(i) substantially completed before the investment is made or (ii) of a value that is at all times substantial in value in relation to the amount of construction loan funds advanced by the insurer on account of the loan and (b) kept insured against loss or damage by fire or windstorm in a reasonable amount for the benefit of the mortgagee.

(5) If there are more than four holders of the issue of such bonds or notes described in subsection (1) or (2) of this section, (a) the security of such bonds or notes, as well as all collateral papers including insurance policies executed in connection therewith, shall be made to and held by a trustee, which trustee shall be a solvent bank or trust company having a paid-in capital of not less than two hundred fifty thousand dollars, except in case of a bank or trust company incorporated under the laws of this state, in which case a paid-in capital of not less than one hundred thousand dollars shall be required, and (b) it shall be agreed that, in case of proper notification of default, such trustee, upon request of at least twenty-five percent of the holders of the par amount of the bonds outstanding and proper indemnification, shall proceed to protect the rights of such bondholders under the provisions of the trust indenture.

(6)(a) An insurer may invest in notes or bonds secured by second mortgages or other second liens, including all inclusive or wraparound mortgages or liens, upon real property encumbered only by a first mortgage or lien which meets the requirements set forth in this section, subject to either of the following conditions:

(i) The insurer also owns the note or bond secured by the prior first mortgage or lien and the aggregate value of both loans does not exceed the loan to market value ratio requirements of this section; or

(ii) The note or bond is secured by an all-inclusive or wraparound lien or mortgage which conforms to the requirements set forth in subdivision (b) of this subsection, if the aggregate value of the resulting loan does not exceed the loan to market value ratio requirements of this section.

(b) For purposes of this subsection, the terms wraparound and all-inclusive lien or mortgage refer to a loan made by an insurer to a borrower on the security of a mortgage or lien on real property other than property containing a residence of one to four units or on which a residence of one to four units is to be constructed, where such real property is encumbered by a first mortgage or lien and which loan is subject to all of the following requirements:

(i) There is no more than one preexisting mortgage or lien on the real property;

(ii) The total amount of the obligation of the borrower to the insurer under the loan is not less than the sum of the amount disbursed by the insurer on account of the loan and the outstanding balance of the obligation secured by the preexisting lien or mortgage;

(iii) The instrument evidencing the lien or mortgage by which the obligation of the borrower to the insurer under the loan is secured, is recorded, and the lien is insured under a policy of title insurance in an amount not less than the total amount of the obligation of the borrower to the insurer under the loan; and

(iv) The insurer either (A) files for record in the office of the recorder of the county in which the real property is located a duly acknowledged request for a copy of any notice of default or of sale under the preexisting lien or (B) is entitled under applicable law to receive notice of default, sale, or foreclosure of the preexisting lien.

(7)(a) An insurer may invest in mezzanine real estate loans subject to the following conditions:

(i) The terms of the mezzanine loan agreement:

(A) Require that each pledgor abstain from granting additional security interests in the equity interest pledged;

(B) Employ techniques to minimize the likelihood or impact of a bankruptcy filing on the part of the real estate owner or the mezzanine real estate loan borrower; and

(C) Require the real estate owner, or mezzanine real estate loan borrower, to: (I) Hold no assets other than, in the case of the real estate owner, the real property, and in the case of the mezzanine borrower, the equity interest in the real estate owner; (II) not engage in any business other than, in the case of the real estate owner, the ownership and operation of the real estate, and in the case of the mezzanine real estate borrower, holding an ownership interest in the real estate owner; and (III) not incur additional debt, other than limited trade payables, a first mortgage loan, and the mezzanine real estate loan; and

(ii) At the time of the initial investment, the mezzanine real estate loan lender shall corroborate that the sum of the first mortgage and the mezzanine real estate loan does not exceed one hundred percent of the value of the real estate as evidenced by a current appraisal.

(b) The value of an insurer's investments authorized under this subsection shall not exceed three percent of its admitted assets.

(c) For purposes of this subsection, mezzanine real estate loan refers to a loan made by an insurer to a borrower on the security of debt obligation, that is not a security, which is secured by a pledge of a direct or indirect equity interest in an entity that owns real estate.

(8) An insurer's investments authorized under this section shall not exceed forty percent of its admitted assets, and an insurer's investments authorized under this section and section 44-5144, in the aggregate, shall not exceed fifty percent of its admitted assets.

Source: Laws 1991, LB 237, § 43; Laws 2004, LB 1047, § 18; Laws 2005, LB 119, § 15.

44-5144 Real estate.

(1) An insurer may acquire and hold unencumbered real estate or certificates evidencing participation with other investors, either directly or through partnership or limited liability company interests, in unencumbered real estate if:

(a) The real estate is leased under a lease contract in which the lessee contracts to pay all assessments, taxes, maintenance, and operating costs;

(b) The net amount of the annual lease payments to the owner of the real estate is sufficient to amortize the cost of the real estate within the duration of the lease, but in no event for a period of longer than forty years, and pay at least three percent per annum on the unamortized balance of the cost of the real estate; and

(c) The amount invested in any such real estate does not exceed its appraised value.

When the lessee under a lease described in this subsection is the United States or any agency or instrumentality thereof, any state or any county, municipality, district, or other governmental subdivision thereof, or any agency, board, authority, or institution established or maintained under the laws of the United States or any state thereof, such lease contract may provide that upon the termination of the term thereof, title to such real estate shall vest in the lessee.

When an insurer owns less than the entire real estate leased under a lease described in this subsection, the legal title to the real estate shall be in the name of a trustee which meets the qualifications set out in subsection (5) of section 44-5143 under a trust agreement which provides, among other things, that upon proper notification of default under such lease and request to such trustee by an investor or investors representing at least twenty-five percent of the equitable ownership of the real estate and proper indemnification, the trustee shall proceed to protect the rights and interest of the investors owning the equitable title to the real estate.

For purposes of this subsection, unencumbered real estate means real estate in which other interests may exist which if enforced would not result in the forfeiture of the insurer's interest.

(2) An insurer may also acquire and hold real estate:

(a) Mortgaged to it in good faith by way of security for a loan previously contracted or for money due;

(b) Conveyed to it in satisfaction of debts previously contracted in the course of its dealings; and

(c) Purchased at sale upon judgments, decrees, or mortgages obtained or made for such debts.

(3) An insurer may invest in real estate required for its home offices or to be otherwise occupied by the insurer or its employees in the transaction of its business and may rent the balance of the space therein. The value of an insurer's investments authorized under this subsection shall not exceed ten percent of its admitted assets.

(4)(a) An insurer with policyholders surplus of at least one million dollars may individually or in conjunction with other investors acquire, own, hold, develop, and improve real estate that is essentially residential or commercial in character, even though subject to an existing mortgage or thereafter mortgaged by the insurer, if such real estate is located in a city or village or within five miles of the limits thereof.

(b) For purposes of this subsection, real estate shall include a leasehold having an unexpired term of at least twenty years, including the term provided by any enforceable option of renewal. The income from such leasehold shall be applied so as to amortize the cost of leasehold and improvements within the lesser of eighty percent of such unexpired term or forty years from acquisition.

(c) The value of an insurer's investments authorized under this subsection shall not exceed ten percent of its admitted assets.

(5) An insurer may also acquire such other real estate as may be acquired ancillary to a corporate merger, acquisition, or reorganization of the insurer.

(6) The value of an insurer's investments authorized under subsections (3), (4), and (5) of this section, in the aggregate, shall not exceed fifteen percent of its admitted assets.

(7) For purposes of this section, value shall mean original cost plus any development and improvement costs whenever expended less the unpaid balance of any mortgage and annual depreciation on improvements of not less than two percent.

(8) An insurer's investments authorized under this section and section 44-5143, in the aggregate, shall not exceed fifty percent of its admitted assets.

Source: Laws 1991, LB 237, § 44; Laws 1993, LB 121, § 260; Laws 1997, LB 273, § 21; Laws 2005, LB 119, § 16.

44-5145 Equipment.

An insurer may invest in equipment or interests in equipment wholly situated or maintained in the United States and Canada which are mortgaged or otherwise encumbered by the insurer as security for a nonrecourse debt and which are leased under a lease contract if:

(1) The annual lease payments to the lessor are sufficient to repay the full cost of the financing thereof within the unexpired term of the lease; and

(2) The lessee or ultimate guarantor of any lease securing the obligation is an entity the obligations of which are authorized investments under sections 44-5123 to 44-5131.

An insurer's investments authorized under this section shall not exceed five percent of its admitted assets.

Source: Laws 1991, LB 237, § 45.

44-5146 Repealed. Laws 1997, LB 273, § 27.

44-5147 Repealed. Laws 1997, LB 273, § 27.

44-5148 Repealed. Laws 1997, LB 273, § 27.

44-5149 Hedging transactions; derivative instruments.

(1) An insurer may use derivative instruments in hedging transactions if:

(a) The aggregate statement value of options, caps, floors, and warrants not attached to any financial instrument and used in hedging transactions does not exceed the lesser of seven and one-half percent of the insurer's admitted assets or seventy-five percent of the insurer's policyholders surplus;

(b) The aggregate statement value of options, caps, and floors written in hedging transactions does not exceed the lesser of three percent of the insurer's admitted assets or thirty percent of the insurer's policyholders surplus; and

(c) The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed the lesser of six and one-half percent of the insurer's admitted assets or sixty-five percent of the insurer's policyholders surplus.

(2)(a) An insurer may use derivative instruments in income-generation transactions by selling:

(i) Covered call options on non-callable fixed income securities or callable fixed income securities if the option expires by its terms prior to the end of the non-callable period;

(ii) Covered call options on equity securities if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(iii) Covered puts on investments that the insurer is permitted to acquire under the Insurers Investment Act if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under that put during the complete term of the put option sold; and

(iv) Covered caps or floors if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under such caps or floors during the complete term that the cap or floor is outstanding.

(b) An insurer may enter into income-generation transactions under this subsection if the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying any derivative instrument subject to call, does not exceed the lesser of ten percent of the insurer's admitted assets or one hundred percent of the insurer's policyholders surplus.

(3) An insurer may use derivative instruments in replication transactions if:

(a) The aggregate statement value of options, caps, floors, and warrants not attached to any financial instrument and used in replication transactions does not exceed the lesser of seven and one-half percent of the insurer's admitted assets or seventy-five percent of the insurer's policyholders surplus;

(b) The aggregate statement value of options, caps, and floors written in replication transactions does not exceed the lesser of three percent of the insurer's admitted assets or thirty percent of the insurer's policyholders surplus;

(c) The aggregate potential exposure of collars, swaps, forwards, and futures used in replication transactions does not exceed the lesser of six and one-half percent of the insurer's admitted assets or sixty-five percent of the insurer's policyholders surplus;

(d) The replication transactions are limited to the replication of investments or instruments otherwise permitted under the Insurers Investment Act; and

(e) The insurer engages in hedging transactions or income generation transactions pursuant to this section and has sufficient experience with derivatives generally such that its performance and procedures reflect that the insurer has been successful in adequately identifying, measuring, monitoring, and limiting exposures associated with such transactions and that the insurer has superior corporate controls over such activities as well as a sufficient number of dedicated staff who are knowledgeable and skilled with these sophisticated financial instruments.

(4) An insurer may purchase or sell one or more derivative instruments to offset any derivative instrument previously purchased or sold, as the case may be, without regard to the quantitative limitations of this section, provided that the derivative instrument is an exact offset to the original derivative instrument being offset.

(5) An insurer shall demonstrate to the director upon request the intended hedging, income-generation, or replication characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analysis.

(6) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations in section 44-5115.

(7) The director may approve additional transactions involving the use of derivative instruments pursuant to rules and regulations adopted and promulgated by the director.

(8) For purposes of this section:

(a) Derivative instrument means an agreement, option, instrument, or a series or combination thereof:

(i) To make or take delivery of, or assume or relinquish, a specified amount of one or more underlying interests or to make a cash settlement in lieu thereof; or

(ii) That has a price, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

Derivative instrument includes all investment instruments or contracts that derive all or almost all of their value from the performance of an underlying market, index, or financial instrument, including, but not limited to, options, warrants, caps, floors, collars, swaps, credit default swaps, swaptions, forwards, and futures. Derivative instrument does not include investments authorized under any other section of the Insurers Investment Act;

(b) Hedging transaction means a derivative transaction which is entered into and maintained to reduce:

(i) The risk of a change in value, yield, price, cash flow, or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(ii) The currency exchange rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring;

(c) Income-generation transaction means a derivative transaction involving the writing of covered call options, covered put options, covered caps, or covered floors that is intended to generate income or enhance return; and

(d) Replication transaction means a derivative transaction or combination of derivative transactions effected either separately or in conjunction with cash market investments included in the insurer's portfolio in order to replicate the investment characteristic of another authorized transaction, investment, or instrument or that may operate as a substitute for cash market investments. A derivative transaction entered into by the insurer as a hedging or income-generation transaction authorized pursuant to this section shall not be considered a replication transaction.

Source: Laws 1991, LB 237, § 49; Laws 1997, LB 273, § 22; Laws 2005, LB 119, § 17.

44-5150 Repealed. Laws 1998, LB 1035, § 28.

44-5151 Other investment grade obligations.

(1) An insurer may hold investments not otherwise authorized under the Insurers Investment Act if such investments:

(a) Have minimum quality ratings as described in subdivision (2) of section 44-5112; and

(b) In the aggregate do not exceed one hundred percent of the insurer's policyholders surplus.

(2) Investments authorized under any other section of the Insurers Investment Act, except section 44-5153, shall not be authorized investments under this section.

Source: Laws 1991, LB 237, § 51; Laws 1997, LB 273, § 23.

44-5152 Securities Valuation Office; designated obligations; limitation.

(1) In addition to investments otherwise authorized under the Insurers Investment Act and subject to the limitations in subsections (2) and (3) of this section, an insurer may invest in obligations having 3, 4, 5, and 6 designations from the Securities Valuation Office.

(2) Subject to the limitation in subsection (3) of this section, an insurer shall not acquire, directly or indirectly through an investment subsidiary, investments in obligations:

(a) Having a 4 designation from the Securities Valuation Office if, as a result of and giving effect to the investment, the aggregate amount of such investments would exceed four percent of the insurer's admitted assets;

(b) Having a 5 designation from the Securities Valuation Office if, as a result of and giving effect to the investment, the aggregate amount of such investments would exceed two percent of the insurer's admitted assets; and

(c) Having a 6 designation from the Securities Valuation Office if, as a result of and giving effect to the investment, the aggregate amount of such investments would exceed one percent of the insurer's admitted assets.

(3) An insurer shall not acquire, directly or indirectly through an investment subsidiary, investments under this section if, as a result of and giving effect to the investment, the aggregate amount would exceed fifteen percent of the insurer's admitted assets.

Source: Laws 1991, LB 237, § 52; Laws 1997, LB 273, § 24; Laws 2007, LB117, § 19.

44-5153 Additional authorized investments.

(1)(a)(i) A life insurer may make investments not otherwise authorized under the Insurers Investment Act in an amount, in the aggregate, not exceeding the lesser of five percent of its admitted assets or one hundred percent of its policyholders surplus.

(ii) An insurer other than a life insurer may make investments not otherwise authorized under the act in an amount, in the aggregate, not exceeding the lesser of twenty-five percent of the amount by which its admitted assets exceed its total liabilities, excluding capital, or five percent of its admitted assets.

(b) Investments authorized under this subsection shall not include obligations having 3, 4, 5, and 6 designations from the Securities Valuation Office.

(2)(a) In addition to the provisions of subdivision (1)(a)(i) of this section, a life insurer may make investments not otherwise authorized under the act in an amount not exceeding that portion of its policyholders surplus which is in excess of ten percent of its admitted assets.

(b) In addition to the provisions of subdivisions (1)(a)(ii) and (b) of this section, an insurer other than a life insurer may make investments not otherwise authorized under the act in an amount not exceeding that portion of its policyholders surplus which is in excess of fifty percent of its annual net written premiums as shown by the most recent annual financial statement filed by the insurer pursuant to section 44-322.

(3) Investments authorized under subsection (1) or (2) of this section shall not include insurance agents' balances or amounts advanced to or owing by insurance agents.

(4) The limitations set forth in this section shall be applied at the time the investment in question is made and at the end of each calendar quarter. An insurer's investment, which at the time of its acquisition was authorized only under the provisions of this section but which has subsequently and while held by such insurer become of such character as to be authorized elsewhere under the act, shall not be included in determining the amount of such insurer's investments, in the aggregate, authorized under this section, and investments otherwise authorized under the act at the time of their acquisition shall not be included in making such determination.

(5) Derivative instruments described in subsections (1), (2), and (3) of section 44-5149 shall not be authorized investments under this section.

Source: Laws 1991, LB 237, § 53; Laws 1997, LB 273, § 25; Laws 2005, LB 119, § 18; Laws 2007, LB117, § 20.

44-5154 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Insurers Investment Act, including, but not limited to, establishing standards for qualification as custodians for insurer investments and establishing requirements for custody agreements.

Source: Laws 1991, LB 237, § 54; Laws 2005, LB 119, § 19.

ARTICLE 52

SMALL EMPLOYER HEALTH INSURANCE

Section
44-5201. Repealed. Laws 1994, LB 1222, § 66.
44-5202. Repealed. Laws 1994, LB 1222, § 66.
44-5203. Repealed. Laws 1994, LB 1222, § 66.
44-5204. Repealed. Laws 1994, LB 1222, § 66.
44-5205. Repealed. Laws 1994, LB 1222, § 66.
44-5206. Repealed. Laws 1994, LB 1222, § 66.
44-5207. Repealed. Laws 1994, LB 1222, § 66.
44-5208. Repealed. Laws 1994, LB 1222, § 66.
44-5209. Repealed. Laws 1994, LB 1222, § 66.
44-5210. Repealed. Laws 1994, LB 1222, § 66.
44-5211. Repealed. Laws 1994, LB 1222, § 66.
44-5212. Repealed. Laws 1994, LB 1222, § 66.
44-5213. Repealed. Laws 1994, LB 1222, § 66.
44-5214. Repealed. Laws 1994, LB 1222, § 66.
44-5215. Repealed. Laws 1994, LB 1222, § 66.
44-5216. Repealed. Laws 1994, LB 1222, § 66.
44-5217. Repealed. Laws 1994, LB 1222, § 66.
44-5218. Repealed. Laws 1994, LB 1222, § 66.
44-5219. Repealed. Laws 1994, LB 1222, § 66.
44-5220. Repealed. Laws 1994, LB 1222, § 66.
44-5221. Repealed. Laws 1994, LB 1222, § 66.
44-5222. Repealed. Laws 1994, LB 1222, § 66.
44-5223. Act, how cited.
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44-5232. Broker, defined.
44-5233. Transferred to section 44-5242.01.
44-5234. Case characteristics, defined.
44-5234.01. Church plan, defined.
44-5235. Class of business, defined.
44-5236. Repealed. Laws 2009, LB 154, § 27.
44-5237. Control, defined.
44-5237.01. Creditable coverage, defined.
44-5238. Dependent, defined.

Section

44-5201 Repealed. Laws 1994, LB 1222, § 66.

44-5202 Repealed. Laws 1994, LB 1222, § 66.

44-5203 Repealed. Laws 1994, LB 1222, § 66.

44-5204 Repealed. Laws 1994, LB 1222, § 66.

44-5205 Repealed. Laws 1994, LB 1222, § 66.

44-5206 Repealed. Laws 1994, LB 1222, § 66.

44-5207 Repealed. Laws 1994, LB 1222, § 66.

44-5208 Repealed. Laws 1994, LB 1222, § 66.

44-5209 Repealed. Laws 1994, LB 1222, § 66.

44-5210 Repealed. Laws 1994, LB 1222, § 66.

44-5211 Repealed. Laws 1994, LB 1222, § 66.

44-5212 Repealed. Laws 1994, LB 1222, § 66.

44-5213 Repealed. Laws 1994, LB 1222, § 66.

44-5214 Repealed. Laws 1994, LB 1222, § 66.

44-5215 Repealed. Laws 1994, LB 1222, § 66.

44-5216 Repealed. Laws 1994, LB 1222, § 66.

44-5217 Repealed. Laws 1994, LB 1222, § 66.

44-5218 Repealed. Laws 1994, LB 1222, § 66.

44-5219 Repealed. Laws 1994, LB 1222, § 66.

44-5220 Repealed. Laws 1994, LB 1222, § 66.

44-5221 Repealed. Laws 1994, LB 1222, § 66.

44-5222 Repealed. Laws 1994, LB 1222, § 66.

44-5223 Act, how cited.

Sections 44-5223 to 44-5267 shall be known and may be cited as the Small Employer Health Insurance Availability Act.

Source: Laws 1994, LB 1222, § 1; Laws 1997, LB 862, § 30; Laws 2000, LB 1253, § 33; Laws 2002, LB 1139, § 29; Laws 2009, LB192, § 5.

44-5224 Purposes of act.

The purposes of the Small Employer Health Insurance Availability Act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of preexisting condition exclusions, to provide for development of basic and standard health benefit plans to be offered to all small employers, and to improve the overall fairness and efficiency of the small group health insurance market. The act is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

Source: Laws 1994, LB 1222, § 2; Laws 2017, LB644, § 6.

44-5225 Definitions, where found.

For purposes of the Small Employer Health Insurance Availability Act, the definitions found in sections 44-5226 to 44-5255.01 shall be used.

Source: Laws 1994, LB 1222, § 3; Laws 1997, LB 862, § 31; Laws 2000, LB 1253, § 34; Laws 2002, LB 1139, § 30; Laws 2009, LB192, § 6.

44-5226 Actuarial certification, defined.

Actuarial certification shall mean a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 44-5258 based upon the person's examination and including a review of the appropriate records and the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

Source: Laws 1994, LB 1222, § 4.

44-5227 Affiliate or affiliated, defined.

Affiliate or affiliated shall mean any entity or person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

Source: Laws 1994, LB 1222, § 5.

44-5227.01 Affiliation period, defined.

Affiliation period means a period of time that must expire before health insurance coverage provided by a carrier becomes effective and during which the carrier is not required to provide benefits.

Source: Laws 2002, LB 1139, § 31.

44-5228 Agent, defined.

Agent shall have the same meaning as insurance producer in section 44-103.

Source: Laws 1994, LB 1222, § 6; Laws 2001, LB 51, § 36.

44-5229 Base premium rate, defined.

Base premium rate shall mean for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

Source: Laws 1994, LB 1222, § 7.

44-5230 Basic health benefit plan, defined.

Basic health benefit plan shall mean a lower cost health benefit plan regulated by the Department of Insurance.

Source: Laws 1994, LB 1222, § 8; Laws 2009, LB154, § 9; Laws 2017, LB644, § 7.

44-5231 Repealed. Laws 2017, LB644, § 21.

44-5231.01 Bona fide association, defined.

Bona fide association means, with respect to health insurance coverage offered in this state, an association that meets the following conditions:

(1) Has been actively in existence for at least five years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) Does not condition membership in the association on a health-status-related factor of an individual, including an employee or a dependent of any employee;

(4) Makes health insurance coverage offered through the association available to any member regardless of a health-status-related factor of the member or individual eligible for coverage through a member; and

(5) Does not make available health insurance coverage offered through the association other than in connection with a member of the association.

Source: Laws 2009, LB192, § 7.

44-5232 Broker, defined.

Broker shall have the same meaning as insurance producer in section 44-103.

Source: Laws 1994, LB 1222, § 10; Laws 2001, LB 51, § 37.

44-5233 Transferred to section 44-5242.01.

44-5234 Case characteristics, defined.

Case characteristics shall mean demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage shall not be case characteristics for purposes of the Small Employer Health Insurance Availability Act.

Source: Laws 1994, LB 1222, § 12.

44-5234.01 Church plan, defined.

Church plan shall mean a plan as defined under 29 U.S.C. 1002.

Source: Laws 1997, LB 862, § 32.

44-5235 Class of business, defined.

Class of business shall mean all or a separate grouping of small employers established pursuant to section 44-5257.

Source: Laws 1994, LB 1222, § 13.

44-5236 Repealed. Laws 2009, LB 154, § 27.

44-5237 Control, defined.

Control shall have the same meaning as in section 44-2121.

Source: Laws 1994, LB 1222, § 15.

44-5237.01 Creditable coverage, defined.

(1) Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., other than coverage consisting solely of benefits under section 1928 of the act, 42 U.S.C. 1396s;

(e) 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003;

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under 5 U.S.C. 8901 et seq.;

(i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on April 19, 1998.

Source: Laws 1997, LB 862, § 33; Laws 1998, LB 1035, § 11; Laws 2003, LB 6, § 2.

44-5238 Dependent, defined.

Dependent shall mean a spouse, an unmarried child under the age of nineteen years, an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.

Source: Laws 1994, LB 1222, § 16.

44-5239 Director, defined.

Director shall mean the Director of Insurance.

Source: Laws 1994, LB 1222, § 17.

44-5240 Eligible employee, defined.

Eligible employee shall mean an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term shall include a sole proprietor, a partner of a partnership, a member of a limited liability company, and an independent contractor, if the sole proprietor, partner, member, or independent contractor is included as an employee under a health

benefit plan of a small employer, but shall not include an employee who works on a part-time, temporary, or substitute basis.

Source: Laws 1994, LB 1222, § 18.

44-5240.01 Enrollment date, defined.

Enrollment date means the first day of coverage in the health benefit plan or, if earlier, the first day of the waiting period.

Source: Laws 2000, LB 1253, § 35.

44-5241 Established geographic service area, defined.

Established geographic service area shall mean a geographic area, as approved by the director and based on the carrier's certificate of authority to transact insurance business in this state, within which the carrier is authorized to provide coverage.

Source: Laws 1994, LB 1222, § 19.

44-5241.01 Governmental plan, defined.

Governmental plan shall mean a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

Source: Laws 1997, LB 862, § 34.

44-5241.02 Group health plan, defined.

Group health plan shall mean an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

Source: Laws 1997, LB 862, § 35.

44-5242 Health benefit plan, defined.

(1) Health benefit plan shall mean any hospital or medical policy or certificate, major medical expense insurance, or health maintenance organization subscriber contract.

(2) Health benefit plan shall not include one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for onsite medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) Health benefit plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited-scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) Health benefit plan shall not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) Health benefit plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

Source: Laws 1994, LB 1222, § 20; Laws 1997, LB 862, § 36; Laws 2003, LB 6, § 3.

44-5242.01 Health carrier or carrier, defined.

Health carrier or carrier shall mean any entity that provides health insurance in this state. Health carrier or carrier shall include an insurance company, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Source: Laws 1994, LB 1222, § 11; R.S.Supp.,1996, § 44-5233; Laws 1997, LB 862, § 37.

44-5242.02 Health-status-related factor, defined.

Health-status-related factor shall mean any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(8) Disability.

Source: Laws 1997, LB 862, § 38.

44-5242.03 Health maintenance organization, defined.

Health maintenance organization means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

Source: Laws 2002, LB 1139, § 32.

44-5243 Index rate, defined.

Index rate shall mean, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

Source: Laws 1994, LB 1222, § 21.

44-5244 Late enrollee, defined.

Late enrollee shall mean an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan if the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual meets the following:

(a) The individual was covered under creditable coverage at the time of the initial enrollment;

(b) The individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, the death of a spouse, divorce, or legal separation; and

(c) The individual requests enrollment within thirty days after termination of the creditable coverage;

(2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(3) A court has ordered coverage be provided for a spouse or a minor or dependent child under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of the court order; or

(4) The individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted.

Source: Laws 1994, LB 1222, § 22; Laws 1997, LB 862, § 39.

44-5244.01 Medical care, defined.

Medical care shall mean amounts paid for:

(1)(a) The diagnosis, care, mitigation, treatment, or prevention of disease or (b) the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1) of this section; and

(3) Insurance covering medical care referred to in subdivisions (1) and (2) of this section.

Source: Laws 1997, LB 862, § 40.

44-5244.02 Network plan, defined.

Network plan shall mean health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Source: Laws 1997, LB 862, § 41.

44-5245 New business premium rate, defined.

New business premium rate shall mean, for each class of business as to a rating period, the lowest premium rate charged or offered or which could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

Source: Laws 1994, LB 1222, § 23.

44-5246 Repealed. Laws 2017, LB644, § 21.

44-5246.01 Plan sponsor, defined.

Plan sponsor shall have the meaning given such term under 29 U.S.C. 1002.

Source: Laws 1997, LB 862, § 42.

44-5246.02 Preexisting condition, defined.

Preexisting condition means a condition whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. Genetic information shall not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

Source: Laws 1997, LB 862, § 43; Laws 2000, LB 1253, § 36.

44-5247 Premium, defined.

Premium shall mean all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

Source: Laws 1994, LB 1222, § 25.

44-5248 Repealed. Laws 2017, LB644, § 21.

44-5249 Repealed. Laws 1997, LB 862, § 50.

44-5250 Rating period, defined.

Rating period shall mean the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Source: Laws 1994, LB 1222, § 28.

44-5251 Repealed. Laws 2017, LB644, § 21.

44-5252 Restricted network provision, defined.

Restricted network provision shall mean any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into contractual arrangement with the carrier to provide health care services to covered individuals.

Source: Laws 1994, LB 1222, § 30.

44-5253 Small employer, defined.

Small employer shall mean any person, political subdivision, firm, corporation, limited liability company, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two and no more than fifty eligible employees, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.

Source: Laws 1994, LB 1222, § 31; Laws 1995, LB 837, § 2; Laws 1997, LB 862, § 44.

44-5254 Small employer carrier, defined.

Small employer carrier shall mean a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state.

Source: Laws 1994, LB 1222, § 32.

44-5255 Standard health benefit plan, defined.

Standard health benefit plan shall mean a health benefit plan regulated by the Department of Insurance.

Source: Laws 1994, LB 1222, § 33; Laws 2009, LB154, § 10; Laws 2017, LB644, § 8.

44-5255.01 Waiting period, defined.

Waiting period means the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the health benefit plan. If an individual enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period.

Source: Laws 2000, LB 1253, § 37.

44-5256 Act; applicability; conditions; waiver.

(1) The Small Employer Health Insurance Availability Act shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

(2) The act shall not apply to individual health benefit plans issued:

(a) To eligible employees of a small employer if the arrangement with the small employer was established prior to January 1, 1995, and met any of the conditions set forth in subsection (1) of this section;

(b) On or after January 1, 1995, to eligible employees of a small employer if the small employer had fewer than three eligible employees when the arrangement was established regardless of whether the small employer subsequently employs three or more employees; or

(c) To eligible employees of a small employer if the full cost of the premium is paid by a salary reduction plan or payroll deduction.

(3)(a) Except as provided in subdivision (b) of this subsection, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by the act shall apply as if all health benefit plans delivered or issued for delivery to small employers in this state by such affiliated carriers were issued by one carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of authority pursuant to the Health Maintenance Organization Act may be considered to be a separate carrier for the purposes of the Small Employer Health Insurance Availability Act.

(c) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. The Assumption Reinsurance Act shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.

(4)(a) A Taft-Hartley trust, or a carrier with the written authorization of such a trust, may make a written request to the director for a waiver from the application of any of the provisions of subsection (1) of section 44-5258 with respect to a health benefit plan provided to the trust.

(b) The director may grant such a waiver if the director finds that application of such subsection with respect to the trust would:

(i) Have a substantial adverse effect on the participants and beneficiaries of such trust; and

(ii) Require significant modifications to one or more collective-bargaining arrangements under which the trust is established or maintained.

(c) A waiver granted under this section shall not apply to an individual if the person participates in such a trust as an associate member of an employee organization.

Source: Laws 1994, LB 1222, § 34; Laws 1995, LB 574, § 48; Laws 1995, LB 837, § 3; Laws 2002, LB 719, § 1.

Cross References

Assumption Reinsurance Act, see section 44-6201.
Health Maintenance Organization Act, see section 44-3292.

44-5257 Separate class of business; established; when; limit.

(1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of section 44-760.

(2) A small employer carrier may establish up to nine separate classes of business.

(3) The director may adopt and promulgate rules and regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) of this section in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.

Source: Laws 1994, LB 1222, § 35.

44-5258 Premium rates; requirements; limitation on transfers; director; powers; disclosures required; small employer carrier; duties.

(1) Premium rates for health benefit plans subject to the Small Employer Health Insurance Availability Act shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent;

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent of the index rate;

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business;

(d) Adjustments in rates for claim experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(e) Premium rates for health benefit plans shall comply with the requirements of this section;

(f) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent;

(g) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1995, a premium rate for a rating period may exceed the ranges set forth in subdivisions (a) and (b) of this subsection for a period of three years following January 1, 1995. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate if such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business;

(h)(i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

(i) For the purposes of this subsection, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision if the restriction of benefits to network providers results in substantial differences in claim costs;

(j) The small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition, and group size without the prior approval of the director; and

(k) The director may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of the act, including regulations that:

(i) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribe the manner in which case characteristics may be used by small employer carriers.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status, or duration of coverage since issue.

(3) The director may suspend for a specified period the application of subdivision (1)(a) of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claim experience, that affect changes in premium rates;

(c) The provisions relating to the renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition provision.

(5)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demon-

strate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with the act and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subdivision (a) of this subsection available to the director upon request. Except in cases of violations of the act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside of the Department of Insurance except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

Source: Laws 1994, LB 1222, § 36; Laws 2017, LB644, § 9.

44-5259 Health benefit plan; renewable; exceptions; small employer carrier; requirements.

(1) A health benefit plan subject to the Small Employer Health Insurance Availability Act shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

(a) The small employer has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(b)(i) Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds, or their representatives; or

(ii) The small employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) Noncompliance with the small employer carrier's minimum participation requirements;

(d) Noncompliance with the small employer carrier's employer contribution requirements;

(e) A decision by the small employer carrier to discontinue offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the small employer carrier in that market only if the small employer carrier:

(i) Provides advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provides notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the small employer carrier. Notice to the director shall be provided at

least three working days prior to the notice to the affected small employers, participants, and beneficiaries;

(iii) Offers to each small employer provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the small employer carrier to small employers in the state; and

(iv) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under subdivision (1)(e)(iii) of this section, acts uniformly without regard to the claims experience of those small employers or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(f) A decision by the small employer carrier to discontinue offering and to nonrenew all its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the small employer carrier shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all affected small employers, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the small employer carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected small employers, participants, and beneficiaries; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and not renew coverage under any health benefit plan issued to a small employer; and

(g) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier that elects not to renew a health benefit plan shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director.

(3) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in that service area.

(4) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) or (2) of this section in the case of the following:

(a) To an eligible person who no longer resides, lives, or works in the service area of the small employer carrier or in an area for which the small employer carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals; or

(b) To a small employer that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the small employer

carrier or the area for which the small employer carrier is authorized to do business.

Source: Laws 1994, LB 1222, § 37; Laws 1997, LB 862, § 45.

44-5260 Small employer, defined; group health plan; health benefit plans; requirements; filing; exceptions; preexisting condition exclusion; network plans.

(1) For purposes of this section, small employer shall mean, in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code shall be treated as one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Small Employer Health Insurance Availability Act that apply to a small employer shall continue to apply at least until the health benefit plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. Any reference in the act to an employer shall include a reference to any predecessor of such employer.

(2)(a) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans it actively markets to small employers in this state, including at least two health benefit plans. One health benefit plan offered by each small employer carrier shall be a basic health benefit plan, and one plan shall be a standard health benefit plan. A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to any small employer not currently receiving a health benefit plan by such small employer carrier. This subdivision shall not require a small employer carrier to offer to small employers a health benefit plan marketed only through a bona fide association.

(b)(i) Subject to subdivision (2)(a) of this section, a small employer carrier shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with the Small Employer Health Insurance Availability Act. However, no small employer carrier shall be required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

(ii) In the case of a small employer carrier that establishes more than one class of business, the small employer carrier shall maintain and issue to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each class of business so established. A small employer

carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business if:

(A) The criteria are not intended to discourage or prevent acceptance of small employers applying for a basic health benefit plan or a standard health benefit plan;

(B) The criteria are not related to the health status or claim experience of employees or dependents of the small employer;

(C) The criteria are applied consistently to all small employers applying for coverage in the class of business; and

(D) The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

The provisions of subdivision (2)(b)(ii) of this section shall not apply to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(3)(a) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the basic health benefit plans and the standard health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection may be used by a small employer carrier beginning thirty days after it is filed unless the director disapproves its use.

(b) The director at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic health benefit plan or standard health benefit plan on the grounds that the plan does not meet the requirements of the act.

(4) Health benefit plans covering small employers shall comply with the following provisions:

(a) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months, or eighteen months in the case of a late enrollee, following the enrollment date of the individual's coverage due to a preexisting condition or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 44-5246.02. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(b) A health benefit plan shall not impose any preexisting condition exclusion:

(i) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(ii) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage;

(c)(i) A small employer carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the aggregate period of time an individual was previously covered by creditable coverage that provided benefits with

respect to such services if the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the employer or the carrier. This subdivision shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(ii) A small employer carrier that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period:

(A) That does not exceed sixty days for new entrants and does not exceed ninety days for late enrollees;

(B) During which the carrier charges no premiums and the coverage issued is not effective; and

(C) That is applied uniformly, without regard to any health-status-related factor.

(iii) This subdivision does not preclude application of any waiting period applicable to all enrollees under the health benefit plan if any carrier waiting period is no longer than sixty days.

(iv)(A) In lieu of the requirements of subdivision (4)(c)(i) of this section, a small employer carrier may elect to reduce the period of any preexisting condition exclusion based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations.

(B) A small employer electing to reduce the period of any preexisting condition exclusion using the alternative method described in subdivision (4)(c)(iv)(A) of this section shall make the election on a uniform basis for all enrollees and count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(C) A small employer carrier electing to reduce the period of any preexisting condition exclusion using the alternative method described in subdivision (4)(c)(iv)(A) of this section shall prominently state that the election has been made in any disclosure statements concerning coverage under the health benefit plan to each enrollee at the time of enrollment under the plan and to each small employer at the time of the offer or sale of the coverage and include in the disclosure statements the effect of the election;

(d)(i) A small employer carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(A) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(B) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

(C) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(D) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(ii)(A) If a small employer carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(B) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (I) the date such dependent coverage is available or (II) the date of the marriage, birth, adoption, or placement for adoption.

(C) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(I) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(II) In the case of the birth of a dependent, as of the date of birth; and

(III) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption;

(e)(i) Except as provided in subdivision (4)(e)(iv) of this section, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii)(A) Except as provided in subdivision (4)(e)(iii)(B) of this section, in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have creditable coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage; and

(f)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer coverage to only certain

individuals in a small employer group or to only part of the group except in the case of late enrollees as provided in subdivision (4)(a) of this section.

(ii) Except as permitted under subdivisions (a) and (d) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(iii) A small employer carrier shall not place any restriction in regard to any health-status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

(5) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section in the case of the following:

(a) To an employee if previous basic health benefit plans or standard health benefit plans have, in the aggregate, paid one million dollars in benefits on behalf of the employee. Benefits paid on behalf of the employee in the immediately preceding two calendar years by prior small employer carriers under basic and standard plans shall be included when calculating the lifetime maximum benefits payable under the succeeding basic or standard plans. In any situation in which a determination of the total amount of benefits paid by prior small employer carriers is required by the succeeding carrier, prior carriers shall furnish a statement of the total benefits paid under basic and standard plans at the succeeding carrier's request; or

(b) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(6)(a) A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (2) of this section to or from a small employer as defined in subsection (1) of this section:

(i) If the small employer does not have eligible employees who live, work, or reside in the service area for such network plan; or

(ii) If the small employer does have eligible employees who live, work, or reside in the service area for such network plan, the carrier has demonstrated, if required, to the director that it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees and that it is applying subdivision (6)(a)(ii) of this section uniformly to all employers without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor relating to such employees and dependents.

(b) A small employer carrier, upon denying health insurance coverage in any service area in accordance with subdivision (6)(a)(ii) of this section, shall not offer coverage in the small employer market within such service area for a period of one hundred eighty days after the date such coverage is denied.

(7) A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection (2) of this section for any period of time for which the director determines that requiring the acceptance of small

employers in accordance with the provisions of such subsection would place the small employer carrier in a financially impaired condition.

Source: Laws 1994, LB 1222, § 38; Laws 1995, LB 837, § 4; Laws 1997, LB 862, § 46; Laws 2002, LB 1139, § 33; Laws 2009, LB192, § 8.

44-5260.01 Certification of creditable coverage.

(1) Small employer carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (2) of this section.

(2) The certification of creditable coverage shall be provided:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage described in subdivision (2)(a) or (b) of this section, whichever is later.

(3) Small employer carriers may provide the certification of creditable coverage required under subdivision (2)(a) of this section at a time consistent with notices required under any applicable COBRA continuation provision.

(4) The certificate of creditable coverage required to be provided pursuant to subsection (1) of this section shall contain:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(5) To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under subsection (1) of this section if the small employer carrier offering the coverage provides for certification in accordance with subsection (2) of this section.

(6)(a) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to subdivision (4)(c)(iv) of section 44-5260 and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (3) of this section, on request of the group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.

(b) The entity providing the information pursuant to subdivision (6)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

Source: Laws 2002, LB 1139, § 34.

44-5261 Repealed. Laws 2017, LB644, § 21.

44-5262 Repealed. Laws 2009, LB 154, § 27.

44-5263 Repealed. Laws 2017, LB644, § 21.

44-5264 Basic health benefit plan; required coverage; applicability.

Except for specified childhood immunizations of children from birth to six years of age, a statute requiring coverage of a health care service or benefit or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner shall not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to the Small Employer Health Insurance Availability Act.

Source: Laws 1994, LB 1222, § 42.

44-5265 Rules and regulations.

The director shall adopt and promulgate rules and regulations to carry out the Small Employer Health Insurance Availability Act.

Source: Laws 1994, LB 1222, § 43.

44-5266 Small employer carrier; market health benefit plan coverage; carrier, agent, or broker; prohibited activities; compensation to agent or broker; denial of application; rules and regulations; unfair trade practice; when; third-party administrator.

(1) Each small employer carrier shall actively market health benefit plan coverage, including the basic health benefit plans and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan.

(2)(a) Except as provided in subdivision (b) of this subsection, no small employer carrier, agent, or broker shall, directly or indirectly, engage in the following activities:

(i) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer; or

(ii) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subdivision (a) of this subsection shall not apply with respect to information provided by a small employer carrier, an agent, or a broker to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3)(a) Except as provided in subdivision (b) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subdivision (a) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent

or broker on the basis of percentage of premium except that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation to an agent or broker, if any, for the sale of a basic health benefit plan or a standard health benefit plan.

(5) No small employer carrier, agent, or broker may induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(6) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(7) The director may establish rules and regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(8)(a) A violation of this section by a small employer carrier, an agent, or a broker shall be an unfair trade practice in the business of insurance under the Unfair Insurance Trade Practices Act.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

Source: Laws 1994, LB 1222, § 44; Laws 2017, LB644, § 10.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-5267 Reissuance of health benefit plan; when; director; powers.

The director may adopt and promulgate rules and regulations to require small employer carriers, as a condition of transacting business with small employers in this state after January 1, 1995, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after six months prior to January 1, 1995. The director may prescribe such terms for the reissuance of coverage as the director finds are reasonable and necessary to provide continuity of coverage to small employers.

Source: Laws 1994, LB 1222, § 45.

ARTICLE 53

HEALTH INSURANCE ACCESS

Section
44-5301. Act, how cited.
44-5302. Legislative findings and declarations.
44-5303. Terms, defined.
44-5304. Policies and contracts; applicability of other laws.
44-5305. Policy or contract; eligibility.
44-5306. Policy or contract; eligibility; limitations.
44-5307. Policy or contract; benefits required; coverage authorized; prohibitions.

Section

44-5301 Act, how cited.

Sections 44-5301 to 44-5311 shall be known and may be cited as the Health Insurance Access Act.

Source: Laws 1991, LB 419, § 29.

44-5302 Legislative findings and declarations.

The Legislature finds and declares that there is a significant number of Nebraskans who lack health insurance and that these uninsured people include many individuals and families who cannot afford the rising cost of medical care but do not qualify for the various income-based assistance programs. The lack of financial means of uninsured people and families to pay for their medical care leaves health care providers with uncollectible debts which are transferred to other patients and to insurers. It is the purpose and intent of the Legislature to provide a mechanism to allow insurers to provide basic levels of health insurance to those people who are uninsured and are not qualified for income-based assistance programs.

Source: Laws 1991, LB 419, § 30; Laws 2009, LB445, § 1.

44-5303 Terms, defined.

For purposes of the Health Insurance Access Act:

(1) Insurer shall mean any insurance company as defined in section 44-103 authorized to transact health insurance business in the State of Nebraska or a health maintenance organization which has obtained a valid certificate of authority;

(2) Medicare shall mean parts A, B, C, and D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

(3) Provider shall mean any physician or hospital who is licensed or authorized in this state to furnish medical care or hospitalization to any individual;

(4) Spell of illness shall mean a continuous period as a hospital inpatient or successive periods as a hospital inpatient when the date of discharge and the following date of admission are less than sixty consecutive days apart; and

(5) Uninsured access coverage shall mean a policy of sickness and accident insurance or a contract for health care services covering individuals, with or without their dependents, issued by an insurer subject to the limitations and requirements in the act.

Source: Laws 1991, LB 419, § 31; Laws 2009, LB445, § 2.

44-5304 Policies and contracts; applicability of other laws.

Policies of sickness and accident insurance and contracts for health care services issued pursuant to the Health Insurance Access Act shall be subject to all applicable provisions of Chapter 44 except as otherwise provided in such chapter.

Source: Laws 1991, LB 419, § 32.

44-5305 Policy or contract; eligibility.

(1) An uninsured access coverage policy or contract shall limit eligibility to individuals or families who are not eligible for medicare or any other medical assistance program, including, but not limited to, the program established pursuant to the Medical Assistance Act.

(2) The uninsured access coverage policy or contract shall allow a transfer to a designated type of individual policy or contract without evidence of insurability and without interruption in coverage subject to payment of premiums. Each uninsured access coverage policy or contract shall specify the type of individual policy or contract to which an insured person may transfer.

Source: Laws 1991, LB 419, § 33; Laws 2006, LB 1248, § 65; Laws 2009, LB445, § 3.

Cross References

Medical Assistance Act, see section 68-901.

44-5306 Policy or contract; eligibility; limitations.

(1) An individual or a family member shall not be eligible for initial or continued coverage under an uninsured access coverage policy or contract if he or she:

(a) Is eligible as an employee or dependent for group insurance coverage sponsored or maintained by an employer; or

(b) Is covered by any other type of hospital, surgical, or medical expense-incurred policy or health maintenance organization contract.

(2) An uninsured access coverage policy or contract may require evidence of insurability but shall not use underwriting guidelines that are more strict than those normally used by the insurer for its regular individual health insurance contracts.

Source: Laws 1991, LB 419, § 34; Laws 2009, LB445, § 4.

44-5307 Policy or contract; benefits required; coverage authorized; prohibitions.

(1) An uninsured access coverage policy or contract may include hospital-only and surgical-only benefits which shall mean:

(a) Inhospital benefits for not less than thirty continuous days nor more than ninety continuous days for each spell of illness; and

(b) Surgical benefits for both inpatient and outpatient surgery.

(2) An uninsured access coverage policy or contract may include prescription drug benefit coverage.

(3) An uninsured access coverage policy or contract may include preventative health care coverage, including, but not limited to, primary care physician visits, immunizations for adults and children, laboratory and X-ray procedures, and preventative cancer screenings such as mammograms, cervical cancer screenings, and noninvasive colorectal or prostate screenings.

(4) An uninsured access coverage policy or contract may not:

(a) Use a definition of spell of illness more restrictive than the definition found in section 44-5303; or

(b) Use a definition of preexisting condition more restrictive than the definition normally used by the insurer for its regular individual health insurance contracts.

(5) Every uninsured access coverage policy or contract shall provide that the benefit payment shall be accepted as payment in full by the provider and there shall be no deductible or coinsurance charged to the insured.

Source: Laws 1991, LB 419, § 35; Laws 2009, LB445, § 5.

44-5308 Policy or contract; contents required.

Each uninsured access coverage policy or contract shall include:

(1) A reasonable description of the geographic area or areas to be served; and

(2) A listing of the providers who have a contract with the insurers to furnish health care services.

Source: Laws 1991, LB 419, § 36.

44-5309 Policy or contract; exemption from mandated benefits.

Notwithstanding any other provision of law, every uninsured access coverage policy or contract shall be exempt from any and all mandated benefits which require coverage of any type of services or conditions.

Source: Laws 1991, LB 419, § 37.

44-5310 Issuing insurer; powers.

An insurer issuing an uninsured access coverage policy or contract may enter into contracts to arrange for health services by certain providers, may limit the number and types of providers with which it contracts, and shall not be required to provide benefits for services furnished by providers who do not contract with the insurer.

Source: Laws 1991, LB 419, § 38.

44-5311 Rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations to carry out the Health Insurance Access Act.

Source: Laws 1991, LB 419, § 39.

ARTICLE 54

UTILIZATION REVIEW

Section
44-5401. Transferred to section 44-5416.
44-5402. Transferred to section 44-5417.
44-5403. Repealed. Laws 1998, LB 1162, § 90.
44-5404. Repealed. Laws 1998, LB 1162, § 90.
44-5405. Repealed. Laws 1998, LB 1162, § 90.
44-5406. Repealed. Laws 1998, LB 1162, § 90.
44-5407. Repealed. Laws 1998, LB 1162, § 90.
44-5408. Repealed. Laws 1998, LB 1162, § 90.
44-5409. Transferred to section 44-5419.
44-5410. Transferred to section 44-5420.
44-5411. Transferred to section 44-5421.
44-5412. Transferred to section 44-5422.

Section

44-5401 Transferred to section 44-5416.

44-5402 Transferred to section 44-5417.

44-5403 Repealed. Laws 1998, LB 1162, § 90.

44-5404 Repealed. Laws 1998, LB 1162, § 90.

44-5405 Repealed. Laws 1998, LB 1162, § 90.

44-5406 Repealed. Laws 1998, LB 1162, § 90.

44-5407 Repealed. Laws 1998, LB 1162, § 90.

44-5408 Repealed. Laws 1998, LB 1162, § 90.

44-5409 Transferred to section 44-5419.

44-5410 Transferred to section 44-5420.

44-5411 Transferred to section 44-5421.

44-5412 Transferred to section 44-5422.

44-5413 Transferred to section 44-5423.

44-5414 Transferred to section 44-5424.

44-5415 Repealed. Laws 1998, LB 1162, § 90.

44-5416 Act, how cited.

Sections 44-5416 to 44-5431 shall be known and may be cited as the Utilization Review Act.

Source: Laws 1992, LB 428, § 1; R.S.1943, (1993), § 44-5401; Laws 1998, LB 1162, § 1.

44-5417 Purpose of act.

The purpose of the Utilization Review Act is to establish requirements and standards of operation for certification of medical utilization review agents. It is proper for the state to oversee utilization review agents as a part of the state's regulation and supervision of the business of insurance and to encourage effective, efficient, and consistent utilization review.

Source: Laws 1992, LB 428, § 2; R.S.1943, (1993), § 44-5402; Laws 1998, LB 1162, § 2.

44-5418 Terms, defined.

For purposes of the Utilization Review Act:

(1) Adverse determination means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefor denied, reduced, or terminated;

(2) Ambulatory review means utilization review of health care services performed or provided in an outpatient setting;

(3) Case management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) Certification means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(5) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(6) Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan;

(7) Concurrent review means utilization review conducted during a patient's hospital stay or course of treatment;

(8) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(9) Department means the Department of Insurance;

(10) Director means the Director of Insurance;

(11) Discharge planning means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(12) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in

serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(13) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(14) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facility does not include physicians' offices;

(15) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(16) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(17) Health care provider or provider means a health care professional or a facility;

(18) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(19) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(20) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(21) Network means the group of participating providers providing services to a managed care plan;

(22) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(23) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(24) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

(25) Prospective review means utilization review conducted prior to an admission or a course of treatment;

(26) Retrospective review means utilization review of medical necessity that is conducted after health services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(27) Second opinion means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(28) Significant beneficial interest means the ownership of any financial interest that is greater than the lesser of (a) five percent of the whole or (b) five thousand dollars;

(29) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment;

(30) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review does not include elective requests for clarification of coverage; and

(31) Utilization review agent means any person, company, health carrier, organization, or other entity performing utilization review. The following shall not be considered utilization review agents:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government or a federally qualified peer review organization or the State of Nebraska but only to the extent that the agent is providing services to the federal government or the State of Nebraska;

(c) An agency of the State of Nebraska;

(d) Internal quality assurance programs conducted by hospitals, home health agencies, preferred provider organizations, health maintenance organizations, other managed care entities, clinics, or private offices for purposes other than for allowing, denying, or making a recommendation on allowing or denying a covered person's claim for payment;

(e) Nebraska licensed pharmacists, pharmacies, or organizations thereof while engaged in the practice of pharmacy, including the dispensing of drugs, participating in drug utilization reviews, and monitoring of patient drug therapy;

(f) Any person performing utilization review of workers' compensation benefits but only to the extent that the person is providing utilization review of workers' compensation benefits;

(g) Any individual or group employed or used by a utilization review agent certified under the Utilization Review Act when performing utilization review for or on behalf of such agent, including nurses and physicians; and

(h) An employee benefit plan or any person on behalf of an employee benefit plan to the extent that the activities of such plan or person are exempt from state regulation of the business of insurance pursuant to the federal Employee Retirement Income Security Act of 1974, as amended.

Source: Laws 1998, LB 1162, § 3.

44-5419 Utilization review agent; certificate required; term.

On or after July 1, 1993, a utilization review agent may not conduct utilization review upon a covered person in this state unless the agent is granted a certificate by the director. Certificates granted under the Utilization Review Act shall be valid for two years from the date of issuance.

Source: Laws 1992, LB 428, § 9; R.S.1943, (1993), § 44-5409; Laws 1998, LB 1162, § 4.

44-5420 Certificate; application; fee.

(1) An applicant for a certificate as a utilization review agent shall submit an application to the department upon a form which may be obtained from the department. The application shall be signed and verified by the applicant.

Along with the application, the applicant shall pay the application fee of three hundred dollars.

(2) As a part of the application, the applicant shall submit the following:

(a) Documentation that the applicant has received approval or accreditation by the American Accreditation HealthCare Commission/URAC, or a similar organization which has standards for utilization review agents that are substantially similar to the standards of the American Accreditation HealthCare Commission/URAC, and which has been approved by the director;

(b) A statement of the street and mailing address of the entity, telephone number of the entity, and a list of the principal officers of the entity responsible for its operation, management, and control; and

(c) Such other reasonable information or documentation as the department requires for enforcement of the Utilization Review Act.

Source: Laws 1992, LB 428, § 10; R.S.1943, (1993), § 44-5410; Laws 1998, LB 1162, § 5.

44-5421 Certificate; director; grant or deny; notice and hearing requirements.

The director shall grant or deny a certificate within forty-five days of receipt of a completed application under section 44-5420. The director shall deny a

certificate if the applicant does not meet the requirements of the Utilization Review Act. If a certificate is denied, the director shall notify the applicant by certified mail and shall specify the reasons for denial in the notice. The applicant shall have ten days from the date of receipt of the notice to request a hearing before the director pursuant to the Administrative Procedure Act, or he or she may reapply and respond to the reasons for the denial.

Source: Laws 1992, LB 428, § 11; R.S.1943, (1993), § 44-5411; Laws 1998, LB 1162, § 6.

Cross References

Administrative Procedure Act, see section 84-920.

44-5422 Utilization review agents; procedures applicable; exceptions.

(1) Utilization review agents operating in this state shall comply with the following provisions:

(a) A utilization review agent, employees of a utilization review agent, or persons acting on behalf of a utilization review agent may not refer a patient who has undergone utilization review by that utilization review agent, employee, or person to:

(i) A health care facility or other provider in which the utilization review agent owns a significant beneficial interest; or

(ii) The utilization review agent's own health care practice;

(b) A utilization review agent, employees of a utilization review agent, or persons acting on behalf of a utilization review agent shall not accept or agree to accept any sum from any person for bringing or referring a patient to a health care provider;

(c) A utilization review agent shall not compensate employees or persons acting on behalf of the utilization review agent based directly on the number of adverse determinations;

(d) A utilization review agent shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for a covered person or his or her representative to notify the utilization review agent and request certification or continuing treatment for the condition;

(e) A covered person or an attending physician on behalf of a covered person may request an appeal of a decision not to approve or certify for clinical reasons. For such appeal, a covered person or attending physician on behalf of a covered person shall, upon request, have timely access to the clinical basis for the decision, including any criteria, standards, or clinical indicators used as a basis for such recommendation or decision;

(f) During a final appeal of a decision not to certify or approve for clinical reasons, a utilization review agent shall assure that a physician is reasonably available to review the case, except that if the health care services were provided or authorized by a provider other than a physician, such appeal may be reviewed by a nonphysician provider whose scope of practice includes the treatment or services. Hospitals, health care providers, or representatives of the covered person may assist in an appeal; and

(g) A utilization review agent shall comply with the standards adopted by the organization that has granted the agent approval or accreditation and upon

which the certificate was granted by the director, whether or not action is taken by such organization to enforce the standards.

(2) Subdivisions (1)(a) and (b) of this section shall not apply to a utilization review agent, employees of the utilization review agent, or other persons acting on behalf of such utilization review agent who refer a patient to:

(a) The health care provider or facility that participates in a health maintenance organization in which the patient is enrolled; or

(b) A preferred provider network of participating providers or facilities to which the patient would otherwise be referred as part of the patient's insurance contract or policy.

Source: Laws 1992, LB 428, § 12; R.S.1943, (1993), § 44-5412; Laws 1998, LB 1162, § 7.

44-5423 Utilization review agent; notify director of changes; when.

A utilization review agent shall notify the director within five working days of any change of the agent's approval or accreditation status or of any material change in the information contained in the agent's application or renewal or that the agent no longer meets the requirements of the Utilization Review Act.

Source: Laws 1992, LB 428, § 13; R.S.1943, (1993), § 44-5413; Laws 1998, LB 1162, § 8.

44-5424 Certificates; renewal; fee.

Certificates granted under the Utilization Review Act may be renewed prior to their expiration date upon the filing of the following with the department (1) a renewal fee of one hundred dollars, (2) a statement detailing any changes in the information or documentation filed with the initial application, and (3) such other reasonable information as the department requires for enforcement of the act.

Source: Laws 1992, LB 428, § 14; R.S.1943, (1993), § 44-5414; Laws 1998, LB 1162, § 9.

44-5425 Health carrier; oversight of utilization review activities.

A health carrier shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of the Utilization Review Act and applicable rules and regulations are met. The health carrier shall also ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

Source: Laws 1998, LB 1162, § 10.

44-5426 Utilization review program; use of clinical review criteria.

A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies.

Source: Laws 1998, LB 1162, § 11.

44-5427 Description of review procedures; toll-free number.

(1) In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures.

(2) A health carrier shall include a summary of its utilization review procedures in enrollment materials intended for prospective covered persons.

(3) A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

Source: Laws 1998, LB 1162, § 12.

44-5428 Agent violation; notice; hearing.

If the director finds that any utilization review agent doing business in this state is engaging in any violation of the Utilization Review Act and that a proceeding in respect thereto would be in the public interest, he or she shall issue and serve upon such utilization review agent a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Source: Laws 1998, LB 1162, § 13.

44-5429 Violation; penalty.

If, after the hearing, the director finds a utilization review agent has violated the Utilization Review Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the utilization review agent charged with the violation a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Utilization Review Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the utilization review agent's license to do business in this state if the utilization review agent knew or reasonably should have known it was in violation of the act.

Source: Laws 1998, LB 1162, § 14.

44-5430 Violation of cease and desist order; penalty.

Any utilization review agent who violates a cease and desist order of the director under section 44-5429 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the utilization review agent's license to do business in this state.

Source: Laws 1998, LB 1162, § 15.

44-5431 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Utilization Review Act.

Source: Laws 1998, LB 1162, § 16.

ARTICLE 55

SURPLUS LINES INSURANCE

Section

44-5501 Act, how cited.

Sections 44-5501 to 44-5515 shall be known and may be cited as the Surplus Lines Insurance Act.

Source: Laws 1992, LB 1006, § 1; Laws 2007, LB117, § 21; Laws 2019, LB469, § 1.

44-5502 Terms, defined.

For purposes of the Surplus Lines Insurance Act, unless the context otherwise requires:

(1) Affiliated group means a group of entities in which each entity, with respect to an insured, controls, is controlled by, or is under common control with the insured;

(2) Control means:

(a) To own, control, or have the power of an entity directly, indirectly, or acting through one or more other persons to vote twenty-five percent or more of any class of voting securities of another entity; or

(b) To direct, by an entity, in any manner, the election of a majority of the directors or trustees of another entity;

(3) Department means the Department of Insurance;

(4) Director means the Director of Insurance;

(5) Domestic surplus lines insurer means a nonadmitted insurer domiciled in this state that has a certificate of authority to operate as a domestic surplus lines insurer in the State of Nebraska issued as provided in section 44-5506.01;

(6)(a) Exempt commercial purchaser means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(i) The person employs or retains a qualified risk manager to negotiate insurance coverage;

(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars in the immediately preceding twelve months; and

(iii) The person meets at least one of the following criteria:

(A) The person possesses a net worth in excess of twenty million dollars, as such amount is adjusted pursuant to subdivision (6)(b) of this section;

(B) The person generates annual revenue in excess of fifty million dollars, as such amount is adjusted pursuant to subdivision (6)(b) of this section;

(C) The person employs more than five hundred full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand employees in the aggregate;

(D) The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars, as such amount is adjusted pursuant to subdivision (6)(b) of this section; or

(E) The person is a municipality with a population in excess of fifty thousand inhabitants as determined by the most recent federal decennial census or the most recent revised certified count by the United States Bureau of the Census.

(b) Beginning on the fifth occurrence of January 1 after July 21, 2011, and each fifth occurrence of January 1 thereafter, the amounts in subdivisions (6)(a)(iii)(A), (B), and (D) of this section shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers published by the Federal Bureau of Labor Statistics;

(7) Foreign, alien, admitted, and nonadmitted, when referring to insurers, have the same meanings as in section 44-103 but do not include a risk retention group as defined in 15 U.S.C. 3901(a)(4);

(8)(a) Except as provided in subdivision (8)(b) of this section, home state means, with respect to an insured, (i) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence or (ii) if one hundred percent of the insured risk is located out of the state referred to in subdivision (8)(a)(i) of this section, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(b) If more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, home state means the home state, as determined pursuant to subdivision (8)(a) of this section, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(c) When determining the home state of the insured, the principal place of business is the state in which the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities of the insured;

(9) Insurer has the same meaning as in section 44-103;

(10) Nonadmitted insurance means any property and casualty insurance permitted to be placed directly or through surplus lines licensees with a nonadmitted insurer eligible to accept such insurance; and

(11) Qualified risk manager means, with respect to a policyholder of commercial insurance, a person who meets the definition in section 527 of the Nonadmitted and Reinsurance Reform Act of 2010, which is Subtitle B of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Public Law 111-203, as such section existed on January 1, 2011.

Source: Laws 1992, LB 1006, § 2; Laws 2007, LB117, § 22; Laws 2011, LB70, § 1; Laws 2017, LB113, § 44; Laws 2019, LB469, § 2.

44-5503 Surplus lines license; issuance.

The department, in consideration of the payment of the license fee, may issue a surplus lines license, revocable at any time, to any individual who currently holds an insurance producer license or to a foreign or domestic corporation. The corporate surplus lines license shall list all officers or employees of the corporation who currently hold an insurance producer license or meet the requirements for an individual surplus lines license and who have authority to transact surplus lines business on behalf of the corporation. Only individuals listed on the corporate surplus lines license shall transact surplus lines business on behalf of the corporate licensee. If the applicant is an individual, the application for the license shall include the applicant's social security number. The director may utilize the national insurance producer database of the National Association of Insurance Commissioners, or any other equivalent uniform national database, for the licensure of an individual or an entity as a surplus lines producer and for renewal of such license.

Source: Laws 1913, c. 154, § 25, p. 408; R.S.1913, § 3161; Laws 1919, c. 190, tit. V, art. III, § 18, p. 587; C.S.1922, § 7762; C.S.1929, § 44-218; R.S.1943, § 44-139; Laws 1955, c. 168, § 3, p. 479; Laws 1978, LB 836, § 1; Laws 1989, LB 92, § 29; R.S.Supp.,1990, § 44-139; Laws 1992, LB 1006, § 3; Laws 1997, LB 752, § 113; Laws 2001, LB 51, § 38; Laws 2002, LB 1139, § 36; Laws 2011, LB70, § 2.

Insurance companies and agents are forbidden to procure or effect fire insurance in companies not licensed to write it. Naeve v. Shea, 128 Neb. 374, 258 N.W. 666 (1935).

44-5504 Nonadmitted insurer; surplus lines license; application; fee; expiration; renewal.

(1) No person, other than an exempt commercial purchaser, shall place, procure, or effect insurance for or on behalf of an insured whose home state is the State of Nebraska in any nonadmitted insurer until such person has first been issued a surplus lines license from the department as provided in section 44-5503.

(2) Application for a surplus lines license shall be made to the department on forms designated and furnished by the department and shall be accompanied

by a license fee as established by the director not to exceed two hundred fifty dollars for each individual and corporate surplus lines license.

(3)(a) All corporate surplus lines licenses shall expire on April 30 of each year, and all individual surplus lines licenses shall expire on the licensee's birthday in the first year after issuance in which his or her age is divisible by two, and all individual surplus lines licenses may be renewed within the ninety-day period before their expiration dates and all individual surplus lines licenses also may be renewed within the thirty-day period after their expiration dates upon payment of a late renewal fee as established by the director not to exceed two hundred dollars in addition to the applicable fee otherwise required for renewal of individual surplus lines licenses as established by the director pursuant to subsection (2) of this section. All individual surplus lines licenses renewed within the thirty-day period after their expiration dates pursuant to this subdivision shall be deemed to have been renewed before their expiration dates. The department shall establish procedures for the renewal of surplus lines licenses.

(b) Every licensee shall notify the department within thirty days of any changes in the licensee's residential or business address.

Source: Laws 1913, c. 154, § 25, p. 408; R.S.1913, § 3161; Laws 1919, c. 190, tit. V, art. III, § 18, p. 587; C.S.1922, § 7762; C.S.1929, § 44-218; R.S.1943, § 44-140; Laws 1978, LB 836, § 2; Laws 1984, LB 801, § 47; Laws 1989, LB 92, § 30; R.S.Supp.,1990, § 44-140; Laws 1992, LB 1006, § 4; Laws 1999, LB 260, § 15; Laws 2002, LB 1139, § 37; Laws 2007, LB117, § 23; Laws 2011, LB70, § 3.

44-5505 Nonadmitted insurer; surplus lines licensee; record of business; contents; how kept.

Each surplus lines licensee shall keep in the licensee's office a true and complete record of the business transacted by the licensee showing (1) the exact amount of insurance or limits of exposure, (2) the gross premiums charged therefor, (3) the return premium paid thereon, (4) the rate of premium charged for such insurance, (5) the date of such insurance and terms thereof, (6) the name and address of the nonadmitted insurer writing such insurance, (7) a copy of the declaration page of each policy and a copy of each policy form issued by the licensee, (8) a copy of the written statement described in subdivision (1)(c) of section 44-5510 or, in lieu thereof, a copy of the application containing such written statement, (9) the name of the insured, (10) the address of the principal residence of the insured or the address at which the insured maintains its principal place of business, (11) a brief and general description of the risk or exposure insured and where located, (12) documentation showing that the nonadmitted insurer writing such insurance complies with the requirements of section 44-5508, and (13) such other facts and information as the department may direct and require. Such records shall be kept by the licensee in the licensee's office within the state for not less than five years and shall at all times be open and subject to the inspection and examination of the department or its officers. The expense of any examination shall be paid by the licensee.

Source: Laws 1913, c. 154, § 25, p. 409; R.S.1913, § 3161; Laws 1919, c. 190, tit. V, art. III, § 18, p. 588; C.S.1922, § 7762; C.S.1929,

§ 44-218; R.S.1943, § 44-141; Laws 1978, LB 836, § 3; Laws 1989, LB 92, § 31; R.S.Supp.,1990, § 44-141; Laws 1992, LB 1006, § 5; Laws 2005, LB 119, § 20; Laws 2011, LB70, § 4.

44-5506 Surplus lines licensee; quarterly statement; tax payment.

(1) Every surplus lines licensee transacting business under the Surplus Lines Insurance Act shall, on or before March 1 for the quarter ending the preceding December 31, June 1 for the quarter ending the preceding March 31, September 1 for the quarter ending the preceding June 30, and December 1 for the quarter ending the preceding September 30 of each year, make and file with the department a verified statement upon a form prescribed by the department or a designee of the director which shall exhibit the true amount of all such business transacted during that period.

(2)(a) Every surplus lines licensee transacting business under the Surplus Lines Insurance Act shall collect and pay to the director or the director's designee, at the time the statement required under subsection (1) of this section is filed, a sum based on the total gross premiums charged, less any return premiums, for surplus lines insurance provided by the licensee pursuant to the license on behalf of an insured whose home state is the State of Nebraska. In no event shall such taxes be determined on a retaliatory basis pursuant to section 44-150.

(b) The sum payable shall be computed based on an amount equal to three percent of the premiums for insurance that covers properties, risks, or exposures located or to be performed in the United States, to be remitted to the State Treasurer in accordance with section 77-912.

(c) The surplus lines licensee is prohibited from rebating, for any reason, any portion of the tax.

Source: Laws 1913, c. 154, § 25, p. 409; R.S.1913, § 3161; Laws 1919, c. 190, tit. V, art. III, § 18, p. 588; C.S.1922, § 7762; C.S.1929, § 44-218; R.S.1943, § 44-142; Laws 1978, LB 836, § 4; Laws 1987, LB 302, § 4; Laws 1989, LB 92, § 32; R.S.Supp.,1990, § 44-142; Laws 1992, LB 1006, § 6; Laws 2011, LB70, § 5; Laws 2016, LB837, § 1.

44-5506.01 Nonadmitted insurer; certificate of authority; director; powers; provisions applicable.

(1) The director may provide written authority in the form of a certificate of authority to operate as a domestic surplus lines insurer in the State of Nebraska to a nonadmitted insurer domiciled in this state if the director determines that such nonadmitted insurer:

(a) Possesses policyholder surplus of at least fifteen million dollars;

(b) Is an eligible surplus lines insurer in at least one state jurisdiction other than this state; and

(c) Is acting pursuant to a resolution passed by its board of directors seeking to be a domestic surplus lines insurer in this state.

(2) All financial and solvency requirements imposed by Chapter 44 upon a domestic admitted insurer shall apply to a domestic surplus lines insurer unless domestic surplus lines insurers are otherwise specifically exempted.

(3) Policies issued by a domestic surplus lines insurer are not subject to the protections or other requirements of the Nebraska Property and Liability Insurance Guaranty Association Act or the Nebraska Life and Health Insurance Guaranty Association Act.

Source: Laws 2019, LB469, § 3.

Cross References

Nebraska Life and Health Insurance Guaranty Association Act, see section 44-2720.
Nebraska Property and Liability Insurance Guaranty Association Act, see section 44-2418.

44-5507 Nonadmitted insurer; personal jurisdiction.

Every nonadmitted insurer accepting business under the Surplus Lines Insurance Act shall be held to have sufficient contact with this state for the exercise of personal jurisdiction over such insurer (1) upon any cause of action arising out of any such transaction or (2) in any proceeding before the director under the act.

Source: Laws 1913, c. 154, § 25, p. 410; R.S.1913, § 3161; Laws 1919, c. 190, tit. V, art. III, § 18, p. 589; C.S.1922, § 7762; C.S.1929, § 44-218; R.S.1943, § 44-145; Laws 1978, LB 836, § 5; Laws 1983, LB 447, § 57; R.S.1943, (1988), § 44-145; Laws 1992, LB 1006, § 7; Laws 2019, LB469, § 4.

44-5508 Surplus lines licensee; requirements; duties of licensee; violations; penalty; nonadmitted insurer; requirements.

(1) A surplus lines licensee shall not place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines licensee has determined that the nonadmitted insurer is a domestic surplus lines insurer or meets the following criteria:

(a) Is authorized to write such insurance in its domiciliary jurisdiction;

(b) Has established satisfactory evidence of good repute and financial integrity; and

(c)(i) Possesses capital and surplus or its equivalent under the laws of its domiciliary jurisdiction that equals the greater of the minimum capital and surplus requirements under the laws of this state or fifteen million dollars; or

(ii) If minimum capital and surplus does not meet the requirements of subdivision (1)(c)(i) of this section, then upon an affirmative finding of acceptability by the director. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. The director shall not make an affirmative finding of acceptability if the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars.

(2) No surplus lines licensee shall place nonadmitted insurance with or procure nonadmitted insurance from a nonadmitted insurer domiciled outside the United States unless the insurer is listed on the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners.

(3) Any surplus lines licensee violating this section shall be guilty of a Class III misdemeanor.

(4)(a) No nonadmitted foreign or alien insurer shall accept business under the Surplus Lines Insurance Act if it does not comply with the surplus and capital requirements of subsection (1) of this section.

(b) In addition to the requirements of subdivision (a) of this subsection, no nonadmitted alien insurer shall accept business under the act if it does not comply with the requirements of subsection (2) of this section.

Source: Laws 1913, c. 154, § 26, p. 410; R.S.1913, § 3162; Laws 1919, c. 190, tit. V, art. III, § 19, p. 589; C.S.1922, § 7763; C.S.1929, § 44-219; R.S.1943, § 44-147; Laws 1951, c. 135, § 2, p. 558; Laws 1971, LB 757, § 1; Laws 1977, LB 40, § 230; Laws 1978, LB 836, § 6; Laws 1989, LB 92, § 33; R.S.Supp.,1990, § 44-147; Laws 1992, LB 1006, § 8; Laws 1994, LB 978, § 31; Laws 2005, LB 119, § 21; Laws 2011, LB70, § 6; Laws 2019, LB469, § 5.

The procuring of insurance with nonexistent and spurious fire insurance companies violated this section. Naeve v. Shea, 132 Neb. 787, 273 N.W. 265 (1937).

44-5509 Surplus lines licensee; policy; information required.

A surplus lines licensee shall stamp or type upon the declaration page of each policy procured and delivered under the Surplus Lines Insurance Act the following information: (1) The licensee's name, business address, and surplus lines license number; (2) the name under which the licensee transacts business if different than the licensee's own name; and (3) the language: This policy is issued by a nonadmitted insurer, and in the event of the insolvency of such insurer, this policy will not be covered by the Nebraska Property and Liability Insurance Guaranty Association.

Source: Laws 1978, LB 836, § 7; Laws 1989, LB 92, § 34; R.S.Supp.,1990, § 44-147.01; Laws 1992, LB 1006, § 9.

Cross References

Nebraska Property and Liability Insurance Guaranty Association, see section 44-2404.

44-5510 Insurance; procurement from nonadmitted insurer; when; terms and conditions; surplus lines licensee; exempt from due diligence search; conditions.

(1) If an applicant for insurance is unable to procure such insurance as he or she deems reasonably necessary to insure a risk or exposure from an admitted insurer, such insurance may be procured from a nonadmitted insurer upon the following terms and conditions:

(a) The insurance shall be procured from a surplus lines licensee;

(b) The insurance procured shall not include any insurance described in subdivisions (1) through (4) of section 44-201, except that this subdivision shall not prohibit the procurement of disability insurance that has a benefit limit in excess of any benefit limit available from an admitted insurer;

(c) Not later than thirty days after the effective date of such insurance, the insured shall provide, in writing, his or her permission for such insurance to be written in a nonadmitted insurer and his or her acknowledgment that, in the event of the insolvency of such insurer, the policy will not be covered by the Nebraska Property and Liability Insurance Guaranty Association; and

(d) Compliance with section 44-5511.

(2) A surplus lines licensee seeking to procure or place nonadmitted insurance for an exempt commercial purchaser whose home state is the State of Nebraska shall not be required to make a due diligence search to determine whether the full amount or type of insurance sought by such exempt commercial purchaser can be obtained from admitted insurers if:

(a) The surplus lines licensee procuring or placing the insurance has disclosed to the exempt commercial purchaser that such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(b) The exempt commercial purchaser has subsequently requested in writing the surplus lines licensee to procure or place such insurance for a nonadmitted insurer.

Source: Laws 1978, LB 836, § 8; Laws 1989, LB 92, § 35; R.S.Supp.,1990, § 44-147.02; Laws 1992, LB 1006, § 10; Laws 2011, LB70, § 7; Laws 2012, LB1064, § 1.

Cross References

Nebraska Property and Liability Insurance Guaranty Association, see section 44-2404.

44-5511 Surplus lines licensee; report; contents; when due.

On or before March 1 for the quarter ending the preceding December 31, June 1 for the quarter ending the preceding March 31, September 1 for the quarter ending the preceding June 30, and December 1 for the quarter ending the preceding September 30 of each year, every surplus lines licensee shall file with the department a report containing such information as the department may require, including: (1) The name of the nonadmitted insurer; (2) the name of the licensee; (3) the number of policies issued by each nonadmitted insurer; (4) except for insurance placed or procured on behalf of an exempt commercial purchaser, a sworn statement by the licensee with regard to the coverages described in the quarterly report that, to the best of the licensee's knowledge and belief, the licensee could not reasonably procure such coverages from an admitted insurer; and (5) the premium volume for each nonadmitted insurer by line of business.

Source: Laws 1978, LB 836, § 9; Laws 1989, LB 92, § 36; R.S.Supp.,1990, § 44-147.03; Laws 1992, LB 1006, § 11; Laws 2011, LB70, § 8; Laws 2018, LB799, § 1.

44-5512 Violations; director; hearing; orders; penalty; appeal.

(1) Whenever the director has reason to believe that any person has engaged in any activities in violation of the Surplus Lines Insurance Act, the director may:

(a) Issue an order and notice of hearing directing such person to cease and desist from engaging in such activities; or

(b) Issue a statement of the charges of violation and a notice of hearing to be held within thirty days to determine whether or not such violation occurred.

(2) Any hearing held pursuant to subsection (1) of this section, and any appeal therefrom, shall be in accordance with the Administrative Procedure Act.

(3) If, after any hearing held pursuant to subsection (1) of this section, the director finds that the person charged has committed a violation as alleged, he or she shall reduce his or her findings to writing and serve a copy of the findings on the person charged and, in addition, the director may order any one or more of the following:

(a) That such person cease and desist from engaging in such activities;

(b) Payment of a fine of not more than five thousand dollars; and

(c) Suspension or revocation of any surplus lines license held by such person for such period of time as the director determines.

(4) Any person who violates a cease and desist order may, after notice and hearing and upon order of the director, be subject to:

(a) Payment of a fine of not more than ten thousand dollars; and

(b) Suspension or revocation of each insurance license held by such person for such period of time as the director determines.

(5) For purposes of this section, person shall include a nonadmitted insurer.

Source: Laws 1978, LB 836, § 10; Laws 1989, LB 92, § 37; R.S.Supp.,1990, § 44-147.04; Laws 1992, LB 1006, § 12; Laws 2018, LB799, § 2.

Cross References

Administrative Procedure Act, see section 84-920.

44-5513 Repealed. Laws 2001, LB 51, § 42.

44-5514 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Surplus Lines Insurance Act.

Source: Laws 1978, LB 836, § 12; Laws 1989, LB 92, § 38; R.S.Supp.,1990, § 44-147.06; Laws 1992, LB 1006, § 14.

44-5515 Exempt commercial purchaser; taxes; form.

Every exempt commercial purchaser whose home state is the State of Nebraska shall, on or before March 1 for the quarter ending the preceding December 31, June 1 for the quarter ending the preceding March 31, September 1 for the quarter ending the preceding June 30, and December 1 for the quarter ending the preceding September 30 of each year, pay to the department a tax in the amount required by subsection (2) of section 44-5506. The calculation of the taxes due pursuant to this section shall be based only on those premiums remitted for the placement or procurement of insurance by an exempt commercial purchaser whose home state is the State of Nebraska. The department shall prescribe a form for an exempt commercial purchaser tax filing.

Source: Laws 2007, LB117, § 24; Laws 2011, LB70, § 9; Laws 2016, LB837, § 2.

ARTICLE 56

REINSURANCE INTERMEDIARY ACT

Section
44-5601. Act, how cited.
44-5602. Terms, defined.

Section

44-5601 Act, how cited.

Sections 44-5601 to 44-5613 shall be known and may be cited as the Reinsurance Intermediary Act.

Source: Laws 1992, LB 1006, § 55; Laws 2002, LB 1139, § 38.

44-5602 Terms, defined.

For purposes of the Reinsurance Intermediary Act:

(1) Actuary shall mean a person who is a member in good standing of the American Academy of Actuaries;

(2) Controlling person shall mean any person, firm, association, or corporation which directly or indirectly has the power to direct or cause to be directed the management, control, or activities of the reinsurance intermediary;

(3) Director shall mean the Director of Insurance;

(4) Insurer shall mean any person, firm, association, or corporation holding a certificate to transact insurance business in this state;

(5) Licensed producer shall mean an agent, broker, or reinsurance intermediary licensed pursuant to Chapter 44;

(6) Qualified United States financial institution shall mean an institution that:

(a) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies; and

(c) Has been determined by either the director or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions the letters of credit of which will be acceptable to the director;

(7) Reinsurance intermediary shall mean a reinsurance intermediary-broker or a reinsurance intermediary-manager;

(8) Reinsurance intermediary-broker shall mean any person other than an officer or employee of the ceding insurer, firm, association, or corporation which solicits, negotiates, or places reinsurance cessions or retrocessions on

behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer;

(9) Reinsurance intermediary-manager shall mean any person, firm, association, or corporation which has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office, and acts as an agent for such reinsurer whether known as a reinsurance intermediary-manager, manager, or other similar term.

Reinsurance intermediary-manager shall not include:

(a) An employee of the reinsurer;

(b) A United States manager of the United States branch of an alien reinsurer;

(c) An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, which is under common control with the reinsurer subject to the Insurance Holding Company System Act, and the compensation of which is not based on the volume of premiums written; or

(d) The manager of a group, association, pool, or organization of insurers which engages in joint underwriting or joint reinsurance and which is subject to examination by the director, commissioner, or equivalent official of the state in which the manager's principal business office is located; and

(10) Reinsurer shall mean an insurer with the authority to assume reinsurance.

Source: Laws 1992, LB 1006, § 56; Laws 1993, LB 583, § 112.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-5603 Reinsurance intermediary-broker; reinsurance intermediary-manager; license; requirements; issuance; director; duties; fee; renewal; exemption.

(1) No person, firm, association, or corporation shall act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office directly, as a member or employee of a firm or association, or as an officer, director, or employee of a corporation:

(a) In this state unless such reinsurance intermediary-broker is a licensed producer or reinsurance intermediary in this state; or

(b) In another state unless such reinsurance intermediary-broker is a licensed producer or reinsurance intermediary in this state or another state having a law substantially similar to the Reinsurance Intermediary Act or such reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

(2) No person, firm, association, or corporation shall act as a reinsurance intermediary-manager:

(a) For a reinsurer domiciled in this state unless such reinsurance intermediary-manager is a licensed producer or reinsurance intermediary in this state; or

(b) In this state if the reinsurance intermediary-manager maintains an office directly, as a member or employee of a firm or association, or as an officer, director, or employee of a corporation in this state unless such reinsurance

intermediary-manager is a licensed producer or reinsurance intermediary in this state.

(3) The director may require a resident reinsurance intermediary-manager subject to subsection (2) of this section to:

(a) File a bond in an amount from an insurer acceptable to the director for the protection of the reinsurer; and

(b) Maintain an errors and omissions policy in an amount acceptable to the director.

(4) The director may issue a reinsurance intermediary license to any person, firm, association, or corporation which has complied with the requirements of the Reinsurance Intermediary Act. Any such license issued to a firm or association shall authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers and any designated employees and directors to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(5) The director may refuse to issue a reinsurance intermediary license if in his or her judgment he or she determines that the applicant, any person named on the application, or any member, principal, officer, or director of the applicant is not trustworthy, that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing have given cause for revocation or suspension of such license or have failed to comply with any prerequisite for the issuance of such license. Upon written request by the applicant, the director shall furnish to the applicant a summary of the basis for refusal to issue a license, which summary shall be privileged and not subject to public disclosure.

(6)(a) Applications for resident reinsurance intermediary licenses shall be made to the director on forms designated and furnished by the director and shall be accompanied by a license fee established by the director not to exceed two hundred fifty dollars. If the applicant is an individual, the application for the license shall also include the applicant's social security number.

(b) The director shall issue a nonresident reinsurance intermediary license if:

(i) The person is currently licensed as a resident reinsurance intermediary or insurance producer and is in good standing in his or her home state;

(ii) The person has submitted or transmitted to the director the application for licensure that the person submitted to his or her home state, or in lieu of that application, a completed application deemed appropriate by the director, accompanied by a license fee established by the director not to exceed two hundred fifty dollars; and

(iii) The person's home state awards nonresident licenses to residents of this state on the same basis.

(c) All reinsurance intermediary licenses shall expire on April 30 of each year. Reinsurance intermediary licenses may be renewed within the ninety-day period before their expiration dates. The director shall establish procedures for the renewal of reinsurance intermediary licenses. Every licensee shall notify the director within thirty days of any change in the licensee's business or residential address.

(7) Attorneys of this state acting in their professional capacity shall be exempt from this section.

Source: Laws 1992, LB 1006, § 57; Laws 1997, LB 752, § 114; Laws 2002, LB 1139, § 39.

44-5603.01 Nonresident reinsurance intermediary license; reciprocal licensure; continuing education.

(1) The director shall waive any requirements for a nonresident reinsurance intermediary license applicant with a valid license from the applicant's home state, except the requirements imposed by section 44-5603, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident reinsurance intermediary's satisfaction of any applicable home-state continuing education requirements, if any, for licensed insurance producers or reinsurance intermediaries shall constitute satisfaction of the continuing education requirements of this state if the home state of the reinsurance intermediary recognizes the satisfaction of its continuing education requirements imposed upon insurance producers or reinsurance intermediaries from this state on the same basis.

Source: Laws 2002, LB 1139, § 40.

44-5603.02 Licensed reinsurance intermediary; consent to jurisdiction.

A reinsurance intermediary, by accepting licensure in this state, is deemed to have consented to the jurisdiction of the director and of the courts of this state with respect to all activities conducted under the license and to have designated the director as its agent for service of process. Each licensed reinsurance intermediary shall furnish the director with the name and address of a designated contact resident of this state to whom notices or orders of the director or process affecting the reinsurance intermediary may be forwarded. The licensee shall promptly notify the director in writing of every change in its designated contact for service of process, and such changes shall not become effective until acknowledged by the director.

Source: Laws 2002, LB 1139, § 41.

44-5604 Reinsurance; written authorization required; contents.

Transactions between a reinsurance intermediary-broker and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization specifying the responsibilities of each party. The authorization shall at a minimum provide that:

(1) The insurer may terminate the reinsurance intermediary-broker's authority at any time;

(2) The reinsurance intermediary-broker will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the reinsurance intermediary-broker, and will remit all funds due to the insurer within thirty days of receipt;

(3) All funds collected for the insurer's account will be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank which is a qualified United States financial institution;

(4) The reinsurance intermediary-broker will comply with section 44-5605;

(5) The reinsurance intermediary-broker will comply with the written standards established by the insurer for the cession or retrocession of all risks; and

(6) The reinsurance intermediary-broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

Source: Laws 1992, LB 1006, § 58.

44-5605 Reinsurance intermediary-broker; records; requirements.

For at least ten years after expiration of each contract of reinsurance transacted by a reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction showing:

(1) Type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) Period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation;

(3) Reporting and settlement requirements of balances;

(4) Rate used to compute the reinsurance premium;

(5) Names and addresses of assuming reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the reinsurance intermediary-broker, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(10) Financial records, including premium and loss accounts; and

(11) When the reinsurance intermediary-broker procures a reinsurance contract on behalf of a ceding insurer:

(a) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(b) If placed through a representative of the assuming reinsurer other than an employee, written evidence that the assuming reinsurer has delegated binding authority to the representative.

The insurer shall have access to and the right to copy and audit all accounts and records maintained by the reinsurance intermediary-broker related to its business in a form usable by the insurer.

Source: Laws 1992, LB 1006, § 59.

44-5606 Insurer; prohibited acts; copy of statement of financial condition; obtain.

(1) An insurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf unless such person, firm, association, or corporation is licensed as required by subsection (1) of section 44-5603.

(2) An insurer may not employ a person who is employed by a reinsurance intermediary-broker with which it transacts business unless such reinsurance

intermediary-broker is under common control with the insurer and subject to the Insurance Holding Company System Act.

(3) An insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

Source: Laws 1992, LB 1006, § 60.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-5607 Reinsurance intermediary-manager; contracts; requirements; records required.

Transactions between a reinsurance intermediary-manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract specifying the responsibilities of each party, which contract shall be approved by the reinsurer's board of directors. At least thirty days before such reinsurer assumes or cedes business through the reinsurance intermediary-manager, a true copy of the approved contract shall be filed with the director for approval. The contract shall at a minimum provide that:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination;

(2) The reinsurance intermediary-manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the reinsurance intermediary-manager, and will remit all funds due under the contract to the reinsurer on not less than a monthly basis;

(3) All funds collected for the reinsurer's account will be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank which is a qualified United States financial institution. The reinsurance intermediary-manager may retain no more than three months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents;

(4) For at least ten years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager will keep a complete record for each transaction showing:

(a) Type of contract, limits, underwriting restrictions, classes or risks, and territory;

(b) Period of coverage, including effective and expiration dates, cancellation provisions, notice required of cancellation, and disposition of outstanding reserves on covered risks;

(c) Reporting and settlement requirements of balances;

(d) Rate used to compute the reinsurance premium;

(e) Names and addresses of assuming reinsurers;

(f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

(g) Related correspondence and memoranda;

(h) Proof of placement;

(i) Details regarding retrocessions handled by the reinsurance intermediary-manager as permitted by subsection (4) of section 44-5609, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(j) Financial records, including premium and loss accounts; and

(k) When the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) If placed through a representative of the assuming reinsurer other than an employee, written evidence that the assuming reinsurer has delegated binding authority to the representative;

(5) The reinsurer will have access to and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer;

(6) The contract cannot be assigned in whole or in part by the reinsurance intermediary-manager;

(7) The reinsurance intermediary-manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks;

(8) The rates, terms, and purposes of commissions, charges, and other fees which the reinsurance intermediary-manager may levy against the reinsurer will be set forth;

(9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(a) All claims will be reported to the reinsurer in a timely manner;

(b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed the lesser of an amount determined by the director or the limit set by the reinsurer;

(ii) Involves a coverage dispute;

(iii) May exceed the reinsurance intermediary-manager's claims-settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of the lesser of an amount set by the director or an amount set by the reinsurer;

(c) All claim files will be the joint property of the reinsurer and reinsurance intermediary-manager. Upon an order of liquidation of the reinsurer, such files shall become the sole property of the reinsurer or its estate, except that the reinsurance intermediary-manager shall have reasonable access to and the right to copy the files on a timely basis; and

(d) Any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination;

(10) If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business or a later period set by the director for specified lines of insurance and not until the adequacy of reserves on remaining claims has been attested to pursuant to subsection (3) of section 44-5609;

(11) The reinsurance intermediary-manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified public accountant;

(12) The reinsurer will at least semiannually conduct an onsite review of the underwriting and claims processing operations of the reinsurance intermediary-manager, will prepare a written report on such review, and will file such written report with the director;

(13) The reinsurance intermediary-manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to the contract; and

(14) Within the scope of its actual or apparent authority, the acts of the reinsurance intermediary-manager will be deemed to be the acts of the reinsurer on behalf of which it is acting.

Source: Laws 1992, LB 1006, § 61.

44-5608 Reinsurance intermediary-manager; prohibited acts.

A reinsurance intermediary-manager shall not:

(1) Cede retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect and, for each such reinsurer, the coverages and amounts or percentages that may be reinsured and commission schedules;

(2) Commit the reinsurer to participate in reinsurance syndicates;

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he or she is appointed;

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent of the reinsurer's policyholders surplus as of December 31 of the last complete calendar year;

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report shall be promptly forwarded to the reinsurer;

(6) Jointly employ an individual who is employed by the reinsurer unless such reinsurance intermediary-manager is under common control with the reinsurer subject to the Insurance Holding Company System Act; or

(7) Appoint a sub-reinsurance-intermediary-manager.

Source: Laws 1992, LB 1006, § 62.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-5609 Reinsurer; prohibited acts; requirements.

(1) A reinsurer shall not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-manager on its behalf unless such person, firm, association, or corporation is licensed as required by subsection (2) of section 44-5603.

(2) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager which such reinsurer has engaged prepared by an independent certified public accountant in a form acceptable to the director.

(3) If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an independent actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. The opinion shall be in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who is not affiliated with the reinsurance intermediary-manager.

(5) Within thirty days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of such termination to the director.

(6) A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This subsection shall not apply to relationships governed by the Insurance Holding Company System Act or the Producer-Controlled Property and Casualty Insurer Act.

Source: Laws 1992, LB 1006, § 63.

Cross References

Insurance Holding Company System Act, see section 44-2120.
Producer-Controlled Property and Casualty Insurer Act, see section 44-5701.

44-5610 Reinsurance intermediary; examination by director.

A reinsurance intermediary shall be subject to examination by the director. The director shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the director. The cost of examination shall be paid by the reinsurance intermediary in the manner provided in Chapter 44 for insurance companies.

Source: Laws 1992, LB 1006, § 64.

44-5611 Violations; penalties; action for damages; act, how construed.

(1) If the director determines that the reinsurance intermediary or any other person has not materially complied with the Reinsurance Intermediary Act, any rule or regulation adopted and promulgated thereunder, or any order issued thereunder, after notice and opportunity to be heard in accordance with the Administrative Procedure Act, the director may:

(a) For each separate violation, order a penalty in an amount not exceeding five thousand dollars;

(b) Order revocation or suspension of the reinsurance intermediary's license; and

(c) If it was found that because of such material noncompliance that the insurer or reinsurer has suffered any loss or damage, maintain a civil action brought by or on behalf of the reinsurer or insurer and its policyholders and creditors for recovery of damages for the benefit of the reinsurer or insurer and its policyholders and creditors and other appropriate relief.

(2) If an order of rehabilitation or liquidation of the insurer has been entered pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, and the receiver appointed under the order determines that the reinsurance intermediary or any other person has not materially complied with the Reinsurance Intermediary Act, any rule and regulation adopted and promulgated thereunder, or any order issued thereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages and other appropriate relief for the benefit of the insurer.

(3) This section shall not affect the right of the director to impose any other penalties provided for in Chapter 44.

(4) The Reinsurance Intermediary Act is not intended to and shall not in any manner limit or restrict the rights of policyholders, claimants, creditors, and other third parties.

Source: Laws 1992, LB 1006, § 65; Laws 1993, LB 583, § 113.

Cross References

Administrative Procedure Act, see section 84-920.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-5612 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Reinsurance Intermediary Act.

Source: Laws 1992, LB 1006, § 66.

44-5613 Compliance with act; when.

No insurer or reinsurer may continue to utilize the services of a reinsurance intermediary on and after January 1, 1993, unless utilization is in compliance with the Reinsurance Intermediary Act.

Source: Laws 1992, LB 1006, § 67.

ARTICLE 57

PRODUCER-CONTROLLED PROPERTY AND CASUALTY INSURERS

Section

44-5701 Act, how cited.

Sections 44-5701 to 44-5708 shall be known and may be cited as the Producer-Controlled Property and Casualty Insurer Act.

Source: Laws 1992, LB 1006, § 68.

44-5702 Terms, defined.

For purposes of the Producer-Controlled Property and Casualty Insurer Act:

(1) Accredited state shall mean a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards established and promulgated from time to time by the National Association of Insurance Commissioners;

(2) Captive insurers shall mean insurance companies owned by another organization the exclusive purpose of which is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds the exclusive purpose of which is to insure risks to member organizations or group members and their affiliates;

(3) Control or controlled shall have the same meaning as in section 44-2121;

(4) Controlled insurer shall mean an insurer which is controlled, directly or indirectly, by a producer;

(5) Controlling producer shall mean a producer which, directly or indirectly, controls an insurer;

(6) Director shall mean the Director of Insurance;

(7) Insurer shall mean any person, firm, association, or corporation holding a certificate of authority to transact property and casualty insurance business in this state. Insurer shall not include:

(a) Residual market pools and joint underwriting authorities or associations; and

(b) Captive insurers other than risk retention groups as defined in 15 U.S.C. 3901 et seq. and 42 U.S.C. 9671, as such sections existed on January 1, 2014; and

(8) Producer shall mean an insurance broker or any other person, firm, association, or corporation when, for any compensation, commission, or other thing of value, such person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association, or corporation.

Source: Laws 1992, LB 1006, § 69; Laws 2014, LB700, § 17.

44-5703 Applicability of act.

The Producer-Controlled Property and Casualty Insurer Act shall apply to insurers either domiciled in this state or domiciled in a state that is not an accredited state. All provisions of the Insurance Holding Company System Act, to the extent they are not superseded by the Producer-Controlled Property and Casualty Insurer Act, shall continue to apply to all parties within holding company systems subject to the Producer-Controlled Property and Casualty Insurer Act.

Source: Laws 1992, LB 1006, § 70.

Cross References

Insurance Holding Company System Act, see section 44-2120.

44-5704 Applicability of section; exception; controlled insurer; controlling producer; requirements; audit committee; filings required; report.

(1) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent of the admitted assets of the controlled insurer, as reported in the controlled insurer's annual statement as of December 31 of the prior year, except that the provisions of this section shall not apply if:

(a) The controlling producer:

(i) Places insurance only with the controlled insurer or only with the controlled insurer and a member or members of the controlled insurer's holding company system or the controlled insurer's parent, affiliate, or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(ii) Accepts insurance placements only from nonaffiliated subproducers and not directly from insureds; and

(b) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

(2) A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the controlled insurer specifying the responsibilities of each party, which contract has been approved by the board of directors of the controlled insurer and contains the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

(b) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the controlling producer;

(c) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted not later than ninety days after the effective date of any policy placed with the controlled insurer under the contract;

(d) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with Chapter 44, except that funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

(e) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

(f) The contract shall not be assigned in whole or in part by the controlling producer;

(g) The controlled insurer shall provide the controlling producer with its underwriting standards, rules, procedures, manuals setting forth the rates to be charged, and conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(h) The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes for those commissions, charges, or fees. The rates of the commissions, charges, and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(i) If the contract provides that the controlling producer, on insurance business placed with the controlled insurer, is to be compensated contingent upon the controlled insurer's profits on that business, such compensation shall not be determined and paid until at least five years after the premiums on liability insurance are earned and at least one year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection (4) of this section;

(j) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The controlled insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(k) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines, including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

For purposes of this subsection, examples of comparable business include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(3) Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the controlled insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the director to review the adequacy of the controlled insurer's loss reserves.

(4) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the director an opinion of an independent casualty actuary or such other independent loss reserve specialist acceptable to the director reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year end, including losses incurred but not reported and loss adjustment expenses, on business placed by the controlling producer. The controlled insurer shall annually report to the director the amount of commissions paid to the controlling producer, the percentage such amount represents of the net premiums written, and comparable amounts and percentages paid to noncontrolling producers for placements of the same kinds of insurance.

Source: Laws 1992, LB 1006, § 71.

44-5705 Notice to prospective insured; exception.

The controlling producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the controlling producer and the controlled insurer, except that if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his or her records a signed commitment from the subproducer that the subproducer is aware of the relationship between the controlled insurer and the controlling producer and that the subproducer has or will notify the insured.

Source: Laws 1992, LB 1006, § 72.

44-5706 Enforcement of act; powers and duties; construction of section.

(1) If the director believes that the controlling producer or any other person has not materially complied with the Producer-Controlled Property and Casualty Insurer Act or any rule or regulation or order after notice and opportunity to be heard, the director may order the controlling producer to cease placing business with the controlled insurer. If it is found that because of such material noncompliance that the controlled insurer or any policyholder has suffered any loss or damage, the director may maintain a civil action or intervene in an action brought by or on behalf of the controlled insurer or policyholder for recovery of compensatory damages for the benefit of the controlled insurer or policyholder or other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act and the receiver appointed under the order believes that the controlling producer or any other person has not materially complied with the Producer-Controlled Property and Casualty Insurer Act or any rule or regulation or order and the controlled insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the controlled insurer.

(3) This section shall not affect the right of the director to impose any other penalties provided for in Chapter 44.

(4) This section is not intended to and shall not in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

Source: Laws 1992, LB 1006, § 73.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-5707 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Producer-Controlled Property and Casualty Insurer Act.

Source: Laws 1992, LB 1006, § 74.

44-5708 Controlled insurers and controlling producers; compliance with act; when.

Controlled insurers and controlling producers who are not in compliance with section 44-5704 on January 1, 1993, shall have until March 1, 1993, to come into compliance and shall comply with section 44-5705 beginning with all policies written or renewed on or after March 1, 1993.

Source: Laws 1992, LB 1006, § 75.

ARTICLE 58

THIRD-PARTY ADMINISTRATORS

Section

44-5801 Act, how cited.

Sections 44-5801 to 44-5816 shall be known and may be cited as the Third-Party Administrator Act.

Source: Laws 1992, LB 1006, § 76.

44-5802 Terms, defined.

For purposes of the Third-Party Administrator Act:

(1) Affiliate or affiliated shall mean any entity or person who, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person;

(2) Control shall have the same meaning as in section 44-2121;

(3) Director shall mean the Director of Insurance;

(4) Insurance or insurance coverage shall mean any coverage offered or provided by an insurer;

(5) Insurer shall mean any person undertaking to provide life insurance, sickness and accident insurance, workers' compensation insurance coverage, or annuities in this state. Insurer shall include an authorized insurance company, a prepaid hospital or medical care plan, a health maintenance organization, or any other person providing a plan of insurance subject to state insurance regulation. Insurer shall include an employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer. Insurer shall not include a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, as the act existed on September 1, 2001;

(6) Third-party administrator shall mean a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state or residents of another state from offices in this state, in connection with life insurance, sickness and accident insurance, workers' compensation insurance coverage, or annuities, except any of the following:

(a) An employer on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of such employer;

(b) A union on behalf of its members;

(c) An insurer which is authorized to transact the business of insurance in this state with respect to a policy lawfully issued and delivered in and pursuant to the laws of this state or another state;

(d) An insurance producer licensed to sell life insurance, sickness and accident insurance, workers' compensation insurance coverage, or annuities in this state whose activities are limited exclusively to the sale of insurance;

(e) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(f) A trust and its trustees, agents, and employees acting pursuant to such trust established in conformity with 29 U.S.C. 186, as such section existed on September 1, 2001;

(g) A trust exempt from taxation under section 501(a) of the Internal Revenue Code as defined in section 49-801.01, its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of section 401(f) of the Internal Revenue Code as defined in section 49-801.01;

(h) A credit union or a financial institution which is subject to supervision or examination by federal or state banking authorities or a mortgage lender, to the extent it collects and remits premiums to licensed insurance agents or authorized insurers in connection with loan payments;

(i) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized collection if the company does not adjust or settle claims;

(j) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life insurance, sickness and accident insurance, workers' compensation insurance coverage, or annuities;

(k) A person who acts solely as a third-party administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974, as the act existed on September 1, 2001; or

(l) A person licensed as a managing general agent in this state whose activities are limited exclusively to the scope of activities allowed under such license; and

(7) Underwrite or underwriting shall include, but not be limited to, the acceptance of employer or individual applications for insurance coverage of individuals in accordance with the written rules of the insurer, the overall planning and coordinating of an insurance program, and the ability to procure bonds and excess insurance.

Source: Laws 1992, LB 1006, § 77; Laws 1995, LB 574, § 49; Laws 2001, LB 51, § 39.

44-5803 Third-party administrator; written agreement; requirements; suspension during dispute.

(1) No third-party administrator shall act as such without a written agreement between the third-party administrator and the insurer, and such written agreement shall be retained as part of the official records of both the insurer and the third-party administrator for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by the Third-Party Administrator Act except insofar as those provisions do not apply to the functions performed by the third-party administrator.

(2) The written agreement shall include a statement of duties which the third-party administrator is expected to perform on behalf of the insurer and the lines, classes, or types of insurance for which the third-party administrator is to be authorized to administer. The written agreement shall make provision with respect to underwriting or other standards pertaining to the insurance business underwritten by such insurer.

(3) The insurer or third-party administrator may, with written notice, terminate the written agreement for cause as provided in the written agreement. The insurer may suspend the underwriting authority of the third-party administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer shall fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the third-party administrator.

Source: Laws 1992, LB 1006, § 78.

44-5804 Payments to third-party administrator; how construed.

If an insurer utilizes the services of a third-party administrator, the payment to the third-party administrator of any charges and premiums by or on behalf of any policyholder, contract holder, certificate holder, or subscriber shall be deemed to have been received by the insurer, and the payment of return of premiums or claim payments forwarded by the insurer to the third-party administrator shall not be deemed to have been paid to the policyholder, contract holder, certificate holder, subscriber, or claimant until the payment is received by the policyholder, contract holder, certificate holder, subscriber, or

claimant. Nothing in this section shall limit any right of the insurer against the third-party administrator resulting from the failure of the third-party administrator to make payments to the insurer, policyholders, contract holders, certificate holders, subscribers, or claimants.

Source: Laws 1992, LB 1006, § 79.

44-5805 Transaction records; requirements; access by director; ownership.

(1) Every third-party administrator shall maintain and make available to the insurer complete records of all transactions performed on behalf of the insurer. The records shall be maintained in accordance with prudent standards of insurance record keeping and shall be maintained for a period of not less than five years from the date of their creation. In the event the insurer and the third-party administrator cancel their written agreement, the third-party administrator may, by written agreement with the insurer, transfer all records to a new third-party administrator rather than retain them for five years. In such cases, the new third-party administrator shall acknowledge, in writing, that it is responsible for retaining the records of the prior third-party administrator as required in this subsection.

(2)(a) The director shall have access to records maintained by a third-party administrator for the purposes of examination, audit, and inspection. Any trade secrets contained in such records, including the identity and addresses of policyholders, contract holders, certificate holders, and subscribers, shall be kept confidential, except that the director may use such information in any proceeding instituted against the third-party administrator and as set forth in subdivisions (2)(b) and (c) of this section.

(b) Records relating to a third-party administrator maintained by the director may be provided to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the records.

(c) The director may receive records maintained by a third-party administrator from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged records received pursuant to this subdivision with notice or the understanding that they are confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

(3) The insurer shall own the records generated by the third-party administrator pertaining to the insurer; however, the third-party administrator shall retain

the right to continuing access to records to permit the third-party administrator to fulfill all of its contractual obligations to policyholders, contract holders, certificate holders, subscribers, claimants, and the insurer.

Source: Laws 1992, LB 1006, § 80; Laws 2001, LB 52, § 50.

44-5806 Approved advertising.

A third-party administrator shall use only such advertising pertaining to the insurance business underwritten by an insurer as has been approved in writing by the insurer in advance of its use.

Source: Laws 1992, LB 1006, § 81.

44-5807 Insurer; third-party administrator; responsibilities.

(1) If an insurer utilizes the services of a third-party administrator, the insurer shall be responsible for determining the benefits, premium rates, underwriting criteria, and claims-payment procedures and for securing reinsurance, if any. The rules pertaining to these matters shall be provided, in writing, by the insurer to the third-party administrator. The responsibilities of the third-party administrator as to any of these matters shall be set forth in the written agreement between the third-party administrator and the insurer.

(2) It shall be the sole responsibility of the insurer to provide for competent administration of its programs.

(3) In cases when a third-party administrator administers benefits for more than one hundred certificate holders or subscribers on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the third-party administrator. At least one such review shall be an onsite audit of the operations of the third-party administrator.

Source: Laws 1992, LB 1006, § 82.

44-5808 Funds collected; held in fiduciary capacity; accounting.

(1) All charges and premiums collected by a third-party administrator on behalf of or for an insurer or insurers and the return of premiums received from that insurer or insurers shall be held by the third-party administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the third-party administrator in a federally insured or state-insured financial institution. The written agreement between the third-party administrator and the insurer shall provide for the third-party administrator to periodically render an accounting to the insurer detailing all transactions performed by the third-party administrator pertaining to the insurance business underwritten by the insurer.

(2) If charges and premiums deposited in a fiduciary account have been collected on behalf of or for one or more insurers, the third-party administrator shall keep records clearly recording the deposits in and withdrawals from the fiduciary account on behalf of each insurer. The third-party administrator shall keep copies of all the records pertaining to such deposits and withdrawals and, upon request of an insurer, shall furnish the insurer with copies of the records.

(3) The third-party administrator shall not pay any claim by withdrawals from a fiduciary account in which charges and premiums are deposited. Withdrawals from such account shall be made as provided in the written

agreement between the third-party administrator and the insurer. The written agreement shall address, but not be limited to, the following:

(a) Remittance to an insurer entitled to remittance;

(b) Deposit in an account maintained in the name of the insurer;

(c) Transfer to and deposit in a claims-paying account, with claims to be paid as provided for in subsection (4) of this section;

(d) Payment to a group policyholder or group contract holder for remittance to the insurer entitled to such remittance;

(e) Payment to the third-party administrator of its commissions, fees, or charges; and

(f) Remittance of return of premium to the person or persons entitled to such return of premium.

(4) All claims paid by the third-party administrator from funds collected on behalf of or for an insurer shall be paid only on drafts or checks of and as authorized by the insurer.

Source: Laws 1992, LB 1006, § 83.

44-5809 Certain contingency agreements prohibited; exceptions.

A third-party administrator shall not enter into any agreement or understanding with an insurer in which the effect is to make the amount of the third-party administrator's commissions, fees, or charges contingent upon savings effected in the adjustment, settlement, and payment of losses covered by the insurer's obligations. This section shall not prohibit a third-party administrator from receiving performance-based compensation for providing hospital or other auditing services. This section shall not prohibit a third-party administrator from receiving compensation based on premiums or charges collected or the number of claims paid or processed.

Source: Laws 1992, LB 1006, § 84.

44-5810 Notice to certificate holder or subscribers; identification and disclosure of collections.

(1) If an insurer utilizes the services of a third-party administrator, the third-party administrator shall provide a written notice approved by the insurer to certificate holders or subscribers advising them of the identity of and relationship among the third-party administrator, the policyholder or contract holder, and the insurer.

(2) When a third-party administrator collects charges, the reason for collection of each item shall be identified to the policyholder or contract holder and each item shall be shown separately from any premium. Additional charges shall not be made for services to the extent the services have been paid for by the insurer.

(3) The third-party administrator shall disclose to the insurer all charges, fees, and commissions received in connection with the providing of administrative services for the insurer, including any fees or commissions paid by insurers providing reinsurance.

Source: Laws 1992, LB 1006, § 85.

44-5811 Written communications; delivery.

Any policies, contracts, certificates, booklets, termination notices, or other written communications delivered by the insurer to the third-party administrator for delivery to policyholders, contract holders, certificate holders, or subscribers shall be delivered by the third-party administrator promptly after receipt of instructions from the insurer to deliver them.

Source: Laws 1992, LB 1006, § 86.

44-5812 Certificate of authority; required; application; contents; fee; issuance; director; powers; term; exceptions.

(1) No person shall act as, offer to act as, or hold himself or herself out to be a third-party administrator in this state without a valid certificate of authority as a third-party administrator issued by the director.

(2) An applicant for a certificate of authority as a third-party administrator shall make application to the director upon a form to be furnished by the director. The application shall include or be accompanied by an application fee of two hundred dollars and by the following information and documents:

(a) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, articles of organization, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations, or similar documents regulating the internal affairs of the applicant;

(c) The names, addresses, official positions, and professional qualifications of the individuals who are responsible for the conduct of affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, limited liability company, or association, shareholders holding directly or indirectly ten percent or more of the voting securities of the applicant, and any other person who exercises control or influence over the affairs of the applicant;

(d) Annual financial statements or reports for the two most recent years which prove that the applicant is solvent and such information as the director may require in order to review the current financial condition of the applicant;

(e) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The business plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping, and underwriting;

(f) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an agent licensed in this state for solicitation and taking of applications. Any applicant which intends to directly solicit insurance contracts or to otherwise act as an insurance agent shall provide proof that it has a license as an insurance agent in this state; and

(g) Such other pertinent information as may be required by the director.

(3) The applicant shall make available for inspection by the director copies of all written agreements with insurers and contracts with other persons utilizing the services of the applicant.

(4) The director may refuse to issue a certificate of authority as a third-party administrator if the director determines that the applicant or any individual responsible for the conduct of affairs of the applicant as described in subdivision (2)(c) of this section is not competent, trustworthy, financially responsible, or of good personal and business reputation or has had an insurance license or certificate of authority or a third-party administrator license or certificate of authority denied or revoked for cause by any state.

(5) A certificate of authority as a third-party administrator issued under this section shall remain valid, unless surrendered to or suspended or revoked by the director, for so long as the third-party administrator continues in business in this state and remains in compliance with the Third-Party Administrator Act.

(6) A third-party administrator shall not be required to hold a certificate of authority as a third-party administrator in this state if all of the following conditions are met:

(a) The third-party administrator has its principal place of business in another state;

(b) The third-party administrator is not soliciting business as a third-party administrator in this state; and

(c) In the case of any group policy, group contract, or plan of insurance serviced by the third-party administrator, the lesser of five percent or one hundred certificate holders or subscribers reside in this state.

(7) A person shall not be required to hold a certificate of authority as a third-party administrator in this state if the person exclusively provides services to one or more bona fide employee benefit plans each of which is established by an employer or an employee organization, or both, and for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974. Such person shall register with the director annually and verify his or her status as described in this section.

(8) A third-party administrator shall immediately notify the director of any material change in its ownership or control or other fact or circumstance affecting its qualification for a certificate of authority as a third-party administrator in this state.

Source: Laws 1992, LB 1006, § 87; Laws 1993, LB 121, § 262; Laws 1993, LB 583, § 114.

44-5813 Application requirements; waiver; when.

Upon request from a third-party administrator, the director may waive the application requirements of subsection (2) of section 44-5812 if the third-party administrator has a valid certificate of authority as a third-party administrator issued in a state which has requirements for third-party administrators that are at least as stringent as those contained in the Third-Party Administrator Act.

Source: Laws 1992, LB 1006, § 88.

44-5814 Annual report; filing; contents; fee; failure to file; effect.

(1) Each third-party administrator shall file an annual report for the preceding calendar year with the director on or before March 1 of each year or within such extension of time therefor as the director for good cause may grant. The annual report shall be in the form and contain such matters as the director

prescribes and shall be verified by at least two officers of the third-party administrator.

(2) The annual report shall include the complete names and addresses of all insurers with which the third-party administrator had a written agreement during the preceding fiscal year.

(3) At the time of filing its annual report, the third-party administrator shall pay to the director a filing fee of two hundred dollars.

(4)(a) Within seven business days after the failure of a third-party administrator to comply with the requirements of this section, the director shall notify the third-party administrator of such failure.

(b) Subject to subdivision (4)(c) of this section, if a third-party administrator fails to comply with the requirements of this section and any rules and regulations adopted and promulgated under this section and any orders issued under this section:

(i) Such third-party administrator shall pay a fine of fifty dollars for each day thereafter such failure continues and the third-party administrator continues to transact any business of insurance; and

(ii) In addition to the fine required under subdivision (4)(b)(i) of this section, the director may suspend the certificate of authority of the third-party administrator until it has complied with the requirements of this section, any rules and regulations adopted and promulgated under this section, and any orders issued under this section. The director shall remit all such fines to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

(c) For good and sufficient cause shown, the director may grant a reasonable extension of time not to exceed thirty days within which the annual report may be filed as required under this section without the fine required under subdivision (4)(b)(i) of this section and without any suspension authorized under subdivision (4)(b)(ii) of this section.

Source: Laws 1992, LB 1006, § 89; Laws 2002, LB 1139, § 42; Laws 2003, LB 216, § 17; Laws 2021, LB21, § 6.
Effective date August 28, 2021.

44-5815 Certificate of authority; suspension or revocation; grounds; administrative penalty; authorized.

(1) The director shall suspend or revoke the certificate of authority as a third-party administrator if the director finds that the third-party administrator:

(a) Is in an unsound financial condition;

(b) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to certificate holders, subscribers, or the public; or

(c) Has failed to pay any judgment rendered against it in this state within sixty days after the judgment has become final.

(2) The director may, in his or her discretion, suspend or revoke the certificate of authority as a third-party administrator if the director finds that the third-party administrator:

(a) Has violated any lawful rule or regulation or order of the director or any provision of the insurance laws of this state;

(b) Has refused to be examined or to produce its accounts, records, and files for examination or if any of its officers has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to such examination, when required by the director;

(c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused certificate holders, subscribers, or claimants to accept less than the amount due them or caused certificate holders, subscribers, or claimants to retain attorneys or bring actions against the third-party administrator to secure full payment or settlement of such claims;

(d) Is affiliated with or under the same general management or interlocking directorate or ownership as another third-party administrator or insurer which unlawfully transacts business in this state without having a certificate of authority as a third-party administrator;

(e) At any time fails to meet any qualification for which issuance of the certificate of authority as a third-party administrator could have been refused had such failure then existed and been known to the director;

(f) Has been convicted of or has entered a plea of guilty or nolo contendere to a felony without regard to whether adjudication was withheld; or

(g) Is under suspension or revocation in another state.

(3) The director may, in his or her discretion and without advance notice or hearing thereon, immediately suspend the certificate of authority as a third-party administrator if the director finds that one or more of the following circumstances exist:

(a) The third-party administrator is insolvent or impaired;

(b) A proceeding for supervision, rehabilitation, conservation, receivership, or other delinquency proceeding regarding the third-party administrator has been commenced in any state; or

(c) The financial condition or business practices of the third-party administrator otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

(4) Except as provided in subsection (4) of section 44-5814, if the director finds that one or more grounds exist for the suspension or revocation of a certificate of authority as a third-party administrator, the director may, in lieu of such suspension or revocation and after notice and hearing, impose an administrative penalty upon the third-party administrator in an amount not less than one thousand dollars nor more than ten thousand dollars.

Source: Laws 1992, LB 1006, § 90; Laws 2002, LB 1139, § 43.

44-5816 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Third-Party Administrator Act.

Source: Laws 1992, LB 1006, § 91.

ARTICLE 59
INSURERS EXAMINATION

Section
44-5901. Act, how cited.

Section

44-5901 Act, how cited.

Sections 44-5901 to 44-5910 shall be known and may be cited as the Insurers Examination Act.

Source: Laws 1993, LB 583, § 1.

44-5902 Purpose of act.

The purpose of the Insurers Examination Act is to provide an effective and efficient system for examining the activities, operations, financial condition, and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the director. The provisions of the act are intended to enable the director to adopt a flexible system of examinations which directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance-related laws of this state.

Source: Laws 1993, LB 583, § 2.

44-5903 Terms, defined.

For purposes of the Insurers Examination Act:

(1) Company shall mean any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory, or taxing authority of the director;

(2) Department shall mean the Department of Insurance;

(3) Director shall mean the Director of Insurance;

(4) Examiner shall mean any individual having been appointed by the director to conduct an examination under the act;

(5) Insurer shall mean any person authorized to transact the business of insurance, including any fraternal benefit society, reciprocal exchange, advisory organization, assessment association, unincorporated mutual association, hospital or physicians mutual insurance association, and professional association mutual insurance company; and

(6) Person shall mean any individual, aggregation of individuals, trust, association, partnership, limited liability company, or corporation or any affiliate thereof.

Source: Laws 1993, LB 583, § 3; Laws 1994, LB 884, § 62.

44-5904 Authority, scope, and scheduling of examinations.

(1) The director or any of his or her examiners may conduct an examination under the Insurers Examination Act of any company incorporated in this state

or in any other state or country admitted to or applying for admission to transact business in this state as often as the director in his or her sole discretion deems appropriate but shall at a minimum conduct an examination of every domestic insurer not less frequently than once every five years. In scheduling and determining the nature, scope, and frequency of the examination of a company, the director shall consider such matters as the results of financial statement analyses and ratios, changes in the company's management or ownership, actuarial opinions, reports of independent certified public accountants, the company's ability to meet and fulfill its obligations, the company's compliance with provisions of law, other facts relating to the company's business methods, the company's management and its dealings with its policyholders, and other criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the director conducts an examination under this section.

(2) For purposes of completing an examination of any company under the act, the director may examine or investigate any person, or the business of any person, insofar as such examination or investigation is, in the sole discretion of the director, necessary or material to the examination of the company.

Source: Laws 1993, LB 583, § 4; Laws 1998, LB 1035, § 12; Laws 2009, LB192, § 9.

44-5905 Conduct of examinations; record retention requirements.

(1) Upon determining that an examination should be conducted, the director or his or her designee shall appoint one or more examiners to conduct the examination and instruct them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The director may also employ such other guidelines or procedures as the director may deem appropriate.

(2)(a) Every company or person from whom information is sought and its officers, directors, employees, and agents shall provide to the examiners appointed under subsection (1) of this section timely, convenient, and free access to all books, records, accounts, papers, documents, and computer or other recordings relating to the property, assets, business, and affairs of the company being examined.

(b)(i)(A) Every company or person subject to the Insurers Examination Act shall retain all books, records, accounts, papers, documents, and computer or other recordings relating to the property, assets, financial accounts, and business of such company or person in a manner that permits examination of such books, records, accounts, papers, documents, and computer or other recordings for five years, or until the period of time in which the transaction took place has undergone a financial examination by the director, whichever is later, following the completion of a transaction relating to the property, assets, financial accounts, and business of such company or person.

(B) Every company or person subject to the act shall retain market conduct records for five years following the completion of a transaction relating to the insurance business and affairs of such company or person. For purposes of this subdivision, market conduct records means all books, records, accounts, papers, documents, and computer or other recordings relating to transactions with insureds, certificate holders, claimants, insurance producers, other insur-

ers, subrogees, and subrogors and recordings related to its trade practices, underwriting, rate and form practices, advertising, regulatory matters, and other affairs of such company or person.

(ii) The books, records, accounts, papers, documents, and computer or other recordings described in subdivisions (2)(b)(i)(A) and (B) of this section and maintained in electronic, computer, micrographic, or other form shall be maintained in a form capable of accurate duplication on paper.

(c) The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the director's jurisdiction. Any such proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to the Administrative Procedure Act.

(d) For purposes of this subsection, officers, directors, employees, and agents shall include general agents, managing agents, attorneys in fact, organizers, promoters, loss adjusters, and any persons having a contract, written or oral, pertaining to the management or control of a company or any function thereof.

(3) The director or any of his or her examiners shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the director may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in the district court with mileage to be computed at the rate provided in section 81-1176, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

(4) When conducting an examination under the Insurers Examination Act, the director may retain attorneys, appraisers, independent actuaries, independent certified public accountants, loss-reserve specialists, or other professionals and specialists, the cost of which shall be borne by the company which is the subject of the examination.

(5) Nothing in the act shall be construed to limit the director's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(6) Nothing contained in the act shall be construed to limit the director's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any

examination in the furtherance of any legal or regulatory action which the director may, in his or her sole discretion, deem appropriate.

Source: Laws 1993, LB 583, § 5; Laws 1999, LB 259, § 12; Laws 2009, LB192, § 10.

Cross References

Administrative Procedure Act, see section 84-920.

44-5906 Examination reports.

(1) All examination reports shall be comprised of only facts appearing upon the books, records, or other documents of the company and its agents or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than forty-five days following completion of the examination, the examiner in charge shall submit to the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within thirty days of the end of the period allowed for the receipt of written submissions or rebuttals, the director shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers, and shall:

(a) Adopt the examination report as submitted or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule, regulation, or prior order of the director, the director may order the company to take any action the director considers necessary and appropriate to cure such violation; or

(b) Reject the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, or information and to resubmit a report pursuant to subsection (2) of this section.

(4) Any company aggrieved by any action of the director pursuant to subsection (3) of this section may, within ten days of such action, make written request to the director for a hearing. Upon receipt of the company's request for a hearing, the director shall provide notice of the hearing no less than ten nor more than thirty days after the date of the company's request. The notice shall identify the subject of the hearing and the specific issues.

(5) Any hearing on an examination report shall be held at such time and place as designated in the notice. A hearing may be adjourned from time to time without other or further notice than the announcement thereof at such hearing. The director shall not appoint an examiner to conduct the hearing. The hearing officer shall have power to administer oaths, examine and cross-examine witnesses, and receive documentary evidence. A full stenographic record may be made at the hearing of all testimony of witnesses and rulings by the hearing officer. Upon written request, a copy of the transcript of such record, if any, shall be furnished to the company at its expense. Any witness or party affected by the hearing shall be permitted to review a transcript of the record at the office of the department. Every person affected shall be allowed to

be present and represented by counsel during the giving of all the testimony and shall be allowed a reasonable opportunity to inspect all adverse documentary proof, to examine and cross-examine witnesses, and to present proof in support of his or her interest. Nothing contained in this section shall require the observance at any such hearing of formal rules of pleading or evidence. Within twenty days of the conclusion of the hearing, the director shall enter an order, which may be appealed. The appeal shall be in accordance with the Administrative Procedure Act.

(6) The examination report, with any modifications and corrections thereof, shall be accepted by the director and filed for public inspection immediately after the expiration of the times specified in subsection (4) of this section in the event that the company has not requested a hearing. Within thirty days of the filing of such report for public inspection, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the report and related orders.

(7) Nothing in the Insurers Examination Act shall prevent or be construed as prohibiting the director from disclosing the contents of an examination report, a preliminary examination report, or any results, or any matter relating thereto, to the National Association of Insurance Commissioners and its affiliates and subsidiaries and to state, federal, foreign, and international regulatory and law enforcement agencies if the recipient agrees in writing to maintain the confidentiality of the information.

(8)(a) Except as set forth in subsection (7) of this section and in this subsection, workpapers, recorded information, documents, and copies of workpapers, recorded information, and documents produced by, obtained by, or disclosed to the director or any other person, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, in the course of an examination conducted under the act shall be given confidential treatment and shall not be subject to subpoena and may not be made public by the director or any other person, except to the extent provided in subsection (7) of this section, and shall not be public records subject to disclosure pursuant to sections 84-712 to 84-712.09. Such workpapers, recorded information, documents, and copies may be provided to other state, federal, foreign, and international regulatory and law enforcement agencies, and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the workpapers, recorded information, documents, and copies.

(b) The director may receive such workpapers, recorded information, documents, and copies from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subdivision if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action

concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

Source: Laws 1993, LB 583, § 6; Laws 2001, LB 52, § 51.

Cross References

Administrative Procedure Act, see section 84-920.

44-5907 Conflict of interest.

(1) No examiner may be appointed by the director if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any company subject to examination under the Insurers Examination Act. This section shall not be construed to automatically preclude an examiner from being:

(a) A policyholder or claimant under an insurance policy;

(b) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(c) An investment owner in shares of regulated diversified investment companies; or

(d) A settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

(2) Notwithstanding the requirements of this section, the director may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions even though the individuals may from time to time be similarly employed or retained by persons subject to examination under the act.

Source: Laws 1993, LB 583, § 7.

44-5908 Cost of examinations.

The reasonable expenses of the examination of a company conducted under the Insurers Examination Act shall be fixed and determined by the director who shall collect the same from the company examined. The company shall reimburse the amount thereof upon presentation of a statement by the director. Reimbursement shall be limited to a reasonable allocation for the salary of each examiner plus actual expenses. All money collected by the director for examination of the affairs of companies shall be remitted in accordance with section 44-116.

Source: Laws 1993, LB 583, § 8.

44-5909 Immunity from liability.

(1) No cause of action shall arise nor shall any liability be imposed against the director, his or her authorized representatives, or any examiner appointed by the director for any statements made or conduct performed in good faith while carrying out the provisions of the Insurers Examination Act.

(2) No cause of action shall arise, nor shall any liability be imposed against any person, for the act of communicating or delivering information or data to the director or his or her authorized representative or examiner pursuant to an

examination made under the Insurers Examination Act if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This section does not abrogate or modify in any way any common-law or statutory privilege or immunity otherwise enjoyed by any person identified in subsection (1) of this section.

(4) A person identified in subsection (1) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of the act and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding shall be substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

Source: Laws 1993, LB 583, § 9.

44-5910 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Insurers Examination Act.

Source: Laws 1993, LB 583, § 10.

ARTICLE 60

INSURERS AND HEALTH ORGANIZATIONS RISK-BASED CAPITAL ACT

Section

44-6001 Act, how cited.

Sections 44-6001 to 44-6026 shall be known and may be cited as the Insurers and Health Organizations Risk-Based Capital Act.

Source: Laws 1993, LB 583, § 13; Laws 1994, LB 978, § 32; Laws 1999, LB 258, § 3.

44-6002 Definitions, where found.

For purposes of the Insurers and Health Organizations Risk-Based Capital Act, the definitions found in sections 44-6003 to 44-6014 shall be used.

Source: Laws 1993, LB 583, § 14; Laws 1994, LB 978, § 33; Laws 1999, LB 258, § 4.

44-6003 Adjusted risk-based capital report, defined.

Adjusted risk-based capital report means a risk-based capital report which has been adjusted by the director in accordance with subsection (6) of section 44-6015.

Source: Laws 1993, LB 583, § 15; Laws 1994, LB 978, § 34; Laws 1999, LB 258, § 5.

44-6004 Corrective order, defined.

Corrective order means an order issued by the director specifying corrective actions which the director has determined are required.

Source: Laws 1993, LB 583, § 16; Laws 1999, LB 258, § 6.

44-6005 Director, defined.

Director means the Director of Insurance.

Source: Laws 1993, LB 583, § 17; Laws 1999, LB 258, § 7.

44-6006 Domestic, defined.

Domestic, when referring to insurers, has the same meaning as in section 44-103.

Source: Laws 1993, LB 583, § 18; Laws 1999, LB 258, § 8.

44-6006.01 Domestic health organization, defined.

Domestic health organization means a health organization domiciled in this state.

Source: Laws 1999, LB 258, § 9.

44-6007 Foreign, defined.

Foreign, when referring to insurers, has the same meaning as in section 44-103.

Source: Laws 1993, LB 583, § 19; Laws 1999, LB 258, § 10.

44-6007.01 Foreign health organization, defined.

Foreign health organization means a health organization that is authorized to do business in this state but is not domiciled in this state.

Source: Laws 1999, LB 258, § 11.

44-6007.02 Health organization, defined.

Health organization means a health maintenance organization, prepaid limited health service organization, prepaid dental service corporation, or other managed care organization. Health organization does not include a life and health insurer, a fraternal benefit society, or a property and casualty insurer as defined in section 44-6008 that is otherwise subject to either life and health or property and casualty risk-based capital requirements.

Source: Laws 1999, LB 258, § 12; Laws 2013, LB426, § 2.

44-6008 Insurer, defined.

Insurer means an insurer as defined in section 44-103 authorized to transact the business of insurance, except that insurer does not include health organizations, unincorporated mutual associations, assessment associations, health maintenance organizations, prepaid dental service corporations, prepaid limited health service organizations, monoline mortgage guaranty insurers, monoline financial guaranty insurers, title insurers, prepaid legal corporations, intergovernmental risk management pools, and any other kind of insurer to which the application of the Insurers and Health Organizations Risk-Based Capital Act, in the determination of the director, would be clearly inappropriate. Insurer includes a risk retention group.

Insurer, when referring to life and health insurers, means an insurer authorized to transact life insurance business and sickness and accident insurance business specified in subdivisions (1) through (4) of section 44-201, or any combination thereof, and also includes fraternal benefit societies authorized to transact business specified in sections 44-1072 to 44-10,109.

Insurer, when referring to property and casualty insurers, means an insurer authorized to transact property insurance business and casualty insurance business specified in subdivisions (5) through (14) and (16) through (20) of section 44-201, or any combination thereof, and also includes an insurer authorized to transact insurance business specified in subdivision (4) of section 44-201 if also authorized to transact insurance business specified in subdivisions (5) through (14) and (16) through (20) of section 44-201.

Source: Laws 1993, LB 583, § 20; Laws 1994, LB 978, § 35; Laws 1999, LB 258, § 13; Laws 2013, LB426, § 3; Laws 2014, LB700, § 18.

44-6009 Negative trend, with respect to a life and health insurer or a fraternal benefit society, defined.

Negative trend, with respect to a life and health insurer or a fraternal benefit society, means a negative trend over a period of time, as determined in accordance with the trend test calculation included in the life risk-based capital instructions.

Source: Laws 1993, LB 583, § 21; Laws 1994, LB 978, § 36; Laws 1999, LB 258, § 14; Laws 2008, LB855, § 29; Laws 2013, LB426, § 4.

44-6010 Risk-based capital instructions, defined.

Risk-based capital instructions means the risk-based capital report, including risk-based capital instructions adopted by the National Association of Insurance Commissioners, as such instructions may be amended by the association from time to time in accordance with the procedures adopted by the association.

Source: Laws 1993, LB 583, § 22; Laws 1999, LB 258, § 15.

44-6011 Risk-based capital level, defined.

Risk-based capital level means an insurer's or a health organization's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital. For purposes of this section:

(1) Authorized control level risk-based capital means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions;

(2) Company action level risk-based capital means, with respect to any insurer or health organization, the product of 2.0 and its authorized control level risk-based capital;

(3) Mandatory control level risk-based capital means the product of 0.7 and the authorized control level risk-based capital; and

(4) Regulatory action level risk-based capital means the product of 1.5 and its authorized control level risk-based capital.

Source: Laws 1993, LB 583, § 23; Laws 1999, LB 258, § 16.

44-6012 Risk-based capital plan, defined.

Risk-based capital plan means a comprehensive financial plan containing the elements specified in subsection (2) of section 44-6016. If the director rejects a plan and it is revised by the insurer or health organization, with or without the director's recommendation, the plan shall be called the revised risk-based capital plan.

Source: Laws 1993, LB 583, § 24; Laws 1999, LB 258, § 17.

44-6013 Risk-based capital report, defined.

Risk-based capital report means the report required in section 44-6015.

Source: Laws 1993, LB 583, § 25; Laws 1999, LB 258, § 18.

44-6014 Total adjusted capital, defined.

Total adjusted capital means the sum of:

(1) An insurer's or a health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under sections 44-322, 44-32,134, 44-3823, and 44-4720; and

(2) Such other items, if any, as the risk-based capital instructions may provide.

Source: Laws 1993, LB 583, § 26; Laws 1999, LB 258, § 19.

44-6015 Risk-based capital reports.

(1) Every domestic insurer or domestic health organization shall annually, on or prior to March 1, referred to in this section as the filing date, prepare and submit to the director a risk-based capital report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing such information as is required by the risk-based capital instructions. In addition, every domestic insurer or domestic health organization shall file its risk-based capital report:

(a) With the National Association of Insurance Commissioners in accordance with the risk-based capital instructions; and

(b) With the insurance commissioner in any state in which the insurer or health organization is authorized to do business if such insurance commissioner has notified the insurer or health organization of its request in writing, in which case the insurer or health organization shall file its risk-based capital report not later than the later of:

(i) Fifteen days after the receipt of notice to file its risk-based capital report with such state; or

(ii) The filing date.

(2) A life and health insurer's or a fraternal benefit society's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance between:

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

Such risks shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(3) A property and casualty insurer's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance between:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

Such risks shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(4) A health organization's risk-based capital shall be determined in accordance with the formula set forth in the risk-based capital instructions. The formula shall take into account and may adjust for the covariance between:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

Such risks shall be determined in each case by applying the factors in the manner set forth in the risk-based capital instructions.

(5) An excess of capital over the amount produced by the risk-based capital requirements contained in the Insurers and Health Organizations Risk-Based Capital Act and the formulas, schedules, and instructions referenced in the act is desirable in the business of insurance. Accordingly, insurers and health organizations should seek to maintain capital above the risk-based capital levels required by the act. Additional capital is used and useful in the insurance business and helps to secure an insurer or a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in the act.

(6) If a domestic insurer or a domestic health organization files a risk-based capital report which in the judgment of the director is inaccurate, the director shall adjust the risk-based capital report to correct the inaccuracy and shall notify the insurer or health organization of the adjustment. The notice shall contain a statement of the reason for the adjustment.

Source: Laws 1993, LB 583, § 27; Laws 1994, LB 978, § 37; Laws 1999, LB 258, § 20; Laws 2013, LB426, § 5.

44-6016 Company action level event.

(1) Company action level event means any of the following events:

(a) The filing of a risk-based capital report by an insurer or a health organization which indicates that:

(i) The insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level risk-based capital but less than its company action level risk-based capital;

(ii) If a life and health insurer or a fraternal benefit society, the insurer or society has total adjusted capital which is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and has a negative trend;

(iii) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty risk-based capital instructions; or

(iv) If a health organization has total adjusted capital which is greater than or equal to its company action level risk-based capital but less than the product of its authorized control level risk-based capital and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health risk-based capital instructions;

(b) The notification by the director to the insurer or health organization of an adjusted risk-based capital report that indicates an event described in subdivision (1)(a) of this section unless the insurer or health organization challenges the adjusted risk-based capital report under section 44-6020; or

(c) If, pursuant to section 44-6020, the insurer or health organization challenges an adjusted risk-based capital report that indicates an event described in subdivision (1)(a) of this section, the notification by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(2) In the event of a company action level event, the insurer or health organization shall prepare and submit to the director a risk-based capital plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer or health organization intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years in the case of an insurer or at least the two succeeding years in the case of a health organization, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus, and risk-based capital levels. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(d) Identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's or health organization's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, and mix of business and use of reinsurance, if any, in each case.

(3) The risk-based capital plan shall be submitted:

(a) Within forty-five days after the occurrence of the company action level event; or

(b) If the insurer or health organization challenges an adjusted risk-based capital report pursuant to section 44-6020, within forty-five days after the notification to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(4) Within sixty days after the submission by an insurer or a health organization of a risk-based capital plan to the director, the director shall notify the insurer or health organization whether the risk-based capital plan shall be implemented or is, in the judgment of the director, unsatisfactory. If the director determines that the risk-based capital plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination and may set forth proposed revisions which will render the risk-based capital plan satisfactory in the judgment of the director. Upon notification from the director, the insurer or health organization shall prepare a revised risk-based capital plan which may incorporate by reference any revisions proposed by the director. The insurer or health organization shall submit the revised risk-based capital plan to the director:

(a) Within forty-five days after the notification from the director; or

(b) If the insurer or health organization challenges the notification from the director under section 44-6020, within forty-five days after a notification to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(5) In the event of a notification by the director to an insurer or a health organization that the insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory, the director may, at the director's discretion and subject to the insurer's or health organization's right to a hearing under section 44-6020, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer or domestic health organization that files a risk-based capital plan or revised risk-based capital plan with the director shall file a copy of the risk-based capital plan or revised risk-based capital plan with the insurance commissioner of any state in which the insurer or health organization is authorized to do business if:

(a) Such state has a law substantially similar to subsection (1) of section 44-6021; and

(b) The insurance commissioner of such state has notified the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the risk-based capital plan or revised risk-based capital plan in such state no later than the later of:

(i) Fifteen days after the receipt of notice to file a copy of its risk-based capital plan or revised risk-based capital plan with the state; or

(ii) The date on which the risk-based capital plan or revised risk-based capital plan is filed under subsection (3) or (4) of this section.

Source: Laws 1993, LB 583, § 28; Laws 1994, LB 978, § 38; Laws 1999, LB 258, § 21; Laws 2008, LB855, § 30; Laws 2013, LB426, § 6; Laws 2014, LB700, § 19.

44-6017 Regulatory action level event.

(1) Regulatory action level event means any of the following events:

(a) The filing of a risk-based capital report by the insurer or health organization which indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level risk-based capital but less than its regulatory action level risk-based capital;

(b) The notification by the director to an insurer or a health organization of an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section unless the insurer or health organization challenges the adjusted risk-based capital report under section 44-6020;

(c) If, pursuant to section 44-6020, the insurer or health organization challenges an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section, the notification by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge;

(d) The failure of the insurer or health organization to file a risk-based capital report by the filing date prescribed in section 44-6015 unless the insurer or health organization has provided an explanation for such failure which is

satisfactory to the director and has cured the failure within ten days after the filing date;

(e) The failure of the insurer or health organization to submit a risk-based capital plan to the director within the time period set forth in subsection (3) of section 44-6016;

(f) Notification by the director to the insurer or health organization that:

(i) The risk-based capital plan or revised risk-based capital plan submitted by the insurer or health organization is, in the judgment of the director, unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to the insurer or health organization unless the insurer or health organization has challenged the determination under section 44-6020;

(g) If, pursuant to section 44-6020, the insurer or health organization challenges a determination by the director under subdivision (1)(f) of this section, the notification by the director to the insurer or health organization that the director has, after a hearing, rejected such challenge;

(h) Notification by the director to the insurer or health organization that the insurer or health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan, but only if such failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its risk-based capital plan or revised risk-based capital plan and the director has so stated in the notification unless the insurer or health organization has challenged the determination under section 44-6020; or

(i) If, pursuant to section 44-6020, the insurer or health organization challenges a determination by the director under subdivision (1)(h) of this section, the notification by the director to the insurer or health organization that the director has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event, the director shall:

(a) Require the insurer or health organization to prepare and submit a risk-based capital plan or, if applicable, a revised risk-based capital plan;

(b) Perform such examination or analysis as the director deems necessary of the assets, liabilities, and operations of the insurer or health organization including a review of its risk-based capital plan or revised risk-based capital plan; and

(c) Subsequent to the examination or analysis, issue a corrective order.

(3) In determining corrective actions, the director may take into account such factors as are deemed relevant with respect to the insurer or health organization based upon the director's examination or analysis of the assets, liabilities, and operations of the insurer or health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the risk-based capital instructions. The risk-based capital plan or revised risk-based capital plan shall be submitted:

(a) Within forty-five days after the occurrence of the regulatory action level event;

(b) If the insurer or health organization challenges an adjusted risk-based capital report pursuant to section 44-6020 and the challenge is not frivolous in the judgment of the director, within forty-five days after the notification to the

insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge; or

(c) If the insurer or health organization challenges a revised risk-based capital plan pursuant to section 44-6020 and the challenge is not frivolous in the judgment of the director, within forty-five days after the notification to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(4) The director may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the director to review the insurer's or health organization's risk-based capital plan or revised risk-based capital plan, to examine or analyze the assets, liabilities, and operations, including contractual relationships in the case of a health organization, of the insurer or health organization, and to formulate the corrective order with respect to the insurer or health organization. The fees, costs, and expenses relating to consultants shall be borne by the affected insurer or health organization or such other party as directed by the director.

Source: Laws 1993, LB 583, § 29; Laws 1994, LB 978, § 39; Laws 1999, LB 258, § 22.

44-6018 Authorized control level event.

(1) Authorized control level event means any of the following events:

(a) The filing of a risk-based capital report by the insurer or health organization which indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level risk-based capital but less than its authorized control level risk-based capital;

(b) The notification by the director to the insurer or health organization of an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section unless the insurer or health organization challenges the adjusted risk-based capital report under section 44-6020;

(c) If, pursuant to section 44-6020, the insurer or health organization challenges an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section, the notification by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge;

(d) The failure of the insurer or health organization to respond, in a manner satisfactory to the director, to a corrective order unless the insurer or health organization has challenged the corrective order under section 44-6020; or

(e) If the insurer or health organization has challenged a corrective order under section 44-6020 and the director has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the director, to the corrective order subsequent to rejection or modification by the director.

(2) In the event of an authorized control level event the director shall:

(a) Take such actions as are required under section 44-6017 regarding an insurer or a health organization with respect to which a regulatory action level event has occurred; or

(b) If the director deems it to be in the best interests of the policyholders and creditors of the insurer or health organization and of the public, take such

actions as are necessary to cause the insurer or health organization to be placed under regulatory control under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. In the event the director takes such actions, the authorized control level event shall be deemed sufficient grounds for the director to take action under the act, and the director shall have the rights, powers, and duties with respect to the insurer or health organization as are set forth in the act. In the event the director takes actions under this subdivision pursuant to an adjusted risk-based capital report, the insurer or health organization shall be entitled to such protections as are afforded to insurers or health organizations under the provisions of the act pertaining to summary proceedings.

Source: Laws 1993, LB 583, § 30; Laws 1994, LB 978, § 40; Laws 1999, LB 258, § 23.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-6019 Mandatory control level event.

(1) Mandatory control level event means any of the following events:

(a) The filing of a risk-based capital report which indicates that the insurer's or health organization's total adjusted capital is less than its mandatory control level risk-based capital;

(b) The notification by the director to the insurer or health organization of an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section unless the insurer or health organization challenges the adjusted risk-based capital report under section 44-6020; or

(c) If, pursuant to section 44-6020, the insurer or health organization challenges an adjusted risk-based capital report that indicates the event described in subdivision (1)(a) of this section, the notification by the director to the insurer or health organization that the director has, after a hearing, rejected the insurer's or health organization's challenge.

(2) In the event of a mandatory control level event, the director shall take such actions as are necessary to place the insurer or health organization under regulatory control under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act or, in the case of a property and casualty insurer which is writing no business and which is running off its existing business, may allow the insurer to continue its run-off under the supervision of the director. In the event the director takes such actions, the mandatory control level event shall be deemed sufficient grounds for the director to take action under the act, and the director shall have the rights, powers, and duties with respect to the insurer or health organization as are set forth in the act. In the event the director takes actions under this subsection pursuant to an adjusted risk-based capital report, the insurer or health organization shall be entitled to such protections as are afforded to insurers or health organizations under the provisions of the act pertaining to summary proceedings. Notwithstanding the provisions of this subsection, the director may forego action for up to ninety days after the mandatory control level event if he or she finds there is a reasonable expecta-

tion that the mandatory control level event may be eliminated within the ninety-day period.

Source: Laws 1993, LB 583, § 31; Laws 1994, LB 978, § 41; Laws 1999, LB 258, § 24.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-6020 Hearings.

Upon any of the following notifications, the insurer or health organization shall have the right to a hearing pursuant to the Administrative Procedure Act at which the insurer or health organization may challenge any determination or action by the director:

(1) Notification to an insurer or a health organization by the director of an adjusted risk-based capital report;

(2) Notification to an insurer or a health organization by the director that:

(a) The insurer's or health organization's risk-based capital plan or revised risk-based capital plan is unsatisfactory; and

(b) Such notification constitutes a regulatory action level event with respect to such insurer or health organization;

(3) Notification to an insurer or a health organization by the director that the insurer or health organization has failed to adhere to its risk-based capital plan or revised risk-based capital plan and that such failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event with respect to the insurer or health organization in accordance with its risk-based capital plan or revised risk-based capital plan; or

(4) Notification to an insurer or a health organization by the director of a corrective order with respect to the insurer or health organization.

The insurer or health organization shall notify the director of its request for a hearing within five days after the notification by the director. Upon receipt of the insurer's or health organization's request for a hearing, the director shall set a date for the hearing, which date shall be no less than ten nor more than thirty days after the date of the insurer's or health organization's request.

Source: Laws 1993, LB 583, § 32; Laws 1999, LB 258, § 25.

Cross References

Administrative Procedure Act, see section 84-920.

44-6021 Confidentiality and prohibition on announcements; prohibited uses.

(1)(a) All risk-based capital reports, to the extent the information in the reports is not required to be set forth in a publicly available annual statement schedule and risk-based capital plans, including the results or reports of any examination or analysis of an insurer or a health organization performed pursuant to the Insurers and Health Organizations Risk-Based Capital Act and any corrective order issued by the director pursuant to examination or analysis, with respect to any domestic insurer or domestic health organization or foreign insurer or foreign health organization which are filed with the director shall constitute information that might be damaging to the insurer or health organization if made available to its competitors and therefor shall be kept confidential by the director and shall not be public records subject to disclosure

pursuant to sections 84-712 to 84-712.09. This information shall not be made public or be subject to subpoena other than by the director and then only for the purpose of enforcement actions taken by the director pursuant to the act or any other provision of the insurance laws of this state.

(b) Such risk-based capital reports, risk-based capital plans, and corrective orders may be provided to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the information.

(c) The director may receive such risk-based capital reports, risk-based capital plans, and corrective orders from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subdivision if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

(2) It is the judgment of the Legislature that the comparison of an insurer's or a health organization's total adjusted capital to any of its risk-based capital levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer or health organization and is not intended as a means to rank insurers or health organizations generally. Therefor, except as otherwise required under the Insurers and Health Organizations Risk-Based Capital Act, the making, publishing, disseminating, circulating, or placing before the public or the causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the risk-based capital levels of any insurer or health organization or of any component derived in the calculation, by any insurer or health organization, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefor prohibited. If any materially false statement with respect to the comparison regarding an insurer's or a health organization's total adjusted capital to any of its risk-based capital levels, or any of them, or an inappropriate comparison of any other amount to the insurers' or health organizations' risk-based capital levels is published in any written publication and the insurer or health organization is able to demonstrate to the director with substantial proof the falsity of such statement or the inappropriateness, as the case may be, the insurer or health

organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) It is the further judgment of the Legislature that the risk-based capital instructions, risk-based capital reports, adjusted risk-based capital reports, risk-based capital plans, and revised risk-based capital plans are intended solely for use by the director in monitoring the solvency of insurers and health organizations and the need for possible corrective action with respect to insurers and health organizations and shall not be used by the director for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the director to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or a health organization or any affiliate is authorized to write.

Source: Laws 1993, LB 583, § 33; Laws 1994, LB 978, § 42; Laws 1999, LB 258, § 26; Laws 2001, LB 52, § 52.

44-6022 Supplemental provisions.

(1) The provisions of the Insurers and Health Organizations Risk-Based Capital Act are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the director under such laws, including, but not limited to, the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

(2) The director may exempt from the application of the Insurers and Health Organizations Risk-Based Capital Act a domestic health organization which:

(a)(i) Writes direct business only in this state;

(ii) Assumes no reinsurance in excess of five percent of direct premium written; and

(iii) Writes direct annual premiums for comprehensive medical business of two million dollars or less; or

(b) Is a limited health service organization that covers fewer than two thousand lives.

Source: Laws 1993, LB 583, § 34; Laws 1994, LB 978, § 43; Laws 1999, LB 258, § 27.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-6023 Foreign insurers or foreign health organization.

(1) Any foreign insurer or foreign health organization shall, upon the written request of the director, submit to the director a risk-based capital report as of the end of the calendar year just ended not later than the later of:

(a) The date a risk-based capital report would be required to be filed by a domestic insurer or domestic health organization under section 44-6015; or

(b) Fifteen days after the request is received by the foreign insurer or foreign health organization.

Any foreign insurer or foreign health organization shall, at the written request of the director, promptly submit to the director a copy of any risk-based capital plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event, a regulatory action level event, or an authorized control level event with respect to any foreign insurer or foreign health organization as determined under the risk-based capital law applicable in the state of domicile of the insurer or health organization or, if no risk-based capital law is in force in that state, under the Insurers and Health Organizations Risk-Based Capital Act, if the insurance commissioner of the state of domicile of the foreign insurer or foreign health organization fails to require the foreign insurer or foreign health organization to file a risk-based capital plan in the manner specified under the risk-based capital law applicable in the state of domicile of the insurer or health organization or, if no risk-based capital law is in force in the state of domicile of the insurer or health organization, under section 44-6016, the director may require the foreign insurer or foreign health organization to file a risk-based capital plan with the director. In such event, the failure of the foreign insurer or foreign health organization to file a risk-based capital plan with the director shall be grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign insurer or foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign insurer or foreign health organization under the rehabilitation and liquidation law applicable in the state of domicile of the foreign insurer or foreign health organization, the director may make application to the district court of Lancaster County under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act with respect to the liquidation of property of foreign insurers or foreign health organizations found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

Source: Laws 1993, LB 583, § 35; Laws 1994, LB 978, § 44; Laws 1999, LB 258, § 28.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-6023.01 Immunity.

There shall be no liability on the part of, and no cause of action shall arise against, the director, the Department of Insurance, or its employees or agents for any action taken by them in the performance of their powers and duties under the Insurers and Health Organizations Risk-Based Capital Act.

Source: Laws 1994, LB 978, § 45; Laws 1999, LB 258, § 29.

44-6024 Notices.

All notices by the director to an insurer or a health organization which may result in regulatory action under the Insurers and Health Organizations Risk-Based Capital Act shall be effective upon dispatch if transmitted by registered or certified mail or, in the case of any other transmission, shall be effective upon the insurer's or health organization's receipt of such notice.

Source: Laws 1993, LB 583, § 36; Laws 1994, LB 978, § 46; Laws 1999, LB 258, § 30.

44-6025 Phase-in provision.

For risk-based capital reports required to be filed by health organizations with respect to 1999 only, the following requirements shall apply in lieu of the provisions of sections 44-6016 to 44-6019:

(1) In the event of a company action level event with respect to a domestic health organization, the director shall take no regulatory action under the Insurers and Health Organizations Risk-Based Capital Act;

(2) In the event of a regulatory action level event under subdivisions (1)(a) through (c) of section 44-6017, the director shall take the actions required under section 44-6016;

(3) In the event of a regulatory action level event under subdivisions (1)(d) through (i) of section 44-6017 or an authorized control level event, the director shall take the actions required under section 44-6017 with respect to the health organization; and

(4) In the event of a mandatory control level event with respect to a health organization, the director shall take the actions required under section 44-6018 with respect to the health organization.

Source: Laws 1993, LB 583, § 37; Laws 1994, LB 978, § 47; Laws 1999, LB 258, § 31.

44-6026 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Insurers and Health Organizations Risk-Based Capital Act.

Source: Laws 1993, LB 583, § 38; Laws 1994, LB 978, § 48; Laws 1999, LB 258, § 32.

ARTICLE 61

DEMUTUALIZATION AND REORGANIZATION OF MUTUAL COMPANIES

(a) INSURERS DEMUTUALIZATION ACT

Section

(a) INSURERS DEMUTUALIZATION ACT

44-6101 Act, how cited.

Sections 44-6101 to 44-6121 shall be known and may be cited as the Insurers Demutualization Act.

Source: Laws 1993, LB 583, § 41; Laws 1997, LB 52, § 4.

44-6102 Legislative findings and declarations.

The Legislature finds and declares that it is in the public interest that a domestic mutual insurer be permitted to convert to a stock insurer on terms and conditions that are fair and equitable to such mutual insurer's policyholders. The Legislature further finds that because it is not possible to anticipate all of the circumstances and considerations which may arise incident to a conversion from a mutual insurer to a stock insurer, the Director of Insurance should have broad authority in reviewing such conversion, and the procedures and criteria to be applied by the director should be flexible within the parameters of the Insurers Demutualization Act. The act shall be liberally construed to effect the legislative intent set forth in this section and shall not be interpreted to limit the powers granted to the director by other provisions of the law.

Source: Laws 1993, LB 583, § 42.

44-6103 Terms, defined.

For purposes of the Insurers Demutualization Act, the terms defined in section 44-103 shall have the same meanings as set forth in such section and:

(1) Final order shall mean the final written order of the director approving or disapproving the conversion of a mutual insurer to a stock insurer; and

(2) Policyholders shall mean the policyholders of the mutual insurer on the day the plan of conversion is initially approved by the board of directors of the mutual insurer.

Source: Laws 1993, LB 583, § 43.

44-6104 Authority to convert.

A domestic mutual insurer may amend its articles of incorporation pursuant to the Insurers Demutualization Act to become a stock insurer under a fair and equitable plan of conversion approved by the director.

Source: Laws 1993, LB 583, § 44.

44-6105 Application; fee.

A domestic mutual insurer may convert to a stock insurer by meeting the requirements of the Insurers Demutualization Act. The mutual insurer shall file an application to convert to a stock insurer with the director. The application shall be accompanied by a nonrefundable application fee of one thousand dollars. The application shall include the following at a minimum:

(1) A plan of conversion containing a description of the structure and form of the proposed consideration to the policyholders, the projected range of the number of shares of capital stock to be issued by the new stock insurer or the holding company of such insurer, whether to policyholders, to be sold or reserved for sale to investors by the new stock insurer or the holding company of such insurer, or to a trust established for the exclusive benefit of policyholders for the purpose of effecting the conversion into which shares of the capital stock of the new stock insurer or the holding company of such insurer are placed pending distribution to the policyholders, and such other proposed conditions and provisions as determined by the mutual insurer not to be inconsistent with the act;

(2) A certification that the plan of conversion has been duly adopted by a vote of not less than two-thirds of the members of the board of directors of the mutual insurer;

(3) A certification adopted by not less than two-thirds of the members of the board of directors of the mutual insurer that the plan of conversion is fair and equitable to the policyholders;

(4) Certified copies of the proposed amendments to the articles of incorporation and bylaws to effectuate the conversion;

(5) A form of the proposed notice to be mailed by the mutual insurer to its policyholders as required in section 44-6109; and

(6) Any other additional information as the director may reasonably request.

Source: Laws 1993, LB 583, § 45; Laws 1999, LB 326, § 6.

44-6106 Consideration.

The plan of conversion required by section 44-6105 shall specify the consideration to the policyholders entitled thereto, which consideration may be in cash, stock, a combination thereof, or such other valuable consideration as the director may approve. The plan of conversion may, subject to the approval of

the director, provide that all or any portion of the consideration distributable to policyholders may be held in a trust, the terms of which are subject to the approval of the director, established by the mutual insurer for a period not greater than three years, which period may be extended beyond three years for additional annual periods not to exceed five years in the aggregate, with the approval of the director, pursuant to and subject to limitations set forth in the plan of conversion. Unless otherwise ordered by the director and notwithstanding any provisions of law to the contrary, policyholders are not required to be given preemptive rights.

Source: Laws 1993, LB 583, § 46; Laws 1999, LB 326, § 7.

44-6107 Public hearing.

The director shall conduct a public hearing within one hundred and twenty days after the date the application is filed pursuant to section 44-6105 unless extended by the director for good cause. Any interested person may appear or otherwise be heard at the public hearing. The director may in his or her discretion continue the public hearing for a reasonable period of time not to exceed sixty days. The mutual insurer applying to convert to a stock insurer shall give such reasonable notice of the public hearing as the director in his or her discretion shall require.

Source: Laws 1993, LB 583, § 47; Laws 1997, LB 52, § 5.

44-6108 Initial determination; application disapproval.

(1) The director shall issue an order making an initial determination to approve or disapprove the application within thirty days after the close of the public hearing as required by section 44-6107.

(2)(a) The director shall not approve the application unless he or she finds that:

(i) The plan of conversion is fair and equitable to the policyholders;

(ii) The plan of conversion does not deprive the policyholders of their property rights or due process of law; and

(iii) The new stock insurer would meet the minimum requirements to be issued a certificate of authority by the director to transact business in this state and the continued operations of the new stock insurer would not be hazardous to future policyholders and the public.

(b) For purposes of this subsection, the director may consider any relevant factor, including, but not limited to:

(i) The capital requirements of the new stock insurer;

(ii) Whether a portion of the statutory surplus has been contributed by persons or entities whose policies or contracts are not in force on the date the plan of conversion is initially approved by the board of directors of the mutual insurer and, in such event, the consideration to policyholders may be less than the statutory surplus;

(iii) Whether the plan of conversion includes preemptive rights for policyholders to purchase securities offered in the initial sale of securities by the new stock insurer;

(iv) Whether the plan of conversion includes establishment of a preference account from which the payment of any shareholder dividends, including a

regular, special, or liquidation dividend, would be prohibited for a reasonable period of time as the director may require;

(v) The suitability of the trustees of any trust created pursuant to the provisions of section 44-6106; and

(vi) Whether the utilization of a trust, if included in the plan of conversion, has a material adverse effect on policyholders, other than delaying receipt of shares of capital stock.

(3) If the director makes a determination to disapprove the application, the director shall issue a final order setting forth specific findings for the disapproval.

Source: Laws 1993, LB 583, § 48; Laws 1997, LB 52, § 6; Laws 1999, LB 326, § 8.

44-6109 Policyholders' vote.

Within forty-five days after the date of the director's initial determination of approval pursuant to section 44-6108, unless extended by the director for good cause, the mutual insurer shall hold a meeting of its policyholders at a reasonable time and place to vote upon the plan of conversion. The mutual insurer shall give notice at least thirty days before the time fixed for the meeting, by first-class mail to the last-known address of each policyholder, that the plan of conversion will be voted upon at a regular or special meeting of the policyholders, which notice shall include a brief description of the plan of conversion and a statement that the director has initially approved the plan of conversion. The notice mailing to each policyholder shall also include a written proxy permitting the policyholder to vote for or against the plan of conversion. The entity to which any group insurance policy is issued, and not any person covered under the group insurance policy, shall be considered the policyholder for purposes of voting. A plan of conversion shall be approved only if not less than two-thirds of the policyholders voting in person or by proxy at the meeting vote in favor of such plan of conversion. Each policyholder shall be entitled to only one vote regardless of the number of policies owned by the policyholder. The director shall supervise and direct the conduct of the vote on the plan of conversion as necessary to ensure that the vote is fair and consistent with the requirements of this section. The director shall enter a final order approving the application to convert to a stock insurer within ten days after receiving a valid certification from the mutual insurer setting forth the vote and certifying that the plan of conversion was approved by not less than two-thirds of the policyholders voting in person or by proxy on the plan of conversion. In such event, the director shall also publish notification of the issuance of the final order in a legal newspaper in Lancaster County and in the county of domicile of the mutual insurer if different than Lancaster County.

Source: Laws 1993, LB 583, § 49; Laws 1997, LB 52, § 7.

44-6110 Conversion.

The director shall issue a certificate of authority to a new stock insurer when the mutual insurer files a certificate with the director stating that all of the conditions set forth in the plan of conversion have been satisfied so long as the board of directors of the mutual insurer has not abandoned the plan of conversion pursuant to section 44-6114. The conversion shall be effective upon the issuance of a certificate of authority by the director. Upon issuance of the

certificate of authority, the insurer's articles of incorporation shall be treated as amended in compliance with section 44-231.

Source: Laws 1993, LB 583, § 50.

44-6111 Appeal from the final order.

Any person affected by a final order issued pursuant to the Insurers Demutualization Act shall have the right to appeal such order to the district court of Lancaster County. The appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1993, LB 583, § 51.

Cross References

Administrative Procedure Act, see section 84-920.

44-6112 Continuation of corporate existence.

Corporate existence of a mutual insurer converting to a stock insurer pursuant to the Insurers Demutualization Act shall not terminate, but the new stock insurer shall be deemed to be a continuation of the mutual insurer and to have been organized on the date the mutual insurer was originally organized.

Source: Laws 1993, LB 583, § 52.

44-6113 Name.

If the name of a mutual insurer converting to a stock insurer pursuant to the Insurers Demutualization Act includes the word mutual, the new stock insurer may continue to use the word mutual in its name if (1) the name includes a word or words that identify the new stock insurer as a stock insurer and (2) the director finds that the continued use of the word mutual in its name is not likely to mislead or deceive the public.

Source: Laws 1993, LB 583, § 53.

44-6114 Abandonment.

A mutual insurer may, by not less than a two-thirds vote of the members of its board of directors and with the approval of the director, abandon the plan of conversion at any time before the issuance of the certificate of authority by the director. Upon such abandonment, all rights and obligations arising out of the plan of conversion shall terminate and the mutual insurer shall continue to conduct its business as a domestic mutual insurer as though no plan of conversion had ever been adopted.

Source: Laws 1993, LB 583, § 54.

44-6115 Anti-takeover provision; procedure.

(1)(a) Except as otherwise specifically provided in the plan of conversion, prior to and for a period of five years following the issuance of a certificate of authority to a new stock insurer under the Insurers Demutualization Act, no person other than the new stock insurer shall directly or indirectly offer to acquire or acquire in any manner the beneficial ownership of five percent or more of any class of a voting security of the new stock insurer or of any institution which owns a majority or all of the voting securities of the new stock

insurer without the prior approval by the director of an application for acquisition filed by such person with the director.

(b) The director shall not approve an application for acquisition filed pursuant to subdivision (1)(a) of this section unless he or she finds that:

(i) The acquisition would not frustrate the plan of conversion as approved by the policyholders and the director;

(ii) The board of directors of the new stock insurer has approved the acquisition or extraordinary circumstances not contemplated in the plan of conversion have arisen which would warrant approval of the acquisition; and

(iii) The acquisition would be consistent with the legislative purpose of the Insurers Demutualization Act to permit conversions on terms and conditions that are fair and equitable to the policyholders.

(c) An application for acquisition filed pursuant to subsection (1) of this section shall describe in sufficient detail the information to be considered under subdivision (1)(b) of this section.

(d) If any material change occurs in the facts set forth in an application for acquisition filed pursuant to subsection (1) of this section, an amendment setting forth the change, together with copies of all documents and other material relevant to such change, shall be filed with the director.

(2) The director may hold a public hearing on an application for acquisition filed pursuant to subsection (1) of this section unless the board of directors of the new stock insurer has approved the acquisition. The public hearing shall be held within thirty days after the person seeking to acquire securities files an application for acquisition with the director pursuant to subsection (1) of this section, with at least twenty days' notice of the hearing given by the director to the person filing the application for acquisition. Not less than seven days' notice of the hearing shall be given by the person filing the application for acquisition to the new stock insurer and to such other persons as may be designated by the director. At the hearing the person filing the application for acquisition, the new stock insurer, any person to whom notice of the hearing was sent, and any other person whose interest may be affected may present evidence, examine and cross-examine witnesses, and offer oral and written arguments, and in connection therewith, may conduct discovery proceedings in the same manner as is presently allowed in the district court. All discovery proceedings shall be concluded not later than three days prior to the commencement of the hearing. If any offer or acquisition referred to in the application for acquisition is proposed by means of a registration statement under the federal Securities Act of 1933, in circumstances requiring the disclosure of similar information under the federal Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement may utilize such documents in furnishing the information called for by the application for acquisition. The person filing the application shall serve the new stock insurer and any institution which owns a majority or all of the voting securities of the new stock insurer with a copy of the application for acquisition and any amendments thereto on the day such documents are filed with the director.

(3) The new stock insurer and any institution which owns a majority or all of the voting securities of the new stock insurer shall be permitted to become a party upon their request.

(4) The director shall make a determination within thirty days after the conclusion of the hearing or, if no hearing is held, within thirty days after the date the application for acquisition is filed with the director pursuant to subsection (1) of this section. Approval or disapproval of an application for acquisition shall be by written order. The order may be appealed to the district court of Lancaster County, and the appeal shall be in accordance with the Administrative Procedure Act.

(5) The director may retain, at the expense of the person filing an application for acquisition pursuant to subsection (1) of this section, any attorneys, actuaries, accountants, and other experts who are not employees of the Department of Insurance as may be reasonably necessary to assist the director in reviewing the application.

Source: Laws 1993, LB 583, § 55; Laws 1997, LB 52, § 8.

Cross References

Administrative Procedure Act, see section 84-920.

44-6115.01 Anti-takeover provision; voting of securities; limitations; enforcement.

No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of section 44-6115 or of any rule, regulation, or order of the director may be voted at any shareholders' meeting or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding, but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the new stock insurer or an institution which owns a majority or all of the voting securities of the new stock insurer or unless the courts of this state have so ordered. If a new stock insurer or the director has reason to believe that any security of the new stock insurer or an institution which owns a majority or all of the voting securities of the new stock insurer has been or is about to be acquired in contravention of the Insurers Demutualization Act or of any rule, regulation, or order of the director, the new stock insurer or the director may apply to the district court of Lancaster County for an order to enjoin any offer or acquisition made in contravention of section 44-6115 or any rule, regulation, or order of the director to enjoin the voting of any security so acquired, to void any vote of such security already cast at any shareholders' meeting, and for such other equitable relief as the nature of the case and the interest of the new stock insurer's policyholders, creditors, and shareholders or the public may require.

Source: Laws 1997, LB 52, § 9.

44-6115.02 Seizure or sequestration of securities; when.

In any case when a person has acquired or is proposing to acquire any voting securities in violation of the Insurers Demutualization Act or any rule, regulation, or order of the director, the district court of Lancaster County may, on such notice as the court deems appropriate, upon the application of the director or the new stock insurer seize or sequester any voting securities of the new stock insurer or an institution which owns a majority or all of the voting securities of the new stock insurer owned directly or indirectly by such person and issue such order with respect thereto as may be appropriate to effectuate

the act. Notwithstanding any other provisions of law, for purposes of the act, situs of the ownership of such securities shall be deemed to be in this state.

Source: Laws 1997, LB 52, § 10.

44-6115.03 Failure to file application; penalty.

Any person who fails to file an application for acquisition and obtain the prior approval of the director as required by section 44-6115 may be required by the director, after notice and hearing, to pay an administrative penalty of one hundred dollars for each day's delay not to exceed an aggregate penalty of ten thousand dollars. The director may reduce the penalty if the person demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the person.

Source: Laws 1997, LB 52, § 11.

44-6115.04 Anti-takeover provision; violation; penalty.

Any director or officer of a person or an agent of the person who knowingly violates or assents to or permits any officer or agent of the person to violate the requirements of section 44-6115 may be required by the Director of Insurance, after notice and hearing, to pay, in his or her individual capacity, an administrative penalty of not more than five thousand dollars per violation. In determining the amount of the penalty, the Director of Insurance shall take into account the appropriateness of the penalty with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

Source: Laws 1997, LB 52, § 12.

44-6115.05 Anti-takeover provision; violation; cease and desist order.

Whenever it appears to the director that any person or any director, officer, employee, or agent of the person has engaged in any conduct in violation of section 44-6115, the director may order the person to cease and desist immediately any further activity. After notice and hearing, the director may also order the person to void any contracts and restore the status quo if such action is in the best interest of the policyholders, the creditors, or the public.

Source: Laws 1997, LB 52, § 13.

44-6116 Stock purchase rights.

Nothing in the Insurers Demutualization Act shall prohibit the inclusion in the plan of conversion of provisions under which individuals comprising the new stock insurer's board of directors, officers, employees, agents, and persons acting as trustees of employee stock ownership plans or other employee benefit plans may be entitled to purchase for cash capital stock of the new stock insurer at the same price initially issued by the new stock insurer under the plan of conversion but no such purchase may be made while any shares of capital stock are held in a trust established pursuant to the plan of conversion.

Source: Laws 1993, LB 583, § 56; Laws 1999, LB 326, § 9.

44-6117 Compensation.

(1)(a) No director, officer, employee, or agent of the mutual insurer and no other person shall receive any fee, commission, or other valuable consideration

whatsoever, other than his or her usual regular salary and compensation, for in any manner aiding, promoting, or assisting in a plan of conversion except as set forth in the plan of conversion approved by the director.

(b) Subdivision (1)(a) of this section shall not prohibit a management-incentive compensation program which is contained in the plan of conversion and approved by the director to be adopted upon conversion to the new stock insurer or prohibit such a program to be later adopted by the new stock insurer.

(c) All fees, commissions, compensation, and valuable consideration described in this subsection shall be subject to the restrictions on salary, compensation, and emoluments in section 44-213.

(2) Subdivision (1)(a) of this section shall not be deemed to prohibit the payment of reasonable fees and compensation to attorneys, accountants, actuaries, and investment bankers for services performed in the independent practice of their professions even though any such person is also a member of the board of directors of the mutual insurer.

Source: Laws 1993, LB 583, § 57; Laws 1997, LB 52, § 14.

44-6118 Insolvent mutual insurers.

Notwithstanding the requirements of section 44-6105, in the event of insolvency of the mutual insurer, its board of directors by a vote of not less than two-thirds of its members may, in its application, request that the director waive the requirements imposing notice to policyholders and policyowner approval for the plan of conversion. The application shall specify both of the following:

(1) The method and basis for the issuance of the new stock insurer's shares of its capital stock to an independent party in connection with an investment by such independent party in an amount sufficient to restore the insurer to a sound financial condition; and

(2) That the conversion shall be accomplished without distribution to the past, present, or future policyholders, if the director finds that the value of the insurer, due to insolvency, is insufficient to warrant any such distribution.

If the director determines that the mutual insurer is insolvent as defined in section 44-4803, he or she shall grant the request to waive the requirements imposing notice to policyholders and policyowner approval for the plan of conversion.

Source: Laws 1993, LB 583, § 58.

44-6119 Experts; costs.

For the purpose of determining whether a plan of conversion meets the requirements of the Insurers Demutualization Act or in connection with any other matters relating to development of a plan of conversion, the director may engage the services of experts. All reasonable costs related to the review of a plan of conversion or such other matters, including those costs attributable to the use of experts, shall be paid by the mutual insurer making the filing or initiating discussions with the director about such matters.

Source: Laws 1993, LB 583, § 59; Laws 1997, LB 52, § 15.

44-6119.01 Information and documents; confidentiality.

(1) All information, documents, and copies of such information and documents obtained by or disclosed to the director or any other person in the course of preparing, filing, and processing an application to convert to a stock insurer pursuant to section 44-6105, other than information or documents distributed to policyholders in connection with the meeting of policyholders under section 44-6109 or filed or submitted as evidence in connection with the public hearing under section 44-6107, shall be given confidential treatment.

(2) The information, documents, and copies described in subsection (1) of this section shall not be subject to subpoena.

(3) The information, documents, and copies described in subsection (1) of this section shall not be made public by the director, the National Association of Insurance Commissioners or its subsidiaries or affiliates, or any other person without the prior written consent of the insurer to which it pertains except that:

(a) If the director, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interests of policyholders, shareholders, or the public will be served by the publication of such information, documents, and copies, the director may publish all or any part of such information, documents, and copies; and

(b) The director may provide the information, documents, and copies described in subsection (1) of this section to state, federal, foreign, and international regulatory and law enforcement agencies, and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the information, documents, and copies.

(4) The director may receive information, documents, and copies described in subsection (1) of this section from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subsection if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subsection, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subsection as a result of information sharing authorized by this section.

Source: Laws 1997, LB 52, § 16; Laws 2001, LB 52, § 53.

44-6120 Rules and regulations; orders.

The director may adopt and promulgate rules and regulations and issue orders to carry out the Insurers Demutualization Act.

Source: Laws 1993, LB 583, § 60; Laws 1997, LB 52, § 18.

44-6121 Violation; penalty; enforcement.

Whenever it appears to the director that any person or any director, officer, employee, or agent of the person has committed or is about to commit a violation of the Insurers Demutualization Act or of any rule, regulation, or order of the director, the director may apply to the district court of Lancaster County for an order enjoining such person, director, officer, employee, or agent from violating or continuing to violate the act or any such rule, regulation, or order and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

Source: Laws 1997, LB 52, § 17.

(b) MUTUAL INSURANCE HOLDING COMPANY ACT

44-6122 Act, how cited.

Sections 44-6122 to 44-6143 shall be known and may be cited as the Mutual Insurance Holding Company Act.

Source: Laws 1997, LB 740, § 1; Laws 1999, LB 259, § 13; Laws 2005, LB 119, § 22.

44-6123 Legislative findings and declarations.

The Legislature finds and declares that it is in the public interest that a domestic mutual insurer be permitted to reorganize in a manner that preserves attributes of its mutuality while facilitating capital raising abilities and corporate affiliations on terms and conditions that are fair and equitable to the mutual insurer's policyholders. The Legislature further finds that because policyholders of a mutual insurer have membership interests in the mutual insurer, the director should have broad authority in reviewing a reorganization and the procedures and criteria to be applied by the director should be flexible within the parameters of the Mutual Insurance Holding Company Act. The act shall be liberally construed to effect the legislative intent set forth in this section and shall not be interpreted to limit the powers granted to the director by other provisions of the law.

Source: Laws 1997, LB 740, § 2.

44-6124 Terms, defined.

For purposes of the Mutual Insurance Holding Company Act:

(1) Director means the Director of Insurance;

(2) Intermediate stock holding company means a holding company of which at least a majority of the voting securities are owned by a mutual insurance holding company and which, directly or indirectly, owns all of the voting securities of a reorganized stock insurer;

(3) Mutual insurance holding company means a holding company based on a mutual plan which at all times owns, directly or indirectly, a majority of the voting securities of one or more intermediate stock holding companies or, if no such intermediate stock holding company exists, which owns a majority of the voting securities of a reorganized stock insurer;

(4) Reorganized stock insurer means a stock insurer subsidiary which results from a reorganization of a domestic mutual insurer pursuant to subsection (1) or (2) of section 44-6125 and in compliance with the act; and

(5) Voting securities means securities of any class or any ownership interest having voting power for the election of directors, trustees, or management, other than securities having voting power only because of the occurrence of a contingency.

Source: Laws 1997, LB 740, § 3; Laws 2004, LB 1047, § 19.

44-6125 Domestic mutual insurer; foreign insurer; transfer domicile; reorganization authorized; effect; holding company; treatment.

(1) A domestic mutual insurer, upon approval of the director, may reorganize (a) by forming a mutual insurance holding company, (b) by merging its policyholders' membership interests into the mutual insurance holding company, and (c) by continuing the mutual insurer's corporate existence as a stock insurer subsidiary of the mutual insurance holding company.

(2) A domestic mutual insurer, upon the approval of the director, may reorganize by merging its policyholders' membership interests into an existing mutual insurance holding company formed under subsection (1) of this section and by continuing the mutual insurer's corporate existence as a stock insurer subsidiary of the mutual insurance holding company.

(3) All of the initial shares of the capital stock of a reorganized stock insurer which has reorganized as described in subsection (1) or (2) of this section shall be issued to the mutual insurance holding company or to one or more intermediate stock holding companies.

(4) Policyholders of a domestic mutual insurer which has reorganized as described in subsection (1) or (2) of this section shall be members of the mutual insurance holding company and their voting rights shall be determined in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall provide its members with the same membership rights as were provided to policyholders of the mutual insurer immediately prior to reorganization. The reorganization shall not reduce, limit, or affect the number or identity of the policyholders who may become members of the mutual insurance holding company or secure for individuals comprising management any unfair advantage through or connected with the reorganization.

(5) If an insurer which is organized under the laws of another state transfers its domicile to this state in accordance with section 44-161 and is a direct or indirect subsidiary of a mutual insurance holding company organized under the laws of such other state, then, in connection with the transfer of the domicile of such insurer, upon approval of the director of a plan of merger and transfer, the foreign mutual insurance holding company may form a mutual insurance holding company under this section, and the foreign mutual insurance holding company may merge into such domestic mutual insurance holding company simultaneously with the transfer of domicile of the insurer to this state. Until the merger takes effect, the foreign mutual insurance holding company shall be the sole member of the domestic mutual insurance holding company. When the merger takes effect, the separate existence of the foreign mutual insurance holding company shall cease, the domestic mutual insurance holding company shall survive and have all the assets and liabilities formerly held by the foreign

mutual insurance holding company, all of the members of the foreign mutual insurance holding company shall become members of the domestic mutual insurance holding company, policyholders of the insurer shall be members of the domestic mutual insurance holding company, and their voting rights shall be determined in accordance with the articles of incorporation and bylaws of the domestic mutual insurance holding company. After the transfer and merger take effect, for purposes of the Mutual Insurance Holding Company Act, the insurer shall be deemed to be a reorganized stock insurer. If the foreign mutual insurance holding company owns a majority of the voting stock of a stock holding company organized under the laws of another state that in turn owns all of the voting stock of the insurer, then the plan of merger and transfer may provide that the stock holding company shall continue as a corporation organized under the laws of the other state.

(6)(a) A mutual insurance holding company or any intermediate stock holding company formed under the Mutual Insurance Holding Company Act shall not be authorized to transact the business of insurance.

(b) A mutual insurance holding company formed under the act shall not issue stock.

(c) The director shall have jurisdiction over a mutual insurance holding company and any intermediate stock holding company to ensure that policyholder interests are protected.

(d) A mutual insurance holding company and any intermediate stock holding company shall be treated as domestic insurers subject to the Insurers Demutualization Act, the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, Chapter 44, article 2, and section 44-301, except that a foreign intermediate stock holding company shall not be subject to Chapter 44, article 2, and section 44-301.

(e) Except with the approval of the director, the aggregate pledges and encumbrances of a mutual insurance holding company's assets shall not affect more than forty-nine percent of the mutual insurance holding company's stock in an intermediate stock holding company or a reorganized stock insurer.

(f) At least fifty percent of the net worth of a mutual insurance holding company, as determined by generally accepted accounting practices, shall be invested in insurers or any other subsidiaries or investments authorized by the Insurance Holding Company System Act.

(g) If any proceeding under the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act is brought against a reorganized stock insurer, the mutual insurance holding company and intermediate stock holding company shall become parties to the proceedings. All of the assets of the mutual insurance holding company are deemed assets of the estate of the reorganized stock insurer to the extent necessary to satisfy policy claims against the reorganized stock insurer.

(h) No distribution to members of a mutual insurance holding company may occur without prior written approval of the director and only upon the director's satisfaction that such distribution is fair and equitable to policyholders as members of the mutual insurance holding company.

(i) No solicitation for the sale of the stock of an intermediate stock holding company or a reorganized stock insurer may be made without the director's prior written approval.

(j) A mutual insurance holding company or an intermediate stock holding company shall not voluntarily dissolve without the approval of the director.

Source: Laws 1997, LB 740, § 4; Laws 2004, LB 1047, § 20; Laws 2005, LB 119, § 23.

Cross References

Insurance Holding Company System Act, see section 44-2120.
Insurers Demutualization Act, see section 44-6101.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-6126 Plan of reorganization; contents.

A domestic mutual insurer shall file a proposed plan of reorganization approved by a vote of not less than two-thirds of the members of its board of directors for review and approval with the director. The proposed plan of reorganization shall be accompanied by a nonrefundable fee of one thousand dollars. A plan of reorganization shall include the following at a minimum:

(1) An analysis of the benefits and risks attendant to the proposed reorganization, including the rationale and comparative benefits and risks of a demutualization;

(2) A statement of how the plan is fair and equitable to the policyholders;

(3) Information sufficient to demonstrate that the financial condition of the mutual insurer will not be diminished upon reorganization;

(4) Provisions to ensure immediate membership in the mutual insurance holding company for all existing policyholders of the mutual insurer;

(5) Provisions for membership interests for future policyholders of the reorganized stock insurer;

(6) Provisions to ensure that, in the event of proceedings for rehabilitation or liquidation involving a stock insurer subsidiary of the mutual insurance holding company, the assets of the mutual insurance holding company will be available to satisfy the policyholder obligations of the stock insurer subsidiary;

(7) Provisions for periodic distribution of accumulated mutual insurance holding company earnings;

(8) Certified copies of the proposed articles of incorporation and bylaws of the mutual insurance holding company, intermediate stock holding company, and reorganized stock insurer or proposed amendments thereto as necessary to effectuate reorganization;

(9) A certification that the plan of reorganization has been duly adopted by a vote of not less than two-thirds of the members of the board of directors of the mutual insurer;

(10) A certification adopted by not less than two-thirds of the members of the board of directors of the mutual insurer that the plan of reorganization is fair and equitable to the policyholders;

(11) The names, addresses, and occupational information of all corporate officers and all members of the board of directors of the proposed mutual insurance holding company in the case of a reorganization described in subsection (1) of section 44-6125;

(12) A description of the nature and content of the annual report and financial statement to be sent by the mutual insurance holding company to each member;

(13) A description of the number of members of the board of directors of the mutual insurance holding company required to be policyholders;

(14) A description of any plans for the initial sale of stock of the intermediate stock holding company or reorganized stock insurer;

(15) A form of the proposed notice to be mailed by the mutual insurer to its policyholders as required in section 44-6129; and

(16) Any other information requested by the director.

Source: Laws 1997, LB 740, § 5.

44-6127 Plan of reorganization; public hearing; notice.

The director shall conduct a public hearing regarding a proposed plan of reorganization within one hundred twenty days after the date the completed proposed plan of reorganization is filed pursuant to section 44-6126 unless extended by the director for good cause. Any interested person may appear or otherwise be heard at the public hearing. The director may in his or her discretion continue the public hearing for a reasonable period of time not to exceed sixty days. The mutual insurer shall give such reasonable notice of the public hearing as the director in his or her discretion may require.

Source: Laws 1997, LB 740, § 6.

44-6128 Plan of reorganization; approval; director; order.

(1) The director shall issue an order approving or disapproving a proposed plan of reorganization within thirty days after the close of the public hearing as required by section 44-6127.

(2) The director shall not approve a proposed plan of reorganization unless he or she finds that:

(a) The plan of reorganization is fair and equitable to the policyholders;

(b) The plan of reorganization does not deprive the policyholders of their property rights or due process of law; and

(c) The reorganized stock insurer would meet the minimum requirements to be issued a certificate of authority by the director to transact the business of insurance in this state and the continued operations of the reorganized stock insurer would not be hazardous to future policyholders and the public.

(3) If the director approves a plan of reorganization, the director shall also publish notification of the issuance of the order in a legal newspaper in Lancaster County and in the county of domicile of the mutual insurer if different than Lancaster County.

(4) If the director approves a plan of reorganization, the approval shall expire if the reorganization is not completed within one hundred eighty days after the date of approval unless extended by the director for good cause.

(5) If the director disapproves a plan of reorganization, the director shall issue an order setting forth specific findings for the disapproval.

Source: Laws 1997, LB 740, § 7.

44-6129 Plan of reorganization; policyholders vote.

(1) Within forty-five days after the date of the director's approval of a plan of reorganization pursuant to section 44-6128, unless extended by the director for

good cause, the mutual insurer shall hold a meeting of its policyholders at a reasonable time and place to vote upon the plan of reorganization. The mutual insurer shall give notice at least thirty days before the time fixed for the meeting, by first-class mail to the last-known address of each policyholder, that the plan of reorganization will be voted upon at a regular or special meeting of the policyholders. The notice shall include a brief description of the plan of reorganization and a statement that the director has approved the plan of reorganization. The notice to each policyholder shall also include a written proxy permitting the policyholder to vote for or against the plan of reorganization. The entity to which any group insurance policy is issued, and not any person covered under the group insurance policy, shall be considered the policyholder for purposes of voting. A plan of reorganization shall be approved only if not less than two-thirds of the policyholders voting in person or by proxy at the meeting vote in favor of such plan of reorganization. Each policyholder shall be entitled to only one vote regardless of the number of policies owned by the policyholder. The director shall supervise and direct the conduct of the vote on the plan of reorganization as necessary to ensure that the vote is fair and consistent with the requirements of this section.

(2) If a mutual insurer complies substantially and in good faith with the notice requirements of this section, the mutual insurer's failure to give any policyholder any required notice does not impair the validity of any action taken under this section.

(3) If the meeting of policyholders to vote upon the plan of reorganization is held coincident with the mutual insurer's annual meeting of the policyholders, only one combined notice of meeting is required.

(4) The form of any proxy shall be filed with and approved by the director.

(5) For purposes of voting, policyholders means the policyholders of the mutual insurer on the day the plan of reorganization is initially approved by the board of directors of the mutual insurer.

Source: Laws 1997, LB 740, § 8.

44-6130 Certificate of authority; issuance.

The director shall issue a certificate of authority to a reorganized stock insurer when the mutual insurer files with the director (1) a certificate stating that all of the conditions set forth in the plan of reorganization have been satisfied so long as the board of directors of the mutual insurer has not abandoned the plan of reorganization pursuant to section 44-6133 and (2) a certificate from the mutual insurer setting forth the vote and certifying that the plan of reorganization was approved by not less than two-thirds of the policyholders voting in person or by proxy on the plan of reorganization. The reorganization shall be effective upon the issuance of a certificate of authority by the director. Upon issuance of the certificate of authority, the insurer's articles of incorporation shall be treated as amended in compliance with section 44-231.

Source: Laws 1997, LB 740, § 9.

44-6131 Appeal; procedure.

Any person affected by a final order issued pursuant to the Mutual Insurance Holding Company Act shall have the right to appeal such order to the district

court of Lancaster County. The appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1997, LB 740, § 10.

Cross References

Administrative Procedure Act, see section 84-920.

44-6132 Corporate existence; continuation.

Corporate existence of a mutual insurer reorganizing pursuant to the Mutual Insurance Holding Company Act shall not terminate, but the reorganized stock insurer shall be deemed to be a continuation of the mutual insurer and to have been organized on the date the mutual insurer was originally organized.

Source: Laws 1997, LB 740, § 11.

44-6132.01 Name.

If the name of a mutual insurer reorganizing as a reorganized stock insurer pursuant to the Mutual Insurance Holding Company Act includes the word mutual, the reorganized stock insurer may continue to use the word mutual in its name if (1) the name includes a word or words that identify the reorganized stock insurer as a stock insurer and (2) the director finds that the continued use of the word mutual in its name is not likely to mislead or deceive the public.

Source: Laws 1999, LB 259, § 14.

44-6133 Plan of reorganization; abandonment.

A mutual insurer may, by not less than a two-thirds vote of the members of its board of directors and with the approval of the director, abandon a plan of reorganization at any time before the issuance of the certificate of authority by the director. Upon such abandonment, all rights and obligations arising out of the plan of reorganization shall terminate and the mutual insurer shall continue to conduct its business as a domestic mutual insurer as though no plan of reorganization had ever been adopted.

Source: Laws 1997, LB 740, § 12.

44-6134 Membership interest; not a security.

A membership interest in a mutual insurance holding company does not constitute a security under the laws of this state.

Source: Laws 1997, LB 740, § 13.

44-6135 Annual statement; audit.

A mutual insurance holding company shall file with the director, by March 1 of each year, an annual statement consisting of an income statement, balance sheet, and cash flows prepared in accordance with generally accepted accounting practices and a confidential statement disclosing any intention to pledge, borrow against, alienate, hypothecate, or in any way encumber the assets of the mutual insurance holding company. A mutual insurance holding company shall also have an annual audit by an independent certified public accountant in a form approved by the director and shall file such audit on or before June 1 of each year for the year ending December 31 immediately preceding.

Source: Laws 1997, LB 740, § 14.

44-6136 Production of records.

The director shall have the power to order production of any records, books, or other information and papers in the possession of a mutual insurance holding company or its affiliates as are reasonably necessary to ascertain the financial condition of the reorganized stock insurer or to determine compliance with Chapter 44.

Source: Laws 1997, LB 740, § 15.

44-6137 Construction of act.

Nothing contained in the Mutual Insurance Holding Company Act shall be construed to prohibit demutualization of a mutual insurance holding company pursuant to the Insurers Demutualization Act.

Source: Laws 1997, LB 740, § 16.

Cross References

Insurers Demutualization Act, see section 44-6101.

44-6138 Fee, commission, or consideration; restrictions.

(1)(a) No director, officer, employee, or agent of the mutual insurer and no other person shall receive any fee, commission, or other valuable consideration whatsoever, other than his or her usual regular salary and compensation, for in any manner aiding, promoting, or assisting in a plan of reorganization except as set forth in the plan of reorganization approved by the director.

(b) Subdivision (1)(a) of this section shall not prohibit a management-incentive compensation program which is contained in the plan of reorganization and approved by the director to be adopted upon reorganization to the reorganized stock insurer or prohibit such a program to be later adopted by the reorganized stock insurer.

(c) All fees, commissions, compensation, and valuable consideration described in this subsection shall be subject to the restrictions on salary, compensation, and emoluments in section 44-213.

(2) Subdivision (1)(a) of this section shall not be deemed to prohibit the payment of reasonable fees and compensation to attorneys, accountants, actuaries, and investment bankers for services performed in the independent practice of their professions even though any such person is also a member of the board of directors of the mutual insurer.

Source: Laws 1997, LB 740, § 17.

44-6139 Experts; costs of review.

For purposes of determining whether a plan of reorganization meets the requirements of the Mutual Insurance Holding Company Act or in connection with any other matters relating to development of a plan of reorganization, the director may engage the services of experts. All reasonable costs related to the review of a plan of reorganization or such other matters, including those costs attributable to the use of experts, shall be paid by the mutual insurer making the filing or initiating discussions with the director about such matters.

Source: Laws 1997, LB 740, § 18.

44-6140 Confidentiality.

(1) All information, documents, and copies of such information and documents obtained by or disclosed to the director or any other person in the course of preparing, filing, and processing an application to reorganize pursuant to section 44-6126, other than information or documents distributed to policyholders in connection with the meeting of policyholders under section 44-6129 or filed or submitted as evidence in connection with the public hearing under section 44-6127, shall be given confidential treatment.

(2) The information, documents, and copies described in subsection (1) of this section shall not be subject to subpoena.

(3) The information, documents, and copies described in subsection (1) of this section shall not be made public by the director, the National Association of Insurance Commissioners or its subsidiaries or affiliates, or any other person without the prior written consent of the insurer to which it pertains, except that:

(a) If the director, after giving the insurer and its affiliates who would be affected thereby notice and opportunity to be heard, determines that the interests of policyholders, shareholders, or the public will be served by the publication of such information, documents, and copies, the director may publish all or any part of such information, documents, and copies; and

(b) The director may provide the information, documents, and copies described in subsection (1) of this section to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the information, documents, and copies.

(4) The director may receive information, documents, and copies described in subsection (1) of this section from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subsection if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subsection, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subsection as a result of information sharing authorized by this section.

Source: Laws 1997, LB 740, § 19; Laws 2001, LB 52, § 54.

44-6141 Enforcement.

Whenever it appears to the director that any person or any director, officer, employee, or agent of the person has committed or is about to commit a violation of the Mutual Insurance Holding Company Act or of any rule, regulation, or order of the director, the director may apply to the district court

of Lancaster County for an order enjoining such person, director, officer, employee, or agent from violating or continuing to violate the act or any such rule, regulation, or order and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors, and shareholders or the public may require.

Source: Laws 1997, LB 740, § 20.

44-6142 Rules and regulations.

The director may adopt and promulgate rules and regulations and issue orders to carry out the Mutual Insurance Holding Company Act.

Source: Laws 1997, LB 740, § 21.

44-6143 Expansion of business; activities authorized; requirements.

(1) A mutual insurance holding company or an intermediate stock holding company may engage in actions and activities related to expanding the business of any company into other insurance, insurance-related, and financial services businesses. Any such expansion may be accomplished through acquisition, merger, consolidation, strategic alliance, joint venture, or other business combination. A mutual insurance holding company may:

(a) Merge or consolidate with, or acquire the assets of, a mutual insurance holding company formed under the laws of the State of Nebraska or any similar entity or organization formed under the laws of any other state;

(b) Either alone or together with one or more intermediate stock holding companies, or other subsidiaries, directly or indirectly acquire the stock of a stock insurance company or a mutual insurance company that reorganizes as a mutual insurance holding company under the laws of the State of Nebraska or the laws of its state of organization;

(c) Together with one or more of its stock insurance company subsidiaries, acquire the assets of a stock insurance company or a mutual insurance company;

(d) Acquire a stock insurance company through the merger of such stock insurance subsidiary with a stock insurance company or intermediate stock insurance company subsidiary of the mutual insurance holding company; or

(e) Acquire the stock or assets of any other person to the same extent as would be permitted for a mutual insurance company.

(2) A plan and agreement for merger or consolidation in accordance with subsection (1) of this section shall be submitted to and approved by two-thirds of the members of each domestic mutual insurance holding company or mutual insurance company involved in the merger or consolidation who vote either in person or by proxy thereon at meetings called for such purposes pursuant to such reasonable notice and procedure as has been approved by the director.

(3) No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the director and approved by the director.

(4) All of the initial shares of the capital stock of the reorganized stock insurer shall be issued either to the mutual insurance holding company or to an intermediate stock holding company that is a subsidiary of the mutual insurance holding company. The membership interests of the policyholders of the

reorganized stock insurer shall become membership interests in the mutual insurance holding company in accordance with the plan and agreement of merger or consolidation. Policyholders of the reorganized stock insurer shall be members of the mutual insurance holding company in accordance with the plan and agreement of merger or consolidation and the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times directly or indirectly own a majority of the voting shares of the capital stock of any reorganized stock insurer.

Source: Laws 2005, LB 119, § 24.

ARTICLE 62
ASSUMPTION REINSURANCE

Section
44-6201. Act, how cited.
44-6202. Purpose of act.
44-6203. Applicability of act.
44-6204. Terms, defined.
44-6205. Notice requirements.
44-6206. Prior approval requirements.
44-6207. Policyholder rights.
44-6208. Effect of consent.
44-6209. Director's discretion.
44-6210. Applicability of act; when.
44-6211. Rules and regulations.

44-6201 Act, how cited.

Sections 44-6201 to 44-6211 shall be known and may be cited as the Assumption Reinsurance Act.

Source: Laws 1993, LB 583, § 62.

44-6202 Purpose of act.

It is the purpose of the Assumption Reinsurance Act to provide for the regulation of the transfer and novation of contracts of insurance by way of assumption reinsurance. The act describes assumption reinsurance and establishes notice and disclosure requirements which protect and define the rights and obligations of policyholders, regulators, and the parties to assumption reinsurance agreements.

Source: Laws 1993, LB 583, § 63.

44-6203 Applicability of act.

(1) The Assumption Reinsurance Act shall apply to any insurer authorized to transact business in this state which either assumes or transfers the obligations or risks on contracts of insurance owned by policyholders residing in this state pursuant to an assumption reinsurance agreement. The act shall not relieve any insurer of any other requirements of the insurance laws of this state.

(2) The act shall not apply to:

(a) Any reinsurance agreement or transaction in which the ceding insurer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement;

(b) The substitution of one insurer for another upon the expiration of insurance coverage pursuant to statutory or contractual requirements and the issuance of a new contract of insurance by another insurer;

(c) The transfer of contracts of insurance pursuant to mergers or consolidations of two or more insurers to the extent that those transactions are regulated by law;

(d) Any insurer subject to a judicial order of rehabilitation or liquidation; or

(e) Any reinsurance agreement or transaction to which a state insurance guaranty association is a party.

Source: Laws 1993, LB 583, § 64.

44-6204 Terms, defined.

For purposes of the Assumption Reinsurance Act:

(1) Assuming insurer shall mean the insurer which acquires an insurance obligation or risk from the transferring insurer pursuant to an assumption reinsurance agreement;

(2) Assumption reinsurance agreement shall mean any contract which both:

(a) Transfers insurance obligations or risks of existing contracts of insurance or contracts of insurance which are in force from a transferring insurer to an assuming insurer; and

(b) Is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks under such contract of insurance are extinguished;

(3) Contract of insurance shall mean any written agreement between an insurer and policyholder pursuant to which the insurer, in exchange for premium or other consideration, agrees to assume an obligation or risk of the policyholder or to make payments on behalf of or to the policyholder or its beneficiaries. The term shall include all lines of insurance specified in section 44-201;

(4) Director shall mean the Director of Insurance;

(5) Notice of transfer shall mean the written notice to the policyholders required by section 44-6205;

(6) Policyholder shall mean any individual or entity which has the right to terminate or otherwise alter the terms of a contract of insurance. The term shall include any certificate holder whose certificate is in force on the proposed effective date of the assumption if the certificate holder has the right to keep the certificate in force without change in benefit following termination of the group policy. Such rights to keep the certificate in force shall not include the right to elect individual coverage under sections 44-1640 to 44-1645 or the federal Consolidated Omnibus Budget Reconciliation Act, section 601 et seq., of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1161 et seq.; and

(7) Transferring insurer shall mean the insurer which transfers an insurance obligation or risk to an assuming insurer pursuant to an assumption reinsurance agreement.

Source: Laws 1993, LB 583, § 65.

44-6205 Notice requirements.

(1) The transferring insurer shall provide or cause to be provided to each policyholder a notice of transfer by first-class mail addressed to the policyholder's last-known address or to the address to which premium notices or other policy documents are sent or, with respect to home-service business, by personal delivery with acknowledged receipt. A notice of transfer shall also be sent to the transferring insurer's agents or brokers of record on the affected policies.

(2) The notice of transfer shall state or provide:

(a) The date the transfer and novation of the policyholder's contract of insurance is proposed to take place;

(b) The names, addresses, and telephone numbers of the assuming insurer and transferring insurer;

(c) That the policyholder has the right to either accept or reject the transfer and novation;

(d) The procedures and time limit for accepting or rejecting the transfer and novation;

(e) A summary of any effect that accepting or rejecting the transfer and novation will have on the policyholder's rights;

(f) A statement that the assuming insurer is authorized to write the type of business being assumed in the state where the policyholder resides or is otherwise authorized, as provided in the Assumption Reinsurance Act, to assume such business;

(g) The name and address of the person at the transferring insurer to whom the policyholder should send its written statement of acceptance or rejection of the transfer and novation;

(h) The address and telephone number of the insurance department of the state where the policyholder resides so that the policyholder may write or call such insurance department for further information regarding the financial condition of the assuming insurer;

(i) The following information regarding both insurers:

(i) Ratings for the last five years if available, or for such lesser period as is available, from two nationally recognized insurance rating services acceptable to the director, including the rating service's explanation of the rating's meaning. If ratings are unavailable for any year of the five-year period, this shall also be disclosed;

(ii) The annual statement balance sheet as of December 31 for the previous two years if available, or for such lesser period as is available, and as of the date of the most recent quarterly statement; and

(iii) An explanation of the reason for the transfer; and

(j) Such other information as the director may by rule and regulation require.

(3) A notice of transfer in a form identical or substantially similar to a form prescribed by the director shall be deemed to comply with the requirements of subsection (2) of this section.

(4) The notice of transfer shall include a preaddressed, postage-paid response card which a policyholder may return as its written statement of acceptance or rejection of the transfer and novation.

(5) The notice of transfer proposed to be used shall be filed with the director as part of the prior approval requirement set forth in subsection (1) of section 44-6206.

Source: Laws 1993, LB 583, § 66.

44-6206 Prior approval requirements.

(1) Prior approval by the director shall be required for any transaction by which an insurer domiciled in this state assumes or transfers obligations or risks on contracts of insurance under an assumption reinsurance agreement. An insurer authorized to transact business in this state shall not transfer obligations or risks on contracts of insurance owned by policyholders residing in this state to any insurer that is not authorized to transact business in this state. An insurer domiciled in this state shall not assume obligations or risks on contracts of insurance owned by policyholders residing in any other state unless it is authorized to transact business in the other state or the insurance department of that state has approved such assumption.

(2) A foreign or alien insurer authorized to transact business in this state that enters into an assumption reinsurance agreement which transfers the obligations or risks on contracts of insurance owned by policyholders residing in this state shall file or cause to be filed the assumption certificate with the director, a copy of the notice of transfer and an affidavit that the transaction is subject to assumption reinsurance requirements adopted by statute or regulation in the state of domicile or port-of-entry state of both the transferring insurer and assuming insurer which are substantially similar to those contained in the Assumption Reinsurance Act.

(3) A foreign or alien insurer authorized to transact business in this state that enters into an assumption reinsurance agreement which transfers the obligations or risks on contracts of insurance owned by policyholders residing in this state shall obtain prior approval of the director and be subject to all other requirements of the act unless the transferring insurer and assuming insurer are subject to assumption reinsurance requirements adopted by statute or regulation in the state of their domicile or port-of-entry state which are substantially similar to those contained in the act.

(4) An insurer required to receive approval of assumption reinsurance transactions under this section shall not enter into an assumption reinsurance transaction until:

(a) Thirty days after the director has received a request for approval and has not within such period disapproved such transaction; or

(b) The director has approved the transaction within the thirty-day period.

(5) The following factors, along with such other factors as the director deems appropriate under the circumstances, shall be considered by the director in reviewing a request for approval:

(a) The financial condition of the transferring insurer and assuming insurer and the effect the transaction will have on the financial condition of each insurer;

(b) The competence, experience, and integrity of those persons who control the operation of the assuming insurer;

(c) The plans or proposals the assuming insurer has with respect to the administration of the policies subject to the proposed transfer;

(d) Whether the transfer is fair and reasonable to the policyholders of both insurers; and

(e) Whether the notice of transfer to be provided by the insurer is fair, adequate, and not misleading.

Source: Laws 1993, LB 583, § 67.

44-6207 Policyholder rights.

(1) Every policyholder shall have the right to reject the transfer and novation of his or her contracts of insurance. Policyholders electing to reject the assumption transaction shall return to the transferring insurer the preaddressed, postage-paid response card or other written notice and indicate thereon that the assumption is rejected.

(2) Payment of the next premium after notice is received to the assuming insurer shall be deemed to indicate the policyholder's acceptance of the transfer to the assuming insurer and a novation shall be deemed to have been effected if the premium notice clearly states that payment of the premium to the assuming insurer shall constitute acceptance of the transfer. Such a premium notice shall also provide a method for the policyholder to pay the premium while reserving the right to reject the transfer.

(3) After no fewer than twelve months after the mailing of the initial notice of transfer required under section 44-6205, if positive acceptance to the transfer and assumption has not been received or acceptance has not been deemed to have occurred under subsection (2) of this section, the transferring insurer shall send to the policyholder a second and final notice of transfer. If the policyholder does not reject the transfer during the two-month period immediately following the date on which the transferring insurer mails the second and final notice of transfer, the policyholder's acceptance will be deemed to have occurred and novation of the contract of insurance will be effected.

(4) The transferring insurer will be deemed to have received the response card on the date it is postmarked. A policyholder may also send a response card by facsimile or other electronic transmission or by registered mail, express delivery, or courier service, in which case the response card shall be deemed to have been received by the assuming insurer on the date of actual receipt by the transferring insurer.

Source: Laws 1993, LB 583, § 68.

44-6208 Effect of consent.

If a policyholder accepts the transfer pursuant to section 44-6207 or if the transfer is effected under section 44-6209, there shall be a novation of the contract of insurance subject to the assumption reinsurance agreement with the result that the transferring insurer shall thereby be relieved of all insurance obligations or risks transferred under the assumption reinsurance agreement and the assuming insurer shall become directly and solely liable to the policyholder for those insurance obligations or risks.

Source: Laws 1993, LB 583, § 69.

44-6209 Director's discretion.

If an insurer domiciled in this state or in a state which does not have assumption reinsurance requirements adopted by statute or regulation substan-

tially similar to those contained in the Assumption Reinsurance Act is deemed by the director to be in hazardous financial condition or an administrative or judicial proceeding has been instituted against it for the purpose of liquidating, reorganizing, or conserving such insurer, and the transfer of the contracts of insurance is in the best interest of the policyholders, as determined by the director, a transfer and novation may be effected notwithstanding the provisions of the act. This may include use of a form of implied acceptance and adequate notification to the policyholder of the circumstances requiring the transfer and novation as approved by the director.

Source: Laws 1993, LB 583, § 70.

44-6210 Applicability of act; when.

The Assumption Reinsurance Act shall apply to all assumption reinsurance agreements entered into on or after January 1, 1994.

Source: Laws 1993, LB 583, § 71.

44-6211 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Assumption Reinsurance Act.

Source: Laws 1993, LB 583, § 72.

ARTICLE 63

DISCLOSURE OF MATERIAL INSURANCE TRANSACTIONS

Section
44-6301. Act, how cited.
44-6302. Terms, defined.
44-6303. Report required; contents; filing; confidentiality.
44-6304. Disclosure; when required; nonconsolidated basis.
44-6305. Ceded reinsurance agreements; reporting requirements.
44-6306. Rules and regulations.

44-6301 Act, how cited.

Sections 44-6301 to 44-6306 shall be known and may be cited as the Disclosure of Material Insurance Transactions Act.

Source: Laws 1994, LB 978, § 1.

44-6302 Terms, defined.

For purposes of the Disclosure of Material Insurance Transactions Act:

(1) Director shall mean the Director of Insurance; and

(2) Insurer shall mean an insurer as defined in section 44-103 authorized to transact the business of insurance in this state, except that insurer shall include health maintenance organizations and insurer shall not include unincorporated mutual associations and assessment associations.

Source: Laws 1994, LB 978, § 2.

44-6303 Report required; contents; filing; confidentiality.

(1) Every insurer domiciled in this state shall file a report with the director disclosing any of the following transactions: Material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded

reinsurance agreements, unless such acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the director for review, approval, or information purposes pursuant to other provisions of the insurance laws of this state, rules and regulations adopted and promulgated thereunder, or other requirements.

(2) The report shall be filed within fifteen days after the end of the calendar month in which any of the transactions occur.

(3) One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall also be filed with the National Association of Insurance Commissioners.

(4) All reports obtained by or disclosed to the director pursuant to the Disclosure of Material Insurance Transactions Act shall be given confidential treatment and shall not be subject to subpoena and shall not be made public by the director, the National Association of Insurance Commissioners or its affiliates and subsidiaries, or any other person, except to other state, federal, foreign, and international regulatory and law enforcement agencies if the recipient agrees in writing to maintain the confidentiality of the information, without the prior written consent of the insurer to which it pertains unless the director, after giving the insurer who would be affected thereby, notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the director may publish all or any part thereof in such manner as he or she deems appropriate.

(5) The director may receive reports described in subsection (1) of this section for foreign or alien insurers from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subsection if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subsection, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subsection as a result of information sharing authorized by this section.

Source: Laws 1994, LB 978, § 3; Laws 2001, LB 52, § 55.

44-6304 Disclosure; when required; nonconsolidated basis.

(1) No acquisitions or dispositions of assets need be reported pursuant to section 44-6303 if the acquisitions or dispositions are not material. A material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period, or material disposition, or the aggregate of any series of related dispositions during any thirty-day period, shall mean one that is nonrecurring and not in the ordinary course of business and involves more

than five percent of the reporting insurer's total admitted assets as reported in its most recent financial statement filed with the director pursuant to section 44-322.

(2) Asset acquisitions subject to the Disclosure of Material Insurance Transactions Act shall include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose. Asset dispositions subject to the act shall include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(3) The following information shall be disclosed in any report of a material acquisition or disposition of assets:

(a) Date of the transaction;

(b) Manner of acquisition or disposition;

(c) Description of the assets involved;

(d) Nature and amount of the consideration given or received;

(e) Purpose of or reason for the transaction;

(f) Manner by which the amount of consideration was determined;

(g) Gain or loss recognized or realized as a result of the transaction; and

(h) Name of the person from whom the assets were acquired or to whom they were disposed.

(4) Insurers shall report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one-hundred-percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Source: Laws 1994, LB 978, § 4.

44-6305 Ceded reinsurance agreements; reporting requirements.

(1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported pursuant to section 44-6303 if the nonrenewals, cancellations, or revisions are not material. A material nonrenewal, cancellation, or revision shall mean one that affects for property and casualty business, including sickness and accident business when written as such, more than fifty percent of an insurer's ceded written premium, or for life, annuity, and sickness and accident business, more than fifty percent of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer's most recent financial statement filed with the director pursuant to section 44-322. No filing shall be required if the insurer's ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less

than ten percent of direct plus assumed written premium or ten percent of the statutory reserve requirement prior to any cession, respectively.

(2) Subject to the criteria in subsection (1) of this section, a report shall be filed without regard to which party has initiated the nonrenewal, cancellation, or revision of ceded reinsurance whenever one or more of the following conditions exist:

(a) The entire cession has been canceled, nonrenewed, or revised and ceded indemnity and loss adjustment expense reserves after any nonrenewal, cancellation, or revision represent less than fifty percent of the comparable reserves that would have been ceded had the nonrenewal, cancellation, or revision not occurred;

(b) An authorized reinsurer has been replaced on an existing cession by an unauthorized reinsurer; or

(c) Collateral requirements previously established for unauthorized reinsurers have been reduced.

Subject to the materiality criteria, for purposes of subdivisions (2)(b) and (c) of this section, a report shall be filed if the result of the revision affects more than ten percent of the cession.

(3) The following information shall be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) The effective date of the nonrenewal, cancellation, or revision;

(b) The description of the transaction with an identification of the initiator thereof;

(c) The purpose of or reason for the transaction; and

(d) If applicable, the identity of the replacement reinsurers.

(4) Insurers shall report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one-hundred-percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent of the insurer's capital and surplus.

Source: Laws 1994, LB 978, § 5.

44-6306 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Disclosure of Material Insurance Transactions Act.

Source: Laws 1994, LB 978, § 6.

ARTICLE 64

UNINSURED AND UNDERINSURED MOTORIST INSURANCE COVERAGE

Section

44-6401 Act, how cited.

Sections 44-6401 to 44-6414 shall be known and may be cited as the Uninsured and Underinsured Motorist Insurance Coverage Act.

Source: Laws 1986, LB 573, § 1; R.S.1943, (1988), § 60-571; Laws 1994, LB 1074, § 1.

The act did not apply where it was not in effect at the time the policies were issued to the insured. Polenz v. Farm Bureau Ins. Co., 227 Neb. 703, 419 N.W.2d 677 (1988).

44-6402 Definitions, where found.

For purposes of the Uninsured and Underinsured Motorist Insurance Coverage Act, the definitions found in sections 44-6403 to 44-6407 shall apply.

Source: Laws 1986, LB 573, § 2; R.S.1943, (1988), § 60-572; Laws 1994, LB 1074, § 2.

44-6403 Affiliated insurer, defined.

Affiliated insurer shall mean an insurer who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

Source: Laws 1986, LB 573, § 6; R.S.1943, (1988), § 60-576; Laws 1994, LB 1074, § 3.

44-6404 Motor vehicle, defined.

Motor vehicle shall mean a motor vehicle as defined in section 60-501.

Source: Laws 1986, LB 573, § 3; R.S.1943, (1988), § 60-573; Laws 1994, LB 1074, § 4.

44-6405 Uninsured motor vehicle, defined.

Uninsured motor vehicle shall mean a motor vehicle with respect to the ownership, operation, maintenance, or use of which:

(1) There is no bodily injury liability insurance or bond applicable at the time of the accident;

(2) There is bodily injury liability insurance or a bond applicable at the time of the accident but the insurer writing such insurance or bond (a) denies coverage or (b) is or becomes insolvent as described in section 44-2403 within four years after the time of the accident which occurred while the named insured's uninsured motorist coverage was in effect;

(3) The owner or operator is unknown and bodily injury, sickness, disease, or death of an insured results from actual physical contact between such motor vehicle and the insured or a motor vehicle occupied by the insured; or

(4) The owner or operator is unknown and bodily injury, sickness, disease, or death of an insured is caused by such motor vehicle without actual physical contact between such motor vehicle and the insured or a motor vehicle occupied by the insured if (a) the accident has been reported, as required by law, to the proper law enforcement authorities and (b) the facts of the accident can be corroborated by competent evidence provided by an independent and disinterested person and not by the insured or any person occupying the insured motor vehicle.

Source: Laws 1994, LB 1074, § 5; Laws 1996, LB 1008, § 1.

44-6406 Underinsured motor vehicle, defined.

Underinsured motor vehicle shall mean a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is bodily injury liability insurance or a bond applicable at the time of the accident and the amount of the insurance or bond is less than or has been reduced by payments to persons, other than an insured, injured in the accident to less than the damages for bodily injury, sickness, disease, or death sustained by the insured. Underinsured motor vehicle shall not include an uninsured motor vehicle.

Source: Laws 1986, LB 573, § 4; Laws 1990, LB 1136, § 123; R.S.Supp.,1992, § 60-574; Laws 1994, LB 1074, § 6.

44-6407 Uninsured or underinsured motor vehicle; exclusions.

An uninsured or underinsured motor vehicle shall not include a motor vehicle:

(1) Insured under the liability coverage of the same policy of which the uninsured or underinsured motorist coverage is a part;

(2) Owned by, furnished, or available for the regular use of the named insured or any resident of the insured's household;

(3) Which is self-insured under sections 60-562 to 60-564 or is self-insured within the meaning of the motor vehicle financial responsibility law of any other state in which the motor vehicle is registered or any federal law which requires maintenance of financial responsibility;

(4) Which is owned by any government, political subdivision, or agency thereof; or

(5) Which is located and used as a residence or premises and not as a vehicle.

Source: Laws 1986, LB 573, § 5; R.S.1943, (1988), § 60-575; Laws 1994, LB 1074, § 7.

A ''regular use'' exclusion in an automobile insurance policy, which mirrors the statutory exclusion, reflects the public policy of this state and is not void as against public policy. Alsidez v. American Family Mut. Ins. Co., 282 Neb. 890, 807 N.W.2d 184 (2011).

Nebraska's Uninsured and Underinsured Motorist Insurance Coverage Act specifically excludes government-owned vehicles from the definition of ''underinsured motor vehicle'' and thus permits exclusion of government-owned vehicles from the definition of ''underinsured motor vehicle'' in an automobile insurance policy. Continental Western Ins. Co. v. Conn, 262 Neb. 147, 629 N.W.2d 494 (2001).

44-6408 Motor vehicle liability policy; uninsured and underinsured motor vehicle insurance coverages; when required.

(1) No policy insuring against liability imposed by law for bodily injury, sickness, disease, or death suffered by a natural person arising out of the ownership, operation, maintenance, or use of a motor vehicle within the United States, its territories or possessions, or Canada shall be delivered, issued for delivery, or renewed with respect to any motor vehicle principally garaged in this state unless coverage is provided for the protection of persons insured who are legally entitled to recover compensatory damages for bodily injury, sickness, disease, or death from (a) the owner or operator of an uninsured motor vehicle in limits of twenty-five thousand dollars because of bodily injury, sickness, disease, or death of one person in any one accident and, subject to such limit for one person, fifty thousand dollars because of bodily injury, sickness, disease, or death of two or more persons in any one accident, and (b) the owner or operator of an underinsured motor vehicle in limits of twenty-five thousand dollars because of bodily injury, sickness, disease, or death of one person in any one accident and, subject to such limit for one person, fifty thousand dollars because of bodily injury, sickness, disease, or death of two or more persons in any one accident.

(2) At the written request of the named insured, the insurer shall provide higher limits of uninsured and underinsured motorist coverages in accordance with its rating plan and rules, except that in no event shall the insurer be required to provide limits higher than one hundred thousand dollars per person and three hundred thousand dollars per accident.

(3) After purchase of uninsured and underinsured motorist coverages, no insurer or any affiliated insurer shall be required to notify any policyholder in any renewal, reinstatement, substitute, amended, altered, modified, transfer, or replacement policy as to the availability of optional limits of such coverages. The named insured may, subject to the limitations of this section, make a written request for additional coverage or coverage more extensive than that provided in a prior policy.

Source: Laws 1986, LB 573, § 7; R.S.1943, (1988), § 60-577; Laws 1994, LB 1074, § 8; Laws 1996, LB 1008, § 2.

An insurer that provides higher underinsured motorist coverage limits than are required by subsection (2) of this section does not thereby escape the minimum requirements of the Uninsured and Underinsured Motorist Insurance Coverage Act. Likewise, an insured who pays for higher coverage does not forfeit the protections of the act. Kline v. Farmers Ins. Exch., 277 Neb. 874, 766 N.W.2d 118 (2009).

This section does not prevent insurers from entering into agreements with insureds providing more underinsured motorist coverage limits than those required by subsection (2) of this section. Kline v. Farmers Ins. Exch., 277 Neb. 874, 766 N.W.2d 118 (2009).

An insurance company's decision to limit both its liability and uninsured coverage for a person ''using'' a vehicle with the consent of the insured to those circumstances in which the use involves the operation and maintenance of the vehicle does not violate public policy. Jones v. Shelter Mut. Ins. Cos., 274 Neb. 186, 738 N.W.2d 840 (2007).

The minimum limit of uninsured benefits for non-named insureds is $25,000. Jones v. Shelter Mut. Ins. Cos., 274 Neb. 186, 738 N.W.2d 840 (2007).

Under this section, when an insurer delivers, issues for delivery, or renews an automobile liability policy, the policy must provide underinsured motorist coverage if Nebraska is the state where the insured intends to keep the vehicle most often compared to any other state during the policy period. Blair v. State Farm Ins. Co., 269 Neb. 874, 697 N.W.2d 266 (2005).

A named driver exclusion will not be applied in a manner that will deny an insured party uninsured or underinsured motorist coverage when the subject of the exclusion is not responsible for the injury and is not seeking coverage. Hood v. AAA Motor Club Ins. Assn., 259 Neb. 63, 607 N.W.2d 814 (2000).

''Persons insured'' are those persons insured under the liability provisions of a motor vehicle policy. Allied Mut. Ins. Co. v. Action Elec. Co., Inc., 256 Neb. 691, 593 N.W.2d 275 (1999).

44-6409 Maximum liability; limits of liability; how construed.

(1) The maximum liability of the insurer under the uninsured motorist coverage or the underinsured motorist coverage shall be the amount of damages for bodily injury, sickness, disease, or death sustained by the insured less the amount paid to the insured by or for any person or organization which may be held legally liable for the bodily injury, sickness, disease, or death, but in no event shall the maximum liability of the insurer under either such coverage be more than the limits of the coverage provided.

(2) The limits of liability of uninsured motorist coverage and underinsured motorist coverage shall not be reduced by the amount of benefits paid under any first party medical payments coverage portion of the policy. The uninsured motorist coverage and underinsured motorist coverage shall be excess over, and shall not pay again, any medical expenses already paid under the first party medical payments coverage portion of the policy.

Source: Laws 1986, LB 573, § 8; Laws 1990, LB 1136, § 124; R.S.Supp.,1992, § 60-578; Laws 1994, LB 1074, § 9; Laws 1997, LB 741, § 1.

Pursuant to a 1990 amendment to this section (transferred from section 60-578), an insured's own carrier must compensate the insured to the limit of the carrier's underinsured motorist coverage if, after payments by any other legally liable person or organization, the insured still has not been fully compensated for his or her injuries. This provision does not apply to claims that accrued before the effective date of the amendment. Shkolnick v. American Family Mut. Ins. Co., 2 Neb. App. 61, 506 N.W.2d 356 (1993).

44-6410 Stacking of coverage; prohibited; exception.

Regardless of the number of vehicles involved, persons covered, claims made, vehicles or premiums shown on the policy, or premiums paid, the limits of liability for uninsured or underinsured motorist coverage for two or more motor vehicles insured under the same policy or separate policies shall not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident except as provided in section 44-6411.

Source: Laws 1986, LB 573, § 9; R.S.1943, (1988), § 60-579; Laws 1994, LB 1074, § 10.

Policies shall not be stacked. American States Ins. Co. v. Farm Bureau Ins. Co., 7 Neb. App. 507, 583 N.W.2d 358 (1998).

44-6411 Maximum amount of recovery; multiple policies; priority of payment.

(1) In the event an insured is entitled to uninsured or underinsured motorist coverage under more than one policy of motor vehicle liability insurance, the maximum amount an insured may recover shall not exceed the highest limit of any one such policy.

(2) In the event of bodily injury, sickness, disease, or death of an insured while occupying a motor vehicle not owned by the insured, payment shall be made in the following order of priority, subject to the limitations in subsection (1) of this section: (a) The uninsured or underinsured motorist coverage on the occupied motor vehicle is primary; and (b) if such primary coverage is exhaust-

ed, other uninsured or underinsured motorist coverage available to the insured is excess.

(3) When multiple policies apply, payment shall be made in the following order of priority, subject to the limit of liability for each applicable policy:

(a) A policy covering a motor vehicle occupied by the injured person at the time of the accident;

(b) A policy covering a motor vehicle which causes bodily injury, sickness, disease, or death of the insured while a pedestrian; and

(c) A policy covering a motor vehicle not involved in the accident with respect to which the injured person is an insured.

Source: Laws 1986, LB 573, § 10; R.S.1943, (1988), § 60-580; Laws 1994, LB 1074, § 11.

Priority-of-payment provisions are not applicable in a case where the passenger in a motor vehicle collision was not an insured under the insurance policy of the vehicle in which he was an occupant at the time of his injury. Accordingly, the passenger is not entitled to benefits under more than one policy. Jones v. Shelter Mut. Ins. Cos., 274 Neb. 186, 738 N.W.2d 840 (2007).

This section establishes the maximum recovery of an insured in the specific circumstances where he or she is entitled to coverage under more than one underinsured motorist policy and, further, establishes the priority by which payments under such policies are to be made. Nicholson v. General Cas. Co. of Wis., 255 Neb. 937, 587 N.W.2d 867 (1999).

Stacking of uninsured motorist coverages is prohibited, and an insured's maximum recovery of uninsured motorist benefits is limited to the highest limit of any one applicable policy. Weston v. Continental Western Ins. Co., 14 Neb. App. 956, 720 N.W.2d 904 (2006).

This section provides for the amount of recovery and the priority of payment when there are multiple policies. American States Ins. Co. v. Farm Bureau Ins. Co., 7 Neb. App. 507, 583 N.W.2d 358 (1998).

44-6412 Insurer; payment; rights of insurer; agreement to settle; notice; subrogation.

(1) In the event of payment under the uninsured or underinsured motorist coverage, the insurer making such payment shall, to the extent of such payment, be entitled to the proceeds of any settlement or judgment to the extent such settlement or judgment exceeds the amount paid under any applicable bodily injury liability policy or bond.

(2) If a tentative agreement to settle for liability limits has been reached with the owner or operator of an underinsured motor vehicle, written notice shall be given by certified or registered mail to the underinsured motorist coverage insurer by its insured. Such notice shall include written documentation of lost wages, medical bills, and written authorization to obtain reports from all employers and medical providers. Within thirty days of receipt of such notice, the underinsured motorist coverage insurer may substitute its payment to the insured for the tentative settlement amount. The underinsured motorist coverage insurer shall then be subrogated to the insured's right of recovery to the extent of such payment and any settlement under the underinsured motorist coverage. If the underinsured motorist coverage insurer fails to pay the insured the amount of the tentative settlement within thirty days of receipt of such notice, the underinsured motorist coverage insurer shall have no right of subrogation for any amount paid under the underinsured motorist coverage.

(3) Whenever an insurer makes payment under uninsured or underinsured motorist coverage because of an insurer insolvency, as described in section 44-2403, the paying insurer's right of recovery or reimbursement shall not include any rights either against the insured of such insolvent insurer, except for the amount which is in excess of the limits of liability of the policy of the insolvent insurer, or against a guaranty account established pursuant to the Nebraska Property and Liability Insurance Guaranty Association Act.

Source: Laws 1986, LB 573, § 11; R.S.1943, (1988), § 60-581; Laws 1994, LB 1074, § 12.

Cross References

Nebraska Property and Liability Insurance Guaranty Association Act, see section 44-2418.

An insured must, within the statute of limitations and utilizing the procedures set forth in this section, file suit against or settle with all underinsured or uninsured tort-feasors involved in an automobile accident. Steffen v. Progressive Northern Ins. Co., 276 Neb. 378, 754 N.W.2d 730 (2008).

44-6413 Uninsured and underinsured motorist coverages; exceptions; exclusions; requirements; rules and regulations.

(1) The uninsured and underinsured motorist coverages provided in the Uninsured and Underinsured Motorist Insurance Coverage Act shall not apply to:

(a) Bodily injury, sickness, disease, or death of the insured with respect to which the insured or his or her representative makes, without the written consent of the insurer, any settlement with or obtains any judgment against any person who may be legally liable for any injuries if such settlement adversely affects the rights of the insurer, except that this subdivision shall not apply to underinsured motorist coverage when the insured has given notice to the insurer, in compliance with subsection (2) of section 44-6412, and the insurer has failed to make the required payment to protect its right of subrogation;

(b) Bodily injury, sickness, disease, or death of an insured while occupying a vehicle owned by, but not insured by, the named insured or a spouse or relative residing with the named insured;

(c) Bodily injury, sickness, disease, or death of an insured while occupying an owned vehicle which is used as a public or livery conveyance and which is not insured as such;

(d) Bodily injury, sickness, disease, or death of an insured through being struck by a vehicle owned by the named insured or a spouse or relative residing with the named insured; and

(e) Bodily injury, sickness, disease, or death of the insured with respect to which the applicable statute of limitations has expired on the insured's claim against the uninsured or underinsured motorist.

(2) Insurers providing motor vehicle liability insurance coverage on an excess or umbrella basis or incidental to some other basic coverage shall not be required to offer, provide, or make available coverage conforming to the Uninsured and Underinsured Motorist Insurance Coverage Act.

(3) An insurer may make underinsured motorist coverage a part of uninsured motorist coverage.

(4) Nothing in the Uninsured and Underinsured Motorist Insurance Coverage Act shall be construed to prevent an insurer from offering, making available, or providing coverage under terms and conditions more favorable to its insured or in limits higher than are required by the act.

(5) No policy subject to the Uninsured and Underinsured Motorist Insurance Coverage Act shall define insured, for purposes of the uninsured and underinsured coverages provided in the act, so as to exclude any person occupying the insured motor vehicle with the express or implied permission of an insured.

(6) The Director of Insurance shall adopt and promulgate rules and regulations as are necessary to provide that the language relating to coverages described in the Uninsured and Underinsured Motorist Insurance Coverage Act

is not unfair, inequitable, misleading, or deceptive and does not encourage misrepresentation of the coverage.

Source: Laws 1986, LB 573, § 12; R.S.1943, (1988), § 60-582; Laws 1994, LB 1074, § 13; Laws 2009, LB152, § 1.

1. Statute of limitations
2. Miscellaneous

1. Statute of limitations

An insured must, within the statute of limitations and utilizing the procedures set forth in section 44-6412, file suit against or settle with all underinsured or uninsured tort-feasors involved in an automobile accident. Steffen v. Progressive Northern Ins. Co., 276 Neb. 378, 754 N.W.2d 730 (2008).

Subdivision (1)(e) of this section does not apply if an insured timely files a claim against an uninsured or underinsured motorist, because the statute of limitations on the insured's claim against the uninsured or underinsured motorist never expired. Reimers-Hild v. State, 274 Neb. 438, 741 N.W.2d 155 (2007).

Subsection (1)(e) of this section does not apply when an insured has settled his or her claim against an uninsured or underinsured motorist before the statute of limitations applicable to that claim would have expired. Reimers-Hild v. State, 274 Neb. 438, 741 N.W.2d 155 (2007).

An insured fails to comply with subdivision (1)(e) when the statute of limitations on her claim against the uninsured or underinsured motorist expires prior to the filing of the suit against her insurer. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

Subdivision (1)(e) of this section applies in the situation where the insured's suit against the uninsured or underinsured motorist is dismissed without prejudice and the suit against the insurer is not filed within the applicable 4-year statute of limitations for actions in tort. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

Subdivision (1)(e) of this section does not apply in situations where the insured files suit against the tort-feasor within the applicable 4-year statute of limitations for actions in tort. In such a situation, the insured's suit for uninsured or underinsured motorist benefits is analyzed under the auspices of the 5-year statute of limitations for actions upon written contracts. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

Subdivision (1)(e) of this section serves to bar certain claims for uninsured and underinsured motorist coverage. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

Subdivision (1)(e) serves as a prerequisite to an insured's suit against the insurer for uninsured or underinsured motorist coverage. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

The dismissal of the insured's suit against the uninsured or underinsured motorist without prejudice does not toll the underlying 4-year statute of limitations for the purposes of subdivision (1)(e) of this section. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

The purpose of subdivision (1)(e) is to protect the insurer under circumstances where it may have to pay uninsured or underinsured motorist benefits by making it the responsibility of the insured to preserve the cause of action against the tort-feasor in order to protect the insurer's rights against the tort-feasor. Dworak v. Farmers Ins. Exch., 269 Neb. 386, 693 N.W.2d 522 (2005).

Subsection (1)(e) of this section operates as a bar to an action for uninsured motorist benefits where the insured claimant does not commence an action against the tort-feasor within the applicable limitations period. Where the injured party claiming underinsured motorist benefits commences a timely claim against the tort-feasor, the 5-year statute of limitations for actions on written contracts set forth in section 25-205 applies, not subsection (1)(e) of this section. Snyder v. Case and EMCASCO Ins. Co., 259 Neb. 621, 611 N.W.2d 409 (2000).

This section is a specific statute addressing the time period within which an uninsured or underinsured motorist coverage claim must be brought against the uninsured or underinsured motorist coverage insurer, and it controls over section 25-205 (5-year statute of limitations) in situations where the applicable statute of limitations has expired on the insured's underlying claim against the uninsured or underinsured motorist. When the statute of limitations has not expired on the insured's underlying claim, section 25-205, which provides for a 5-year statute of limitations on written contracts, is the governing statute of limitations and this section is inapplicable. Schrader v. Farmers Mut. Ins. Co., 259 Neb. 87, 608 N.W.2d 194 (2000).

Subsection (1)(e) of this section operates as a statute of limitations by creating a specific limitation period for actions against insurers for uninsured motorist benefits. Subsection (1)(e) of this section limits liability of insurer to period of time during which insured still has viable claim against uninsured motorist. Kratochvil v. Motor Club Ins. Assn., 255 Neb. 977, 588 N.W.2d 565 (1999).

2. Miscellaneous

Unless one of the exclusions set forth in this section applies, an insured is entitled to recover for injuries sustained in any accident, so long as the injuries were caused by an uninsured or underinsured motor vehicle. In other words, the exclusions provided by the Uninsured and Underinsured Motorist Insurance Coverage Act in this section are the only exceptions permitted to the coverage mandated by the act. Kline v. Farmers Ins. Exch., 277 Neb. 874, 766 N.W.2d 118 (2009).

An uninsured or underinsured motorist policy that excluded coverage for vehicles owned by the insured, but not covered under ''this policy'' did not violate this section or public policy. Van Ert v. State Farm Mut. Auto. Ins. Co., 276 Neb. 908, 758 N.W.2d 36 (2008).

If the insured is injured in a ''motor vehicle'' that the insured or a family member residing with the insured could have insured, but did not, then uninsured/underinsured motorist coverage will not be mandated for injuries arising out of that accident. Steffen v. Progressive Northern Ins. Co., 276 Neb. 378, 754 N.W.2d 730 (2008).

Subsection (1)(e) of this section does not require that the insured file an action against or settle with all motorists tangentially involved in an accident, and uninsured or underinsured motorist coverage is not barred where the person alleged to have been ''the uninsured or underinsured motorist'' was not, in fact a tort-feasor against whom the motorist had any ''claim.'' Steffen v. Progressive Northern Ins. Co., 276 Neb. 378, 754 N.W.2d 730 (2008).

Unless one of the exclusions set forth in this section applies, an insured is entitled to recover for injuries sustained in any accident, so long as the injuries were caused by an ''underinsured motor vehicle'' or an ''uninsured motor vehicle.'' Steffen v. Progressive Northern Ins. Co., 276 Neb. 378, 754 N.W.2d 730 (2008).

The purpose of subsection (1)(e) of this section is the protection of the insurer when it may have to pay uninsured or underinsured motorist benefits. This section makes it the responsibility of the insured to preserve the claim against the tort-feasor in order to protect the insurer's rights against the tort-feasor. Reimers-Hild v. State, 274 Neb. 438, 741 N.W.2d 155 (2007).

This section is irrelevant when the party seeking coverage under an uninsured motorist policy provision is not a named insured of that policy. Hillabrand v. American Fam. Mut. Ins. Co., 271 Neb. 585, 713 N.W.2d 494 (2006).

The term ''settlement'' as used in subsection (1)(a) of this section means that the parties to a controversy must come to an agreement that is a final resolution of the controversy. Horace Mann Cos. v. Pinaire, 248 Neb. 640, 538 N.W.2d 168 (1995).

Insurers providing excess or umbrella coverage need not provide uninsured motorist coverage, and insurers may make underinsured motorist coverage part of uninsured motorist coverage. American States Ins. Co. v. Farm Bureau Ins. Co., 7 Neb. App. 507, 583 N.W.2d 358 (1998).

44-6414 Rules and regulations.

The Director of Insurance may adopt and promulgate rules and regulations to carry out the Uninsured and Underinsured Motorist Insurance Coverage Act.

Source: Laws 1994, LB 1074, § 14.

The Director of Insurance shall adopt and promulgate the carrying out of the provisions of the Uninsured and Underinsured Motorist Insurance Coverage Act. American States Ins. Co. v. Farm Bureau Ins. Co., 7 Neb. App. 507, 583 N.W.2d 358 (1998).

ARTICLE 65

INTERSTATE INSURANCE RECEIVERSHIP COMPACT

Section
44-6501. Repealed. Laws 2006, LB 875, § 24.

44-6501 Repealed. Laws 2006, LB 875, § 24.

ARTICLE 66

INSURANCE FRAUD

Section
44-6601. Act, how cited.
44-6602. Purpose of act.
44-6603. Terms, defined.
44-6604. Fraudulent insurance acts; enumerated.
44-6605. Immunity from civil liability.
44-6606. Insurance Fraud Prevention Division; powers and duties; public inspection; limitations; fee.
44-6607. Civil penalty; costs; section, how construed.
44-6608. Act, how construed.

44-6601 Act, how cited.

Sections 44-6601 to 44-6608 shall be known and may be cited as the Insurance Fraud Act.

Source: Laws 1995, LB 385, § 1.

44-6602 Purpose of act.

The purpose of the Insurance Fraud Act is to confront the problem of insurance fraud in Nebraska by facilitating the detection of insurance fraud, eliminating the occurrence of insurance fraud through the development of fraud prevention programs, authorizing imposition of civil penalties, authorizing restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.

Source: Laws 1995, LB 385, § 2.

44-6603 Terms, defined.

For purposes of the Insurance Fraud Act:

(1) Department means the Department of Insurance;

(2) Director means the Director of Insurance;

(3) Insurer means any person or entity transacting insurance as defined in section 44-102 with or without a certificate of authority issued by the director. Insurer also means health maintenance organizations, legal service insurance corporations, prepaid limited health service organizations, dental and other similar health service plans, discount medical plan organizations, and entities licensed pursuant to the Intergovernmental Risk Management Act and the Comprehensive Health Insurance Pool Act. Insurer also means an employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer; and

(4) Statement includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical records, X-rays, test result, or other evidence of loss, injury, or expense, whether oral, written, or computer-generated.

Source: Laws 1995, LB 385, § 3; Laws 1997, LB 272, § 2; Laws 2002, LB 547, § 2; Laws 2008, LB855, § 31.

Cross References

Comprehensive Health Insurance Pool Act, see section 44-4201.
Intergovernmental Risk Management Act, see section 44-4301.

44-6604 Fraudulent insurance acts; enumerated.

For purposes of the Insurance Fraud Act, a person or entity commits a fraudulent insurance act if he or she:

(1) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any agent of an insurer, any statement as part of, in support of, or in denial of a claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(2) Assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit from an insurer or pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim;

(3) Makes any false or fraudulent representations as to the death or disability of a policy or certificate holder or a covered person in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

(4) Knowingly and willfully transacts any contract, agreement, or instrument which violates this section;

(5) Receives money for the purpose of purchasing insurance and converts the money to the person's own benefit;

(6) Willfully embezzles, abstracts, purloins, misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance;

(7) Knowingly and with intent to defraud or deceive issues or possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(8) Knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the department;

(9) Knowingly and with intent to defraud or deceive removes, conceals, alters, diverts, or destroys assets or records of an insurer or person engaged in the business of insurance or attempts to remove, conceal, alter, divert, or destroy assets or records of an insurer or person engaged in the business of insurance;

(10) Knowingly and with the intent to defraud or deceive provides false, incomplete, or misleading information to an insurer concerning the number, location, or classification of employees for the purpose of lessening or reducing the premium otherwise chargeable for workers' compensation insurance coverage;

(11) Willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 44-8306; or

(12) Willfully collects fees for purported membership in a discount medical plan but purposefully fails to provide the promised benefits.

Source: Laws 1995, LB 385, § 4; Laws 1997, LB 272, § 3; Laws 2002, LB 547, § 3; Laws 2008, LB855, § 32; Laws 2009, LB208, § 2.

44-6605 Immunity from civil liability.

(1) Any person or entity, including the department, an insurer, or a person employed by or authorized by an insurer whose activities include the investigation of or reporting of suspected insurance fraud, acting without malice, fraudulent intent, or bad faith shall be immune from civil liability for furnishing any information relating to suspected fraudulent insurance acts to:

(a) The director or his or her agents or employees;

(b) Law enforcement officials or their agents or employees;

(c) The Nebraska Workers' Compensation Court or its agents or employees;

(d) Persons or entities subject to Chapter 44 or their agents or employees; or

(e) The National Association of Insurance Commissioners or any organization established to detect and prevent fraudulent insurance acts or its agents, employees, or designees.

(2) This section does not abrogate or modify in any way any common-law or statutory privilege or immunity.

Source: Laws 1995, LB 385, § 5; Laws 1997, LB 272, § 4.

44-6606 Insurance Fraud Prevention Division; powers and duties; public inspection; limitations; fee.

(1) In order to investigate activities involving insurance fraud, the director shall appoint a sufficient staff to be known as the Insurance Fraud Prevention Division.

(2)(a) As specified by the director, division investigators who are certified law enforcement officers of the State of Nebraska shall be vested with the authority

and power of a peace officer to carry out the laws of this state administered by the director. The general laws of this state applicable to peace officers shall be applicable to such investigators. Such investigators shall be empowered, among other powers, to search and arrest with or without a warrant, file and serve any lien, seize property, serve and return a summons, warrant, or subpoena issued by a court of law or the director, and bring an offender before any court with jurisdiction in this state, except that such investigators shall not be authorized to enforce any laws other than laws administered by the director.

(b) Subdivision (a) of this subsection shall not be construed to restrict any other law enforcement officer of this state from enforcing any state law, insurance or otherwise.

(3) The division shall:

(a) Initiate independent inquiries and conduct independent investigations when the division has cause to believe that an act of insurance fraud has been or is currently being committed;

(b) Review reports or complaints of alleged insurance fraud to determine whether such reports require further investigation and to conduct such investigation;

(c) Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts; and

(d) Cooperate with federal, state, and local law enforcement, prosecuting attorneys, and the Attorney General in the investigation and prosecution of insurance fraud violations. At the request of the division, through the director, the Attorney General shall prosecute fraudulent insurance acts through criminal or civil proceedings as authorized by the Insurance Fraud Act if, after investigation, the Attorney General is convinced that there is sufficient legal merit to justify the proceeding. The Attorney General, after consultation with the director, may refer cases of fraudulent insurance acts to a special assistant attorney general or county attorney for prosecution. Any costs directly associated with the prosecution and attorney's fees for any special assistant attorney general shall be paid by the division.

(4)(a) The director or his or her designee may: Administer oaths and affirmations; subpoena witnesses; compel attendance of witnesses; take evidence; and require the production of any books, papers, correspondence, memoranda, agreements, documents, records, and other tangible things which constitute or contain evidence that is deemed relevant or material to an investigation or enforcement of the Insurance Fraud Act, when it shall appear that such action is necessary and proper. The attendance of witnesses and the production of records shall be required from any place within the State of Nebraska. Witnesses summoned by the director or by his or her designee shall be paid the same fees that are paid witnesses in the courts of the State of Nebraska and mileage at the rate provided in section 81-1176.

(b) A subpoena of the director or of his or her designee may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by certified mail or personal delivery of the subpoena to him or her. Service may be made upon a domestic or foreign insurer, corporation, or partnership, upon a domestic or foreign limited liability company, or upon any other unincorporated association which is subject to suit under a common name, or any other entity by delivering the subpoena to an officer, a managing

or general agent, a member, or any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

(c) If any person refuses to obey a subpoena issued by the director or by his or her designee, the director or his or her designee may invoke the aid of any court of the State of Nebraska within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, carries on business, or may otherwise be found, to compel compliance with such subpoena.

(d) The court may issue an order requiring the subpoenaed person to appear before the director or his or her designee to produce records, if so ordered, or to give testimony concerning the matter under investigation. Nothing in this section shall be construed to suspend or otherwise interfere with the operation of the Free Flow of Information Act.

(e) Any failure to obey the order of the court may be punished by the court as contempt. All process in any such case may be served in the judicial district in which the subpoenaed person is an inhabitant, carries on business, or may otherwise be found.

(5) If the division seeks evidence, documentation, or related materials located outside this state pertinent to an investigation or examination, it may designate representatives or deputies, including officials of the state where the matter is located, to secure and inspect the evidence, documentation, or materials on its behalf.

(6) The papers, documents, reports, and evidence of the department regarding the subject of an investigation of insurance fraud shall not be subject to public inspection for so long as the director deems reasonably necessary to complete the investigation or to protect the person investigated from unwarranted injury or so long as the director deems it to be in the public interest. Such papers, documents, reports, and evidence regarding the subject of an investigation of insurance fraud shall not be subject to subpoena until they are opened for public inspection by the department, unless the director consents, or until after notice to the department and a hearing, the court determines the department would not be unnecessarily hindered by such subpoena. Department investigators shall not be subject to subpoena in civil actions by any court of this state to testify concerning any matter of which they have knowledge regarding a pending insurance fraud investigation by the department.

(7)(a) The director may provide the papers, documents, reports, and evidence described in subsection (6) of this section to other state, federal, foreign, and international regulatory and law enforcement agencies and the National Association of Insurance Commissioners and its affiliates and subsidiaries if the recipient agrees in writing to maintain the confidentiality of the information.

(b) The director may receive papers, documents, reports, and evidence described in subsection (6) of this section from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain as confidential or privileged information received pursuant to this subdivision if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to

disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

(8)(a) On or before March 1 each year, each insurer as defined in section 44-103 holding a certificate of authority to transact the business of insurance in this state shall pay a fee as established by the director not to exceed two hundred dollars to the director to be remitted to the State Treasurer for credit to the Department of Insurance Cash Fund, which fees may be appropriated only to carry out the purposes of the Insurance Fraud Act. Assessment associations and unincorporated mutual associations shall not be subject to this subsection.

(b) On or before March 1 each year, each employer who is approved by the Nebraska Workers' Compensation Court as a self-insurer shall pay a fee as established by the director not to exceed one thousand dollars to the Nebraska Workers' Compensation Court to be remitted to the State Treasurer for credit to the Department of Insurance Cash Fund, which fees may be appropriated only to carry out the purposes of the Insurance Fraud Act. Willful refusal by any such self-insurer to pay the fee required under this subdivision shall be grounds for the compensation court to suspend or revoke the approval of such self-insurer to provide self-insurance coverage of workers' compensation liability pursuant to section 48-145.

Source: Laws 1994, LB 1074, § 15; R.S.Supp.,1994, § 44-112.01; Laws 1995, LB 385, § 6; Laws 1996, LB 969, § 9; Laws 1997, LB 272, § 5; Laws 2001, LB 52, § 56; Laws 2002, LB 547, § 4.

Cross References

Free Flow of Information Act, see section 20-147.

44-6607 Civil penalty; costs; section, how construed.

(1) A person or entity who is found by a court of competent jurisdiction, pursuant to an action initiated by the Director of Insurance, to have committed a fraudulent insurance act set forth in section 44-6604 is subject to a civil penalty not to exceed five thousand dollars for the first violation, ten thousand dollars for the second violation, and fifteen thousand dollars for each subsequent violation. An action under this section shall be in lieu of a prosecution under section 28-631.

(2) Costs and expenses incurred in any investigation or other action arising out of a violation under the Insurance Fraud Act may be sought in any judgment, court decree, or other final result. Any recovered costs, except civil or criminal penalties, shall be deposited by the director in the fund from which the costs were expended. The court may make such additional orders or judgments as may be necessary to restore to any person in interest any compensation which may have been acquired by means of any act prohibited in section 44-6604.

(3) This section shall not be construed to prohibit the director and the alleged violator from entering into a written agreement upon commencement of a civil action in which the alleged violator does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding relating to any violation of the act.

Source: Laws 1995, LB 385, § 7.

44-6608 Act, how construed.

The Insurance Fraud Act does not:

(1) Preempt the authority or relieve the duty of any other law enforcement agency to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency;

(3) Limit any of the powers granted elsewhere by the laws of this state to the Director of Insurance or the Department of Insurance to investigate and examine possible violations of law and to take appropriate action; or

(4) Limit any of the powers granted elsewhere by the laws of this state to the Nebraska Workers' Compensation Court to investigate and examine possible violations of law and to take appropriate action.

Source: Laws 1995, LB 385, § 8.

ARTICLE 67

HEALTH CARE PURCHASING POOL ACT

Section
44-6701. Act, how cited.
44-6702. Legislative intent.
44-6703. Repealed. Laws 1996, LB 1044, § 985.
44-6704. Repealed. Laws 1996, LB 1044, § 985.

44-6701 Act, how cited.

Sections 44-6701 and 44-6702 shall be known and may be cited as the Health Care Purchasing Pool Act.

Source: Laws 1995, LB 837, § 5; Laws 1996, LB 1044, § 259.

44-6702 Legislative intent.

The Legislature recognizes that a pooling mechanism offers the potential to purchase health care at more affordable prices. The Legislature further recognizes that health care purchasing pools do not require that all groups have the same type of health care coverage or benefits and that many options are available.

It is the intent of the Legislature to establish a process to determine whether there should be a coordinated purchasing process for some or all publicly sponsored health care coverage in order to reduce costs and to promote the most efficient methods of financing and coordinating health care services. It is also the intent of the Legislature that the process established also determine whether a health care purchasing pool if established should be made available to individuals, small employer groups, and other associations.

Source: Laws 1995, LB 837, § 6.

44-6703 Repealed. Laws 1996, LB 1044, § 985.

44-6704 Repealed. Laws 1996, LB 1044, § 985.

ARTICLE 68
EMERGENCY MEDICAL SERVICES

(a) MANAGED CARE EMERGENCY SERVICES ACT

Section
44-6801. Transferred to section 44-6825.
44-6802. Transferred to section 44-6826.
44-6803. Repealed. Laws 1998, LB 1162, § 90.
44-6804. Repealed. Laws 1998, LB 1162, § 90.
44-6805. Repealed. Laws 1998, LB 1162, § 90.
44-6806. Repealed. Laws 1998, LB 1162, § 90.
44-6807. Repealed. Laws 1998, LB 1162, § 90.
44-6808. Repealed. Laws 1998, LB 1162, § 90.
44-6809. Repealed. Laws 1998, LB 1162, § 90.
44-6810. Repealed. Laws 1998, LB 1162, § 90.
44-6811. Repealed. Laws 1998, LB 1162, § 90.
44-6812. Repealed. Laws 1998, LB 1162, § 90.
44-6813. Repealed. Laws 1998, LB 1162, § 90.
44-6814. Repealed. Laws 1998, LB 1162, § 90.
44-6815. Repealed. Laws 1998, LB 1162, § 90.
44-6816. Repealed. Laws 1998, LB 1162, § 90.
44-6817. Repealed. Laws 1998, LB 1162, § 90.
44-6818. Repealed. Laws 1998, LB 1162, § 90.
44-6819. Repealed. Laws 1998, LB 1162, § 90.
44-6820. Transferred to section 44-6828.
44-6821. Repealed. Laws 1998, LB 1162, § 90.
44-6822. Repealed. Laws 1998, LB 1162, § 90.
44-6823. Transferred to section 44-6829.
44-6824. Repealed. Laws 1998, LB 1162, § 90.
44-6825. Act, how cited.
44-6826. Purpose of act.
44-6827. Terms, defined.
44-6828. Applicability of act.
44-6829. Health carrier; emergency services; how treated.
44-6830. Health carrier violation; notice; hearing.
44-6831. Violation; penalty.
44-6832. Violation of cease and desist order; penalty.
44-6833. Rules and regulations.

(b) OUT-OF-NETWORK EMERGENCY MEDICAL CARE ACT

44-6834. Act, how cited.
44-6835. Definitions, where found.
44-6836. Covered person, defined.
44-6837. Emergency medical condition, defined.
44-6838. Emergency services, defined.
44-6839. Health benefits plan, defined.
44-6840. Health care facility, defined.
44-6841. Health care professional, defined.
44-6842. Health care provider, defined.
44-6843. Insurer, defined.
44-6844. Medical assistance program, defined.
44-6845. Medically necessary, defined.
44-6846. TRICARE, defined.
44-6847. Emergency services; facility, bill; limitation.
44-6848. Emergency services; health care provider, bill; limitation.
44-6849. Emergency services; insurer; duties; payment; presumed reasonable; dispute resolution procedure.

Section
44-6850. Settlement, negotiation; mediation, when.

(a) MANAGED CARE EMERGENCY SERVICES ACT

44-6801 Transferred to section 44-6825.

44-6802 Transferred to section 44-6826.

44-6803 Repealed. Laws 1998, LB 1162, § 90.

44-6804 Repealed. Laws 1998, LB 1162, § 90.

44-6805 Repealed. Laws 1998, LB 1162, § 90.

44-6806 Repealed. Laws 1998, LB 1162, § 90.

44-6807 Repealed. Laws 1998, LB 1162, § 90.

44-6808 Repealed. Laws 1998, LB 1162, § 90.

44-6809 Repealed. Laws 1998, LB 1162, § 90.

44-6810 Repealed. Laws 1998, LB 1162, § 90.

44-6811 Repealed. Laws 1998, LB 1162, § 90.

44-6812 Repealed. Laws 1998, LB 1162, § 90.

44-6813 Repealed. Laws 1998, LB 1162, § 90.

44-6814 Repealed. Laws 1998, LB 1162, § 90.

44-6815 Repealed. Laws 1998, LB 1162, § 90.

44-6816 Repealed. Laws 1998, LB 1162, § 90.

44-6817 Repealed. Laws 1998, LB 1162, § 90.

44-6818 Repealed. Laws 1998, LB 1162, § 90.

44-6819 Repealed. Laws 1998, LB 1162, § 90.

44-6820 Transferred to section 44-6828.

44-6821 Repealed. Laws 1998, LB 1162, § 90.

44-6822 Repealed. Laws 1998, LB 1162, § 90.

44-6823 Transferred to section 44-6829.

44-6824 Repealed. Laws 1998, LB 1162, § 90.

44-6825 Act, how cited.

Sections 44-6825 to 44-6833 shall be known and may be cited as the Managed Care Emergency Services Act.

Source: Laws 1997, LB 279, § 1; R.S.Supp.,1997, § 44-6801; Laws 1998, LB 1162, § 17.

44-6826 Purpose of act.

The purpose of the Managed Care Emergency Services Act is to establish standards for health carriers that offer managed care plans to provide for access by covered persons to and delivery of emergency services.

Source: Laws 1997, LB 279, § 2; R.S.Supp.,1997, § 44-6802; Laws 1998, LB 1162, § 18.

44-6827 Terms, defined.

For purposes of the Managed Care Emergency Services Act:

(1) Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan;

(2) Covered benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) Director means the Director of Insurance;

(5) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(6) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(7) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facilities does not include physicians' offices;

(8) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(9) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law;

(10) Health care provider means a health care professional or a facility;

(11) Health care services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(12) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other

entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(13) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(14) Network means the group of participating providers providing services to a managed care plan;

(15) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(16) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(17) Person means an individual, a corporation, a partnership, an association, a joint venture, joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing; and

(18) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.

Source: Laws 1998, LB 1162, § 19.

44-6828 Applicability of act.

The Managed Care Emergency Services Act applies to all health carriers that offer managed care plans.

Source: Laws 1997, LB 279, § 20; R.S.Supp.,1997, § 44-6820; Laws 1998, LB 1162, § 20.

44-6829 Health carrier; emergency services; how treated.

(1) A health carrier which provides a covered benefit for emergency services is, subject to the terms and conditions of the health benefit plan, responsible for charges for medically necessary emergency services provided to a covered person, including services furnished outside the network and services deemed approved under subsection (2) of this section.

(2) If a treating physician or other emergency department personnel who have provided emergency services to a covered person determine that addition-

al medically necessary services are promptly needed by the covered person and they have requested health carrier approval for such services, the health carrier is deemed to have approved the request if the treating physician or other emergency department personnel involved:

(a) Has made a reasonable effort to contact the individual at the health carrier authorized to approve such requests and the health carrier has not provided access to that individual; or

(b) Has requested authorization from the individual at the health carrier authorized to approve such requests and the individual has not denied authorization within thirty minutes after the time the request was made, unless the health carrier can document that it had made a good faith effort but was unable to reach the emergency physician within thirty minutes after receiving a request for authorization.

A request which is deemed approved under this subsection shall be treated as approval for any medically necessary covered benefits that are required to treat the medical condition identified by the treating physician or other emergency department personnel.

(3) A health carrier may impose a reasonable copayment for emergency services to deter inappropriate use of services of hospital emergency departments if the copayment is the same without regard to whether the health care provider has a contractual or other arrangement with the health carrier.

Source: Laws 1997, LB 279, § 23; R.S.Supp.,1997, § 44-6823; Laws 1998, LB 1162, § 21.

44-6830 Health carrier violation; notice; hearing.

If the director finds that any health carrier doing business in this state is engaging in any violation of the Managed Care Emergency Services Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Source: Laws 1998, LB 1162, § 22.

44-6831 Violation; penalty.

If, after the hearing, the director finds a health carrier has violated the Managed Care Emergency Services Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Managed Care Emergency Services Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Source: Laws 1998, LB 1162, § 23.

44-6832 Violation of cease and desist order; penalty.

Any health carrier who violates a cease and desist order of the director under section 44-6831 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Source: Laws 1998, LB 1162, § 24.

44-6833 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Managed Care Emergency Services Act.

Source: Laws 1998, LB 1162, § 25.

(b) OUT-OF-NETWORK EMERGENCY MEDICAL CARE ACT

44-6834 Act, how cited.

Sections 44-6834 to 44-6850 shall be known and may be cited as the Out-of-Network Emergency Medical Care Act.

Source: Laws 2020, LB997, § 1.

44-6835 Definitions, where found.

For purposes of the Out-of-Network Emergency Medical Care Act, the definitions found in sections 44-6836 to 44-6846 apply.

Source: Laws 2020, LB997, § 2.

44-6836 Covered person, defined.

Covered person means a person on whose behalf an insurer is obligated to pay health care expense benefits or provide health care services.

Source: Laws 2020, LB997, § 3.

44-6837 Emergency medical condition, defined.

Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (2) serious impairment to such person's bodily functions, (3)

serious impairment of any bodily organ or part of such person, or (4) serious disfigurement of such person.

Source: Laws 2020, LB997, § 4.

44-6838 Emergency services, defined.

Emergency services means health care services medically necessary to screen and stabilize a covered person in connection with an emergency medical condition.

Source: Laws 2020, LB997, § 5.

44-6839 Health benefits plan, defined.

(1) Health benefits plan means a benefits plan which pays or provides hospital and medical expense benefits for covered services and is delivered or issued for delivery in this state by or through an insurer.

(2) Health benefits plan does not include the medical assistance program, medicare, medicare advantage, accident-only, credit, disability, or long-term care coverage, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance, and hospital confinement indemnity coverage.

Source: Laws 2020, LB997, § 6.

44-6840 Health care facility, defined.

Health care facility means a general acute hospital, satellite emergency department, or ambulatory surgical center licensed pursuant to the Health Care Facility Licensure Act.

Source: Laws 2020, LB997, § 7.

Cross References

Health Care Facility Licensure Act, see section 71-401.

44-6841 Health care professional, defined.

Health care professional means an individual who is credentialed pursuant to the Uniform Credentialing Act, who is acting within the scope of his or her credential, and who provides a covered service defined by the health benefits plan.

Source: Laws 2020, LB997, § 8.

Cross References

Uniform Credentialing Act, see section 38-101.

44-6842 Health care provider, defined.

Health care provider means a health care professional or health care facility.

Source: Laws 2020, LB997, § 9.

44-6843 Insurer, defined.

Insurer means an entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefits plan, including (1) any individual or group sickness and accident insurance

policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for a policy that provides coverage for a specified disease or other limited-benefit coverage, and (2) any self-funded employee benefit plan to the extent not preempted by federal law.

Source: Laws 2020, LB997, § 10.

44-6844 Medical assistance program, defined.

Medical assistance program means the medical assistance program established pursuant to the Medical Assistance Act.

Source: Laws 2020, LB997, § 11.

Cross References

Medical Assistance Act, see section 68-901.

44-6845 Medically necessary, defined.

Medically necessary means a health care service that a health care provider, exercising his or her prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing, or treating an illness, an injury, or a disease, or its symptoms, and that is in accordance with the generally accepted standards of medical practice; that is clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; that is not primarily for the convenience of the covered person or the health care provider; and that is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease.

Source: Laws 2020, LB997, § 12.

44-6846 TRICARE, defined.

TRICARE means a health care program of the United States Department of Defense Military Health System.

Source: Laws 2020, LB997, § 13.

44-6847 Emergency services; facility, bill; limitation.

If a covered person receives emergency services at any health care facility, the facility shall not bill the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

Source: Laws 2020, LB997, § 14.

44-6848 Emergency services; health care provider, bill; limitation.

If a covered person receives emergency services at an in-network or out-of-network health care facility, the health care provider performing those services shall not bill the covered person in excess of any deductible, copayment, or coinsurance amount applicable to in-network services pursuant to the covered person's health benefits plan.

Source: Laws 2020, LB997, § 15.

44-6849 Emergency services; insurer; duties; payment; presumed reasonable; dispute resolution procedure.

(1) If a covered person receives emergency services at an in-network or out-of-network health care facility, the insurer shall ensure that the covered person incurs no greater out-of-pocket costs than the covered person would have incurred with an in-network health care provider for covered services.

(2) With respect to emergency services at an in-network or out-of-network health care facility, if the out-of-network health care provider bills an insurer directly, any reimbursement paid by the insurer shall be paid directly to the out-of-network health care provider. The insurer shall provide the out-of-network health care provider with a written remittance of payment that specifies the proposed reimbursement and the applicable deductible, copayment, or coinsurance amounts owed by the covered person.

(3) If emergency services provided at an in-network or out-of-network health care facility are performed, the out-of-network health care provider may bill the insurer for the services rendered. The insurer may pay the billed amount. A claim or a payment shall be presumed reasonable if it is based on the higher of (a) the contracted rate under any then-existing in-network contractual relationship between the insurer and the out-of-network health care provider for the same or similar services or (b) one hundred seventy-five percent of the payment rate for medicare services received from the federal Centers for Medicare and Medicaid Services for the same or similar services in the same geographic area. If the out-of-network health care provider deems the payment made by the insurer unreasonable, the out-of-network health care provider shall return payment to the insurer and utilize the dispute resolution procedure under section 44-6850.

Source: Laws 2020, LB997, § 16.

44-6850 Settlement, negotiation; mediation, when.

(1) If an insurer or an out-of-network health care provider provides notification that it considers a claim or payment to be not reasonable, the insurer and the health care provider shall have thirty days after the date of such notification to negotiate a settlement. If a settlement has not been reached after such thirty-day period, the insurer and the health care provider shall engage in mediation in accordance with the Uniform Mediation Act. The insurer may attempt to negotiate a final reimbursement amount with the out-of-network health care provider which differs from the amount paid by the insurer pursuant to this section.

(2) Following completion of the mediation process, the cost of mediation shall be split evenly and paid by the insurer and the health care provider.

(3) Mediation shall not be used when the insurer and the health care provider agree to a separate payment arrangement.

Source: Laws 2020, LB997, § 17.

Cross References

Uniform Mediation Act, see section 25-2930.

ARTICLE 69
GROUP HEALTH PLANS

Section

44-6901 Definitions, where found.

For purposes of sections 44-6901 to 44-6918, the definitions found in sections 44-6902 to 44-6915.01 shall be used.

Source: Laws 1997, LB 862, § 1; Laws 2000, LB 1253, § 38; Laws 2002, LB 1139, § 44.

44-6902 Affiliation period, defined.

Affiliation period means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.

Source: Laws 1997, LB 862, § 2.

44-6903 Church plan, defined.

Church plan means a plan as defined under 29 U.S.C. 1002.

Source: Laws 1997, LB 862, § 3.

44-6904 Creditable coverage, defined.

(1) Creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act;

(d) Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., other than coverage consisting solely of benefits under section 1928 of the act, 42 U.S.C. 1396s;

(e) 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003;

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

(h) A health plan offered under 5 U.S.C. 8901 et seq.;

(i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and

(j) A health benefit plan under 22 U.S.C. 2504.

(2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage.

(3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on April 19, 1998.

Source: Laws 1997, LB 862, § 4; Laws 1998, LB 1035, § 13; Laws 2003, LB 6, § 4.

44-6905 Director, defined.

Director means the Director of Insurance.

Source: Laws 1997, LB 862, § 5.

44-6905.01 Enrollment date, defined.

Enrollment date means the first day of coverage in the health benefit plan or, if earlier, the first day of the waiting period.

Source: Laws 2000, LB 1253, § 39.

44-6906 Governmental plan, defined.

Governmental plan means a plan as defined under 29 U.S.C. 1002 and any plan maintained for its employees by the United States Government or by any agency or instrumentality of the United States Government.

Source: Laws 1997, LB 862, § 6.

44-6907 Group health plan, defined.

Group health plan means an employee welfare benefit plan as defined by 29 U.S.C. 1002 to the extent that the plan provides any hospital, surgical, or medical expense benefits to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

Source: Laws 1997, LB 862, § 7.

44-6908 Health benefit plan, defined.

(1) Health benefit plan means any employer group hospital or medical policy or certificate or employer group health maintenance organization subscriber contract.

(2) Health benefit plan does not include one or more, or any combination, of the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for onsite medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) Health benefit plan does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited-scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) Health benefit plan does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor, and such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) Health benefit plan does not include the following if it is offered as a separate policy, certificate, or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

Source: Laws 1997, LB 862, § 8; Laws 2003, LB 6, § 5.

44-6909 Health carrier, defined.

Health carrier means any entity that provides a health benefit plan including an insurance company, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

Source: Laws 1997, LB 862, § 9.

44-6909.01 Health maintenance organization, defined.

Health maintenance organization means a person that undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles or both.

Source: Laws 2002, LB 1139, § 45.

44-6910 Health-status-related factor, defined.

Health-status-related factor means any of the following factors:

(1) Health status;

(2) Medical condition, including both physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

(7) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(8) Disability.

Source: Laws 1997, LB 862, § 10.

44-6911 Late enrollee, defined.

Late enrollee means an eligible employee or dependent who requests enrollment in a health benefit plan following the initial enrollment period during which the individual is entitled to enroll under the terms of the health benefit plan if the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(1) The individual meets each of the following:

(a) The individual was covered under creditable coverage at the time of the initial enrollment;

(b) The individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, divorce, or legal separation; and

(c) The individual requests enrollment within thirty days after termination of the creditable coverage;

(2) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;

(3) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order; or

(4) The individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted.

Source: Laws 1997, LB 862, § 11.

44-6912 Medical care, defined.

Medical care means amounts paid for:

(1)(a) The diagnosis, care, mitigation, treatment, or prevention of disease or (b) the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in subdivision (1) of this section; and

(3) Insurance covering medical care referred to in subdivisions (1) and (2) of this section.

Source: Laws 1997, LB 862, § 12.

44-6913 Network plan, defined.

Network plan means health insurance coverage offered by a health carrier under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the health carrier.

Source: Laws 1997, LB 862, § 13.

44-6914 Plan sponsor, defined.

Plan sponsor has the meaning given such term under 29 U.S.C. 1002.

Source: Laws 1997, LB 862, § 14.

44-6915 Preexisting condition, defined.

Preexisting condition means a condition whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. Genetic information shall not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information.

Source: Laws 1997, LB 862, § 15; Laws 2000, LB 1253, § 40.

44-6915.01 Waiting period, defined.

Waiting period means the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the health benefit plan. If an individual enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period.

Source: Laws 2000, LB 1253, § 41.

44-6916 Health carrier; health benefit plan; restrictions; duties; preexisting condition exclusion; late enrollee; when.

(1) A health carrier shall not:

(a) Offer coverage to only certain individuals in an employer group or to only a part of the group except in the case of late enrollees;

(b) Require any individual to pay a premium which is greater than such premium for a similarly situated individual enrolled in the health benefit plan on the basis of any health-status-related factor in relation to the individual or a dependent; or

(c) Establish rules for eligibility and continued eligibility of any individual to enroll under the terms of the health benefit plan based on a health-status-related factor of the individual or a dependent.

(2) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than twelve months, or eighteen months in the case of a late enrollee, following the enrollment date of the individual's coverage due to a preexisting condition or the first date of the waiting period for enrollment if that date is earlier than the enrollment date. Genetic information shall not be treated as a preexisting condition unless there is a diagnosis of the condition related to such information. A health benefit plan shall not define a preexisting condition more restrictively than as defined in section 44-6915. A health benefit plan shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(3) A health benefit plan shall not impose any preexisting condition exclusion:

(a) To an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage, and the individual had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage; or

(b) To a child less than eighteen years of age who is adopted or placed for adoption and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage, and the child had creditable coverage that was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage.

(4) A health carrier shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in a health benefit plan for the aggregate period of time an individual was previously covered by creditable coverage that provided benefits with respect to such services if the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of new coverage. The period of continuous coverage shall not include any waiting period or affiliation period for the effective date of the new coverage applied by the plan sponsor or the health carrier. This subsection shall not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(5)(a) A health carrier shall permit an eligible employee or dependent, who requests enrollment following the open enrollment opportunity, to enroll, and the eligible employee or dependent shall not be considered a late enrollee if the eligible employee or dependent:

(i) Was covered under another health benefit plan at the time the eligible employee or dependent was eligible to enroll;

(ii) Stated in writing at the time of the open enrollment period that coverage under another health benefit plan was the reason for declining enrollment but

only if the health benefit plan or health carrier required such a written statement and provided a notice of the consequences of such written statement;

(iii) Has lost coverage under another health benefit plan as a result of the termination of employment, the termination of the other health benefit plan's coverage, death of a spouse, legal separation, or divorce or was under a continuation-of-coverage policy or contract available under federal law and the coverage was exhausted; and

(iv) Requests enrollment within thirty days after the termination of coverage under the other health benefit plan.

(b)(i) If a health carrier issues a health benefit plan and makes coverage available to a dependent of an eligible employee and such dependent becomes a dependent of the eligible employee through marriage, birth, adoption, or placement for adoption, then such health benefit plan shall provide for a dependent special enrollment period during which the dependent may be enrolled under the health benefit plan and, in the case of the birth or adoption of a child, the spouse of an eligible employee may be enrolled if otherwise eligible for coverage.

(ii) A dependent special enrollment period shall be a period of not less than thirty days and shall begin on the later of (A) the date such dependent coverage is available or (B) the date of the marriage, birth, adoption, or placement for adoption.

(iii) If an eligible employee seeks to enroll a dependent during the first thirty days of such a dependent special enrollment period, the coverage of the dependent shall become effective:

(A) In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(B) In the case of the birth of a dependent, as of the date of birth; and

(C) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(6)(a) A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion with respect to any particular coverage option may impose an affiliation period for such coverage option but only if:

(i) Such period is applied uniformly without regard to any health-status-related factors; and

(ii) Such period does not exceed two months or, in the case of a late enrollee, three months.

(b) An affiliation period under a group health plan shall run concurrently with any waiting period under the group health plan.

(c) A health maintenance organization may use alternative methods, from those described in subdivision (6)(a) of this section, to address adverse selection, as approved by the director.

Source: Laws 1997, LB 862, § 16; Laws 2002, LB 1139, § 46.

44-6917 Health benefit plan; renewable; exceptions.

(1) A health benefit plan shall be renewable with respect to all eligible employees or dependents, at the option of the plan sponsor, except in any of the following cases:

(a) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments;

(b) The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) Noncompliance with the health carrier's minimum participation requirements;

(d) Noncompliance with the health carrier's employer contribution requirements;

(e) A health carrier decides to discontinue offering a particular type of group health benefit plan in this state. A health carrier discontinuing such plan shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all affected plan sponsors, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least ninety days prior to the nonrenewal of any health benefit plans by the health carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected plan sponsors, participants, and beneficiaries;

(iii) Offer to each plan sponsor provided the type of group health benefit plan the option to purchase all other health benefit plans currently being offered by the health carrier to plan sponsors in this state; and

(iv) In exercising the option to discontinue the particular type of group health benefit plan and in offering the option of coverage under subdivision (1)(e)(iii) of this section, act uniformly without regard to the claims experience of those plan sponsors or any health-status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(f) A health carrier decides to discontinue offering and nonrenews all its health benefit plans delivered or issued for delivery to plan sponsors in this state. A health carrier that discontinues such plans shall:

(i) Provide advance notice of its decision to the commissioner of insurance in each state in which it is licensed;

(ii) Provide notice of the decision not to renew coverage to all affected plan sponsors, participants, and beneficiaries, and to the commissioner of insurance in each state in which an affected insured individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the health carrier. Notice to the director shall be provided at least three working days prior to the notice to the affected plan sponsors, participants, and beneficiaries; and

(iii) Discontinue all health insurance issued or delivered for issuance in the state's employer market and not renew coverage under any health benefit plan issued to an employer; and

(g) The director finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the health carrier's ability to meet its contractual obligations.

(2) A health carrier that elects not to renew all of its health benefit plans in the state under subdivision (1)(f) of this section shall be prohibited from writing new business in the large employer market in this state for a period of five years after the date of notice to the director.

(3) A health carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection (1) or (2) of this section in the case of the following:

(a) To an eligible person who no longer resides, lives, or works in the service area of the health carrier or in an area for which the health carrier is authorized to do business, but only if coverage is terminated under this section uniformly without regard to any health-status-related factor of covered individuals; or

(b) To a plan sponsor that no longer has any enrollee in connection with such plan who lives, resides, or works in the service area of the health carrier or in an area for which the health carrier is authorized to do business.

Source: Laws 1997, LB 862, § 17.

44-6917.01 Certification of creditable coverage.

(1) Health carriers shall provide written certification of creditable coverage to individuals in accordance with subsection (2) of this section.

(2) The certification of creditable coverage shall be provided:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage described in subdivision (2)(a) or (b) of this section, whichever is later.

(3) Health carriers may provide the certification of creditable coverage required under subdivision (2)(a) of this section at a time consistent with notices required under any applicable COBRA continuation provision.

(4) The certificate of creditable coverage required to be provided pursuant to subsection (1) of this section shall contain:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

(5) To the extent medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under subsection (1) of this section if the health carrier offering the coverage provides for certification in accordance with subsection (2) of this section.

(6)(a) If an individual enrolls in a group health plan that uses the alternative method of counting creditable coverage pursuant to subdivision (6)(c) of section 44-6916 and the individual provides a certificate of coverage that was provided to the individual pursuant to subsection (3) of this section, on request of the

group health plan, the entity that issued the certification to the individual promptly shall disclose to the group health plan information on the classes and categories of health benefits available under the entity's health benefit plan.

(b) The entity providing the information pursuant to subdivision (6)(a) of this section may charge the requesting group health plan the reasonable cost of disclosing the information.

Source: Laws 2002, LB 1139, § 47.

44-6918 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out sections 44-6901 to 44-6918.

Source: Laws 1997, LB 862, § 18; Laws 2000, LB 1253, § 42; Laws 2002, LB 1139, § 48.

ARTICLE 70

HEALTH CARE PROFESSIONAL CREDENTIALING VERIFICATION ACT

Section

44-7001 Act, how cited.

Sections 44-7001 to 44-7013 shall be known and may be cited as the Health Care Professional Credentialing Verification Act.

Source: Laws 1998, LB 1162, § 26.

44-7002 Purpose and intent.

The Health Care Professional Credentialing Verification Act requires a health carrier to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification. The standards set out in the act address the initial credentialing verification and subsequent recredentialing process.

Source: Laws 1998, LB 1162, § 27.

44-7003 Terms, defined.

For purposes of the Health Care Professional Credentialing Verification Act:

(1) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(2) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(3) Credentialing verification means the process of obtaining and verifying information about a health care professional, and evaluating that health care professional, when that health care professional applies to become a participating provider in a managed care plan offered by a health carrier;

(4) Director means the Director of Insurance;

(5) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facility does not include physicians' offices;

(6) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(7) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(8) Health care provider or provider means a health care professional or a facility;

(9) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(10) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(11) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(12) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(13) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(14) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

(15) Primary verification means verification by the health carrier of a health care professional's credentials based upon evidence obtained from the issuing source of the credential; and

(16) Secondary verification means verification by the health carrier of a health care professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential, such as copies of certificates provided by the applying health care professional.

Source: Laws 1998, LB 1162, § 28.

44-7004 Applicability of act.

The Health Care Professional Credentialing Verification Act applies to health carriers that offer closed plans or combination plans having a closed component.

Source: Laws 1998, LB 1162, § 29.

44-7005 Use of nationally recognized private accrediting entities; authorized.

The director may recognize accreditation by one or more nationally recognized private accrediting entities, with established and maintained standards, as evidence of meeting some or all of the requirements of the Health Care Professional Credentialing Verification Act. A recognized accrediting entity shall make available to the director its current standards to demonstrate that the entity's standards meet or exceed this state's requirements. The health carrier may provide the director with documentation that a managed care plan has been accredited by the entity.

Source: Laws 1998, LB 1162, § 30.

44-7006 Health carrier; credentialing verification duties.

(1) A health carrier shall:

(a) Establish written policies and procedures for credentialing verification of all health care professionals with whom the health carrier contracts and apply these standards consistently;

(b) Verify the credentials of a health care professional before entering into a contract with that health care professional. The medical director of the health carrier or other designated health care professional shall have responsibility for, and shall participate in, credentialing verification;

(c) Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification;

(d) Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures;

(e) Retain all records and documents relating to a health care professional's credentialing verification process for at least five years; and

(f) Keep confidential all information obtained in the credentialing verification process except as otherwise provided by law.

(2) Nothing in the Health Care Professional Credentialing Verification Act shall be construed to require a health carrier to select a provider as a participating provider solely because the provider meets the health carrier's credentialing verification standards or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

(3) The policies and procedures for credentialing verification shall be available for review by the director, and, in the case of a health maintenance organization, shall also be available for review by the chief medical officer, if one is appointed pursuant to section 81-3115, and if not, then the Director of Public Health.

Source: Laws 1998, LB 1162, § 31; Laws 2007, LB296, § 198.

44-7007 Health carrier; primary verification; secondary verification; duties.

A health carrier shall:

(1) Obtain primary verification of at least the following information about the applicant:

(a) Current license, certificate, or registration to practice a health care profession in this state and history of licensure, certification, or registration;

(b) Current level of professional liability coverage, if applicable;

(c) Status of hospital privileges, if applicable;

(d) Specialty board certification status, if applicable;

(e) Current federal Drug Enforcement Agency registration certificate, if applicable;

(f) Graduation from a health care professional school; and

(g) Completion of postgraduate training, if applicable;

(2) Obtain, subject to either primary or secondary verification at the health carrier's discretion:

(a) The health care professional's licensure, certification, or registration history in this and all other states;

(b) The health care professional's malpractice history; and

(c) The health care professional's practice history;

(3) At least every three years obtain primary verification of a participating health care professional's:

(a) Current license, certificate, or registration to practice a health care profession in this state;

(b) Current level of professional liability coverage, if applicable;

(c) Status of hospital privileges, if applicable;

(d) Current federal Drug Enforcement Agency registration certificate, if applicable; and

(e) Specialty board certification status, if applicable; and

(4) Require all participating providers to notify the health carrier of changes in the status of any of the items listed in this section at any time and identify for

participating providers the individual to whom they should report changes in the status of an item listed in this section.

Source: Laws 1998, LB 1162, § 32.

44-7008 Health care professional's right to review credentialing verification information.

(1) A health carrier shall provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification application as set forth below.

(2)(a) Each health care professional who is subject to the credentialing verification process shall have the right to review all information, including the source of that information, obtained by the health carrier to satisfy the requirements of the Health Care Professional Credentialing Verification Act during the health carrier's credentialing process.

(b) A health carrier shall notify a health care professional of any information obtained during the health carrier's credentialing verification process that does not meet the health carrier's credentialing verification standards or that varies substantially from the information provided to the health carrier by the health care professional, except that the health carrier shall not be required to reveal the source of information if the information is not obtained to meet the requirements of the act or if disclosure is prohibited by law.

(c) A health care professional shall have the right to correct any erroneous information. A health carrier shall have a formal process by which a health care professional may submit supplemental or corrected information to the health carrier's credentialing verification committee and request a reconsideration of the health care professional's credentialing verification application if the health care professional feels that the health carrier's credentialing verification committee has received information that is incorrect or misleading. Supplemental information shall be subject to confirmation by the health carrier.

Source: Laws 1998, LB 1162, § 33.

44-7009 Contracts; duties.

Whenever a health carrier contracts to have another entity perform the credentialing functions required by the Health Care Professional Credentialing Verification Act or applicable rules and regulations, the director shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met.

Source: Laws 1998, LB 1162, § 34.

44-7010 Health carrier violation; notice; hearing.

If the director finds that any health carrier doing business in this state is engaging in any violation of the Health Care Professional Credentialing Verification Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Source: Laws 1998, LB 1162, § 35.

44-7011 Violation; penalty.

If, after the hearing, the director finds a health carrier has violated the Health Care Professional Credentialing Verification Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Health Care Professional Credentialing Verification Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Source: Laws 1998, LB 1162, § 36.

44-7012 Violation of cease and desist order; penalty.

Any health carrier who violates a cease and desist order of the director under section 44-7011 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Source: Laws 1998, LB 1162, § 37.

44-7013 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Health Care Professional Credentialing Verification Act.

Source: Laws 1998, LB 1162, § 38.

ARTICLE 71

MANAGED CARE PLAN NETWORK ADEQUACY ACT

Section

44-7101 Act, how cited.

Sections 44-7101 to 44-7112 shall be known and may be cited as the Managed Care Plan Network Adequacy Act.

Source: Laws 1998, LB 1162, § 39.

44-7102 Purpose and intent.

The purpose and intent of the Managed Care Plan Network Adequacy Act are to establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility, and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

Source: Laws 1998, LB 1162, § 40.

44-7103 Terms, defined.

For purposes of the Managed Care Plan Network Adequacy Act:

(1) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(2) Covered benefits or benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) Director means the Director of Insurance;

(5) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(6) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(7) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facility does not include physicians' offices;

(8) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(9) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(10) Health care provider or provider means a health care professional or a facility;

(11) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(12) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(13) Intermediary means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network;

(14) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(15) Network means the group of participating providers providing services to a managed care plan;

(16) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(17) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(18) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

(19) Primary care professional means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person; and

(20) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.

Source: Laws 1998, LB 1162, § 41.

44-7104 Applicability of act.

The Managed Care Plan Network Adequacy Act applies to all health carriers that offer managed care plans.

Source: Laws 1998, LB 1162, § 42.

44-7105 Network adequacy.

(1) A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the health carrier, including, but not limited to: Provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(a) In any case in which the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit and the health carrier shall reimburse the nonparticipating provider at the health carrier's usual and customary rate or at an agreed-upon rate.

(b) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under consideration.

(2) A health carrier shall maintain an access plan meeting the requirements of the Managed Care Plan Network Adequacy Act for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to the director or any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:

(a) The health carrier's network;

(b) The health carrier's procedures for making referrals within and outside its network;

(c) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

(d) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(e) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with health care services;

(f) The health carrier's method of informing covered persons of the managed care plan's services and features, including, but not limited to, the managed care plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) The health carrier's process for enabling covered persons to change primary care professionals;

(i) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner; and

(j) Any other information required by the director to determine compliance with the provisions of the act.

Source: Laws 1998, LB 1162, § 43.

44-7106 Requirements for health carriers and participating providers.

(1) A health carrier offering a managed care plan shall satisfy all the requirements contained in this section.

(2)(a) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on health care services.

(b) Every contract between a health carrier that offers closed plans or combination plans having a closed component and a participating provider shall set forth in writing a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

''Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement

from, or have any recourse against a covered person or a person, other than the health carrier or intermediary, acting on behalf of the covered person for health care services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide health care services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue health care services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.''

(c) Every contract between a health carrier that offers closed plans or combination plans having a closed component and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered benefits to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

(d) The contract provisions that satisfy the requirements of subdivisions (2)(b) and (c) of this section shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by such subdivisions.

(e) In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

(f) A health carrier shall make its selection standards for participating providers available for review by the director.

(g) At the time the participating providers execute contracts with the health carrier, a health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs.

(h) A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary health care services to a covered person.

(i) A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options or from advocating on behalf of covered

persons within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

(j) A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

(k) A health carrier and participating provider shall provide at least sixty days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of a termination within fifteen working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified.

(l) The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

(m) A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the managed care plan as a private purchaser of the managed care plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render health care services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(n) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered health care services.

(o) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

(p) A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the health carrier.

(q) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the health carrier.

(r) A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or the Managed Care Plan Network Adequacy Act.

(3) Subdivisions (2)(a) through (g) and (j) through (r) of this section become operative on July 1, 1999.

Source: Laws 1998, LB 1162, § 44.

44-7107 Intermediaries.

(1) A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

(2)(a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of section 44-7106.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

(c) A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the health carrier's covered persons.

(d) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty days' prior written notice from the health carrier. A health carrier may meet the requirements of this subdivision by maintaining a copy of the intermediary health care subcontract forms used by its intermediaries, and if the health carrier does so, the health carrier shall also maintain a copy of any portion of an intermediary health care subcontract which substantially differs from the intermediary health care subcontract form in subject areas other than reimbursement.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information, and documentation of health care services provided to covered persons at its principal place of business in the state and preserve them for five years in a manner that facilitates regulatory review.

(g) An intermediary shall allow the director and a health maintenance organization shall allow the director and the Department of Health and Human Services access to the intermediary's books, records, financial information, and any documentation of health care services provided to covered persons, as necessary to determine compliance with the Managed Care Plan Network Adequacy Act.

(h) A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Source: Laws 1998, LB 1162, § 45; Laws 2007, LB296, § 199.

44-7108 Filing requirements.

(1) A health carrier that offers closed plans or combination plans having a closed component shall file with the director sample contract forms proposed for use with its participating providers and intermediaries.

(2) A health carrier that offers closed plans or combination plans having a closed component shall submit material changes to a contract that would affect a provision required by the Managed Care Plan Network Adequacy Act or applicable rules and regulations to the director for approval. Changes in

provider payment rates, coinsurance, copayments, or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.

(3) If the director takes no action within thirty days after submission of a material change to a contract by a health carrier, the change is deemed approved.

(4) The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days' prior written notice from the director.

Source: Laws 1998, LB 1162, § 46.

44-7109 Health carrier violation; notice; hearing.

If the director finds that any health carrier doing business in this state is engaging in any violation of the Managed Care Network Adequacy Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Source: Laws 1998, LB 1162, § 47.

44-7110 Violation; penalty.

If, after the hearing, the director finds a health carrier has violated the Managed Care Network Adequacy Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Managed Care Network Adequacy Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Source: Laws 1998, LB 1162, § 48.

44-7111 Violation of cease and desist order; penalty.

Any health carrier who violates a cease and desist order of the director under section 44-7110 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Source: Laws 1998, LB 1162, § 49.

44-7112 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Managed Care Plan Network Adequacy Act.

Source: Laws 1998, LB 1162, § 50.

ARTICLE 72

QUALITY ASSESSMENT AND IMPROVEMENT ACT

Section

44-7201 Act, how cited.

Sections 44-7201 to 44-7215 shall be known and may be cited as the Quality Assessment and Improvement Act.

Source: Laws 1998, LB 1162, § 51.

44-7202 Purpose and intent.

The Quality Assessment and Improvement Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans and for the quality improvement activities of health carriers issuing closed plans or combination plans having a closed component. The purpose of the criteria is to enable health carriers to evaluate, maintain, and improve the quality of health care services provided to covered persons.

Source: Laws 1998, LB 1162, § 52.

44-7203 Terms, defined.

For purposes of the Quality Assessment and Improvement Act:

(1) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(2) Consumer means someone in the general public who may or may not be a covered person or a purchaser of health care, including employers;

(3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) Department means the Department of Insurance;

(5) Director means the Director of Insurance;

(6) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient

centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facility does not include physicians' offices;

(7) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(8) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(9) Health care provider or provider means a health care professional or a facility;

(10) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(11) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(12) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(13) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(14) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(15) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

(16) Quality assessment means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations; and

(17) Quality improvement means the effort to improve the processes and outcomes related to the provision of care within the health benefit plan.

Source: Laws 1998, LB 1162, § 53.

44-7204 Applicability of act.

The Quality Assessment and Improvement Act applies to all health carriers that offer closed plans or combination plans having a closed component on and after July 15, 1998. The act, except sections 44-7207 to 44-7209, applies to all health carriers that offer open plans on and after July 1, 1999.

Source: Laws 1998, LB 1162, § 54.

44-7205 Use of nationally recognized private accrediting entities; authorized.

The director may recognize accreditation by one or more nationally recognized private accrediting entities, with established and maintained standards, as evidence of meeting some or all of the requirements of the Quality Assessment and Improvement Act. A recognized accrediting entity shall make available to the director its current standards to demonstrate that the entity's standards meet or exceed this state's requirements. The health carrier may provide the director with documentation that a managed care plan has been accredited by the entity.

Source: Laws 1998, LB 1162, § 55.

44-7206 Quality assessment; infrastructure and disclosure systems.

A health carrier that provides managed care plans shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of managed care plans offered by the health carrier. A health carrier shall:

(1) Establish a system designed to assess the quality of health care provided to covered persons and appropriate to the types of managed care plans offered by the health carrier. The system shall include systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements;

(2) Communicate findings in a timely manner to applicable regulatory agencies, providers, and consumers as provided in section 44-7209;

(3) Report to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider. A health carrier acting in good faith shall be granted immunity from any cause of action under state law in making the report; and

(4) Develop a written description of the quality assessment program available for review by the director, which shall include a signed certification by a corporate officer of the health carrier that the filing meets the requirements of the Quality Assessment and Improvement Act. The written description of the quality assessment program of a health maintenance organization shall also be available for review by the Department of Health and Human Services.

Source: Laws 1998, LB 1162, § 56; Laws 2007, LB296, § 200.

44-7207 Quality improvement; internal structures and activities.

A health carrier that issues a closed plan or a combination plan having a closed component shall, in addition to complying with the requirements of section 44-7206, develop and maintain the internal structures and activities necessary to improve quality as required by this section. A health carrier subject to the requirements of this section shall:

(1) Establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement;

(2) Use the findings generated by the system to work, on a continuing basis, with participating providers and other staff within the closed plan or closed component to improve the health care services delivered to covered persons;

(3) Develop and maintain an organizational program for designing, measuring, assessing, and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program filed with the director and consistent with the provisions of the Quality Assessment and Improvement Act. This program shall be under the direction of the chief medical officer or clinical director of the health carrier. The organizational program shall include:

(a) A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities, and an annual effectiveness review of the quality improvement program;

(b) A written quality improvement plan that describes how the health carrier intends to:

(i) Analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

(ii) Identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the health carrier shall consider practices and diagnoses that affect a substantial number of the managed care plan's covered persons or that could place covered persons at serious risk. This section shall not be construed to require a health carrier to review every disease, illness, and condition that may affect a covered person under a managed care plan offered by the health carrier;

(iii) Use a range of appropriate methods to analyze quality, including:

(A) Collection and analysis of information on over-utilization and under-utilization of health care services;

(B) Evaluation of courses of treatment and outcomes of health care services, including health status measures, consistent with reference databases such as current medical research, knowledge, standards, and practice guidelines; and

(C) Collection and analysis of information specific to a covered person or persons or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of covered persons;

(iv) Compare program findings with past performance, as appropriate, and with internal goals and external standards, when available, adopted by the health carrier;

(v) Measure the performance of participating providers and conduct peer review activities, such as:

(A) Identifying practices that do not meet the health carrier's standards;

(B) Taking appropriate action to correct deficiencies;

(C) Monitoring participating providers to determine whether they have implemented corrective action; and

(D) Taking appropriate action when the participating provider has not implemented corrective action;

(vi) Utilize treatment protocols and practice parameters developed with appropriate clinical input and using the evaluations described in subdivisions (3)(b)(i) and (ii) of this section, or utilize acquired treatment protocols developed with appropriate clinical input; and provide participating providers with sufficient information about the protocols to enable participating providers to meet the standards established by these protocols;

(vii) Evaluate access to care for covered persons according to standards established by the insurance laws of this state. The quality improvement plan shall describe the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate or maintain communication with public health agencies;

(viii) Implement improvement strategies related to program findings; and

(ix) Evaluate periodically, but not less than annually, the effectiveness of the strategies implemented in subdivision (3)(b)(viii) of this section; and

(4) Assure that participating providers have the opportunity to participate in developing, implementing, and evaluating the quality improvement system.

Source: Laws 1998, LB 1162, § 57.

44-7208 Quality assessment and quality improvement activities; oversight.

The chief medical officer or clinical director of the health carrier shall have primary responsibility for the quality assessment and quality improvement activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of the Quality Assessment and Improvement Act are met. The chief medical officer or clinical director shall approve the written quality assessment and quality improvement programs, as applicable, implemented in compliance with the act, and shall periodically review and revise the program document and act to assure ongoing appropriateness. Not less than semiannually, the chief medical officer or clinical director shall review reports of quality assessment and quality improvement activities. The director shall hold the health carrier responsible for the actions of the chief medical officer or clinical director carried out on behalf of the health carrier and shall hold the health carrier responsible for ensuring that all requirements of the act are met.

Source: Laws 1998, LB 1162, § 58.

44-7209 Reporting and disclosure requirements.

(1) A health carrier shall document and communicate information, as provided in this section, about its quality assessment program and its quality improvement program, if it has one, and shall include a description of its quality assessment and quality improvement programs and a statement of patient rights and responsibilities with respect to those programs in the certificate of coverage or handbook provided to newly enrolled covered persons.

(2)(a) A health carrier shall certify to the director annually that its quality assessment program and its quality improvement program, if it has one, along with the materials provided to providers and consumers in accordance with

subsection (1) of this section, meet the requirements of the Quality Assessment and Improvement Act.

(b) A health carrier shall make available for review by the public upon request, subject to a reasonable fee, the materials certified pursuant to subdivision (2)(a) of this section, except for the materials subject to the confidentiality requirements of section 44-7210 and materials that are proprietary to the health benefit plan. A health carrier shall retain all certified materials for at least three years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

Source: Laws 1998, LB 1162, § 59.

44-7210 Confidentiality; immunity.

(1) Data or information pertaining to the diagnosis, treatment, or health of a covered person obtained from the person or from a provider by a health carrier is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of the Quality Assessment and Improvement Act and as allowed by state law; or upon the express consent of the covered person; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of a claim or litigation between the covered person and the health carrier in which the data or information is pertinent, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer retrievable form. If any data or information pertaining to the diagnosis, treatment, or health of any covered person or applicant is disclosed pursuant to the provisions of this subsection, the health carrier making this required disclosure shall not be liable for the disclosure or any subsequent use or misuse of the data. A health carrier shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the health carrier is entitled to claim.

(2) A person who, in good faith and without malice, takes an action or makes a decision or recommendation as a member, agent, or employee of a health carrier's quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, or who furnishes any records, information, or assistance to a quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, shall not be subject to liability for civil damages or any legal action in consequence of his or her action, nor shall the health carrier that established the quality committee or the officers, directors, employees, or agents of the health carrier be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(3)(a) The information considered by a quality committee and the records of its actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing agency, or in an appeal, if permitted, from the quality committee's findings or recommendations. No member of a quality committee, or officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee, or engaged in the health carrier's quality assessment or quality improvement activities, or any person assisting or furnishing information to the

quality committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities.

(b) Information considered by a quality committee and the records of its actions and proceedings that are used pursuant to subdivision (3)(a) of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of a quality committee.

(4) To fulfill its obligations under this section, the health carrier shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any covered person.

Source: Laws 1998, LB 1162, § 60.

44-7211 Contracts; duties.

Whenever a health carrier contracts to have another entity perform the quality assessment or quality improvement functions required by the Quality Assessment and Improvement Act or applicable rules and regulations, the director shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met.

Source: Laws 1998, LB 1162, § 61.

44-7212 Health carrier violation; notice; hearing.

If the director finds that any health carrier doing business in this state is engaging in any violation of the Quality Assessment and Improvement Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

Source: Laws 1998, LB 1162, § 62.

44-7213 Violation; penalty.

If, after the hearing, the director finds a health carrier has violated the Quality Assessment and Improvement Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Quality Assessment and Improvement Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Source: Laws 1998, LB 1162, § 63.

44-7214 Violation of cease and desist order; penalty.

Any health carrier who violates a cease and desist order of the director under section 44-7213 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Source: Laws 1998, LB 1162, § 64.

44-7215 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Quality Assessment and Improvement Act.

Source: Laws 1998, LB 1162, § 65.

ARTICLE 73

HEALTH CARRIER GRIEVANCE PROCEDURE ACT

Section
44-7301. Act, how cited.
44-7302. Purpose of act.
44-7303. Terms, defined.
44-7304. Applicability of act.
44-7305. Use of nationally recognized private accrediting entities; authorized.
44-7306. Grievance register.
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44-7308. Grievance review.
44-7309. Repealed. Laws 2013, LB 147, § 24.
44-7310. Standard review of adverse determinations.
44-7311. Expedited reviews.
44-7312. Health carrier violations; notice; hearing.
44-7313. Violation; penalty.
44-7314. Violation of cease and desist order; penalty.
44-7315. Rules and regulations.

44-7301 Act, how cited.

Sections 44-7301 to 44-7315 shall be known and may be cited as the Health Carrier Grievance Procedure Act.

Source: Laws 1998, LB 1162, § 66.

44-7302 Purpose of act.

The purpose of the Health Carrier Grievance Procedure Act is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of their grievances as defined in the act.

Source: Laws 1998, LB 1162, § 67.

44-7303 Terms, defined.

For purposes of the Health Carrier Grievance Procedure Act:

(1) Adverse determination means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, contin-

ued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefor denied, reduced, or terminated;

(2) Ambulatory review means utilization review of health care services performed or provided in an outpatient setting;

(3) Case management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) Certification means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(5) Clinical peer means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review;

(6) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(8) Concurrent review means utilization review conducted during a patient's hospital stay or course of treatment;

(9) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(10) Director means the Director of Insurance;

(11) Discharge planning means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(12) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(13) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(14) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and

rehabilitation and other therapeutic health settings. Facility does not include physicians' offices;

(15) Grievance means a written complaint submitted in accordance with the health carrier's formal grievance procedure by or on behalf of a covered person regarding any aspect of the managed care plan, relative to the covered person, such as:

(a) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling, or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between a covered person and a health carrier;

(16) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(17) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(18) Health care provider or provider means a health care professional or a facility;

(19) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(20) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(21) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(22) Network means the group of participating providers providing services to a managed care plan;

(23) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(24) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(25) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing;

(26) Prospective review means utilization review conducted prior to an admission or a course of treatment;

(27) Retrospective review means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(28) Second opinion means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(29) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment;

(30) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review does not include elective requests for clarification of coverage; and

(31) Written means transmission of correspondence by mail, facsimile, or electronic medium.

Source: Laws 1998, LB 1162, § 68.

44-7304 Applicability of act.

Except as otherwise specified, the Health Carrier Grievance Procedure Act applies to all health carriers that offer managed care plans.

Source: Laws 1998, LB 1162, § 69.

44-7305 Use of nationally recognized private accrediting entities; authorized.

The director may recognize accreditation by one or more nationally recognized private accrediting entities, with established and maintained standards, as evidence of meeting some or all of the requirements of the Health Carrier Grievance Procedure Act. A recognized accrediting entity shall make available to the director its current standards to demonstrate that the entity's standards meet or exceed this state's requirements. The health carrier may provide the

director with documentation that a managed care plan has been accredited by the entity.

Source: Laws 1998, LB 1162, § 70.

44-7306 Grievance register.

(1) A health carrier shall maintain in a grievance register written records to document all grievances received during a calendar year. A request for a review of an adverse determination shall be processed in compliance with section 44-7308 but not considered a grievance for purposes of the grievance register unless such request includes a written grievance. For each grievance required to be recorded in the grievance register, the grievance register shall contain, at a minimum, the following information:

(a) A general description of the reason for the grievance;

(b) Date received;

(c) Date of each review or hearing;

(d) Resolution of the grievance;

(e) Date of resolution; and

(f) Name of the covered person for whom the grievance was filed.

(2) The grievance register shall be maintained in a manner that is reasonably clear and accessible to the director. A grievance register maintained by a health maintenance organization shall also be accessible to the Department of Health and Human Services.

(3) A health carrier shall retain the grievance register compiled for a calendar year for the longer of three years or until the director has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

Source: Laws 1998, LB 1162, § 71; Laws 2007, LB296, § 201; Laws 2013, LB147, § 19.

44-7307 Grievance procedures.

(1) Except as specified in section 44-7311, a health carrier shall use written procedures for receiving and resolving grievances from covered persons.

(2)(a) A copy of the grievance procedures, including all forms used to process a grievance, shall be made available to the director upon request. A health carrier shall file annually with the director a certificate of compliance stating that the health carrier has established and maintains grievance procedures that fully comply with the provisions of the Health Carrier Grievance Procedure Act.

(b) A description of the grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(c) The grievance procedure documents shall include a statement of a covered person's right to contact the director's office for assistance at any time. The statement shall include the telephone number and address of the director.

Source: Laws 1998, LB 1162, § 72.

44-7308 Grievance review.

(1) If a covered person makes a request to a health carrier for a health care service and the request is denied, the health carrier shall provide the covered person with an explanation of the reasons for the denial, a written notice of how to submit a grievance, and the telephone number to call for information and assistance. The health carrier, at the time of a determination not to certify an admission, a continued stay, or other health care service, shall inform the attending or ordering provider of the right to submit a grievance or a request for an expedited review and, upon request, shall explain the procedures established by the health carrier for initiating a review. A grievance involving an adverse determination may be submitted by the covered person, the covered person's representative, or a provider acting on behalf of a covered person, except that a provider may not submit a grievance involving an adverse determination on behalf of a covered person in a situation in which federal or other state law prohibits a provider from taking that action. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise. A health carrier shall issue a copy of the written decision to a provider who submits a grievance on behalf of a covered person. A health carrier shall conduct a review of a grievance involving an adverse determination in accordance with subsection (3) of this section and section 44-7310, but such a grievance is not subject to the grievance register reporting requirements of section 44-7306 unless it is a written grievance.

(2)(a) A grievance concerning any matter except an adverse determination may be submitted by a covered person or a covered person's representative. A health carrier shall issue a written decision to the covered person or the covered person's representative within fifteen working days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If the health carrier cannot make a decision within fifteen working days due to circumstances beyond the health carrier's control, the health carrier may take up to an additional fifteen working days to issue a written decision, if the health carrier provides written notice to the covered person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

(b) A covered person does not have the right to attend, or to have a representative in attendance, at the grievance review. A covered person is entitled to submit written material. The health carrier shall provide the covered person the name, address, and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within three working days after receiving a grievance.

(3) The written decision issued pursuant to the procedures described in subsections (1) and (2) of this section and section 44-7310 shall contain:

(a) The names, titles, and qualifying credentials of the person or persons acting as the reviewer or reviewers participating in the grievance review process;

(b) A statement of the reviewers' understanding of the covered person's grievance;

(c) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(d) A reference to the evidence or documentation used as the basis for the decision;

(e) In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(f) Notice of the covered person's right to contact the director's office. The notice shall contain the telephone number and address of the director's office.

Source: Laws 1998, LB 1162, § 73; Laws 2013, LB147, § 20.

44-7309 Repealed. Laws 2013, LB 147, § 24.

44-7310 Standard review of adverse determinations.

(1) A health carrier shall establish written procedures for a standard review of an adverse determination. Review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

(2) When reasonably necessary or when requested by the provider acting on behalf of a covered person, standard reviews shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination.

(3) For standard reviews the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within fifteen working days after the request for a review. The written decision shall contain the provisions required in subsection (3) of section 44-7308.

(4) In any case in which the standard review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law.

Source: Laws 1998, LB 1162, § 75; Laws 2013, LB147, § 21.

44-7311 Expedited reviews.

(1) A health carrier shall establish written procedures for the expedited review of a grievance involving a situation in which the timeframe of the standard grievance procedures set forth in sections 44-7308 to 44-7310 would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. A request for an expedited review of an adverse determination may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. However, for purposes of the grievance register requirements of section 44-7306, a request for an expedited review shall not be included in the grievance register unless the request is submitted in writing. Expedited review procedures shall be available to a covered person and to the

provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

(2) Expedited reviews which result in an adverse determination shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers shall not have been involved in the initial adverse determination.

(3) A health carrier shall provide expedited review to all requests concerning an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility.

(4) An expedited review may be initiated by a covered person or a provider acting on behalf of a covered person.

(5) In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the provider acting on behalf of a covered person by telephone, facsimile, or the most expeditious method available.

(6) In an expedited review, a health carrier shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the review is commenced. If the expedited review is a concurrent review determination, the health care service shall be continued without liability to the covered person until the covered person has been notified of the determination.

(7) A health carrier shall provide written confirmation of its decision concerning an expedited review within two working days after providing notification of that decision, if the initial notification was not in writing. The written decision shall contain the provisions required in subsection (3) of section 44-7308.

(8) A health carrier shall provide reasonable access, not to exceed one business day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

(9) In any case in which the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. Except as expressly provided in this section, in conducting the review, the health carrier shall adhere to timeframes that are reasonable under the circumstances.

(10) A health carrier shall not be required to provide an expedited review for retrospective adverse determinations.

Source: Laws 1998, LB 1162, § 76; Laws 2013, LB147, § 22.

44-7312 Health carrier violations; notice; hearing.

If the director finds that any health carrier doing business in this state is engaging in any violation of the Health Carrier Grievance Procedure Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that

respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

Source: Laws 1998, LB 1162, § 77.

44-7313 Violation; penalty.

If, after the hearing, the director finds a health carrier has violated the Health Carrier Grievance Procedure Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Health Carrier Grievance Procedure Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Source: Laws 1998, LB 1162, § 78.

44-7314 Violation of cease and desist order; penalty.

Any health carrier who violates a cease and desist order of the director under section 44-7313 may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Source: Laws 1998, LB 1162, § 79.

44-7315 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Health Carrier Grievance Procedure Act.

Source: Laws 1998, LB 1162, § 80.

ARTICLE 74

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN INSURANCE ACT

Section

Section
44-7409. Rules and regulations.
44-7410. Applicability to actions on or after July 15, 1998.

44-7401 Act, how cited.

Sections 44-7401 to 44-7410 shall be known and may be cited as the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Source: Laws 1998, LB 1035, § 14.

44-7402 Terms, defined.

For purposes of the Unfair Discrimination Against Subjects of Abuse in Insurance Act:

(1) Abuse means the occurrence of one or more of the following acts by a current or former family member or household member:

(a)(i) Attempting to cause or intentionally or knowingly causing another person, including a minor child, bodily injury, physical harm, rape, sexual assault, or involuntary sexual intercourse, or (ii) attempting to cause or recklessly causing another person, including a minor child, bodily injury, physical harm, severe emotional distress, or psychological trauma so as to intimidate or attempt to control the behavior of another person, including a minor child;

(b) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including a minor child, including following the person or minor child without proper authority, under circumstances that place the person or minor child in reasonable fear of bodily injury or physical harm;

(c) Subjecting another person, including a minor child, to false imprisonment; or

(d) Attempting to cause or intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person, including a minor child;

(2) Abuse-related claim means a claim under a policy for a loss resulting from an act of abuse;

(3) Abuse-related medical condition means a medical condition sustained by a subject of abuse which arises in whole or in part out of an act or pattern of abuse;

(4) Abuse status means the fact or the perception on the part of the insurer that a person is, has been, or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions or incurred abuse-related claims;

(5) Confidential abuse information means information about acts of abuse or abuse status of a subject of abuse, the address and home and work telephone number of a subject of abuse or the status of an applicant or insured as a family member, employer, or associate of, or a person in a relationship with, a subject of abuse;

(6) Director means the Director of Insurance;

(7) Health benefit plan or plan means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan includes accident-only, credit accident and health, dental, vision, Medicare

supplement, or long-term care insurance, coverage issued as a supplement to liability insurance, short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis. Health benefit plan does not include workers' compensation or similar insurance;

(8) Health carrier means an entity subject to the insurance laws and insurance rules and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, or any other entity providing a plan of health insurance, health benefits, or health services;

(9) Insured means a party named on a policy as the person with legal rights to benefits provided by such policy, except that for life insurance, insured means the person whose life is covered under the policy. For group plans and group insurance, insured includes a covered person;

(10) Insurer means a person or other legal entity engaged in the business of insurance in this state, including agents, brokers, adjusters, and third-party administrators. Insurer includes a health carrier;

(11) Policy means a contract or certificate of insurance, annuity, or indemnity, including endorsements, riders, and binders, issued, proposed for issuance, or intended for issuance in this state by an insurer. Policy includes a health benefit plan; and

(12) Subject of abuse means a person against whom an act of abuse has been directed (a) who has current or prior injuries, illnesses, or disorders that resulted from abuse or (b) who seeks, may have sought, or had reason to seek (i) medical or psychological treatment for abuse, or (ii) protection, court-ordered protection, or shelter from abuse.

Source: Laws 1998, LB 1035, § 15.

44-7403 Purpose of act.

The purpose of the Unfair Discrimination Against Subjects of Abuse in Insurance Act is to prohibit unfair discrimination by insurers on the basis of abuse.

Source: Laws 1998, LB 1035, § 16.

44-7404 Applicability of act.

The Unfair Discrimination Against Subjects of Abuse in Insurance Act applies to all insurers issuing, providing, delivering, arranging for, or renewing in this state any policy of insurance.

Source: Laws 1998, LB 1035, § 17.

44-7405 Subject of abuse; prohibited acts.

An insurer shall not engage in an unfairly discriminatory act or practice against a subject of abuse.

Source: Laws 1998, LB 1035, § 18.

44-7406 Prohibited acts and practices; enumerated; immunity.

(1) The following acts or practices by an insurer are prohibited as unfairly discriminatory:

(a) Denying, refusing to issue, renew, or reissue, canceling, or otherwise terminating, restricting, or excluding coverage on or adding a premium differential to any policy on the basis of the applicant's or insured's abuse status;

(b) Excluding or limiting coverage for losses, denying benefits, or denying a claim incurred by an insured as a result of abuse on the basis of the insured's abuse status except as otherwise permitted or required by the laws of this state relating to acts of abuse committed by a life insurance beneficiary;

(c) Terminating group health coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from, or lost custody of the subject of abuse, or the abuser's coverage has terminated voluntarily or involuntarily;

(d) In the case of a property and casualty insurer, (i) denying or limiting payment for a covered loss or denying a covered claim incurred as a result of abuse by a person other than a coinsured or (ii) failing to pay losses arising out of abuse to an innocent first-party claimant to the extent of such claimant's legal interest in the covered property if the loss is caused by the intentional act of an insured or using other exclusions or limitations on coverage which the director has determined unreasonably restrict the ability of subjects of abuse to be indemnified for such losses. Subdivision (1)(d) of this section does not require payment in excess of the loss or policy limits. Nothing in subdivision (1)(d) of this section shall be construed to prohibit an insurer from applying reasonable standards of proof to claims under such subdivision;

(e) When the insurer has information in its possession that clearly indicates that the applicant, insured, or claimant is a subject of abuse, disclosing or transferring by a person employed by or contracting with the insurer of confidential abuse information for any purpose or to any person, except:

(i) To a subject of abuse or a person specifically designated in writing by the subject of abuse;

(ii) To a health care provider for the direct provision of health care services;

(iii) To a licensed physician identified and designated by the subject of abuse;

(iv) When ordered by the director or a court of competent jurisdiction or otherwise required by law;

(v) When necessary for a valid business purpose to transfer information that includes confidential abuse information, confidential abuse information may be disclosed only to the following persons:

(A) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without such disclosure;

(B) A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurer;

(C) Medical or claims personnel contracting with the insurer, including parent or affiliate companies of the insurer that have service agreements with the insurer, only when necessary to process an application or perform the insurer's duties under the policy or to protect the safety or privacy of a subject of abuse; and

(D) With respect to address and telephone number, an entity with whom the insurer transacts business when the business cannot be transacted without the address and telephone number;

(vi) To an attorney who needs the information to represent the insurer effectively, if the insurer notifies the attorney of its obligations under the Unfair Discrimination Against Subjects of Abuse in Insurance Act and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer;

(vii) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about the abuse status; and

(viii) To any other entity deemed appropriate by the director; and

(f) Requesting information about acts of abuse or abuse status, or making use of such information, however obtained, except:

(i) For the limited purpose of complying with legal obligations;

(ii) When verifying a person's claim to be a subject of abuse or to have sustained an abuse-related medical condition or incurred an abuse-related claim; or

(iii) When cooperating with a subject of abuse in seeking protection from abuse or facilitating the treatment of an abuse-related medical condition.

(2) Nothing in subdivision (1)(c) of this section prohibits the health carrier from requiring the subject of abuse to provide satisfactory evidence that he or she is a subject of abuse, from requiring the subject of abuse to pay the full premium for coverage under the health benefit plan from the date of termination of the group coverage forward, or from requiring as a condition of coverage that the subject of abuse reside or work within its service area, if the requirements are applied to all insureds of the health carrier. The subject of abuse shall make application for the continuation coverage required by subdivision (1)(c) of this section within sixty days after termination of the group coverage. Any continuation coverage required by subdivision (1)(c) of this section shall cease upon termination of the underlying group coverage. The health carrier may terminate the continuation coverage required by subdivision (1)(c) of this section after it has been in force for eighteen months, if the health carrier offers conversion to an equivalent individual plan. The continuation coverage required by subdivision (1)(c) of this section shall be satisfied by coverage required under 29 U.S.C. 1161 et seq. provided to a subject of abuse and is not intended to be in addition to coverage provided under 29 U.S.C. 1161 et seq.

(3) Subdivision (1)(e) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(4) A subject of abuse may provide evidence of abuse to a health carrier for the limited purpose of facilitating treatment of an abuse-related medical condition or demonstrating that a medical condition is abuse-related, and this section does not authorize the health carrier to disregard that information.

(5) This section does not prohibit a life insurer from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy, and if:

(a) The applicant or prospective owner of the policy lacks an insurable interest in the prospective insured;

(b) The applicant or prospective owner of the policy is known, on the basis of medical, police, or court records, to have committed an act of abuse against the prospective insured; or

(c) The insured or prospective insured is a subject of abuse, and that person, or a person who has assumed the care of that person if a minor or incapacitated, has objected to the issuance of the policy on the ground that the policy would be issued to or for the direct or indirect benefit of the abuser.

(6) This section does not prohibit a property and casualty insurer from denying a property claim when the damage or loss is the result of intentional conduct by a named insured who commits an act of abuse, except that the property and casualty insurer shall make payment on such a claim to an innocent coinsured subject of abuse to the extent of the innocent coinsured's interest in the property and within the limits of coverage when the damage or loss was proximately related to and in furtherance of abuse. A property and casualty insurer paying such a claim shall be subrogated to the rights of the innocent coinsured subject of abuse to recover for any damages paid by the insurance.

(7) This section does not prohibit an insurer from asking an applicant or insured about a medical condition or a claim or from using information thereby obtained to underwrite or to evaluate and carry out its rights and duties under the policy, even if the information is related to a medical condition or claim that the insurer knows or has reason to know is abuse-related, to the extent otherwise permitted under the act and other applicable law.

(8) An insurer shall not be held civilly or criminally liable for the death of or injury to an insured resulting from any action taken in a good faith effort to comply with the requirements of the act. However, this subsection does not prevent an action by the director to investigate or enforce a violation of the act or to assert any other claims authorized by law.

(9) An insurer shall not be liable for a violation of the act by a person who is a contractor with the insurer unless the insurer directed the act, practice, or omission that constitutes the violation.

Source: Laws 1998, LB 1035, § 19.

44-7407 Adverse effect on subject of abuse; explanation required.

An insurer that takes an action that adversely affects a subject of abuse on the basis of a medical condition or on the basis of claims history or other underwriting information that the insurer knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

(1) Does not treat abuse status as a medical condition or underwriting criterion;

(2) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or a similar claim or claims history without regard to whether the condition is or the claims are abuse-related; and

(3) Except for claims actions, is based on a determination, made in conformance with sound actuarial principles or otherwise supported by actual or

reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

Source: Laws 1998, LB 1035, § 20.

44-7408 Violation of act; unfair trade practice.

In addition to any other remedies available under the laws of this state, each violation of the Unfair Discrimination Against Subjects of Abuse in Insurance Act and any rules and regulations adopted and promulgated thereunder shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

Source: Laws 1998, LB 1035, § 21.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-7409 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

Source: Laws 1998, LB 1035, § 22.

44-7410 Applicability to actions on or after July 15, 1998.

The Unfair Discrimination Against Subjects of Abuse in Insurance Act applies to all actions taken on or after July 15, 1998, except as otherwise explicitly stated. Nothing in the act shall require an insurer to conduct a comprehensive search of its contract files existing on July 15, 1998, solely to determine which applicants or insureds are subjects of abuse.

Source: Laws 1998, LB 1035, § 23.

ARTICLE 75

PROPERTY AND CASUALTY INSURANCE RATE AND FORM ACT

Section

44-7501 Act, how cited.

Sections 44-7501 to 44-7535 shall be known and may be cited as the Property and Casualty Insurance Rate and Form Act.

Source: Laws 2000, LB 1119, § 1; Laws 2001, LB 444, § 1; Laws 2003, LB 216, § 18.

44-7502 Purposes of act.

The purposes of the Property and Casualty Insurance Rate and Form Act are:

(1) To prohibit price-fixing agreements and other anticompetitive behavior by insurers;

(2) To protect policyholders and the public against excessive rates and the adverse effects of inadequate or unfairly discriminatory rates;

(3) To regulate insurance contracts so they: (a) Are not unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy; (b) are not written so as to encourage the misrepresentation of coverage; (c) reasonably provide the general coverage for policies of that type; (d) comply with the provisions and the intent of the laws of this state; and (e) do not provide coverage contrary to the public interest;

(4) To promote rates that reflect the benefits of competition;

(5) To provide appropriate data reporting systems;

(6) To provide regulatory oversight in the absence of competition;

(7) To authorize essential cooperative action among insurers in the development of policy forms, prospective loss costs, and other information and to regulate such activity to prevent practices that tend to substantially lessen competition or create a monopoly; and

(8) To promote the dissemination of price and other information to enable consumers to purchase insurance suitable for their needs and to foster competitive insurance markets.

Source: Laws 2000, LB 1119, § 2.

44-7503 Competition and uniformity; construction of act.

Nothing in the Property and Casualty Insurance Rate and Form Act shall prohibit or discourage reasonable competition or prohibit or discourage uniformity in policy forms, rating systems, or underwriting practices except to the extent necessary to accomplish the purposes of the act. The act shall be liberally interpreted to carry into effect the purposes of the act.

Source: Laws 2000, LB 1119, § 3.

44-7504 Terms, defined.

For purposes of the Property and Casualty Insurance Rate and Form Act:

(1) Advisory organization means any entity, including its affiliates or subsidiaries, which (a) has majority ownership or control by two or more insurers and assists two or more insurers in activities related to ratemaking, the promulgation of policy forms, or related matters or (b) makes the same prospective loss cost or policy form filings on behalf of or to be available for two or more insurers. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. Advisory organization does not include joint reinsurance pools, joint underwriting pools, or insurers engaged in joint underwriting;

(2) Classification means the process of grouping insureds with similar loss or expense characteristics so that differences in losses and expenses may be recognized;

(3) Client means client as defined in section 48-2702;

(4) Director means the Director of Insurance;

(5) Exempt commercial policyholder means an entity to which specific aspects of rate or policy form regulation do not apply or have been relaxed in accordance with rules and regulations adopted and promulgated pursuant to section 44-7515;

(6) Expense means that portion of a rate attributable to acquisition, field supervision, collection expense, general expense, taxes, licenses, and fees. Expense does not include loss adjustment expense;

(7) Experience rating plan means a rating formula and related procedures that use past loss experience of an individual policyholder to forecast future losses by measuring the policyholder's loss experience against the expected losses for policyholders in that classification to produce a prospective premium credit, debit, or unity modification;

(8) Joint reinsurance pool means an ongoing voluntary arrangement pursuant to which two or more insurers participate in the reinsurance of risks written by one or more member insurers and reinsured by one or more other member insurers. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. A joint reinsurance pool may operate through an association, syndicate, or other arrangement;

(9) Joint underwriting means a voluntary arrangement established on an individual risk basis by which two or more insurers jointly contract to provide coverage for an insured. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. Joint underwriting does not include any arrangement by which the participants are reinsuring the direct obligation of another risk-assuming entity;

(10) Joint underwriting pool means an ongoing voluntary arrangement pursuant to which two or more insurers participate in the sharing of risks written as their direct obligations according to a predetermined basis and the insurance remains the direct obligation of the pool participants. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer. A joint underwriting pool may operate through an association, syndicate, or other arrangement;

(11) Loss adjustment expense means the expense incurred by an insurer in the course of settling claims;

(12) Master policy means master policy as defined in section 48-2702;

(13) Multiple coordinated policy means multiple coordinated policy as defined in section 48-2702;

(14) Policy form means all policies, certificates, or other contracts providing insurance coverage. Policy form includes bonds and includes riders, endorsements, or other amendments to the policy form;

(15) Premium means the cost of insurance to the policyholder after all audit adjustments have been made and any dividends payable have been subtracted;

(16) Professional employer organization means professional employer organization as defined in section 48-2702;

(17) Prospective loss cost means that portion of a rate intended to provide for expected losses and loss adjustment expenses. Prospective loss costs may provide for anticipated special assessments. Prospective loss costs do not include provisions for profits, dividends, or expenses other than loss adjustment expenses;

(18) Rating system means the information needed to determine the applicable rate or premium including rates, any manual or plan of rates, classifications, rating schedules, minimum premiums, policy fees, payment plans, rating plans or rules, anniversary rating date rules, and other similar information. Rating system does not include dividend rating plans or other provisions for the possible payment of dividends if such dividends are declared by the insurer's board of directors and are not guaranteed;

(19) Special assessments means guaranty fund assessments made pursuant to section 44-2407, Workers' Compensation Trust Fund assessments made pursuant to section 48-162.02, residual market assessments made pursuant to section 44-3,158 or 44-7528, and similar assessments. Special assessments are not expenses or losses;

(20) Statistical agent means an entity that, for the purpose of fulfilling the statistical reporting obligations of two or more insurers under the act, collects or compiles statistics from two or more insurers or provides reports developed from these statistics to the director. For purposes of this subdivision, a group of insurers under common ownership or control shall be considered a single insurer; and

(21) Supporting information means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer, the interpretation of any other data relied upon by the filer, descriptions of methods used in developing a rating system, and any other information required by the director to be filed.

Source: Laws 2000, LB 1119, § 4; Laws 2001, LB 4, § 1; Laws 2007, LB117, § 25; Laws 2010, LB579, § 12.

44-7505 Applicability of act.

(1) The Property and Casualty Insurance Rate and Form Act applies to any insurer holding a certificate of authority issued by the director to transact insurance business in this state for the lines of insurance specified in subdivisions (5) through (14) and (16) through (20) of section 44-201 and to any combination of any of the foregoing on risks or operations in this state.

(2) The act does not apply to:

(a) Reinsurance, except as provided in section 44-7525 for joint reinsurance pools;

(b) Ocean marine insurance;

(c) Rating systems for insurance against loss or damage to aircraft or against liability, other than workers' compensation and employers liability, arising out of the ownership, maintenance, or use of aircraft;

(d) Rating systems or policy forms used by insurers to provide warranties or service contracts, or rating systems or policy forms used by insurers to provide coverage for the risk assumed by businesses that provide warranties or service contracts for their customers;

(e) Rating systems or policy forms for financial guaranty insurance as defined in subdivision (19) of section 44-201, except that the act applies to financial guaranty coverage for loss of value for motor vehicles leased or sold on credit to private parties;

(f) Rating systems for the lines of insurance specified in subdivisions (5), (7), and (18) of section 44-201 for insurance written by domestic assessment associations doing business under Chapter 44, article 8; and

(g) Policy forms or rates for contracts of suretyship, except that policy forms and prospective loss costs developed or filed by advisory organizations are subject to the act.

Source: Laws 2000, LB 1119, § 5; Laws 2002, LB 1139, § 49.

44-7506 Rating systems and prospective loss costs; filing required.

(1) All rating systems and prospective loss costs shall be filed with the director in accordance with section 44-7508, except that filings for the following shall be filed in accordance with sections 44-7510 and 44-7511:

(a) Filings made by advisory organizations;

(b) Medical professional liability insurance;

(c) Insurance in noncompetitive markets as determined pursuant to section 44-7507;

(d) Liability and physical damage coverages relating to the rental of private passenger automobiles on a nonfleet basis;

(e) Insurance written by joint underwriting pools or joint reinsurance pools;

(f) Insurance written in an assigned risk plan; and

(g) Insurance covering risks of a personal nature written for business entities if the costs for the insurance are charged to individuals. This does not include coverage provided without a separate charge by business entities for their customers.

(2)(a) If the director, after notice and hearing in accordance with the Administrative Procedure Act, finds that an insurer has made filings pursuant to section 44-7508 that have failed to meet the filing standards contained in that section with such frequency as to indicate a general business practice that disregards the requirements of that section, the director shall order that the insurer's filings be made subject to the requirements of sections 44-7510 and 44-7511.

(b) Upon application by an insurer affected by an order issued pursuant to subdivision (2)(a) of this section, demonstrating that its filings made subsequent to the order have been in compliance with section 44-7508 without the need for the director to request that the original filings be amended, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

(c) For insurers whose rating system filings that would otherwise be subject to this section have been made subject to the prior approval requirements of section 44-7511 through the application of this subsection, the percentage rating flexibilities provided in section 44-7509 shall apply to such rating system filings made by such insurers once the rating system filing has been approved pursuant to section 44-7511.

Source: Laws 2000, LB 1119, § 6; Laws 2005, LB 119, § 25.

Cross References

Administrative Procedure Act, see section 84-920.

44-7507 Monitoring competition; determining competitive markets; hearing.

(1) The director shall monitor competition and the availability of insurance in commercial insurance markets. Such monitoring may include requests for information from insurers regarding the lines, types, and classes of insurance that the insurer is seeking and able to write. When requested by an insurer with its response, the director shall keep such responses confidential except as they may be compiled in summaries.

(2) If the director finds that a commercial insurance coverage is contributing to problems in the insurance marketplace due to excessive rates or lack of availability, the director shall submit electronically a report of this finding to the Legislature. Such report may be a separate report or a supplement to the annual report required by section 44-113.

(3) A competitive market is presumed to exist unless the director, after notice and hearing in accordance with the Administrative Procedure Act, determines by order that a degree of competition sufficient to warrant reliance upon competition as a regulator of rating systems, policy forms, or both does not exist in the market. In determining whether a sufficient degree of competition exists, the director may consider:

(a) Relevant tests of workable competition pertaining to market structure, market performance, and market conduct;

(b) The practical opportunities available to consumers in the market to acquire pricing and other consumer information and to compare and obtain insurance from competing insurers;

(c) Whether long-term and short-term profitability provides evidence of excessive rates;

(d) Whether rating systems filed under section 44-7508 would frequently require amendment or disapproval if filed under sections 44-7510 and 44-7511;

(e) Whether additional competition would appear likely to significantly lower rates or improve the policy forms offered to insureds;

(f) Whether rates would be lowered or policy forms would be improved by the imposition of a system of prior approval regulation;

(g) Whether policy forms filed under section 44-7508.02 would frequently require amendment or disapproval if filed under section 44-7513; and

(h) Any other relevant factors.

(4) If a market for a particular type of insurance is found to lack sufficient competition to warrant reliance upon competition as a regulator of rating systems or policy forms, the director shall identify factors that appear to be the cause and the extent to which remediation can be achieved on a short-term or long-term basis. To the extent that significant remediation can be achieved consistent with the other goals of the Property and Casualty Insurance Rate and Form Act, the director shall take such action as may be within the director's authority to accomplish such remediation or to promote the accomplishment of such remediation.

(5) If the director finds pursuant to a hearing held in accordance with subsection (3) of this section that the lack of sufficient competition warrants the application of sections 44-7510 and 44-7511 to the rates charged for a type of insurance, an order shall be issued pursuant to this section that applies sections 44-7510 and 44-7511 to the type of insurance. If the director finds pursuant to a hearing held in accordance with subsection (3) of this section that the lack of sufficient competition warrants the application of section 44-7513 to regulate the forms offered for a type of insurance, an order shall be issued pursuant to this section that applies section 44-7513 to the type of insurance. An order issued under this subsection shall expire no later than one year after its original issue unless the director renews the order after a hearing and a finding of a continued lack of sufficient competition. Any order that is renewed after its first year shall not exceed three years after reissue unless the director renews the order after a hearing and a finding of a continued lack of sufficient competition.

(6) The director shall keep on file in one location all complaints from the public and insurance industry sources alleging that a competitive market does not exist. The director shall investigate each complaint to the extent necessary to determine the truth of the allegations. The director shall keep a summary of his or her findings and conclusions with the complaint.

Source: Laws 2000, LB 1119, § 7; Laws 2003, LB 216, § 20; Laws 2012, LB782, § 55.

Cross References

Administrative Procedure Act, see section 84-920.

44-7508 Rating systems; filing requirements; hearing.

(1) Each insurer to which this section applies as provided in section 44-7506 shall file with the director every rating system and every modification of such rating system that it chooses to use. No insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act, except:

(a) As provided in subsections (6) and (7) of this section;

(b) As provided by rules and regulations adopted and promulgated pursuant to section 44-7515; or

(c) For types of inland marine risks that have, by custom of the industry, not been written according to manual rates or rating plans. For types of inland marine risks for which the custom of the industry has not been established, the director shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.

(2) Every filing shall state its effective date, which shall not be prior to the date that the director receives the filing.

(3) Every filing shall provide an objective description of the risks and the coverages to which the rating system will apply. If the insurer has another rating system on file that applies to some or all of these same risks, the filing shall disclose this and shall objectively identify those risks to which each rating system will apply. Filings shall include a list of manual pages and other rating system elements that will be replaced when the approval of a filing will result in the replacement or alteration of previously filed rating systems. In addition, insurers shall maintain listings of manual pages and other rating system elements that have been filed with the director so that such listings can be provided upon request.

(4) Each insurer shall file or incorporate by reference to material filed with the director all supporting information relating to a rating system. If a filing is not accompanied by such information or if additional information is required to complete review of the filing, the director may require such insurer to furnish the information, and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If an insurer fails to furnish the required information within sixty days, the director may disapprove the filing based on the insurer's failure to provide the requested information. Disapproval shall be by written notice sent to the insurer ordering discontinuance of the filing within thirty days after the date of notice.

(5) An insurer may authorize the director to accept rating system filings and prospective loss cost filings made on its behalf by an advisory organization. The insurer shall file additional information as is necessary to complete its rating systems on file with the director.

(6) A rate or premium in excess of that provided by a filing otherwise applicable may be used on any specific risk upon the prior written consent of the insured that describes the insured's unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that class of risk. Such signed consent shall be filed with the director no later than thirty days after the effective date of the insurance to which it applies. Insurers may not use the procedure set forth in this subsection as a regular means to gain more

rate flexibility than is otherwise allowed by the Property and Casualty Insurance Rate and Form Act. The director shall monitor such rate applications to assure compliance with this subsection. The director may, after a hearing, require by order that such applications for an insurer that has demonstrated a pattern of using this rating device for risks that do not possess unusual or extrahazardous exposures or that otherwise fails to comply with this subsection shall be subject to prior approval pursuant to subdivision (6)(a) of section 44-7511. Upon application by an insurer affected by such order, demonstrating that its filings made subsequent to the order have been in compliance with this subsection, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

(7) The director may by rules and regulations or by order suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which rating systems cannot practicably be filed before they are used. In making this finding, the director shall ascertain whether a system of rating classifications and exposure bases that would equitably reflect the differences in expense requirements and expected losses between individual risks has been developed or appears reasonably capable of being developed. The director may examine insurers as is necessary to ascertain whether any rating systems affected by such rules and regulations meet the standards contained in this section and in section 44-7510.

(8) No filing or any supporting information provided pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the date on which the director completes review of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

(9) The director shall review filings as soon as reasonably possible after they have been submitted. The director shall disapprove a filing if:

(a) The filing proposes a rating system that would produce inadequate premiums. A premium level is inadequate if it would endanger the solvency of the insurer. A premium level that would not be expected to generate a profit on a direct basis and that would be likely to have the effect of diminishing competition is also inadequate. A premium level that does not endanger the solvency of the insurer and is not likely to have the effect of diminishing competition is not inadequate;

(b) The insurer has more than one rating system applicable to the line or type of insurance and the insurer fails to specify objective differences between risks to determine the risks and the coverages to which the rating system will apply;

(c) The filing proposes to discriminate between risks based on optional commission differences for agents;

(d) The filing proposes to discriminate between risks based on race, creed, national origin, or religion of the insured;

(e) The filing would violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act;

(f) The filing discriminates between risks based on subjective factors, except that an experience rating plan may use loss reserves without being considered as subjective; or

(g) The filing proposes to discriminate between risks based solely on the fact that the insured is deployed in the military on Title 10 orders that require the insured to be mobilized outside of the United States, United States territories, and the District of Columbia for a period of six months or greater.

(10) Within thirty days after receipt, the director shall disapprove a filing that requires disapproval pursuant to subsection (9) of this section, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer. A filing shall be deemed to meet the requirements of this section unless disapproved by the director within the review period or any extension thereof.

(11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of subsection (9) of this section, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and order discontinuance of the filing within thirty days after the date of notice.

(12) An insurer whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

(13) If, at any time after the expiration of the review period provided by subsection (10) of this section or any extension thereof, the director finds that a rating system or modification thereof does not meet or no longer meets the requirements of subsection (9) of this section, the director shall hold a hearing in accordance with section 44-7532.

(14) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

(15) If, after a hearing held pursuant to subsection (13) or (14) of this section, the director finds that a filing does not meet the requirements of subsection (9) of this section, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such rating system or aspect of a rating system shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Source: Laws 2000, LB 1119, § 8; Laws 2021, LB77, § 1.
Effective date August 28, 2021.

Cross References

Unfair Discrimination Against Subjects of Abuse in Insurance Act, see section 44-7401.

44-7508.01 Policy forms and related rules of attachment; filing; contents; failure to file; effect.

(1) All policy forms and related rules of attachment shall be filed with the director in accordance with section 44-7508.02, except that an insurer may at its option file policy forms and related rules of attachment in accordance with section 44-7513 and filings for the following shall be filed in accordance with section 44-7513:

(a) Filings made by advisory organizations;

(b) Workers' compensation and employers liability insurance;

(c) Excess workers' compensation and employers liability insurance;

(d) Medical professional liability insurance;

(e) Insurance in noncompetitive markets as determined pursuant to section 44-7507;

(f) Liability and physical damage coverages relating to the rental of private passenger automobiles on a nonfleet basis;

(g) Insurance written by joint underwriting pools or joint reinsurance pools;

(h) Insurance written in an assigned risk plan; and

(i) Insurance covering risks of a personal nature written for business entities if the costs for the insurance are charged to individuals. This does not include coverage provided without a separate charge by business entities for their customers.

(2)(a) If the director, after notice and hearing in accordance with the Administrative Procedure Act, finds that an insurer has made filings pursuant to section 44-7508.02 that have failed to meet the filing standards contained in such section with such frequency as to indicate a general business practice that disregards the requirements of such section or finds that the insurer committed one or more egregious acts relating to the filing standards, the director shall order that the insurer's filings be made subject to the requirements of section 44-7513.

(b) Upon application by an insurer affected by an order issued pursuant to subdivision (2)(a) of this section demonstrating that its filings made subsequent to the order have been in compliance with section 44-7508.02 without the need for the director to request that the original filings be amended, the director may vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

Source: Laws 2003, LB 216, § 19; Laws 2005, LB 119, § 26.

Cross References

Administrative Procedure Act, see section 84-920.

44-7508.02 Policy forms; filing; director; powers and duties.

(1) For policy forms to which this section applies as provided in section 44-7508.01, each insurer shall file with the director every policy form and related attachment rule and every modification thereof which it proposes to use. For policy forms to which this section applies, no insurer shall issue a contract or policy except in accordance with the filings that are in effect for

such insurer as provided in the Property and Casualty Insurance Rate and Form Act except as provided in subsection (10) or (11) of this section, section 44-7514, or rules and regulations adopted and promulgated pursuant to section 44-7515.

(2) Every filing shall state its effective date, which shall not be prior to the date that the director receives such filing.

(3) Every policy form filing shall explain the intended use of such policy form. Filings shall include a list of policy forms that will be replaced when the approval of a filing will result in the replacement of previously approved policy forms. In addition, insurers shall maintain listings of policy forms that have been filed so that such listings can be provided upon request.

(4) The director shall acknowledge receipt of a policy form filing as soon as practical. A review of the filing by the director is not required to issue this acknowledgment, and acknowledgment shall not constitute an approval by the director.

(5) The director may review a policy form filing at any time after it has been made. The director shall review a policy form filing for insurance covering risks of a personal nature, including insurance for homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs, within thirty days after the filing has been made. Following such review, the director shall disapprove a filing that contains provisions, exceptions, or conditions that: (a) Are unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy; (b) are written so as to encourage the misrepresentation of coverage; (c) fail to reasonably provide the general coverage for policies of that type; (d) fail to comply with the provisions or the intent of the laws of this state; or (e) would provide coverage contrary to the public interest.

(6) If, within thirty days after its receipt, the director disapproves a filing that requires disapproval pursuant to subsection (5) of this section, then a written disapproval notice shall be sent to the insurer. The disapproval notice shall specify in what respects the filing fails to meet these requirements. Upon receipt of the notice of disapproval, the insurer shall cease use of the filing as soon as practical but may use the form for policies that have already been issued or when pending coverage proposals are outstanding.

(7) If, within thirty days after its receipt, the director requests additional information to complete review of a policy form filing, the thirty-day review period allowed in subsection (6) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may disapprove the filing based on the insurer's failure to provide the requested information. Disapproval shall be by written notice sent to the insurer ordering discontinuance of the filing within thirty days after the date of notice.

(8) An insurer whose filing is disapproved pursuant to subsection (6) of this section may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

(9) An insurer may authorize the director to accept policy form filings made on its behalf by an advisory organization.

(10)(a) Subject to the requirements of this subsection, policy forms unique in character and designed for and used with regard to an individual risk under

common ownership subject to the rate filing provisions of section 44-7508 shall be exempt from subsection (1) of this section.

(b) At the earliest practical opportunity, but no later than thirty days after the effective date of the policy using unfiled provisions, the insurer shall provide the prospective insured with a written listing of the policy forms that have not been filed with the director. This requirement does not apply to renewals using the same unfiled policy forms.

(c) A policy form that has been used in this state or elsewhere by the insurer for another risk shall not be subject to the exemption provided by this subsection, except that an insurer may use a policy form previously developed for a single risk for a second risk if the policy form is filed within sixty days after its second usage.

(d) The exemption provided by this subsection shall not apply to policy forms that, prior to their use by the insurer, had been filed by an advisory organization in this state or had been filed by the insurer in any jurisdiction, regardless of whether approval was received.

(e) The director may by rule and regulation or by order make specific restrictions relating to the exemption provided by this subsection and may require the informational filing of policy forms subject to such exemption within a reasonable time after their use. Any such informational filings specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

(11) The director may by rule and regulation suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which policy forms cannot practicably be filed before they are used. The director may examine insurers as is necessary to ascertain whether any policy forms affected by such rules and regulations meet the standards contained in the Property and Casualty Insurance Rate and Form Act.

(12) If, at any time after the expiration of the review period provided by subsection (6) of this section or any extension thereof, the director finds that a policy form, attachment rule, or modification thereof does not meet or no longer meets the requirements of subsection (5) of this section, the director shall hold a hearing in accordance with section 44-7532.

(13) Any insured aggrieved with respect to any policy form filing subject to this section may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

(14) If, after a hearing held pursuant to subsection (12) or (13) of this section, the director finds that a filing does not meet the requirements of subsection (5) of this section, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such policy form or attachment rule shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or

policy made or issued prior to the expiration of the period set forth in the order.

Source: Laws 2003, LB 216, § 21; Laws 2005, LB 119, § 27; Laws 2008, LB855, § 49; Laws 2019, LB469, § 6.

44-7509 Premium adjustments.

(1) For medical professional liability insurance and for insurance subject to section 44-7508, insurers may increase or decrease premiums on an individual risk basis up to forty percent based on any factor except:

(a) The rate adjustment cannot be based upon the race, creed, national origin, or religion of the insured;

(b) The rate adjustment cannot violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act;

(c) The rate adjustment cannot apply to (i) insurance covering risks of a personal nature, including insurance for homeowners, tenants, private passenger nonfleet automobiles, mobile homes, and other property and casualty insurance for personal, family, or household needs or (ii) insurance covering farms and ranches, including crop insurance; and

(d) The rate adjustment cannot be based solely upon the fact that the insured is deployed in the military on Title 10 orders that require the insured to be mobilized outside of the United States, United States territories, and the District of Columbia for a period of six months or greater.

(2) If the director finds after a hearing that (a) the utilization of this section by the insurance industry has produced a significant number of rate modifications at or near the upper limit and at the lower limit of the allowable range of modification and (b) the modifiers at and near the upper and lower limits of the allowable range of modification appear to be predominantly correlated with individual risk factors that relate to expected losses and expenses, the director may, by rules and regulations, broaden the range of plus or minus forty percent for any line or type of insurance subject to section 44-7508.

(3) If the director finds after a hearing that modifiers at or near the upper or lower limits of the allowable range of modification are not predominantly correlated with individual risk factors that relate to expected losses and expenses, the director may, by rules and regulations, reduce the range of plus or minus forty percent for any line or type of insurance subject to section 44-7508, but such reduction shall not be to less than plus or minus twenty-five percent.

Source: Laws 2000, LB 1119, § 9; Laws 2002, LB 1139, § 50; Laws 2005, LB 119, § 28; Laws 2021, LB77, § 2.
Effective date August 28, 2021.

Cross References

Unfair Discrimination Against Subjects of Abuse in Insurance Act, see section 44-7401.

44-7510 Standards for rating systems and prospective loss costs for lines subject to prior approval.

(1) Rating systems shall not produce premiums that are excessive. A premium level is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if expenses are unreasonably high in relation to

services rendered. In the evaluation of a premium level, due consideration shall be given to loss experience within and outside this state; reasonably anticipated trends; investment income; special assessments, conflagration, and catastrophe hazards; a reasonable margin for profit; dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to policyholders, members, or subscribers; expense experience both countrywide and specially applicable to this state; and other relevant factors.

(2) Rating systems shall not produce premiums that are inadequate. A premium level is inadequate only if (a) it would endanger the solvency of the insurer or (b) it would not be expected to generate a profit on a direct basis and would be likely to have the effect of diminishing competition.

(3)(a) Rating systems shall not produce premiums that are unfairly discriminatory. Premiums are unfairly discriminatory if, after allowing for practical limitations, price differentials fail to equitably reflect differences in expense requirements or expected losses.

(b) Risks may be grouped by classification groupings that identify objective risk differences for the establishment of rates and prospective loss costs and for the use of rating systems.

(c) Rates and premiums may be modified for individual risks or groups of risks in accordance with objective standards for measuring differences among risks or groups of risks that can be demonstrated to have a probable effect upon losses or expenses. The fact that experience rating plans use loss reserves shall not be interpreted as making experience rating plans subjective.

(d) Notwithstanding subdivisions (3)(b) and (c) of this section, fire insurance rating plans applying to commercial risks for the sole use by advisory organizations that contain reasonable subjective rating factors, but that otherwise meet the standards contained in the Property and Casualty Insurance Rate and Form Act, shall be approved.

(e) A rate is not unfairly discriminatory if it is averaged broadly among persons insured under a group, franchise, or blanket policy or a mass marketed plan. Mass marketed plan means a method of selling property liability insurance wherein:

(i) The insurance is offered to employees of particular employers, members of particular associations or organizations, or stockholders of publicly held corporations or to persons grouped in other ways, except groupings formed principally for the purpose of obtaining such insurance; and

(ii) The employer or other organization has agreed to, or otherwise affiliated itself with, the sale of such insurance to its employees or other groupings of persons affiliated with it.

(f) An insurer may have different rate levels for otherwise similar insureds based on expense differences between coverage sold:

(i) Through direct sales using employees of the insurer;

(ii) Through direct sales by the insurer using the Internet; and

(iii) Through agents that are not employees of the insurer.

(g) No risk classification or grouping may be based upon the race, creed, national origin, or religion of the insured.

(h) No rating system may violate the Unfair Discrimination Against Subjects of Abuse in Insurance Act.

(i) No risk classification or grouping may be based solely upon the fact that the insured is deployed in the military on Title 10 orders that require the insured to be mobilized outside of the United States, United States territories, and the District of Columbia for a period of six months or greater.

(4) Prospective loss costs shall be as near as is practical to the expected cost of future losses, including loss adjustment expenses. Anticipated special assessments may be included with prospective loss costs.

Source: Laws 2000, LB 1119, § 10; Laws 2002, LB 1139, § 51; Laws 2021, LB77, § 3.
Effective date August 28, 2021.

Cross References

Unfair Discrimination Against Subjects of Abuse in Insurance Act, see section 44-7401.

44-7511 Rating systems; filing requirements for lines subject to prior approval; hearings.

(1) Each insurer to which this section applies as provided in section 44-7506 shall file with the director every rating system and every modification of such rating system that it proposes to use. No insurer shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act, except:

(a) As provided in subsections (6) and (7) of this section;

(b) As provided by rules and regulations adopted and promulgated pursuant to section 44-7515; or

(c) For types of inland marine risks that have, by custom of the industry, not been written according to manual rates or rating plans. For types of inland marine risks for which the custom of the industry has not been established, the director shall consider the similarity of the new insurance to existing types of insurance and classes of risk and whether it would be reasonably practical to create and file rating systems prior to use.

(2) Every filing shall state its proposed effective date, which shall not be prior to the date that the director receives the filing. Instead of a specific date, a filing may indicate that it will be effective a reasonable specified period of time after approval or that the insurer will notify the director of the effective date within ninety days after approval.

(3) Every filing shall provide an objective description of the risks and the coverages to which the rating system will apply. If the insurer has another rating system on file or pending that applies to some or all of these same risks, the filing shall disclose this and shall objectively identify those risks to which each rating system will apply. Filings shall include a list of manual pages and other rating system elements that will be replaced when the approval of a filing will result in the replacement or alteration of previously approved rating systems. In addition, insurers shall maintain listings of manual pages and other rating system elements that have been approved by the director so that such listings can be provided upon request.

(4) Each insurer shall file or incorporate by reference to material filed with the director all supporting information relating to a rating system. If a filing is not accompanied by such information or if additional information is required to complete review of the filing, the director may require the filer to furnish the information, and in that event the review period in subsection (10) of this

section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(5) An insurer may authorize the director to accept rating system filings and prospective loss cost filings made on its behalf by an advisory organization. The insurer shall file additional information as is necessary to complete its rating systems on file with the director.

(6)(a) Except as otherwise provided in subdivision (6)(b) of this section for medical professional liability insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used on any specific risk upon the prior written application of the insured that describes the insured's unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that class of risk, filed with and approved by the director.

(b) For medical professional liability insurance, a rate or premium in excess of that provided by a filing otherwise applicable may be used for any specific medical professional upon the prior written consent of the medical professional that describes its unusual or extrahazardous exposures that are not otherwise contemplated by the rates on file for that medical professional's rate classification. Such signed consent shall be filed with the director no later than thirty days after the effective date of the insurance to which it applies. The director shall monitor such rate applications to assure compliance with this subdivision. The director may, after a hearing, require by order that such applications for an insurer that has demonstrated a pattern of using this rating device for medical professionals that do not possess unusual or extrahazardous exposures, or that otherwise fails to comply with this subdivision, shall be subject to prior approval pursuant to subdivision (6)(a) of this section. Upon application by an insurer affected by such order, demonstrating that its filings made subsequent to the order have been in compliance with this subdivision, the director shall vacate such order. The director shall consider any such application within thirty days after its receipt for any order that has been in effect for more than nine months since its inception or since it was last reviewed by the director pursuant to an application by the insurer.

(7) The director may by rules and regulations or by order suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which rating systems cannot practicably be filed before they are used. In making this finding, the director shall ascertain whether a system of rating classifications and exposure bases that would equitably reflect the differences in expense requirements and expected losses between individual risks has been developed or appears reasonably capable of being developed. The director may examine insurers as is necessary to ascertain whether any rating systems affected by such rules and regulations meet the standards contained in this section.

(8) No filing or any supporting information provided by an insurer pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the approval or disapproval of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

(9) The director shall review filings as soon as reasonably possible after they have been made. The director shall disapprove a filing if:

(a) The filing fails to meet the standards contained in section 44-7510;

(b) The insurer has more than one rating system applicable to the line or type of insurance and the insurer fails to specify objective differences between risks to determine the risks and the coverages to which the rating system will apply;

(c) The filing proposes to discriminate between risks based on optional commission differences for agents; or

(d) The filing discriminates between risks based on subjective factors, except that (i) an experience rating plan may use loss reserves without being considered as subjective and (ii) a fire insurance rating plan applying to commercial risks filed for the sole use by an advisory organization may be approved even though it contains subjective rating factors.

(10) Within thirty days after receipt, the director shall approve a filing that meets the requirements of the act, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer or advisory organization. A filing shall be deemed to meet the requirements of the act unless disapproved by the director within the review period or any extension thereof.

(11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of the act, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and state that such filing shall not become effective.

(12) Filings shall become effective on their proposed effective date if approved or deemed approved on or before that date. Filings approved or deemed approved after their proposed effective dates shall become effective after notification by the insurer of a revised effective date, which shall not be prior to the date that the insurer mails the notification to the director. If an insurer fails to furnish a revised effective date within a reasonable period of time not less than ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(13) An insurer or advisory organization whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

(14) If, at any time after approval, the director finds that a rating system or modification thereof does not meet or no longer meets the requirements of the act, the director shall hold a hearing in accordance with section 44-7532.

(15) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

(16) If, after a hearing initiated pursuant to subsection (14) or (15) of this section, the director finds that a filing does not meet the requirements of the act, the director shall issue an order stating in what respects such filing fails to

meet the requirements and when, within a reasonable period thereafter, such rating system or aspect of a rating system shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Source: Laws 2000, LB 1119, § 11; Laws 2002, LB 1139, § 52; Laws 2005, LB 119, § 29.

44-7512 Repealed. Laws 2019, LB469, § 10.

44-7513 Policy form filings.

(1) Each insurer to which this section applies as provided in section 44-7508.01 shall file with the director every policy form and related attachment rule and every modification thereof which it proposes to use. No insurer to which this section applies shall issue a contract or policy except in accordance with the filings that are in effect for such insurer as provided in the Property and Casualty Insurance Rate and Form Act except as provided in subsection (6) or (7) of this section, section 44-7514, or rules and regulations adopted and promulgated pursuant to section 44-7515.

(2) Every filing shall state its proposed effective date, which shall not be prior to the date that the director receives the filing. Instead of a specific date, a filing may indicate that it will be effective a reasonable specified period of time after approval or that the insurer will notify the director of the effective date within ninety days after approval.

(3) Every policy form filing shall explain the intended use of such policy forms. Filings shall include a list of policy forms that will be replaced when the approval of a filing will result in the replacement of previously approved policy forms. In addition, insurers shall maintain listings of policy forms that have been filed and approved by the director so that such listings can be provided upon request.

(4) If additional information is needed to complete review of a policy form filing, the director may require the filer to furnish the information and in that event the review period in subsection (10) of this section shall commence on the date such information is received by the director. If a filer fails to furnish the required information within ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(5) An insurer may authorize the director to accept policy form filings made on its behalf by an advisory organization.

(6)(a) Subject to the following requirements, policy forms unique in character and designed for and used with regard to an individual risk under common ownership subject to the rate filing provisions of section 44-7508 shall be exempt from the approval requirements contained in subsection (1) of this section.

(b) At the earliest practical opportunity, but no later than thirty days after the effective date of the policy using unfiled provisions, the insurer shall provide the prospective insured with a written listing of the policy forms that have not been approved by the director and receive written acknowledgment from prospective insureds for which it ultimately provides coverage. This requirement does not apply to renewals using the same unfiled policy forms.

(c) A policy form that has been used in this state or elsewhere by the insurer for another risk shall not be subject to the exemption provided by this subsection, except that an insurer may use a policy form previously developed for a single risk for a second risk if the policy form is filed for approval within sixty days after its second usage.

(d) The exemption provided by this subsection shall not apply to workers' compensation or excess workers' compensation insurance policy forms or to policy forms that, prior to their use by the insurer, had been filed by an advisory organization in this state or had been filed by the insurer in any jurisdiction, regardless of whether approval was received.

(e) The director may by rules and regulations or by order make specific restrictions relating to the exemption provided by this subsection and may require the informational filing of policy forms subject to such exemption within a reasonable time after their use.

(7) The director may by rules and regulations suspend or modify the filing requirements of this section as to any type of insurance or class of risk for which policy forms cannot practicably be filed before they are used. The director may examine insurers as is necessary to ascertain whether any policy forms affected by such rules and regulations meet the standards contained in the act.

(8) No filing or any supporting information provided by an insurer pursuant to this section shall be open to public inspection pursuant to sections 84-712 to 84-712.09 before the approval or disapproval of the filing unless publicly disclosed in an open court, open administrative proceeding, or open meeting or disclosed by the director pursuant to statute. Correspondence specifically relating to individual risks shall be confidential and may not be made public by the director except as may be compiled in summaries of such activity.

(9) The director shall review filings as soon as reasonably possible after they have been made. The director shall disapprove a filing that contains provisions, exceptions, or conditions that: (a) Are unjust, unfair, ambiguous, inconsistent, inequitable, misleading, deceptive, or contrary to public policy; (b) are written so as to encourage the misrepresentation of coverage; (c) fail to reasonably provide the general coverage for policies of that type; (d) fail to comply with the provisions or the intent of the laws of this state; or (e) would provide coverage contrary to the public interest.

(10) Within thirty days after receipt, the director shall approve filings that meet the requirements of the act, except that this review period may be extended for an additional period not to exceed thirty days if the director gives written notice within the original review period to the insurer or advisory organization. A filing shall be deemed to meet the requirements of the act unless disapproved by the director within the review period or any extension thereof.

(11) If, within the review period provided by subsection (10) of this section or any extension thereof, the director finds that a filing does not meet the requirements of the act, a written disapproval notice shall be sent to the insurer. Such notice shall specify in what respects the filing fails to meet these requirements and state that such filing shall not become effective.

(12) Filings shall become effective on their proposed effective date if approved or deemed approved on or before that date. Filings approved or deemed approved after their proposed effective dates shall become effective after

notification by the insurer of a revised effective date, which shall not be prior to the date that the insurer mails the notification to the director. If an insurer fails to furnish a revised effective date within a reasonable period of time not less than ninety days, the director may, by written notice sent to the insurer, deem the filing as withdrawn and not available for use.

(13) An insurer or advisory organization whose filing is disapproved may, within thirty days after receipt of a disapproval notice, request a hearing in accordance with section 44-7532.

(14) If, at any time after approval, the director finds that a policy form, attachment rule, or modification thereof does not meet or no longer meets the requirements of the act, the director shall hold a hearing in accordance with section 44-7532.

(15) Any insured aggrieved with respect to any filing may make written application to the director for a hearing on such filing. The hearing application shall specify the grounds to be relied upon by the applicant. If the director finds that the hearing application is made in good faith, that a remedy would be available if the grounds are established, or that such grounds otherwise justify holding a hearing, the director shall hold a hearing in accordance with section 44-7532.

(16) If, after a hearing initiated pursuant to subsection (14) or (15) of this section, the director finds that a filing does not meet the requirements of the act, the director shall issue an order stating in what respects such filing fails to meet the requirements and when, within a reasonable period thereafter, such policy form or attachment rule shall no longer be used. Copies of the order shall be sent to the applicant, if applicable, and to every affected insurer and advisory organization. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

Source: Laws 2000, LB 1119, § 13; Laws 2002, LB 1139, § 53; Laws 2003, LB 216, § 22; Laws 2006, LB 875, § 12; Laws 2019, LB469, § 7.

44-7514 Policy form approval requirements applying to qualifying multistate commercial policyholder; exemption.

(1) The policy form approval requirements set forth in section 44-7513 shall not apply to policies written for individual commercial risks of a qualifying multistate commercial policyholder. For the purposes of this section, a qualifying multistate commercial policyholder is an entity that meets the following qualifications:

(a) The policyholder is commercial in nature;

(b) If the policyholder is comprised of multiple corporations or other entities, there is common or majority ownership of each of the members by the same parent entity. Qualifying multistate commercial policyholder does not include franchise arrangements or other groups where individual members of the group are under different ownership; and

(c) The office with the largest number of the officers and senior management of the policyholder is located outside of Nebraska. If this criteria is not meaningful or is ambiguous for a policyholder, then the total premiums for lines of insurance subject to the Property and Casualty Insurance Rate and

Form Act that are attributable to another jurisdiction must exceed those premiums attributable to Nebraska.

(2) Policy forms for commercial risks exempted by this section may include language that conflicts with sections 44-357, 44-358, and 44-501.02. If a conflict results between a policy form and the requirements of such sections, such sections shall apply.

(3) Policy forms for commercial risks exempted by this section may include language that conflicts with sections 44-349, 44-350, 44-501, 44-514 to 44-518, 44-520 to 44-523, and 44-6408 and the provision of section 44-601 that prohibits policies with a term longer than five years. If a conflict results between a policy form and the requirements of any of these sections, the language in the policy form shall apply to the extent that it is inconsistent with such sections.

(4) Except as set forth in subsections (2) and (3) of this section, the policy forms exempted from policy form approval requirements shall not violate any law of this state.

Source: Laws 2000, LB 1119, § 14; Laws 2019, LB469, § 8.

44-7515 Exemption from the requirement for insurers to use filed rates and policy forms for certain commercial policyholders; eligibility for professional employer organizations.

(1) The director shall adopt and promulgate rules and regulations to modify or eliminate requirements for insurers to use filed rates and policy forms for commercial policyholders under common ownership identified through the application of subsection (4) of this section. Unless set forth by rules and regulations, on and after January 1, 2012, eligibility for a professional employer organization shall be based upon the professional employer organization's total premiums, including premiums for multiple coordinated policies written for the professional employer organization's clients. Unless otherwise set forth in the rules and regulations, the rules and regulations apply to multiple coordinated policies written on behalf of an eligible professional employer organization.

(2) The rules and regulations adopted and promulgated pursuant to this section may establish requirements and thresholds that differ by line or type of insurance or that differ for rates and policy forms.

(3) The rules and regulations adopted and promulgated pursuant to this section shall require insurers to inform exempt commercial policyholders at the earliest practical date, but no later than thirty days after the inception of coverage, of those policy forms applying to them that have not been approved by the director.

(4) The director shall consider the following factors in determining those commercial policyholders to which the rules and regulations adopted and promulgated pursuant to this section shall apply:

(a) For modification or elimination of the applicability of filed rates, characteristics of insureds that are likely to avail themselves of regular price comparisons between competing insurers and are likely to study and understand the differences and details of pricing proposals that they receive;

(b) For modification or elimination of the applicability of filed rates, characteristics of insureds for which filed rates and rating plans are less likely to

provide the lowest premiums otherwise consistent with the provisions of the Property and Casualty Insurance Rate and Form Act;

(c) Modification or elimination of the applicability of filed rates for commercial insureds that are primarily located in another jurisdiction where they are subject to similar exemptions or waivers in that jurisdiction;

(d) For modification or elimination of the applicability of filed policy forms, characteristics of insureds that are likely to study and understand the details of their business risks and insurance coverages and exclusions;

(e) For modification or elimination of the applicability of filed policy forms, characteristics of insureds that are likely to require individually written policies, as contrasted to insureds that can customarily have their coverage needs met using policy forms that could also be used for other insureds;

(f) For both rates and policy forms, favorable or adverse experiences with the modification or elimination of regulatory requirements, especially the experience in this state; and

(g) Any other relevant factor.

(5) For exempt commercial policyholders to which rating system regulation is made otherwise inapplicable, insurers shall allocate premiums between policies, exposures, and states in proportion to the expected losses and expenses for those policies, exposures, and states.

(6) The following restrictions apply to rules and regulations adopted and promulgated pursuant to this section:

(a) The rules and regulations may not allow any reduction of the benefits payable under workers' compensation or excess workers' compensation policies or any alteration of provisions for the handling and settlement of claims under such policies, but the rules and regulations may allow exempt commercial policyholders to negotiate workers' compensation or excess workers' compensation premiums and premium payment provisions;

(b) The rules and regulations may not allow any reduction of automobile insurance coverage limits to less than those required by Nebraska law, but the rules and regulations may allow exempt commercial policyholders to negotiate automobile insurance premiums and premium payment provisions;

(c) The rules and regulations may not allow any limitation of the coverage provisions necessary for health care providers to qualify under the Nebraska Hospital-Medical Liability Act, but the rules and regulations may allow exempt commercial policyholders to negotiate medical professional liability insurance premiums and premium payment provisions;

(d) The rules and regulations may not reduce the rate regulatory requirements applying to insurance written for a professional employer organization on or after January 1, 2012, or to any insurance written for an individual policyholder that is not a client of a professional employer organization with total premiums of less than twenty-five thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act; and

(e) The rules and regulations may not reduce the form regulatory requirements applying to insurance written for a professional employer organization on or after January 1, 2012, or to any insurance written for an individual policyholder that is not a client of a professional employer organization with total premiums of less than fifty thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act.

(7) Policy forms for commercial risks exempted by the rules and regulations adopted and promulgated pursuant to this section may include language that conflicts with section 44-501. If a conflict results between a policy form and the requirements of section 44-501, the language in the policy form shall apply to the extent that it is inconsistent with such section.

Source: Laws 2000, LB 1119, § 15; Laws 2002, LB 1139, § 54; Laws 2003, LB 216, § 23; Laws 2010, LB579, § 13.

Cross References

Nebraska Hospital-Medical Liability Act, see section 44-2855.

44-7516 Use of nonadmitted insurers by exempt commercial policyholders.

(1) The director shall adopt and promulgate rules and regulations to allow exempt commercial policyholders to be exempt from those provisions of sections 44-5510 and 44-5511 that require, as a condition for the purchase of insurance from a nonadmitted insurer, that applicants demonstrate an inability to obtain insurance from a licensed insurer. Such exemption shall not apply to workers' compensation insurance, excess workers' compensation insurance, or automobile liability insurance, except that such exemption may apply to automobile liability insurance purchased as excess insurance over a policy that provides limits that are at least equal to the minimum limits of liability required by section 60-534.

(2) The rules and regulations adopted and promulgated pursuant to this section may establish requirements and thresholds that differ by line or type of insurance or that differ from the requirements and thresholds for exemption from rate and policy form requirements adopted and promulgated pursuant to section 44-7515.

(3) In addition to the factors specified in section 44-7515, the director shall consider the following in making a determination of the requirements and thresholds that will apply:

(a) The relationship of deductibles, self-insured retentions, and limits of liability purchased by insureds versus the protection provided by the Nebraska Property and Liability Insurance Guaranty Association;

(b) The characteristics of insureds likely to be able to evaluate the ability of a nonadmitted insurer to meet its policy obligations; and

(c) The characteristics of insureds likely to be able to resolve policy and claims disputes that they may have with a nonadmitted insurer.

(4) The rules and regulations may not exempt any policyholder with total premiums of less than one hundred thousand dollars for lines of insurance subject to the Property and Casualty Insurance Rate and Form Act.

Source: Laws 2000, LB 1119, § 16.

44-7516.01 Private passenger automobile liability policy; disclosure; requirements.

(1) On and after July 1, 2002, no private passenger automobile liability policy shall be delivered, issued for delivery, or renewed with respect to any motor vehicle licensed in this state unless accompanied by a disclosure showing the location used to determine the rate charged to the named insured and if any credit-based rating was used to determine the rate charged.

(2) For an insurer determined by the director to be an insurer with a substantial market share of the private passenger automobile insurance premium written in this state:

(a) The private passenger automobile liability insurance rating territories for motor vehicles located in a city of the metropolitan class that are contained in the insurer's qualifying rate filing made on or after January 1, 2002, shall be deemed to expire three years after their effective date unless they are refiled;

(b) Unless the insurer has made a qualifying rate filing with an effective date on or after January 1, 2002, as provided in subdivision (2)(a) of this section, all filings made by the insurer of private passenger automobile insurance that justify the rating relativities of a rating territory for motor vehicles located in a city of the metropolitan class shall expire July 1, 2003;

(c) If necessary for the director to complete his or her study of a rating system filing that is proposed as a qualifying rate filing, the director shall extend the three-year period if the insurer has made a proposed qualifying rate filing prior to the end of the three-year period with a requested effective date no later than three years after the effective date of its last qualifying rate filing;

(d) A filing made by an advisory organization on behalf of an insurer shall be deemed to be a filing by the insurer for purposes of the expiration requirement of this subsection; and

(e) For purposes of this subsection:

(i) Insurer with a substantial market share of the private passenger automobile insurance premium written in this state means:

(A) An insurer that is one of the ten insurers writing the largest amount of private passenger automobile insurance premium in this state; or

(B) An insurer that meets any other standard prescribed by rule and regulation adopted and promulgated by the director; and

(ii) Qualifying rate filing means an approved rating system filing that justifies the rating relativities of the private passenger automobile liability insurance rating territories for motor vehicles located in a city of the metropolitan class made on or after January 1, 2002.

Source: Laws 2001, LB 444, § 2.

44-7517 Information to be furnished insureds; hearing; appeal.

Within a reasonable time after receiving a written request and after receiving payment of such reasonable charge as it may require, every insurer and advisory organization shall furnish all pertinent information to any insured affected by a rate, premium, or prospective loss cost made by the insurer or advisory organization. Upon written request, every insurer and advisory organization shall provide within this state reasonable means by which the insured aggrieved by the application of the advisory organization's or insurer's rating system may be heard, in person or by an authorized representative, to review the manner in which such rating system has been applied in connection with the insurance afforded the insured. If the insurer or advisory organization fails to act upon such request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. An insured affected by the action of the insurer or advisory organization on such request may appeal to the director within thirty days after written notice of such action. The director, after a hearing held in accordance with section 44-7532, may

affirm the action of the insurer or advisory organization or order remedial action to be undertaken by the insurer or advisory organization.

Source: Laws 2000, LB 1119, § 17.

44-7518 Advisory organizations and statistical agents; certificate of authority required; application; director; powers.

(1) No advisory organization or statistical agent shall provide any service relating to insurance subject to the Property and Casualty Insurance Rate and Form Act, and no insurer shall use the services of such advisory organization or statistical agent for such purposes, unless the advisory organization or statistical agent has been issued a certificate of authority by the director. Such certificate of authority shall expire on April 30 each year and shall be renewed annually if the advisory organization or statistical agent has continued to comply with the laws of this state and the rules and regulations of the director.

(2) No advisory organization or statistical agent shall refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

(3) An advisory organization or statistical agent applying to the director for a certificate of authority shall include with its application:

(a) A copy of its constitution, charter, articles of incorporation, organization, agreement, or association, bylaws, plan of operation, and other rules or regulations governing the conduct of its business;

(b) The names of insurers that own or have control over the applicant, and a description of their ownership or control;

(c) The name and address of a resident of this state upon whom notices, process, or orders of the director may be served;

(d) Information showing its qualifications for acting in the capacity for which it seeks a certificate of authority;

(e) Biographical information on its officers; and

(f) Any other relevant information and documents that the director may require.

(4) Every applicant for a certificate of authority shall notify the director of all material changes in the information or documents on which its application was based. Any amendment to a document filed under this section shall be filed at least thirty days before it becomes effective.

(5) The director shall issue a certificate of authority stating the authorized activity of the applicant for those applicants that meet all requirements of the law and are competent, trustworthy, and qualified to provide the services proposed. The authorized activity of an advisory organization or statistical agent may be limited to specified lines or types of insurance.

(6) The director may at any time, after a hearing in accordance with section 44-7532, suspend or revoke the certificate of authority of an advisory organization or statistical agent that does not comply with the requirements of the act.

(7) An applicant requesting a certificate of authority to operate both as an advisory organization and as a statistical agent may be so authorized under a single certificate.

Source: Laws 2000, LB 1119, § 18.

44-7519 Insurers, advisory organizations, and statistical agents; prohibited acts.

(1) No insurer, advisory organization, or statistical agent shall attempt to monopolize or combine or conspire with any other person to monopolize an insurance market or to engage in a boycott, on a concerted basis, of an insurance market.

(2) No insurer shall agree with any other insurer or with any advisory organization or statistical agent to require adherence to or to require use of any aspect of any rating system, form, prospective loss cost, dividend payment practice, underwriting rule or practice, survey, inspection, or similar material except as required by section 44-7524 or as is necessary to develop statistical plans. This subsection shall not apply to agreements between insurers under the same ownership.

(3) No advisory organization or statistical agent shall agree with any insurer or with another advisory organization or statistical agent to require adherence to or to require use of any aspect of any rating system, form, prospective loss cost, dividend payment practice, underwriting rule or practice, survey, inspection, or similar material except as required by section 44-7524 or as is necessary to develop statistical plans.

(4) The fact that two or more insurers, whether or not members or subscribers of an advisory organization, consistently or intermittently use the same rates, rating systems, forms, prospective loss costs, underwriting rules or practices, surveys, inspections, or similar materials shall not be sufficient basis to establish a violation of this section.

(5) No insurer, advisory organization, or statistical agent shall make any arrangement with any other insurer, advisory organization, statistical agent, or other person which has the purpose or effect of unreasonably restraining trade or of substantially lessening competition in the business of insurance.

Source: Laws 2000, LB 1119, § 19.

44-7520 Advisory organizations and statistical agents; prohibited activities.

Except as permitted in sections 44-7521 and 44-7522, no advisory organization or statistical agent shall compile, file, or distribute recommendations relating to rating systems that include profits, dividends, or expenses other than loss adjustment expenses.

Source: Laws 2000, LB 1119, § 20.

44-7521 Statistical agents; authorized activities.

A statistical agent may, for the lines of insurance for which it has been licensed:

(1) Develop statistical plans including territorial and class definitions;

(2) Collect and distribute statistical data from insurers or any other source;

(3) Collect, compile, and publish past and current rates charged by individual insurers if such information is also made available to the general public at no more than a reasonable cost;

(4) Collect and compile exposure and loss experience for the purpose of individual risk experience ratings;

(5) Undertake educational activities relating to the collection, compilation, or interpretation of insurance-related data;

(6) Distribute any other information that is filed with the director; and

(7) Furnish any other services, as approved or directed by the director, related to those enumerated in this section.

Source: Laws 2000, LB 1119, § 21.

44-7522 Advisory organizations; authorized activities.

An advisory organization may, for the lines of insurance for which it has been licensed:

(1) Engage in those activities enumerated in section 44-7521;

(2) Prepare, file, and distribute prospective loss costs;

(3) Prepare, file, and distribute manuals of rating rules, rating schedules, experience rating plans and other supplementary rating information that do not include final rates, expense provisions, profit provisions, or minimum premiums;

(4) Prepare and distribute experience rating plan modifiers for individual policyholders;

(5) Prepare, file, and distribute factors, calculations, or formulas pertaining to classification, territory, and other variables;

(6) Prepare, file, and distribute increased limits factors, which may include an incremental profit load, also called a risk load;

(7) Conduct research and inspections in order to prepare classifications of public fire defenses or to evaluate the effectiveness of building codes and their enforcement;

(8) Conduct inspections to determine rating classifications for individual insureds;

(9) Consult with public officials regarding public fire protection as it would affect members, subscribers, and others;

(10) Conduct research in order to discover, identify, and classify information relating to causes or prevention of losses;

(11) Prepare, file, and distribute policy forms and gather information from members, subscribers, and others relative to the application and interpretation of the policy forms;

(12) Conduct research and inspections for the purpose of providing risk information relating to individual structures;

(13) If instructed by the director, file rates instead of prospective loss costs for assigned risk or other residual market mechanisms;

(14) Conduct research to determine the impact of statutory changes upon prospective loss costs;

(15) Undertake educational activities on the use of policy forms, analysis of losses, loss trends, loss reserves, expenses, and other policy form and ratemaking topics;

(16) For workers' compensation insurance, establish a committee that may include insurance company representatives to review the application of the

classification system for individual insureds and to suggest modifications to the classification system;

(17) Distribute any other information that is filed with the director; and

(18) Furnish any other services approved or directed by the director related to the services enumerated in this section.

Source: Laws 2000, LB 1119, § 22.

44-7523 Advisory organizations; general filing requirements applicable.

Filings by an advisory organization of prospective loss costs, rating systems or policy forms and related attachment rules shall be subject to the provisions of the Property and Casualty Insurance Rate and Form Act applicable to filings generally. Rating system filings by an advisory organization shall be subject to the provisions of sections 44-7510 and 44-7511.

Source: Laws 2000, LB 1119, § 23.

44-7524 Workers' compensation; uniform classification system required; premiums; how calculated.

(1) Every workers' compensation insurer shall adhere to a uniform classification system and shall report its experience in accordance with statistical plans and other reporting requirements to ensure that data is combined for all insurers for the development of prospective loss costs and the application of experience rating.

(2) Every insurer shall utilize experience rating plan modifiers developed by an advisory organization pursuant to an experience rating plan approved by the director.

(3) A workers' compensation insurer may develop subclassifications of the uniform classification system upon which a rate may be made. Such subclassifications and the filing shall be subject to the provisions of the Property and Casualty Insurance Rate and Form Act applicable to rating system filings generally.

(4) The director shall disapprove subclassifications, rating plans, or other variations from manual rules filed by a workers' compensation insurer or advisory organization if the insurer or advisory organization fails to demonstrate that the data produced can be reported consistently with the uniform classification system and experience rating system and will allow for the application of experience rating.

(5) Workers' compensation premiums shall be calculated on a basis that, as nearly as is practicable, after the effects of experience rating and other applicable rating plans have been considered, the sum of expected losses and expected expenses as a percentage of premium shall be the same for high-wage-paying and low-wage-paying employers in the same job classification.

Source: Laws 2000, LB 1119, § 24.

44-7525 Joint underwriting; joint reinsurance; requirements; director; powers.

(1) Every joint underwriting pool or joint reinsurance pool shall file with the director a copy of its constitution, articles of incorporation, organization, agreement, or association, bylaws, and other rules and regulations governing

its activities, a listing of its members, the name and address of a resident of this state upon whom notices, process, or orders of the director may be served, and any amendments or changes thereto.

(2) Notwithstanding section 44-7519, insurers participating in joint underwriting or in joint underwriting pools or joint reinsurance pools may, in connection with such activity, act in cooperation with each other in the development of rates, rating systems, policy forms, underwriting rules, surveys, inspections, and investigations, the furnishing of loss and expense statistics or other information, or the conducting of research.

(3) Except as provided in this section, joint underwriting, joint underwriting pool, and joint reinsurance pool activities shall be subject to the Property and Casualty Insurance Rate and Form Act.

(4) If, after a hearing in accordance with section 44-7532, the director finds that any activity or practice of an insurer participating in joint underwriting, a joint underwriting pool, or a joint reinsurance pool will tend to lessen competition in any market or is otherwise inconsistent with the provisions or purposes of the act, the director may issue an order requiring the discontinuance of such activity or practice.

Source: Laws 2000, LB 1119, § 25.

44-7526 Examinations.

(1) To ascertain compliance with the Property and Casualty Insurance Rate and Form Act, the director may, as often as is deemed to be expedient, make or cause to be made an examination of each advisory organization, statistical agent, joint underwriting pool, or joint reinsurance pool doing business in this state. The advisory organization, statistical agent, or pool examined shall pay the reasonable costs of any such examination. The officers, manager, agents, and employees of such advisory organization, statistical agent, or pool may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation.

(2) In lieu of any such examination, the director may accept (a) the report of an examination made by the insurance supervisory official of another state or (b) the report of an independent certified public accountant in good standing with the American Institute of Certified Public Accountants. Every such advisory organization, statistical agent, joint underwriting pool, or joint reinsurance pool shall, within thirty days after the receipt of a final examination report of any other state, provide a copy of the report to the director. Every such advisory organization, statistical agent, joint underwriting pool, or joint reinsurance pool shall, within thirty days after the publication or public filing of a report made by an independent certified public accountant, provide a copy of the report to the director.

Source: Laws 2000, LB 1119, § 26.

44-7527 Statistical data; collection and exchange; rules and regulations.

(1) The director shall adopt and promulgate rules and regulations to assure that the experience of all insurers is provided to the director at least annually in such form and detail as is necessary to aid in effecting the purposes of the Property and Casualty Insurance Rate and Form Act. The director may designate one or more statistical agents to assist in gathering such experience and

making compilations thereof. The scope of such rules and regulations may include the data which must be reported by insurers, definitions of data elements, the timing and frequency of statistical reporting by insurers, data quality standards, data edit and audit requirements, data retention requirements, reports to be generated by statistical agents to fulfill the requirements of this section, and the timing of such reports.

(2) Should the director choose to designate more than one statistical agent to assist for a line or type of insurance, the director may adopt and promulgate rules and regulations necessary to ensure that statistical data that the director has required is combined for reports to the director.

(3) The following provisions apply only to the disclosure of data and reports provided to the director pursuant to this section and to the disclosure of reports produced by the director from data and reports provided pursuant to this section:

(a) The director shall not disclose data that identifies individual insurers;

(b) The director shall not disclose data that is likely to identify individual policyholders or claimants or when there is reason to suspect that individual open claim reserves may be identified with individual policyholders or claimants;

(c) The director may agree in advance to withhold data from public disclosure when confidentiality is requested by the statistical agent providing the data to the director, but only if the data include data elements that the director had not required, prior to their writing or occurrence, to be recorded by insurers; and

(d) All other data contained in reports made pursuant to this section shall be subject to public disclosure.

(4) The director may adopt and promulgate rules and regulations for the interchange of data necessary for the application of rating plans.

(5) In order to further uniform administration of rate regulatory laws, the director and every insurer and advisory organization may exchange information and experience data with insurance supervisory officials, insurers, and advisory organizations in other states and may consult with them with respect to the application of rating systems.

Source: Laws 2000, LB 1119, § 27.

44-7528 Applicants unable to procure insurance; apportionment among insurers.

Insurers may agree to the equitable apportionment among them of insurance to be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods. Such insurers may agree on the use of policy forms, rating systems, and reasonable modifications thereof for such insurance. Such agreements may include pooling arrangements or reinsurance. Such agreements, policy forms, rating systems, and modifications thereof shall be subject to the approval of the director.

Source: Laws 2000, LB 1119, § 28.

44-7529 False or misleading information; prohibited acts.

No person shall willfully withhold information that will affect the forms applicable, dividends payable, or rates or premiums chargeable from the director or any statistical agent, advisory organization, or insurer. No person shall knowingly give false or misleading information that will affect the policy forms applicable, dividends payable, or rates or premiums chargeable to the director or any statistical agent, advisory organization, or insurer. A person who violates this section shall be subject to provisions of section 44-7530.

Source: Laws 2000, LB 1119, § 29.

44-7530 Violations; director; hearing; powers and duties.

(1) Whenever the director has reason to believe that any person has violated any provision of the Property and Casualty Insurance Rate and Form Act, the director shall hold a hearing in accordance with section 44-7532. If, after such hearing, the director determines that the person has violated any provision of the act, the director may order any one or more of the following:

(a) Payment of an administrative penalty of not more than one thousand dollars for every act or violation but not to exceed an aggregate penalty of ten thousand dollars in any six-month period unless the person knew or reasonably should have known of the violation of the act, in which case the penalty shall be not more than five thousand dollars for every act or violation not to exceed an aggregate penalty of fifty thousand dollars in any six-month period; and

(b) Suspension or revocation of the person's license or certificate of authority if such person knew or reasonably should have known of the violation.

(2) The powers, remedies, procedures, and penalties provided in the act shall be in addition to any other penalty, remedies, procedures, and penalties provided by law.

Source: Laws 2000, LB 1119, § 30.

44-7531 Hearing; request.

Any insurer, joint underwriting pool, joint reinsurance pool, statistical agent, or advisory organization aggrieved by any order or decision of the director made without a hearing may, within thirty days after notice of the order, make written request to the director for a hearing thereon in accordance with section 44-7532. Pending such hearing and decision, the director may suspend the effective date of his or her action.

Source: Laws 2000, LB 1119, § 31.

44-7532 Hearing; procedure.

If a hearing is held at the request of a party other than the director, unless mutually agreed upon by the director and all interested parties, notice of hearing shall be provided within thirty days after the director's receipt of a written request for a hearing. Notice of hearing shall be given to all interested parties and shall state the time, place, and purpose of the hearing. Unless mutually agreed upon by the director and all interested parties, the hearing shall be held not less than ten days after notice is served. Unless mutually agreed upon by the director and all interested parties or unless the hearing is being held at the request of the director, the hearing shall be held not more than thirty days after notice is served.

Source: Laws 2000, LB 1119, § 32.

The language in this section referring to notice to ''all interested parties'' contemplates notice by the Nebraska Department of Insurance to both the insured and the insurer regarding the adversarial proceeding to come. It would not be a sensible reading of the statutes to require notice to only one of the parties, where both parties are active in the proceeding but seek different outcomes. Travelers Indem. Co. v. Gridiron Mgmt. Group, 281 Neb. 113, 794 N.W.2d 143 (2011).

44-7533 Appeals.

Any order or decision of the director made pursuant to the Property and Casualty Insurance Rate and Form Act may be appealed by any party in interest. The appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 2000, LB 1119, § 33.

Cross References

Administrative Procedure Act, see section 84-920.

44-7534 Electronic filings and correspondence.

The director may make reasonable arrangements and adopt and promulgate rules and regulations to allow or to facilitate the use of electronic media to make filings or to engage in correspondence required by the Property and Casualty Insurance Rate and Form Act.

Source: Laws 2000, LB 1119, § 34.

44-7535 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Property and Casualty Insurance Rate and Form Act. The rules and regulations shall not be effective prior to January 1, 2001.

Source: Laws 2000, LB 1119, § 35.

ARTICLE 76

MULTIPLE EMPLOYER WELFARE ARRANGEMENT ACT

Section

44-7601 Act, how cited.

Sections 44-7601 to 44-7618 shall be known and may be cited as the Multiple Employer Welfare Arrangement Act.

Source: Laws 2002, LB 1139, § 1; Laws 2020, LB1014, § 1.

44-7602 Legislative findings and intent.

(1) The Legislature finds and declares that the United States Congress recognized multiple employer welfare arrangements as vehicles for offering traditional accident and health benefit programs through the Employee Retirement Income Security Act of 1974. Multiple employer welfare arrangements may be subject to state regulatory and fiscal standards not inconsistent with the federal act if the multiple employer welfare arrangement offers health benefit plans that are not fully insured. The provisions of the Multiple Employer Welfare Arrangement Act are consistent with and authorized by the federal act, which confers upon the states authority to regulate multiple employer welfare arrangements.

(2) It is the intent of the Legislature:

(a) To promote the legitimacy and the financial integrity of health benefit plans that are not fully insured by requiring multiple employer welfare arrangements offering such plans to obtain a certificate of registration from the director;

(b) That the Multiple Employer Welfare Arrangement Act not apply to fully insured health benefit plans offered by multiple employer welfare arrangements;

(c) That the act shall be construed to mean that multiple employer welfare arrangements are not insurers for purposes of the insurance laws of this state; and

(d) That the insurance laws of this state not apply to health benefit plans offered by multiple employer welfare arrangements except as specifically set forth in the act.

Source: Laws 2002, LB 1139, § 2.

44-7603 Terms, defined.

For purposes of the Multiple Employer Welfare Arrangement Act:

(1) Certificate of registration means a document issued by the director authorizing a multiple employer welfare arrangement to offer a health benefit plan that is not fully insured;

(2) Covered individual means (a) an employee who is covered by a health benefit plan provided through a multiple employer welfare arrangement in which the employer is participating or (b) a self-employed individual who is covered by a health benefit plan provided through a multiple employer welfare arrangement. Covered individual includes a dependent of an employee or self-employed individual as defined under the terms of the health benefit plan;

(3) Director means the Director of Insurance;

(4) Fully insured health benefit plan means a health benefit plan which provides for health benefits, all of which are guaranteed under a contract or policy of insurance issued by an insurance company licensed to transact the business of insurance in this state;

(5) Health benefit plan means an employee welfare benefit plan to the extent that it provides any hospital, surgical, or medical expense benefits to covered individuals directly or through insurance, reimbursement, or otherwise. Health benefit plan does not include (a) accident-only, disability income, hospital confinement indemnity, dental, or credit insurance, (b) coverage issued as a supplement to liability insurance, (c) medicare or insurance provided as a supplement to medicare, (d) insurance arising from workers' compensation provisions, (e) automobile medical payment insurance, (f) any other specific limited coverage, or (g) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy;

(6) Multiple employer welfare arrangement means a multiple employer welfare arrangement as defined by 29 U.S.C. 1002, as such section existed on January 1, 2002, if the multiple employer welfare arrangement is sponsored by an association of employers that offers a health benefit plan that is not fully insured. Such association of employers may include self-employed individuals;

(7) Participating employer means an employer or self-employed individual that participates in a multiple employer welfare arrangement; and

(8) Self-employed individual means an individual who:

(a) Has an ownership interest in a trade or business in Nebraska, regardless of whether the trade or business is incorporated or unincorporated;

(b) Earns wages or self-employment income from the trade or business; and

(c) Works at least twenty hours per week or eighty hours per month providing personal services to the trade or business or earns annual income from the trade or business in an amount that is no less than the individual's and any covered dependent's annual cost for health benefit plan coverage under the multiple employer welfare arrangement.

Source: Laws 2002, LB 1139, § 3; Laws 2020, LB1014, § 2.

44-7604 Health benefit plan; offer to self-employed individual or employer; restrictions.

No multiple employer welfare arrangement may offer to a self-employed individual or to an employer that is domiciled in this state or that has its principal headquarters or principal administrative offices in this state a health benefit plan unless the health benefit plan is a fully insured health benefit plan or unless the multiple employer welfare arrangement obtains and maintains a certificate of registration pursuant to the Multiple Employer Welfare Arrangement Act.

Source: Laws 2002, LB 1139, § 4; Laws 2020, LB1014, § 3.

44-7605 Certificate of registration; procedure.

(1) A multiple employer welfare arrangement seeking to offer a health benefit plan that is not fully insured shall apply for a certificate of registration in a form prescribed by the director. The application shall be completed and submitted to the director together with a one-thousand-dollar fee and the following:

(a) Copies of all articles, bylaws, agreements, and other documents or instruments describing the organizational structure of the applicant;

(b) Copies of all materials and documents describing the rights and obligations of participating employers and covered individuals with respect to the applicant;

(c) A copy of the trust agreement of the applicant;

(d) A copy of the unaudited financial statement required by section 44-7613;

(e) A statement showing in full detail the plan for offering a health benefit plan by the applicant;

(f) Copies of all contracts and other instruments proposed to be made, offered, or sold by the applicant to its participating employers, together with a copy of its summary plan description and the proposed advertising matter to be used in the solicitation of participating employers;

(g) A copy of the contract with the third-party administrator retained, if any, to administer the health benefit plan;

(h) A copy of the stop-loss insurance policy required by section 44-7609; and

(i) Any other reasonable information requested by the director.

(2) The director shall deny a certificate of registration if the applicant does not meet the requirements of the Multiple Employer Welfare Arrangement Act. Notice of denial shall be in writing and shall set forth the basis for the denial. If the applicant submits a written request for reconsideration within thirty days after the notice was sent by the director, the director shall conduct a hearing on the denial pursuant to the Administrative Procedure Act.

Source: Laws 2002, LB 1139, § 5; Laws 2020, LB1014, § 4.

Cross References

Administrative Procedure Act, see section 84-920.

44-7606 Association of participating employers or covered individuals; requirements.

A multiple employer welfare arrangement may only be established and maintained by an association of participating employers or covered individuals who are self-employed individuals. The association shall not condition membership in the association, the amounts of dues or other payments for membership, or coverage under a health benefit plan on the basis of health-status-related factors with respect to the covered individuals offered coverage under the health benefit plan. The association shall:

(1) Have been in existence and engaged in substantive activity for its members other than sponsorship of a health benefit plan for more than three years prior to application for a certificate of registration;

(2) Be composed of two or more members, all of which are in the same trade or industry; and

(3) Have, before application for a certificate of registration is made, applications for participation (a) from two or more members who are participating employers with an aggregate of two hundred or more covered individuals or (b) from at least two hundred covered individuals who are self-employed individuals.

Source: Laws 2002, LB 1139, § 6; Laws 2020, LB1014, § 5.

44-7607 Trust required; when.

(1) A multiple employer welfare arrangement offering a health benefit plan that is not fully insured shall establish a trust pursuant to a written trust agreement to hold all funds pertaining to the health benefit plan. The trust shall be operated by a board of trustees pursuant to the trust agreement.

(2)(a) All members of the board of trustees shall be owners, partners, officers, directors, or employees of one or more participating employers.

(b) No person may be a member of the board of trustees if such person:

(i) Is an owner, officer or employee, or a partner in, or a contract administrator, or other service provider to the health benefit plan or of any third-party administrator of the multiple employer welfare arrangement; or

(ii) Has been convicted of any felony or a Class I, II, or III misdemeanor.

Source: Laws 2002, LB 1139, § 7.

44-7608 Board of trustees; duties.

The board of trustees of the multiple employer welfare arrangement as required by section 44-7607 shall:

(1) Serve as a fiduciary of the trust;

(2) Be responsible as plan administrator for all operations of the health benefit plan;

(3) Have in effect rules of operation and financial control based on an annual plan of operation, adequate to carry out the terms of the health benefit plan and to meet all requirements of the Multiple Employer Welfare Arrangement Act;

(4) Consider applications of association members for participation in the multiple employer welfare arrangement; and

(5) Hold and maintain a stop-loss insurance policy pursuant to the requirements of section 44-7609.

Source: Laws 2002, LB 1139, § 8.

44-7609 Stop-loss insurance policy; requirements.

(1) A multiple employer welfare arrangement offering a health benefit plan that is not fully insured shall be a named insured under a stop-loss insurance policy that provides coverage in excess of the multiple employer welfare arrangement's retention of one hundred twenty-five percent of the multiple employer welfare arrangement's expected health claims costs as determined on an aggregate basis.

(2) A policy issued to satisfy the requirements of subsection (1) of this section shall:

(a) Be evidenced by a binder or policy by an insurer licensed to transact the business of insurance in this state; and

(b) Contain a provision that the coverage may not be terminated by the insurer unless the multiple employer welfare arrangement and the director receive a written notice of termination from the insurer at least thirty days before the effective date of the termination.

Source: Laws 2002, LB 1139, § 9.

44-7610 Assessments authorized.

If the assets of, and stop-loss insurance policy issued to, a multiple employer welfare arrangement are at any time insufficient to pay claims made against a health benefit plan, discharge liabilities and obligations relating to health benefit plan claims, and maintain adequate reserves and surpluses, the board of trustees shall be authorized to assess the participating employers in an amount necessary to remedy the deficiency.

Source: Laws 2002, LB 1139, § 10.

44-7611 Termination; liability.

Any participating employer that voluntarily terminates its participation in the multiple employer welfare arrangement or that is involuntarily terminated by the multiple employer welfare arrangement shall remain liable subsequent to the date of termination for all contractual obligations it has entered into with the multiple employer welfare arrangement on or before the date of termination.

Source: Laws 2002, LB 1139, § 11.

44-7612 Coverage notification; summary plan description; claim or appeal denial notice; statement required.

(1) A multiple employer welfare arrangement shall notify in writing each participating employer and each covered individual applying for coverage by the multiple employer welfare arrangement that a health benefit plan provided by the multiple employer welfare arrangement is not:

(a) Insurance;

(b) Subject to state laws and requirements that apply to health insurance offered by a licensed insurer; and

(c) Covered by the Nebraska Life and Health Insurance Guaranty Association.

(2) The notice required by subsection (1) of this section shall, in ten-point or greater type, disclose that the multiple employer welfare arrangement is authorized under state law to assess participating employers for claims under the health benefit plan in addition to other remedies the multiple employer welfare arrangement may take if the multiple employer welfare arrangement is unable to pay claims.

(3) If the multiple employer welfare arrangement provides coverage to covered individuals who are self-employed individuals, the multiple employer welfare arrangement shall include a statement in the summary plan description and any claim or appeal denial notice that self-employed covered individuals may contact the Director of Insurance. Such statement shall include the mailing address and telephone number for the Department of Insurance.

Source: Laws 2002, LB 1139, § 12; Laws 2020, LB1014, § 6.

Cross References

Nebraska Life and Health Insurance Guaranty Association, see section 44-2705.

44-7613 Annual financial statement; fee; actuarial statement; certificate of compliance.

(1) On an annual basis and within ninety days after the last day of the fiscal year of a multiple employer welfare arrangement, each multiple employer welfare arrangement holding a certificate of registration shall file with the

director a financial statement, attested to by at least two members of the board of trustees, one of whom shall be the chairperson or president of the board of trustees, and accompanied by a fee of two hundred dollars. The director shall review the financial statement and shall require additional filings as the director finds reasonably necessary to assure the legitimacy and the financial integrity of the multiple employer welfare arrangement.

(2) On an annual basis and within ninety days after the last day of the fiscal year of a multiple employer welfare arrangement, a statement from a qualified actuary that the rates charged and reserves, both (a) incurred and (b) incurred but not reported, regarding sufficiency to pay claims and associated expenses for the health benefit plan shall be obtained and given to the director. The actuarial statement shall include a confirmation that the stop-loss insurance policy required by section 44-7609 is in force. The actuarial statement shall meet the requirements of any rules or regulations which shall be adopted and promulgated by the director.

(3) On an annual basis and within ninety days after the last day of the fiscal year of a multiple employer welfare arrangement, each multiple employer welfare arrangement holding a certificate of registration shall file with the director a certificate of compliance signed by at least two members of the board of trustees, one of whom shall be the chairperson or president of the board of trustees, certifying that the multiple employer welfare arrangement, to the best of their knowledge, information, and belief, has been conducted in accordance with applicable provisions of Nebraska law and rules and regulations relating to multiple employer welfare arrangements.

Source: Laws 2002, LB 1139, § 13; Laws 2008, LB855, § 51.

44-7614 Disciplinary action.

(1) After notice and a hearing conducted pursuant to the Administrative Procedure Act, the director may suspend or revoke a certificate of registration or may impose an administrative fine not to exceed one thousand dollars per violation, or any combination of actions, if the director finds the multiple employer welfare arrangement:

(a) Fails to maintain the stop-loss insurance policy as required by section 44-7609;

(b) Engages in financial practices that make further transaction of business in this state hazardous or injurious to its participating employers, covered individuals, or the public;

(c) Within fifteen business days, fails to respond or request a reasonable amount of additional time to respond in which time a response is made, to an inquiry of the director;

(d) Fails for an unreasonable period to pay any final judgment rendered against it in this state on any contractual obligation;

(e) Conducts business fraudulently or has not met its contractual obligations in good faith;

(f) Made, published, disseminated, circulated, or placed before the public or caused, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio or television station, or in any other way, an advertisement, announcement, or

statement containing any assertion, representation, or statement with respect to the health benefit plan or with respect to any insurer in the conduct of his or her business which is untrue, deceptive, or misleading; or

(g) Violates any provision of the Multiple Employer Welfare Arrangement Act or section 44-106 or 44-114.

(2) Instead of or in addition to the penalties set forth in subsection (1) of this section, the director may issue a cease and desist order to a multiple employer welfare arrangement if such multiple employer welfare arrangement engages in any of the activities set forth in subsection (1) of this section.

Source: Laws 2002, LB 1139, § 14; Laws 2020, LB1014, § 7.

Cross References

Administrative Procedure Act, see section 84-920.

44-7615 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Multiple Employer Welfare Arrangement Act.

Source: Laws 2002, LB 1139, § 15.

44-7616 Offering of plan; how construed.

(1) The offering of a health benefit plan by any multiple employer welfare arrangement shall not be deemed transacting business as an insurer, association, or exchange, except as specifically set forth in the Multiple Employer Welfare Arrangement Act. The insurance laws of this state do not apply to health benefit plans offered by multiple employer welfare arrangements except as specifically set forth in the act.

(2) Nothing in the act shall be construed to include an insolvent multiple employer welfare arrangement within the provisions of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act.

Source: Laws 2002, LB 1139, § 16.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-7617 Act; applicability.

(1) Except as provided in subsection (2) of this section, the Multiple Employer Welfare Arrangement Act shall apply to multiple employer welfare arrangements offering health benefit plans on or after July 20, 2002.

(2) The Multiple Employer Welfare Arrangement Act shall apply to multiple employer welfare arrangements providing health care coverage to self-employed individuals on or after January 1, 2020.

Source: Laws 2002, LB 1139, § 17; Laws 2020, LB1014, § 9.

44-7618 Compliance with provisions of federal law, required; trust; surplus; amount required.

(1) A multiple employer welfare arrangement that provides health care coverage to self-employed individuals shall comply with the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, as such acts

existed on January 1, 2020, and the following protections for covered individuals that would otherwise be required under the Employee Retirement Income Security Act of 1974:

(a) Fiduciary duties in section 404 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1104;

(b) Claims and appeal procedures in section 503 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1133;

(c) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. 1185a;

(d) The Newborns' and Mothers' Health Protection Act of 1996, 29 U.S.C. 1185; and

(e) The Genetic Information Nondiscrimination Act of 2008, 29 U.S.C. 1182.

(2) A multiple employer welfare arrangement that provides health care coverage to covered individuals who are self-employed individuals shall establish and maintain a surplus in the trust established pursuant to section 44-7607 in an amount equal to at least seven hundred fifty thousand dollars. The director may increase the amount required to be deposited in the trust based on the director's determination that such an increase is necessary after considering the level of aggregate and specific stop-loss insurance provided with respect to such multiple employer welfare arrangement and other factors related to solvency risk, such as the multiple employer welfare arrangement's projected levels of participation or claims, the nature of the multiple employer welfare arrangement's liabilities, and the types of assets available to assure that such liabilities are met.

Source: Laws 2020, LB1014, § 8.

ARTICLE 77

MODEL ACT REGARDING USE OF CREDIT INFORMATION IN PERSONAL INSURANCE

Cross References

Credit Report Protection Act, see section 8-2601.

Section
44-7701. Act, how cited.
44-7702. Purpose of act.
44-7703. Act; applicability.
44-7704. Terms, defined.
44-7705. Insurer; credit information; prohibited acts.
44-7706. Credit information; notice; insurer; duties.
44-7707. Disclosures; required.
44-7708. Adverse action; notice requirements.
44-7709. Scoring models or processes; filing.
44-7710. Indemnification of insurance producers.
44-7711. Consumer reporting agency; prohibited acts.
44-7712. Applicability of act.

44-7701 Act, how cited.

Sections 44-7701 to 44-7712 shall be known and may be cited as the Model Act Regarding Use of Credit Information in Personal Insurance.

Source: Laws 2003, LB 487, § 1.

44-7702 Purpose of act.

The purpose of the Model Act Regarding Use of Credit Information in Personal Insurance is to regulate the use of credit information for personal insurance, so that consumers are afforded certain protections with respect to the use of such information.

Source: Laws 2003, LB 487, § 2.

44-7703 Act; applicability.

The Model Act Regarding Use of Credit Information in Personal Insurance applies to personal insurance and not to commercial insurance. For purposes of the act, personal insurance means private passenger automobile, homeowners, motorcycle, autocycle, mobile homeowners, noncommercial dwelling fire, and boat, personal watercraft, snowmobile, and recreational vehicle insurance policies. Such policies must be individually underwritten for personal, family, or household use. No other type of insurance shall be included as personal insurance for purposes of the act.

Source: Laws 2003, LB 487, § 3; Laws 2015, LB231, § 1.

44-7704 Terms, defined.

For purposes of the Model Act Regarding Use of Credit Information in Personal Insurance:

(1) Adverse action means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance;

(2) Affiliate means any company that controls, is controlled by, or is under common control with another company;

(3) Applicant means an individual who has applied to be covered by a personal insurance policy with an insurer;

(4) Consumer means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy;

(5) Consumer reporting agency means any person which, for monetary fees, for dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties;

(6) Credit information means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered credit information, regardless of whether it is contained in a credit report or in an application or is used to calculate an insurance score;

(7) Credit report means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement; and

(8) Insurance score means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

Source: Laws 2003, LB 487, § 4.

44-7705 Insurer; credit information; prohibited acts.

An insurer authorized to do business in Nebraska that uses credit information to underwrite or rate risks shall not:

(1) Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

(2) Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by subdivision (1) of this section;

(3) Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information;

(4) Take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information;

(5) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(a) Treat the consumer as otherwise approved by the Director of Insurance, if the insurer presents information that such an absence or inability relates to the risk for the insurer;

(b) Treat the consumer as if the applicant or insured had neutral credit information, as defined by the insurer; or

(c) Exclude the use of credit information as a factor and use only other underwriting criteria;

(6) Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within ninety days prior to the date the policy is first written or renewal is issued;

(7) Use credit information, unless not later than every thirty-six months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subdivision:

(a) At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period;

(b) The insurer shall have the discretion to obtain current credit information upon any renewal before the thirty-six months, if consistent with its underwriting guidelines; and

(c) No insurer need obtain current credit information for an insured, despite the requirements of subdivision (7)(a) of this section, if one of the following applies:

(i) The insurer is treating the consumer as otherwise approved by the director;

(ii) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order such report if consistent with its underwriting guidelines;

(iii) Credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal if consistent with its underwriting guidelines; or

(iv) The insurer reevaluates the insured beginning no later than thirty-six months after inception and thereafter based upon other underwriting or rating factors, excluding credit information; or

(8) Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

(a) Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information;

(b) Inquiries relating to insurance coverage if so identified on a consumer's credit report;

(c) Collection accounts with a medical industry code if so identified on the consumer's credit report;

(d) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty days of one another, unless only one inquiry is considered; or

(e) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty days of one another, unless only one inquiry is considered.

Source: Laws 2003, LB 487, § 5.

44-7706 Credit information; notice; insurer; duties.

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, as such act existed on January 1, 2003, 15 U.S.C. 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination either from the consumer reporting agency or from the insured, the insurer shall reunderwrite and rerate the consumer within thirty days after receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid a premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last twelve months of coverage or the actual policy period.

Source: Laws 2003, LB 487, § 6.

44-7707 Disclosures; required.

(1) If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

(2) Use of the following example disclosure statement constitutes compliance with this section: ''In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score.''.

Source: Laws 2003, LB 487, § 7.

44-7708 Adverse action; notice requirements.

If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of both subdivisions (1) and (2) of this section. Such insurer shall:

(1) Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, as such act existed on January 1, 2003, 15 U.S.C. 1681m(a); and

(2) Provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as poor credit history, poor credit rating, or poor insurance score does not meet the explanation requirements of this subdivision. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are deemed to comply with this section.

Source: Laws 2003, LB 487, § 8.

44-7709 Scoring models or processes; filing.

Insurers that use insurance scores to underwrite and rate risks shall file their scoring models or other scoring processes with the Department of Insurance. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information. Any filing relating to credit information is considered a trade secret.

Source: Laws 2003, LB 487, § 9.

44-7710 Indemnification of insurance producers.

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an insurance producer who obtains or uses credit information or insurance scores for an insurer if the insurance producer follows the instructions of or procedures established by the insurer and com-

plies with any applicable law or regulation. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

Source: Laws 2003, LB 487, § 10.

44-7711 Consumer reporting agency; prohibited acts.

(1) No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

(2) The restrictions provided in subsection (1) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance producer from whom information was received, the insurer on whose behalf such insurance producer acted, or such insurer's affiliates or holding companies.

(3) Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Source: Laws 2003, LB 487, § 11.

44-7712 Applicability of act.

The Model Act Regarding Use of Credit Information in Personal Insurance applies to personal insurance policies either written to be effective or renewed on or after nine months after August 31, 2003.

Source: Laws 2003, LB 487, § 12.

ARTICLE 78

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Section
44-7801. Interstate Insurance Product Regulation Compact; ratification.
44-7802. Representative of state.

44-7801 Interstate Insurance Product Regulation Compact; ratification.

The State of Nebraska ratifies the following Interstate Insurance Product Regulation Compact:

Article I. PURPOSES

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II. DEFINITIONS

For purposes of this Compact:

1. ''Advertisement'' means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. ''Bylaws'' mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. ''Compacting State'' means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. ''Commission'' means the ''Interstate Insurance Product Regulation Commission'' established by this Compact.

5. ''Commissioner'' means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. ''Domiciliary State'' means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. ''Insurer'' means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. ''Member'' means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. ''Non-compacting State'' means any State which is not at the time a Compacting State.

10. ''Operating Procedures'' mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. ''Product'' means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. ''Rule'' means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. ''State'' means any state, district or territory of the United States of America.

14. ''Third-Party Filer'' means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. ''Uniform Standard'' means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

Article III. ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The Compacting States hereby create and establish a joint public agency known as the ''Interstate Insurance Product Regulation Commission.'' Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

Article IV. POWERS OF THE COMMISSION

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rule-making authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation

adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission;

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V. ORGANIZATION OF THE COMMISSION

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that

nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. MEETINGS AND ACTS OF THE COMMISSION

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

Article VII. RULES AND OPERATING PROCEDURES: RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its

intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. ''Opt out'' shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the

opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

Article VIII. COMMISSION RECORDS AND ENFORCEMENT

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating

Procedures. If a non-complying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

Article IX. DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

Article X. PRODUCT FILING AND APPROVAL

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

Article XI. REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

1. Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

Article XII. FINANCE

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any workpapers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII. COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

Article XIV. WITHDRAWAL, DEFAULT AND TERMINATION

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact (''Withdrawing State'') by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted (''Defaulting State'') in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

Article XV. SEVERABILITY AND CONSTRUCTION

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI. BINDING EFFECT OF COMPACT AND OTHER LAWS

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commis-

sion's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

Source: Laws 2005, LB 119, § 36.

44-7802 Representative of state.

The Director of Insurance is hereby designated to serve as the representative of this state to the Interstate Insurance Product Regulation Commission.

Source: Laws 2005, LB 119, § 37.

ARTICLE 79

PROPERTY AND CASUALTY ACTUARIAL OPINION ACT

Section
44-7901. Act, how cited.
44-7902. Statement of Actuarial Opinion; filing; supporting documents; appointed actuary; immunity.
44-7903. Statement of Actuarial Opinion; supporting documents; disclosure allowed; when.

44-7901 Act, how cited.

Sections 44-7901 to 44-7903 shall be known and may be cited as the Property and Casualty Actuarial Opinion Act.

Source: Laws 2005, LB 119, § 39.

44-7902 Statement of Actuarial Opinion; filing; supporting documents; appointed actuary; immunity.

(1) Beginning January 1, 2007, every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled Statement of Actuarial Opinion. This opinion shall be filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions.

(2)(a) Every property and casualty insurance company domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the Statement of Actuarial Opinion required in subsection (1) of this section.

(b) A property and casualty insurance company authorized to do business in this state but not domiciled in this state shall provide the actuarial opinion summary to the Director of Insurance upon request.

(3)(a) An actuarial report and underlying workpapers as required by the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions shall be prepared to support each Statement of Actuarial Opinion.

(b) If the insurance company fails to provide a supporting actuarial report or workpapers at the request of the director or the director determines that the supporting actuarial report or workpapers provided by the insurance company is otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

(4) The appointed actuary shall not be liable for damages to any person, other than the insurance company or the director, for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

Source: Laws 2005, LB 119, § 40.

44-7903 Statement of Actuarial Opinion; supporting documents; disclosure allowed; when.

(1) The Statement of Actuarial Opinion shall be provided with the annual statement in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be a public document.

(2)(a) Documents, materials, or other information in the possession or control of the Department of Insurance that are considered an actuarial report, workpapers, or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the Director of Insurance in connection with the actuarial report, workpapers, or actuarial opinion summary, shall be confidential by law and privileged, shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09,

shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(b) This section shall not be construed to limit the director's authority to release the documents to the Actuarial Board for Counseling and Discipline if the material is required for the purpose of professional disciplinary proceedings and that the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the director for preserving the confidentiality of the documents, nor shall this section be construed to limit the director's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the director's official duties.

(3) Neither the director nor any person who received documents, materials, or other information while acting under the authority of the director shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (2) of this section.

(4) The director:

(a) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (2) of this section with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, if the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality; and

(b) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information from other state, federal, foreign, or international regulatory and law enforcement agencies and from the National Association of Insurance Commissioners and its affiliates and subsidiaries. The director shall maintain information received pursuant to this subdivision as confidential or privileged if received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the information. Such information shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, subject to subpoena, subject to discovery, or admissible in evidence in any private civil action, except that the director may use such information in any regulatory or legal action brought by the director. The director, and any other person while acting under the authority of the director who has received information pursuant to this subdivision, may not, and shall not be required to, testify in any private civil action concerning any information subject to this section. Nothing in this section shall constitute a waiver of any applicable privilege or claim of confidentiality in the information received pursuant to this subdivision as a result of information sharing authorized by this section.

Source: Laws 2005, LB 119, § 41.

ARTICLE 80

HEALTH CARE PROMPT PAYMENT ACT

Section

Section

44-8001 Act, how cited.

Sections 44-8001 to 44-8010 shall be known and may be cited as the Health Care Prompt Payment Act.

Source: Laws 2005, LB 389, § 1.

44-8002 Terms, defined.

For purposes of the Health Care Prompt Payment Act:

(1) Claim form means an insurer's standard printed or electronic transaction form that complies with the standards issued by the Secretary of the United States Department of Health and Human Services or, if an insurer does not have a standard printed or electronic transaction form, any form which complies with such standards;

(2) Clean claim means a claim for payment of health care services that is submitted by a Nebraska health care provider to an insurer on a claim form with all required fields completed with information to adjudicate the claim in accordance with any published filing requirements of the insurer;

(3) Director means the Director of Insurance;

(4) Insurer means an entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, a participant in an insurance arrangement as defined in section 44-4105, or any other entity providing a plan of health insurance, health benefits, or health care services. Insurer does not include the medical assistance program established pursuant to the Medical Assistance Act, a property and liability insurer, a motor vehicle insurer, a workers' compensation insurer, a risk management pool, or a self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(5) Prompt payment act compliance statement means a certification made in good faith by an insurer that, during the twenty-four-month period ending on the preceding June 30, it paid, denied, or settled more than ninety percent of its clean claims within the time periods set forth in subsections (1) and (2) of section 44-8004;

(6) Repricer means an entity that receives claims from health care providers and submits them to insurers after adjudicating or repricing such claims; and

(7) Unfair payment pattern means any of the following patterns of conduct:

(a) Engaging in a demonstrable and unjust pattern of reviewing or processing complete and accurate claims that results in payment delays;

(b) Engaging in a demonstrable and unjust pattern of reducing the amount of payment or denying complete and accurate claims;

(c) Repeated failure to pay the uncontested portions of a claim within the time periods specified in section 44-8004; or

(d) Failing on a repeated basis to pay the interest when due on claims pursuant to section 44-8005.

Source: Laws 2005, LB 389, § 2; Laws 2006, LB 1248, § 66.

Cross References

Medical Assistance Act, see section 68-901.

44-8003 Claim; date of receipt; rebuttable presumption.

If a claim is submitted electronically, the claim is presumed to have been received on the date of the electronic verification of receipt by the insurer or the insurer's clearinghouse. If a claim is submitted by mail, the claim is presumed to have been received five business days after the claim has been placed in the United States mail with first-class postage prepaid. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

Source: Laws 2005, LB 389, § 3.

44-8004 Action on claim; deadline.

(1) A clean claim shall be paid, denied, or settled within thirty calendar days after receipt by the insurer if submitted electronically and within forty-five calendar days after receipt if submitted in a form other than electronically.

(2) If the resolution of a claim requires additional information, the insurer shall, within thirty calendar days after receipt of the claim, give the health care provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The applicable time period set forth in subsection (1) of this section shall be tolled as of the date the additional information is requested until the date all such additional information necessary to resolve the claim is received. The person receiving a request for such additional information shall submit all additional information requested by the insurer within thirty calendar days after receipt of such request. After such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the insurer within the remaining applicable time period set forth in subsection (1) of this section. Failure to furnish additional information within the time period required shall not invalidate or reduce the claim if it was not reasonably possible to give such information within such time period. The insurer may deny a claim if a health care provider receives a request for additional information and fails to submit additional information requested under this subsection.

(3) For purposes of subsection (1) of this section, a clean claim shall not include a claim:

(a) For which the insurer needs additional information in order to resolve one or more issues concerning coverage, eligibility, coordination of benefits, investigation of preexisting conditions, subrogation, determination of medical necessity, or the use of unlisted procedural codes; or

(b) For which the insurer has a reasonable belief supported by specific information that the claim has been submitted fraudulently.

(4) If a claim is submitted to a repricer, the time periods for payment, denial, or settlement of such claims set forth in this section shall commence upon receipt of the claim by the repricer.

Source: Laws 2005, LB 389, § 4.

44-8005 Interest; rate; payment.

(1) An insurer that fails to pay, deny, or settle a clean claim in accordance with the time periods set forth in subsection (1) of section 44-8004 or to take other required action within the time periods set forth in subsection (2) of section 44-8004 shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to section 44-8004.

(2) To the extent that interest is not paid concurrently with the claim, it may be paid on a quarterly basis or when the aggregate interest for a health care provider exceeds ten dollars.

Source: Laws 2005, LB 389, § 5.

44-8006 Prompt payment act compliance statement; filing; effect; list available.

An insurer shall be exempt from the requirements of section 44-8005 during a calendar year when the insurer has a prompt payment act compliance statement on file with the director. Any insurer desiring to obtain the exemption shall file a prompt payment act compliance statement with the director not later than December 1 of the year prior to the exemption year. A list of insurers with prompt payment act compliance statements on file shall be publicly available from the director.

Source: Laws 2005, LB 389, § 6.

44-8007 Claims processing functions; delegation; requirements.

If an insurer delegates its claims processing functions to a third party, the delegation agreement shall provide that the third party shall consent to an examination and cooperate with that examination by the director and shall comply with the requirements of the Health Care Prompt Payment Act. Any delegation by the insurer shall not be construed to limit the insurer's responsibility to comply with the act.

Source: Laws 2005, LB 389, § 7.

44-8008 Compliance with act; unfair payment pattern; director; powers and duties; enforcement; penalty.

(1) An insured, a representative of an insured, or a health care provider acting on behalf of the insured may notify the director of activities related to an unfair payment pattern. The director shall compile a record of notices, and if it appears to the director that an insurer, or a third party working on behalf of an insurer, may be engaged in an unfair payment pattern or that an insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, the director may examine and investigate the affairs of such insurer or third party, either as part of a regularly scheduled examination

or as part of an examination called solely for the purposes of determining compliance with the Health Care Prompt Payment Act. The insurer shall reimburse the Department of Insurance for the expense of the examination of the insurer or third party working on behalf of the insurer in the same manner as provided for examination of insurance companies in the Insurers Examination Act.

(2) If as a result of an examination conducted under subsection (1) of this section, the director finds that any insurer doing business in this state is engaged in any unfair payment pattern, or that the insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such insurer a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

(3) If, after a hearing conducted pursuant to the Administrative Procedure Act, the director finds that an insurer or a third party working on behalf of an insurer has engaged in an unfair payment pattern or that the insurer has filed a prompt payment act compliance statement that the insurer knows or has reason to know is false, the director shall reduce the findings to writing and shall issue and cause to be served upon the insurer a copy of the findings and an order requiring the insurer or any third party working on behalf of the insurer to cease and desist from engaging in the act or practice and the director may order any one or more of the following:

(a) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Health Care Prompt Payment Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars;

(b) Suspension or revocation of the insurer's license or certificate of authority if the insurer knew or reasonably should have known it was in violation of the act; and

(c) Withdrawal of the insurer's prompt payment act compliance statement for such time as the director determines.

(4) Any insurer who violates a cease and desist order under subsection (3) of this section may, after notice and hearing and upon order of the director, be subject to:

(a) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(b) Suspension or revocation of the insurer's license or certificate of authority.

Source: Laws 2005, LB 389, § 8.

Cross References

Administrative Procedure Act, see section 84-920.
Insurers Examination Act, see section 44-5901.

44-8009 Applicability of act.

The Health Care Prompt Payment Act does not apply to any individual or group policies that provide coverage for a specific disease, accident-only coverage, hospital indemnity coverage, disability income coverage, medicare supplement coverage, long-term care coverage, or other limited-benefit coverage. The act does not apply to any claim submitted before January 1, 2006.

Source: Laws 2005, LB 389, § 9.

44-8010 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Health Care Prompt Payment Act.

Source: Laws 2005, LB 389, § 10.

ARTICLE 81
NEBRASKA PROTECTION IN ANNUITY TRANSACTIONS ACT

Section
44-8101. Act, how cited.
44-8102. Purpose of act; cause of action; liability; act, how construed.
44-8103. Applicability of act; rules and regulations.
44-8104. Act; exemptions.
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44-8107. Insurer; duties; Director of Insurance; powers; violations.
44-8108. Producer; duties.
44-8109. Changes made to act; applicability.

44-8101 Act, how cited.

Sections 44-8101 to 44-8109 shall be known and may be cited as the Nebraska Protection in Annuity Transactions Act.

Source: Laws 2006, LB 875, § 13; Laws 2007, LB117, § 26; Laws 2012, LB887, § 21.

44-8102 Purpose of act; cause of action; liability; act, how construed.

(1) The purpose of the Nebraska Protection in Annuity Transactions Act is to require producers to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations so that the consumers' insurance needs and financial objectives at the time of the transaction are appropriately addressed.

(2) Nothing in the Nebraska Protection in Annuity Transactions Act shall be construed to create or imply a private cause of action for a violation of the act or to subject a producer to civil liability under the best interest standard of care outlined in section 44-8106 or under standards governing the conduct of a fiduciary or fiduciary relationship.

Source: Laws 2006, LB 875, § 14; Laws 2007, LB117, § 27; Laws 2012, LB887, § 22; Laws 2021, LB22, § 1.
Effective date April 8, 2021.

44-8103 Applicability of act; rules and regulations.

(1) The Nebraska Protection in Annuity Transactions Act applies to any recommendation or sale of an annuity.

(2) The Director of Insurance may adopt and promulgate rules and regulations to carry out the Nebraska Protection in Annuity Transactions Act.

Source: Laws 2006, LB 875, § 15; Laws 2007, LB117, § 28; Laws 2012, LB887, § 23; Laws 2021, LB22, § 2.
Effective date April 8, 2021.

44-8104 Act; exemptions.

Unless otherwise specifically included, the Nebraska Protection in Annuity Transactions Act does not apply to transactions involving:

(1) Direct response solicitations if there is no recommendation based on information collected from the consumer pursuant to the act; or

(2) Contracts used to fund:

(a) An employee pension or welfare benefit plan that is covered by the federal Employee Retirement Income Security Act of 1974;

(b) A plan described by section 401(a), 401(k), 403(b), 408(k), or 408(p) of the Internal Revenue Code if established or maintained by an employer;

(c) A government or church plan defined in section 414 of the Internal Revenue Code, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the Internal Revenue Code;

(d) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(e) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(f) Contracts entered into pursuant to the Burial Pre-Need Sale Act.

Source: Laws 2006, LB 875, § 16; Laws 2007, LB117, § 29; Laws 2012, LB887, § 24.

Cross References

Burial Pre-Need Sale Act, see section 12-1101.

44-8105 Terms, defined.

For purposes of the Nebraska Protection in Annuity Transactions Act:

(1) Annuity means an annuity that is an insurance product under state law and is individually solicited, whether the product is classified as an individual or group annuity;

(2) Cash compensation means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer from an insurer or intermediary or directly from the consumer in connection with the recommendation or sale of an annuity;

(3) Consumer profile information means any information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs, and financial objectives, including, at a minimum, the consumer's:

(a) Age;

(b) Annual income;

(c) Financial situation and needs, including debts and other obligations;

(d) Financial experience;

(e) Insurance needs;

(f) Financial objectives;

(g) Intended use of the annuity;

(h) Financial time horizon;

(i) Existing assets or financial products, including investment, annuity, and insurance holdings;

(j) Liquidity needs;

(k) Liquid net worth;

(l) Risk tolerance, including, but not limited to, willingness to accept non-guaranteed elements in the annuity;

(m) Financial resources used to fund the annuity; and

(n) Tax status;

(4) Continuing education credit means one clock hour of an approved continuing education activity certified by the Director of Insurance pursuant to subsection (1) of section 44-3905;

(5) Continuing education provider means an individual or entity that is approved to offer continuing education activities pursuant to subsection (1) of section 44-3905;

(6) Insurer means a company required to be licensed under the laws of this state to provide insurance products, including annuities;

(7) Intermediary means an entity contracted (a) directly with an insurer or (b) with another entity that is contracted with an insurer to facilitate the sale of the insurer's annuities by producers;

(8) Material conflict of interest means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation, but does not include cash compensation or noncash compensation;

(9) Noncash compensation means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support, and retirement benefits;

(10) Nonguaranteed elements means the premiums, credited interest rates, including any bonus, benefits, values, dividends, non-interest-based credits, charges, or elements of formulas used to determine any of the listed elements that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if its calculation uses any underlying nonguaranteed element;

(11) Producer means (a) a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, including annuities, or (b) if no person described in subdivision (11)(a) of this section is involved, an insurer;

(12) Recommendation means advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, an exchange, or a replacement of an annuity in accordance with that advice, but does not include general communication to the public, generalized consumer services

assistance or administrative support, general education information and tools, prospectuses, or other product and sales material; and

(13) Replacement means a transaction in which a new annuity is to be purchased, and it is known or should be known to the proposing producer or the proposing insurer that, by reason of the transaction, an existing annuity or other insurance policy has been or is to be:

(a) Lapsed, forfeited, surrendered, or partially surrendered, assigned to the replacing insurer, or otherwise terminated;

(b) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(c) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(d) Reissued with any reduction in cash value; or

(e) Used in a financed purchase.

Source: Laws 2006, LB 875, § 17; Laws 2007, LB117, § 30; Laws 2012, LB887, § 25; Laws 2018, LB743, § 28; Laws 2021, LB22, § 3. Effective date April 8, 2021.

44-8106 Recommendation of annuity; obligations; requirements; supervision system, required; producer; insurer; prohibited acts; safe harbor requirements; maintenance of records; Director of Insurance; powers.

(1) The producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest ahead of the consumer's interest. A producer has acted in the best interest of the consumer and met the best interest obligation if the following care, disclosure, conflict of interest, and documentation obligations are satisfied:

(a)(i) In meeting the care obligation for making a recommendation, the producer shall exercise reasonable diligence, care, and skill to:

(A) Know the consumer's financial situation, insurance needs, and financial objectives;

(B) Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

(C) Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

(D) Communicate the basis or bases of the recommendation.

(ii) The care obligation requirements under subdivision (a)(i) of this subsection include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(iii) The care obligation requires a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs, and financial objectives. This does not require analysis or consideration of any products outside the authority

and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.

(iv) The care obligation does not create a fiduciary obligation or relationship and only creates a regulatory obligation as established in this subsection.

(v) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives, but the level of importance of each factor under the care obligation may vary depending on the facts and circumstances. However, in no instance shall each factor be considered in isolation.

(vi) The care obligation requires the producer to have a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit, or other insurance-related features.

(vii) The care obligation requirements under subdivision (1)(a) of this section apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and to riders and similar product enhancements, if any.

(viii) The care obligation does not require that the annuity with the lowest one-time or multiple occurrence compensation structure be recommended.

(ix) The care obligation does not include an ongoing monitoring obligation for the producer, although an ongoing monitoring obligation may be separately owed under the terms of a fiduciary, consulting, investment advising, or financial planning agreement between the consumer and the producer.

(x) In the case of an exchange or replacement of an annuity, the care obligation requires the producer to consider the whole transaction, which includes taking into consideration whether:

(A) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living, or other contractual benefits, or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;

(B) The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(C) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding sixty months.

(xi) Nothing in the Nebraska Protection in Annuity Transactions Act shall be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit, or negotiate insurance in this state, including, but not limited to, any securities license, in order to fulfill the duties of the care obligation, except that a producer shall not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring another professional license without first obtaining the appropriate license;

(b)(i) In meeting the disclosure obligation, the producer shall, prior to the recommendation or sale of an annuity, prominently disclose to the consumer on a form created or previously approved by the Department of Insurance:

(A) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

(B) An affirmative statement on whether the producer is licensed and authorized to sell the following products: Fixed annuities; fixed indexed annuities; variable annuities; life insurance; mutual funds; stocks and bonds; or certificates of deposit;

(C) An affirmative statement describing the insurers the producer is authorized, contracted, appointed, or otherwise able to sell insurance products for using one of the following descriptions: From one insurer; from two or more insurers; or from two or more insurers although primarily contracted with one insurer;

(D) A description of the sources and types of cash compensation and noncash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission, as part of a premium, by other remuneration received from the insurer, intermediary, or other producer, or by fee as a result of a contract for advice or consulting services; and

(E) A notice of the consumer's right to request additional information regarding cash compensation as described in subdivision (b)(ii) of this subsection.

(ii) As part of the disclosure obligation, the producer shall, upon request of the consumer or the consumer's designated representative, disclose:

(A) A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and

(B) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrences, which may be stated as a range of amounts or percentages.

(iii) As part of the disclosure obligation, the producer shall, prior to or at the time of the recommendation or sale of an annuity, have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders, or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in nonguaranteed elements of the annuity, insurance and investment components, and market risk;

(c) In meeting the conflict of interest obligation, the producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including, but not limited to, material conflicts of interest related to an ownership interest;

(d) In meeting the documentation obligation, a producer shall at the time of sale:

(i) Make a written record of any recommendation subject to the Nebraska Protection in Annuity Transactions Act and of the basis for such recommendation;

(ii) Obtain a consumer-signed statement on a form created or previously approved by the Department of Insurance documenting:

(A) Any refusal by the consumer to provide consumer profile information; and

(B) The consumer's understanding of the ramifications of not providing consumer profile information or providing insufficient consumer profile information; and

(iii) Obtain a consumer-signed statement on a form created or previously approved by the Department of Insurance acknowledging that the annuity transaction is not recommended if a consumer decides to enter into an annuity transaction that is not based on the producer's recommendation; and

(e) Any best interest obligation requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

(2)(a) Except as provided in subdivision (2)(b) of this section, a producer shall have no obligation to a consumer under subdivision (1)(a) of this section related to any annuity transaction if:

(i) No recommendation is made;

(ii) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the consumer;

(iii) A consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or

(iv) A consumer decides to enter into an annuity transaction that is not based on a recommendation of the producer.

(b) An insurer's issuance of an annuity subject to subdivision (2)(a) of this section shall be deemed reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

(3)(a) Except as permitted under subsection (2) of this section, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would effectively address the particular consumer's financial situation, insurance needs, and financial objectives based on the consumer's consumer profile information.

(b) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its producers' compliance with the Nebraska Protection in Annuity Transactions Act, including, but not limited to, the following:

(i) The insurer shall maintain reasonable procedures to inform its producers of the requirements of the act and shall incorporate such requirements into relevant producer training manuals;

(ii) The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of section 44-8108;

(iii) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its producers;

(iv) The insurer shall establish and maintain procedures for review of each recommendation prior to issuance of an annuity that are designed to ensure that there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs, and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(v) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with subsections (1), (2), (4), and (5) of this section. This may include, but is not limited to, confirmation of the consumer profile information, systematic consumer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations, and programs of internal monitoring. Nothing in this subdivision shall prevent an insurer from complying with this subdivision by applying sampling procedures or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity;

(vi) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(vii) The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information;

(viii) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and noncash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subdivision are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as such benefits are not based upon the volume of sales of a specific annuity within a limited period of time; and

(ix) The insurer shall annually provide a written report to senior management, including the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(c)(i) Nothing in this subsection restricts an insurer from contracting for performance of a function, including maintenance of procedures, required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to section 44-8107 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subdivision (b) of this subsection.

(ii) An insurer's supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:

(A) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(B) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a reasonable basis to represent, and does represent, that the function is properly performed.

(d) An insurer is not required to include in its system of supervision:

(i) A producer's recommendations to consumers of products other than the annuities offered by the insurer; or

(ii) Consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer.

(4) Neither a producer nor an insurer shall dissuade, or attempt to dissuade, a consumer from:

(a) Truthfully responding to an insurer's request for confirmation of the consumer profile information;

(b) Filing a complaint; or

(c) Cooperating with the investigation of a complaint.

(5)(a) Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the safe harbor requirements under this subsection. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls, and procedures that satisfy a comparable standard even if such standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subsection shall limit the ability of the Director of Insurance to investigate and enforce the provisions of this subsection.

(b) Nothing in subdivision (a) of this subsection shall limit the insurer's obligation to comply with subdivision (3)(a) of this section, although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(c) For subdivision (a) of this subsection to apply, an insurer shall:

(i) Monitor the relevant conduct of the financial professional seeking to rely on subdivision (a) of this subsection or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal securities laws using information collected in the normal course of an insurer's business; and

(ii) Provide to the entity responsible for supervising the financial professional seeking to rely on subdivision (a) of this subsection, such as the financial professional's broker-dealer or investment adviser registered under federal securities laws, information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

(d) For purposes of this subsection, financial professional means a producer that is regulated and acting as:

(i) A broker-dealer registered under federal securities laws or a registered representative of a broker-dealer;

(ii) An investment adviser registered under federal securities laws or an investment adviser representative associated with a federal registered investment adviser; or

(iii) A plan fiduciary under section 3(21) of the federal Employee Retirement Income Security Act of 1974 or a fiduciary under section 4975(e)(3) of the Internal Revenue Code of 1986, as such sections existed on January 1, 2021.

(e) For purposes of this subsection, comparable standards means:

(i) With respect to broker-dealers and registered representatives of broker-dealers, applicable federal Securities and Exchange Commission and Financial Industry Regulatory Authority rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest, as such rules existed on January 1, 2021;

(ii) With respect to investment advisers registered under federal securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the federal Investment Advisers Act of 1940, including, but not limited to, Form ADV and interpretations of Form ADV as such form and interpretations existed on January 1, 2021; and

(iii) With respect to plan fiduciaries or fiduciaries, the duties, obligations, prohibitions, and all other requirements attendant to such status under the federal Employee Retirement Income Security Act of 1974 or the Internal Revenue Code of 1986, as such acts existed on January 1, 2021.

(6)(a) Insurers, general agents, independent agencies, and producers shall maintain or be able to make available to the Director of Insurance records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for insurance transactions for five years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a producer.

(b) Records required to be maintained by this subsection may be maintained in paper, photographic, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

Source: Laws 2006, LB 875, § 18; Laws 2007, LB117, § 31; Laws 2012, LB887, § 26; Laws 2021, LB22, § 4.
Effective date April 8, 2021.

44-8107 Insurer; duties; Director of Insurance; powers; violations.

(1) An insurer is responsible for compliance with the Nebraska Protection in Annuity Transactions Act. If a violation occurs, either because of the action or inaction of the insurer or its producer, the Director of Insurance may order:

(a) An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with the Nebraska Protection in Annuity Transactions Act by the insurer, an entity contracted to perform the insurer's supervisory duties, or by the producer;

(b) A general agency, an independent agency, or the producer to take reasonably appropriate corrective action for any consumer harmed by the producer's violation of the act; and

(c) Appropriate penalties and sanctions.

(2) A violation of the act shall be an unfair trade practice in the business of insurance under the Unfair Insurance Trade Practices Act.

(3) The director may reduce or eliminate any applicable penalty under section 44-1529 for a violation of the Nebraska Protection in Annuity Transactions Act if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

Source: Laws 2006, LB 875, § 19; Laws 2007, LB117, § 32; Laws 2012, LB887, § 27; Laws 2021, LB22, § 5.
Effective date April 8, 2021.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-8108 Producer; duties.

(1) A producer shall not solicit the sale of an annuity product unless the producer has adequate knowledge of the product to recommend the annuity and the producer is in compliance with the insurer's standards for product training. A producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

(2)(a)(i) A producer who engages in the sale of annuity products shall complete a one-time four-credit training course approved by the Department of Insurance and provided by a department-approved education provider.

(ii) Producers who hold a life insurance line of authority on July 1, 2021, and who desire to sell annuities shall complete the requirements of this subsection within six months after July 1, 2021. Individuals who obtain a life insurance line of authority on or after July 1, 2021, shall not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

(b) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four continuing education credits, but may be longer.

(c) The training required under this subsection shall include information on the following topics:

(i) The types of annuities and various classifications of annuities;

(ii) Identification of the parties to an annuity;

(iii) How fixed, variable, and indexed annuity contract provisions affect consumers;

(iv) The application of income taxation of qualified and nonqualified annuities;

(v) The primary uses of annuities; and

(vi) Appropriate sales practices and replacement and disclosure requirements.

(d) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

(e) A provider of an annuity training course intended to comply with this subsection shall register as a continuing education provider in this state and comply with the requirements applicable to insurance producer continuing education activities as set forth in section 44-3905.

(f) A producer who has completed an annuity training course approved by the Department of Insurance prior to July 1, 2021, shall, within six months after July 1, 2021, complete either:

(i) A new four-credit training course approved by the Department of Insurance after April 8, 2021; or

(ii) An additional one-time, one-credit training course approved by the Department of Insurance and provided by a Department of Insurance approved education provider on appropriate sales practices and replacement and disclosure requirements under the Nebraska Protection in Annuity Transactions Act.

(g) Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with sections 44-3901 to 44-3908.

(h) Providers of annuity training shall comply with the reporting requirements and shall issue certificates of completion in accordance with sections 44-3901 to 44-3908.

(i) The satisfaction of training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection.

(j) The satisfaction of the components of the training requirements of any course or courses with components substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection.

(k) An insurer shall verify that each producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by National Association of Insurance Commissioners-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

Source: Laws 2012, LB887, § 28; Laws 2018, LB743, § 29; Laws 2021, LB22, § 6.
Effective date April 8, 2021.

44-8109 Changes made to act; applicability.

The changes made to the Nebraska Protection in Annuity Transactions Act by Laws 2021, LB22, shall apply to solicitations occurring on and after January 1, 2022.

Source: Laws 2012, LB887, § 29; Laws 2021, LB22, § 7.
Effective date April 8, 2021.

ARTICLE 82

CAPTIVE INSURERS ACT

Section
44-8201. Act, how cited.
44-8202. Purposes of act.
44-8203. Terms, defined.
44-8204. Name.
44-8205. Certificate of authority; application; fee; plan of operation; filings required; director; powers; subsequent amendments; books and records.

Section

44-8201 Act, how cited.

Sections 44-8201 to 44-8218 shall be known and may be cited as the Captive Insurers Act.

Source: Laws 2007, LB117, § 35.

44-8202 Purposes of act.

The purposes of the Captive Insurers Act are to set forth the procedures for organizing and regulating the operations of captive insurers within the State of Nebraska and to encourage integrity, financial solvency, and stability of captive insurers for the purpose of promoting the development of Nebraska businesses.

Source: Laws 2007, LB117, § 36.

44-8203 Terms, defined.

For purposes of the Captive Insurers Act:

(1) Affiliated entity means any entity that directly or indirectly controls, is controlled by, or is under common control with a captive insurer;

(2) Captive insurer means a domestic insurer authorized under the act to provide insurance and reinsurance to its parent, any affiliated entity, or both. Such insurance and reinsurance shall be limited to the risks, hazards, and liabilities of its parent and affiliated entities;

(3) Control means the power to direct or cause the direction of the management and policies of an entity through ownership of voting securities;

(4) Director means the Director of Insurance; and

(5) Parent means an entity that directly or indirectly owns, controls, or holds, with power to vote, more than fifty percent of the outstanding voting securities or other ownership interest of a captive insurer.

Source: Laws 2007, LB117, § 37.

44-8204 Name.

No captive insurer shall adopt the name of any existing insurer or any name that may be misleading to the public.

Source: Laws 2007, LB117, § 38.

44-8205 Certificate of authority; application; fee; plan of operation; filings required; director; powers; subsequent amendments; books and records.

(1) No person shall transact the business of insurance as a captive insurer without first applying for and obtaining from the director a certificate of authority. An applicant shall submit a nonrefundable application fee of five hundred dollars with a plan of operation which includes:

(a) Articles of incorporation and bylaws or other documents of organization;

(b) Pro forma financial statements for two years;

(c) The source and nature of initial and ongoing capital;

(d) A feasibility study which discloses the types and adequacy of the insurance programs of the captive insurer, the identity of the parent and affiliated entities benefiting from such insurance program, and the relationships to the captive insurer as well as all projected expenses, contracts, and a holding company system chart identifying the ownership and relationship of the parent and affiliated entities;

(e) Copies of all insurance and reinsurance agreements of the captive insurer as well as disclosure of all transactions material to the insurance operations;

(f) Financial condition of the parent and, if requested by the director, any affiliated entities, benefiting from the captive insurance program;

(g) A management overview including competence, experience, and integrity of those controlling the insurance operations;

(h) A statement submitting to the jurisdiction of the director; and

(i) An explanation of how the operation of the captive insurer promotes the development of a Nebraska business.

(2) If the plan of operation is accepted and approved by the director, the articles and other documents of organization shall be filed in the office of the Secretary of State. A copy of the articles or other documents of organization, certified by the Secretary of State, shall be filed with the director. Amendments to organizational documents shall be deemed a change to the plan of operation and shall be filed with and approved by the director before they are submitted to the Secretary of State.

(3) The director may refuse to issue a certificate of authority until he or she is reasonably satisfied that the plan of operation contains sufficient indication of a successful insurance operation and that the captive insurer will be able to meet expected or ongoing policy obligations.

(4) A captive insurer shall obtain prior written approval of any subsequent amendments to any components of the original plan of operation. The director shall deem that any captive insurer that has failed to disclose a transaction or a series of transactions that would circumvent the Captive Insurers Act to be in hazardous financial condition with respect to the public or its policyholders and subject to suspension or revocation of the certificate of authority of the captive insurer.

(5) Except as otherwise authorized in section 44-8216, a captive insurer may only transact any line or lines of insurance specified in subdivisions (5), (7), (8), (9), (10), and (18) of section 44-201. A captive insurer shall not transact directors and officers insurance.

(6) Every captive insurer shall provide to the director books and records in the state as to enable the financial examination of the captive insurer by the director.

Source: Laws 2007, LB117, § 39.

44-8206 Management of business; director or officer; restriction.

A board of directors or other governing body consisting of not less than three individuals shall manage the business of each captive insurer. The organizational documents or bylaws shall provide for the terms, meetings, and elections of the directors and officers of the governing body. No individual may serve as a director or officer who has been convicted of fraud involving any financial institution or of a felony involving misuse of funds.

Source: Laws 2007, LB117, § 40.

44-8207 Certificate of authority; expiration; renewal; fee.

The certificate of authority issued to a captive insurer shall expire on June 30 of each year. The director shall renew the certificate of authority upon payment of an annual renewal fee of five hundred dollars and all other required fees and the filing of all required reports.

Source: Laws 2007, LB117, § 41.

44-8208 Report; filing required; form; director; other reports.

(1) Every captive insurer with a certificate of authority to transact business in this state pursuant to the Captive Insurers Act shall file with the director a report, signed and sworn to by its chief officers, of its financial condition as of the end of each fiscal year. The report shall be in a form prescribed by the director and contain such information as the director deems necessary for the purpose of ascertaining whether the captive insurer can continue to meet its policy obligations to its parent, affiliated entities, and claimants. The report shall be filed within sixty days following the end of the captive insurer's fiscal year. The director may require that the report include the information required by section 44-322, including any instructions, procedures, and guidelines consistent with the act.

(2) The director may prescribe the format and frequency of other reports to be filed, which may include, but not be limited to, summary loss reports, quarterly financial statements, audited annual financial statements, holding company statements, biographical information on officers and directors, and other professional reports.

Source: Laws 2007, LB117, § 42.

44-8209 Total capital and surplus requirements; director; powers; letter of credit requirements.

(1) No captive insurer shall be permitted to transact any business in this state unless it maintains total capital and surplus in the amount of at least one hundred thousand dollars in such form as is acceptable to the director.

(2) Upon a written finding by the director that the approved plan of operation or the operational results of the captive insurer require either additional capital or a larger surplus than required by this section, the director may require that additional capital or surplus, or both, be obtained. Additional capital or surplus

may be tendered in the form of an irrevocable evergreen letter of credit acceptable to the director.

(3) Any letter of credit provided to satisfy the requirements of the Captive Insurers Act shall be:

(a) Jointly held under the control of the director and the captive insurer for the benefit of claimants;

(b) Issued or confirmed by an institution that is insured by the Federal Deposit Insurance Corporation;

(c) The sole property of such captive insurer; and

(d) Free and clear of any claim or encumbrance.

Source: Laws 2007, LB117, § 43.

44-8210 Examinations.

The director may examine the financial condition, affairs, and management of any applicant or captive insurer pursuant to the Insurers Examination Act.

Source: Laws 2007, LB117, § 44.

Cross References

Insurers Examination Act, see section 44-5901.

44-8211 Investments; limitation on loans and investments.

(1) Captive insurers shall be subject to the types and nature of investments as set forth in the Insurers Investment Act, but not subject to any limitations contained in such act as to invested amounts, except that the director may prohibit or limit any investment that threatens the solvency or liquidity of any such captive insurer or if such investments are not made in accordance with the approved plan of operation.

(2) No captive insurer may make a loan to or an investment in its parent or affiliated entities without prior written approval of the director and any such transaction shall be evidenced by documentation approved by the director. Loans of minimum capital and surplus funds are prohibited.

Source: Laws 2007, LB117, § 45.

Cross References

Insurers Investment Act, see section 44-5101.

44-8212 Credit for reserves ceded to reinsurer.

(1) Except as otherwise provided in subsection (2) of this section, any captive insurer authorized to do business in this state may take credit for reserves on risks ceded to a reinsurer pursuant to the provisions of sections 44-416.05 to 44-416.10 and any rules and regulations adopted and promulgated under such sections.

(2) Notwithstanding the provisions of subsection (1) of this section, any captive insurer may cede risks to a reinsurer not meeting the standards of sections 44-416.05 to 44-416.10 and may take reserve credits if the captive insurer receives prior written approval from the director.

Source: Laws 2007, LB117, § 46.

44-8213 Membership in guaranty associations.

A captive insurer shall not be a member of the Nebraska Property and Liability Insurance Guaranty Association or the Nebraska Life and Health Insurance Guaranty Association. The Nebraska Property and Liability Insurance Guaranty Association Act and the Nebraska Life and Health Insurance Guaranty Association Act shall not be applicable to coverage offered by a captive insurer.

Source: Laws 2007, LB117, § 47.

Cross References

Nebraska Life and Health Insurance Guaranty Association Act, see section 44-2720.
Nebraska Property and Liability Insurance Guaranty Association Act, see section 44-2418.

44-8214 Voluntary dissolution; approval of director required; effect of dissolution.

The director shall approve any voluntary dissolution of a captive insurer if the director determines that all obligations of the captive insurer have been satisfied. The dissolution of a captive insurer shall not impair the right of any person to commence an action against the captive insurer for any liability previously incurred.

Source: Laws 2007, LB117, § 48.

44-8215 Suspension or revocation of certificate of authority; administrative fine; grounds; notice; hearing; cease and desist order.

(1) After notice and a hearing conducted pursuant to the Administrative Procedure Act, the director may suspend or revoke a certificate of authority or may impose an administrative fine not to exceed one thousand dollars per violation, or any combination of such actions, if the director finds the captive insurer:

(a) Engages in financial practices that make further transaction of business in this state hazardous or injurious to claimants or the public as defined by rule and regulation adopted and promulgated by the director;

(b) Within fifteen business days fails to respond to an inquiry of the director;

(c) Fails to pay any final judgment rendered against it in this state on any contractual obligation in a reasonable period of time;

(d) Conducts business fraudulently or has not met its contractual obligations in good faith; or

(e) Violates any provision of the laws of this or any other state.

(2) In lieu of or in addition to the administrative fines set forth in subsection (1) of this section, the director may issue a cease and desist order to a captive insurer if the captive insurer engages in any of the activities set forth in subsection (1) of this section.

Source: Laws 2007, LB117, § 49.

Cross References

Administrative Procedure Act, see section 84-920.

44-8216 Creation of special purpose financial captive insurers; applicability of section; form of organization; powers; duties; powers of director; limitation on dividends; confidentiality.

(1) This section provides for the creation of special purpose financial captive insurers to diversify and broaden insurers' access to sources of capital.

(2) For purposes of this section:

(a) Counterparty means a special purpose financial captive insurer's parent or affiliated entity, which is an insurer domiciled in Nebraska that cedes life insurance risks to the special purpose financial captive insurer pursuant to the special purpose financial captive insurer contract;

(b) Guaranty of a parent means an agreement to pay specified obligations of the special purpose financial captive insurer by a parent of the special purpose financial captive insurer approved by the director that is not a counterparty and the guarantor has sufficient equity, less the equity of all counterparties that are subsidiaries of the guarantor, to satisfy the agreement during the life of the guaranty;

(c) Insolvency or insolvent means that the special purpose financial captive insurer is unable to pay its obligations when they are due, unless those obligations are the subject of a bona fide dispute;

(d) Insurance securitization means a package of related risk transfer instruments, capital market offerings, and facilitating administrative agreements, under which a special purpose financial captive insurer obtains proceeds either directly or indirectly through the issuance of securities, and may hold the proceeds in trust to secure the obligations of the special purpose financial captive insurer under one or more special purpose financial captive insurer contracts, in that the investment risk to the holders of the securities is contingent upon the obligations of the special purpose financial captive insurer to the counterparty under the special purpose financial captive insurer contract in accordance with the transaction terms and pursuant to the Captive Insurers Act;

(e) Organizational document means the special purpose financial captive insurer's articles of incorporation, articles of organization, bylaws, operating agreement, or other foundational documents that establish the special purpose financial captive insurer as a legal entity or prescribes its existence;

(f) Permitted investments means those investments that meet the qualifications set forth in section 44-8211;

(g) Securities means debt obligations, equity investments, surplus certificates, surplus notes, funding agreements, derivatives, and other legal forms of financial instruments;

(h) Special purpose financial captive insurer means a captive insurer which has received a certificate of authority from the director for the limited purposes provided for in this section;

(i) Special purpose financial captive insurer contract means a contract between the special purpose financial captive insurer and the counterparty pursuant to which the special purpose financial captive insurer agrees to provide insurance or reinsurance protection to the counterparty for risks associated with the counterparty's insurance or reinsurance business; and

(j) Special purpose financial captive insurer securities means the securities issued by a special purpose financial captive insurer.

(3)(a) The provisions of the Captive Insurers Act, other than those in subdivision (3)(b) of this section, apply to a special purpose financial captive insurer. If

a conflict occurs between a provision of the act not in this section and a provision of this section, the latter controls.

(b) The requirements of this section shall not apply to specific special purpose financial captive insurers if the director finds a specific requirement is inappropriate due to the nature of the risks to be insured by the special purpose financial captive insurer and if the special purpose financial captive insurer meets criteria established by rules and regulations adopted and promulgated by the director.

(c) In determining whether to issue a certificate of authority or to approve an amended plan of operation for a special purpose financial captive insurer required under section 44-8205, the director may consider any additional factors the director may deem relevant, including the specific type of life insurance risks insured by the special purpose financial captive insurer, the financial ability of a parent that issues a guaranty pursuant to this section to satisfy such guaranty, and any actuarial opinions or other statements or documents required by the director to evaluate such application.

(d) At the time a special purpose financial captive insurer files an application for a certificate of authority or submits an amended plan of operation in accordance with section 44-8205, and on each date the special purpose financial captive insurer is required to file an annual financial statement in this state, a senior actuarial officer of each ceding insurer shall file with the director a certification that the ceding insurer's transactions with the special purpose financial captive insurer are not being used to gain an unfair advantage in the pricing of the ceding insurer's products. A ceding insurer shall not be deemed to have gained an unfair advantage if the pricing of the policies and contracts reinsured by the special purpose financial captive insurer reflects, at the time those policies and contracts were issued, a reasonable long-term estimate of the cost to the ceding insurer of an alternative third-party transaction and utilizes current pricing assumptions.

(4) A special purpose financial captive insurer may be established as a stock corporation or other form of organization approved by the director.

(5)(a) A special purpose financial captive insurer may not issue a contract for assumption of risk or indemnification of loss other than a special purpose financial captive insurer contract. However, the special purpose financial captive insurer may cede risks assumed through a special purpose financial captive insurer contract to third-party reinsurers through the purchase of reinsurance or retrocession protection if approved by the director.

(b) A special purpose financial captive insurer may enter into contracts and conduct other commercial activities related or incidental to and necessary to fulfill the purposes of the special purpose financial captive insurer contract, insurance securitization, and this section. Those activities may include, but are not limited to: Entering into special purpose financial captive insurer contracts; entering into agreements in connection with obtaining guaranties of its parent; issuing securities of the special purpose financial captive insurer in accordance with applicable securities law; complying with the terms of these contracts or securities; entering into trust, swap, tax, administration, reimbursement, or fiscal agent transactions; or complying with trust indenture, reinsurance, retrocession, and other agreements necessary or incidental to effectuate a special purpose financial captive insurer contract or an insurance securitization in

compliance with this section and in the plan of operation approved by the director.

(6)(a) A special purpose financial captive insurer may issue securities, subject to and in accordance with applicable law, its approved plan of operation, and its organization documents.

(b) A special purpose financial captive insurer, in connection with the issuance of securities, may enter into and perform all of its obligations under any required contracts to facilitate the issuance of these securities.

(c) The obligation to repay principal or interest, or both, on the securities issued by the special purpose financial captive insurer shall be designed to reflect the risk associated with the obligations of the special purpose financial captive insurer to the counterparty under the special purpose financial captive insurer contract.

(7) A special purpose financial captive insurer may enter into swap agreements, or other forms of asset management agreements, including guaranteed investment contracts, or other transactions that have the objective of leveling timing differences in funding of up-front or ongoing transaction expenses or managing asset, credit, prepayment, or interest rate risk of the investments in the trust to ensure that the investments are sufficient to assure payment or repayment of the securities, and related interest or principal payments, issued pursuant to a special purpose financial captive insurer insurance securitization transaction or the obligations of the special purpose financial captive insurer under the special purpose financial captive insurer contract or for any other purpose approved by the director. All asset management agreements entered into by the special purpose financial captive insurer must be approved by the director.

(8)(a) A special purpose financial captive insurer, at any given time, may enter into and effectuate a special purpose financial captive insurer contract with a counterparty if the special purpose financial captive insurer contract obligates the special purpose financial captive insurer to indemnify the counterparty for losses and contingent obligations of the special purpose financial captive insurer under the special purpose financial captive insurer contract are securitized through a special purpose financial captive insurer insurance securitization, which security for such obligations may be funded and secured with assets held in trust for the benefit of the counterparty pursuant to agreements contemplated by this section and invested in a manner that meet the criteria as provided in section 44-8211.

(b) A special purpose financial captive insurer may enter into agreements with affiliated companies and third parties and conduct business necessary to fulfill its obligations and administrative duties incidental to the insurance securitization and the special purpose financial captive insurer contract. The agreements may include management and administrative services agreements and other allocation and cost-sharing agreements, or swap and asset management agreements, or both, or agreements for other contemplated types of transactions provided in this section.

(c) A special purpose financial captive insurer contract must contain provisions that:

(i) Require the special purpose financial captive insurer to either (A) enter into a trust agreement specifying what recoverables or reserves, or both, the agreement is to cover and to establish a trust account for the benefit of the

counterparty and the security holders or (B) establish such other method of security acceptable to the director, including letters of credit or guaranties of a parent as described in subsection (9) of this section;

(ii) Stipulate that assets deposited in the trust account must be valued in accordance with their current fair market value and must consist only of permitted investments;

(iii) If a trust arrangement is used, require the special purpose financial captive insurer, before depositing assets with the trustee, to execute assignments, to execute endorsements in blank, or to take such actions as are necessary to transfer legal title to the trustee of all shares, obligations, or other assets requiring assignments, in order that the counterparty, or the trustee upon the direction of the counterparty, may negotiate whenever necessary the assets without consent or signature from the special purpose financial captive insurer or another entity; and

(iv) If a trust arrangement is used, stipulate that the special purpose financial captive insurer and the counterparty agree that the assets in the trust account, established pursuant to the provisions of the special purpose financial captive insurer contract, may be withdrawn by the counterparty, or the trustee on its behalf, at any time, only in accordance with the terms of the special purpose financial captive insurer contract, and must be utilized and applied by the counterparty or any successor of the counterparty by operation of law, including, subject to the provisions of this section, but without further limitation, any liquidator, rehabilitator, or receiver of the counterparty, without diminution because of insolvency on the part of the counterparty or the special purpose financial captive insurer, only for the purposes set forth in the credit for reinsurance laws and rules and regulations of this state.

(d) The special purpose financial captive insurer contract may contain provisions that give the special purpose financial captive insurer the right to seek approval from the counterparty to withdraw from the trust all or part of the assets, or income from them, contained in the trust and to transfer the assets to the special purpose financial captive insurer if such provisions comply with the credit for reinsurance laws and rules and regulations of this state.

(9) A special purpose financial captive insurer contract meeting the provisions of this section must be granted credit for reinsurance treatment or otherwise qualify as an asset or a reduction from liability for reinsurance ceded by a domestic insurer to a special purpose financial captive insurer as an assuming insurer for the benefit of the counterparty if and only to the extent:

(a)(i) Of the value of:

(A) The assets held in trust;

(B) Clean, or irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution as defined in section 44-416.08, or as approved by the director; or

(C) Guaranties of the parent; and

(ii) For the benefit of the counterparty under the special purpose financial captive insurer contract; and

(b) Assets of the special purpose financial captive insurer are held or invested in one or more of the forms allowed in section 44-8211.

(10)(a)(i) Notwithstanding the provisions of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, the director may apply to the district

court of Lancaster County for an order authorizing the director to rehabilitate or liquidate a special purpose financial captive insurer domiciled in this state on one or more of the following grounds:

(A) There has been embezzlement, wrongful sequestration, dissipation, or diversion of the assets of the special purpose financial captive insurer intended to be used to pay amounts owed to the counterparty or the holders of special purpose financial captive insurer securities; or

(B) The special purpose financial captive insurer is insolvent and the holders of a majority in outstanding principal amount of each class of special purpose financial captive insurer securities request or consent to conservation, rehabilitation, or liquidation pursuant to the provisions of this section.

(ii) The court may not grant relief provided by subdivision (10)(a)(i) of this section unless, after notice and a hearing, the director establishes that relief must be granted.

(b) Notwithstanding any other applicable law, rule, or regulation, upon any order of rehabilitation or liquidation of a special purpose financial captive insurer, the receiver shall manage the assets and liabilities of the special purpose financial captive insurer pursuant to the provisions of subsection (11) of this section.

(c) With respect to amounts recoverable under a special purpose financial captive insurer contract, the amount recoverable by the receiver must not be reduced or diminished as a result of the entry of an order of conservation, rehabilitation, or liquidation with respect to the counterparty, notwithstanding another provision in the contracts or other documentation governing the special purpose financial captive insurer insurance securitization.

(d) An application or petition, or a temporary restraining order or injunction issued pursuant to the provisions of the Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, with respect to a counterparty does not prohibit the transaction of a business by a special purpose financial captive insurer, including any payment by a special purpose financial captive insurer made pursuant to a special purpose financial captive insurer security, or any action or proceeding against a special purpose financial captive insurer or its assets.

(e) Notwithstanding the provisions of any applicable law or rule or regulation, the commencement of a summary proceeding or other interim proceeding commenced before a formal delinquency proceeding with respect to a special purpose financial captive insurer, and any order issued by the court, does not prohibit the payment by a special purpose financial captive insurer made pursuant to a special purpose financial captive insurer security or special purpose financial captive insurer contract or the special purpose financial captive insurer from taking any action required to make the payment.

(f) Notwithstanding the provisions of any other applicable law, rule, or regulation:

(i) A receiver of a counterparty may not void a nonfraudulent transfer by a counterparty to a special purpose financial captive insurer of money or other property made pursuant to a special purpose financial captive insurer contract; and

(ii) A receiver of a special purpose financial captive insurer may not void a nonfraudulent transfer by the special purpose financial captive insurer of money or other property made to a counterparty pursuant to a special purpose

financial captive insurer contract or made to or for the benefit of any holder of a special purpose financial captive insurer security on account of the special purpose financial captive insurer security.

(g) With the exception of the fulfillment of the obligations under a special purpose financial captive insurer contract, and notwithstanding the provisions of any other applicable law or rule or regulation, the assets of a special purpose financial captive insurer, including assets held in trust, must not be consolidated with or included in the estate of a counterparty in any delinquency proceeding against the counterparty pursuant to the provisions of this section for any purpose including, without limitation, distribution to creditors of the counterparty.

(11) A special purpose financial captive insurer may not declare or pay dividends in any form to its owners other than in accordance with the insurance securitization transaction agreements, and in no instance shall the dividends decrease the capital of the special purpose financial captive insurer below two hundred fifty thousand dollars, and, after giving effect to the dividends, the assets of the special purpose financial captive insurer, including any assets held in trust pursuant to the terms of the insurance securitization, must be sufficient to satisfy the director that it can meet its obligations. Approval by the director of an ongoing plan for the payment of dividends, interest on securities, or other distribution by a special purpose financial captive insurer must be conditioned upon the retention, at the time of each payment, of capital or surplus equal to or in excess of amounts specified by, or determined in accordance with formulas approved for the special purpose financial captive insurer by, the director.

(12) Information submitted pursuant to the provisions of this section shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the director or any other person, except to other state, federal, foreign, and international regulatory and law enforcement agencies if the recipient agrees in writing to maintain the confidentiality of the information, without the prior written consent of the special purpose financial captive insurer unless the director, after giving the special purpose financial captive insurer notice and opportunity to be heard, determines that the best interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event he or she may publish all or any part thereof in such manner as he or she may deem appropriate.

Source: Laws 2007, LB117, § 50; Laws 2012, LB887, § 30; Laws 2016, LB758, § 2.

Cross References

Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

44-8217 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Captive Insurers Act.

Source: Laws 2007, LB117, § 51.

44-8218 Applicability of insurance laws.

(1) The insurance laws of this state shall not apply to captive insurers except as permitted in the Captive Insurers Act.

(2) The following provisions of Chapter 44 apply to captive insurers:

(a) The Insurers Examination Act;

(b) Sections 44-101, 44-101.01, 44-102, 44-103, 44-114, 44-116, 44-154, 44-205.01, 44-231, 44-301, 44-318, 44-320, 44-326, and 44-360; and

(c) The Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act. Such act shall only apply to a captive insurer that provides insurance and reinsurance to a parent or affiliated entity that is an insurer.

Source: Laws 2007, LB117, § 52.

Cross References

Insurers Examination Act, see section 44-5901.
Nebraska Insurers Supervision, Rehabilitation, and Liquidation Act, see section 44-4862.

ARTICLE 83

DISCOUNT MEDICAL PLAN ORGANIZATION ACT

Section

44-8301 Act, how cited.

Sections 44-8301 to 44-8316 shall be known and may be cited as the Discount Medical Plan Organization Act.

Source: Laws 2008, LB855, § 33.

44-8302 Purpose of act.

The purpose of the Discount Medical Plan Organization Act is to promote the public interest by establishing standards for discount medical plan organizations to protect consumers from unfair or deceptive marketing, sales, or enrollment practices and to facilitate consumer understanding of the role and

function of discount medical plan organizations in providing access to medical or ancillary services.

Source: Laws 2008, LB855, § 34.

44-8303 Terms, defined.

For purposes of the Discount Medical Plan Organization Act:

(1) Affiliate means a person that directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the person specified;

(2) Ancillary services includes, but is not limited to, audiology, dental, vision, mental health, substance abuse, chiropractic, and podiatry services;

(3) Control or controlled by or under common control with means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person;

(4) Director means the Director of Insurance;

(5)(a) Discount medical plan means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, offers access for its members to providers of medical or ancillary services and the right to receive discounts on medical or ancillary services provided under the discount medical plan from those providers.

(b) Discount medical plan does not include a plan that does not charge a membership or other fee to use the plan's discount medical card;

(6) Discount medical plan organization means an entity that, in exchange for fees, dues, charges, or other consideration, provides access for discount medical plan members to providers of medical or ancillary services and the right to receive medical or ancillary services from those providers at a discount. It is the organization that contracts with providers, provider networks, or other discount medical plan organizations to offer access to medical or ancillary services at a discount and determines the charge to discount medical plan members;

(7) Facility means an institution providing medical or ancillary services or a health care setting. Facility includes, but is not limited to:

(a) A hospital or other licensed inpatient center;

(b) An ambulatory surgical or treatment center;

(c) A skilled nursing center;

(d) A residential treatment center;

(e) A rehabilitation center; and

(f) A diagnostic, laboratory, or imaging center;

(8) Health care professional means a physician, pharmacist, or other health care practitioner who is licensed, accredited, or certified to perform specified medical or ancillary services within the scope of his or her license, accreditation, certification, or other appropriate authority and consistent with state law;

(9) Health carrier means an entity certified under and subject to the insurance laws and rules and regulations of this state or subject to the jurisdiction of

the director that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or medical or ancillary services;

(10) Marketer means a person or entity that markets, promotes, sells, or distributes a discount medical plan including a private label entity that places its name on and markets or distributes a discount medical plan pursuant to a marketing agreement with a discount medical plan organization;

(11) Medical services means any maintenance care of, or preventive care for, the human body or care, service, or treatment of an illness or dysfunction of, or injury to, the human body. Medical services includes, but is not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, laboratory services, and medical equipment and supplies. Medical services does not include pharmacy services or ancillary services;

(12) Member means any individual who pays fees, dues, charges, or other consideration for the right to receive the benefits of a discount medical plan;

(13) Person means an individual, a corporation, a partnership, an association, a joint venture, a joint-stock company, a trust, an unincorporated organization, or any similar entity or any combination of the foregoing;

(14) Provider means any health care professional or facility that has contracted, directly or indirectly, with a discount medical plan organization to provide medical or ancillary services to members; and

(15) Provider network means an entity that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider to provide medical or ancillary services to members.

Source: Laws 2008, LB855, § 35.

44-8304 Control; presumption.

Control as used in the Discount Medical Plan Organization Act is presumed to exist if any person, directly or indirectly, owns, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in subsection (11) of section 44-2132 that control does not exist in fact. The director may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

Source: Laws 2008, LB855, § 36.

44-8305 Applicability of act.

(1) The Discount Medical Plan Organization Act applies to all discount medical plan organizations doing business in or from this state.

(2) A discount medical plan organization that is a health carrier is not required to obtain a certificate of registration under section 44-8306, except that each of its affiliates that operates as a discount medical plan organization in this state shall obtain a certificate of registration under section 44-8306 and comply with all other provisions of the act. The discount medical plan organization is required to comply with sections 44-8308 to 44-8311 and report, in the

form and manner as the director may require, any of the information described in subsection (2) of section 44-8313 that is not otherwise already reported.

(3) A provider who provides discounts to his or her own patients without any cost or fee of any kind to the patient is not required to obtain and maintain a certificate of registration under the act as a discount medical plan organization.

Source: Laws 2008, LB855, § 37.

44-8306 Certificate of registration; application; fee; director; duties; renewal; application; fee; disciplinary actions; grounds; hearing; cease and desist order; penalty.

(1) Before doing business in or from this state as a discount medical plan organization, a discount medical plan organization:

(a) May transact business in this state under Chapter 21; and

(b) Shall obtain a certificate of registration from the director to operate as a discount medical plan organization.

(2) Each application for a certificate of registration to operate as a discount medical plan organization shall:

(a) Be in a form prescribed by the director and verified by an officer or authorized representative of the applicant;

(b) Be accompanied by an application fee not to exceed five hundred dollars;

(c) Include information on whether:

(i) A previous application for a certificate of registration or licensure has been denied, revoked, suspended, or terminated for cause in any jurisdiction; and

(ii) The applicant is under investigation for or the subject of any pending action or has been found in violation of a statute or regulation in any jurisdiction within the previous five years; and

(d) Include information as the director may require that permits the director, after reviewing all of the information submitted pursuant to this subsection, to make a determination that the applicant:

(i) Is financially responsible;

(ii) Has adequate expertise or experience to operate a discount medical plan organization; and

(iii) Is of good character.

(3) After the receipt of an application filed pursuant to subsection (2) of this section, the director shall review the application and notify the applicant of any deficiencies in the application.

(4) No more than ninety days after the date of receipt of a completed application, the director shall issue a certificate of registration if the director is satisfied that the applicant has met the requirements of subsection (2) of this section or shall deny the application and state the grounds for denial.

(5) Prior to issuance of a certificate of registration by the director, each discount medical plan organization shall establish an Internet website in order to conform to the requirements of subsection (2) of section 44-8309.

(6)(a) A registration is effective for one year unless before its expiration it is renewed in accordance with this subsection or suspended or revoked in accordance with subsection (7) of this section.

(b) At least ninety days before a certificate of registration is set to expire, the discount medical plan organization shall submit:

(i) A renewal application form; and

(ii) The renewal fee.

(c) The director shall renew the certificate of registration of each holder that meets the requirements of the Discount Medical Plan Organization Act and pays the renewal fee of three hundred dollars.

(7)(a) The director may suspend or revoke a certificate of registration after notice and hearing held in accordance with the Administrative Procedure Act if the director finds that any of the following conditions exist:

(i) The discount medical plan organization is not operating in compliance with the Discount Medical Plan Organization Act;

(ii) The discount medical plan organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising;

(iii) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization; or

(iv) The continued operation of the discount medical plan organization would be hazardous to its members.

(b) If the director has cause to believe that grounds for the denial or nonrenewal of a certificate of registration exist, the director shall notify the discount medical plan organization in writing specifically stating the grounds for the refusal to grant or renew the certificate of registration. The applicant or registrant has thirty days after receipt of such notification to demand a hearing. The hearing shall be held no more than thirty days after receipt of such demand by the director and shall be held in accordance with the Administrative Procedure Act.

(c)(i) The director shall, in his or her order suspending the authority of the discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, that must be met by the discount medical plan organization prior to reinstatement of its certificate of registration to enroll members.

(ii) The director may rescind or modify the order of suspension prior to the expiration of the suspension period.

(iii) The certificate of registration of a discount medical plan organization shall not be reinstated unless requested by the discount medical plan organization. The director shall not grant the request for reinstatement if the director finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(8) In lieu of suspending or revoking a discount medical plan organization's certificate of registration under subsection (7) of this section, if the discount medical plan organization has violated any provision of the Discount Medical Plan Organization Act, the director may:

(a) Issue and cause to be served upon the organization charged with the violation a copy of the findings and an order requiring the organization to cease and desist from engaging in the act or practice that constitutes the violation; and

(b) Impose a monetary penalty of not more than one thousand dollars for each violation.

(9) Each registered discount medical plan organization shall notify the director immediately whenever the discount medical plan organization's certificate of registration or other form of authority to operate as a discount medical plan organization in another state is suspended, revoked, or not renewed in that state.

Source: Laws 2008, LB855, § 38.

Cross References

Administrative Procedure Act, see section 84-920.

44-8307 Director; examination or investigation; powers; expenses.

(1) The director may examine or investigate the business and affairs of any discount medical plan organization to protect the interests of the residents of this state based on the following reasons, including, but not limited to, complaint indices, recent complaints, information from other states, or as the director deems necessary.

(2) An examination or investigation conducted as provided in subsection (1) of this section shall be performed in accordance with the provisions of the Insurers Examination Act.

(3) The director may:

(a) Order any discount medical plan organization or applicant that operates a discount medical plan organization to produce any records, books, files, advertising and solicitation materials, or other information; and

(b) Take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest.

(4) The discount medical plan organization or applicant that is the subject of the examination or investigation shall pay the expenses incurred in conducting the examination or investigation. Failure by the discount medical plan organization or applicant to pay such expenses is grounds for denial of a certificate of registration to operate as a discount medical plan organization or revocation of a certificate of registration to operate as a discount medical plan organization.

Source: Laws 2008, LB855, § 39.

Cross References

Insurers Examination Act, see section 44-5901.

44-8308 Charges authorized; right to cancel membership; plan sold in conjunction with other products; duties.

(1) A discount medical plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount medical plan.

(2)(a)(i) If a member cancels his or her membership in the discount medical plan organization within thirty days after the date of receipt of the written document for the discount medical plan described in subsection (4) of section 44-8311, the member shall receive a reimbursement of all periodic charges and the amount of any one-time processing fee that exceeds thirty dollars upon return of the discount medical plan card to the discount medical plan organization.

(ii)(A) Cancellation occurs when notice of cancellation is given to the discount medical plan organization.

(B) Notice of cancellation is deemed given when delivered by hand or deposited in a mailbox, properly addressed, and postage prepaid to the mailing address of the discount medical plan organization.

(iii) A discount medical plan organization shall return any periodic charge charged or collected after the member has returned the discount medical plan card or given the discount medical plan organization notice of cancellation.

(b) If the discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

(3) When a marketer or discount medical plan organization sells a discount medical plan in conjunction with any other products, the marketer or discount medical plan organization shall:

(a) Provide the charges for each discount medical plan in writing to the member; or

(b) Reimburse the member for all periodic charges for the discount medical plan if the member cancels his or her membership in accordance with subdivision (2)(a) of this section.

(4) Any discount medical plan organization that is a health carrier that provides a discount medical plan product that is incidental to the insured product is not subject to this section.

Source: Laws 2008, LB855, § 40.

44-8309 Written provider agreement required; contents; Internet website; information required; toll-free telephone number.

(1)(a) A discount medical plan organization shall have a written provider agreement with all providers offering medical or ancillary services to its members. The written provider agreement may be entered into directly with the provider or indirectly with a provider network to which the provider belongs.

(b) A provider agreement between a discount medical plan organization and a provider shall provide the following:

(i) A list of the medical or ancillary services and products to be provided at a discount;

(ii) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(iii) That the provider will not charge members more than the discounted rates.

(c) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers that:

(i) Contain the provisions described in subdivision (1)(b) of this section;

(ii) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; and

(iii) Require the provider network to maintain an up-to-date list of its contracted providers and to provide the list on a monthly basis to the discount medical plan organization.

(d) A provider agreement between a discount medical plan organization and an entity that contracts with a provider network shall require that the entity, in its contract with the provider network, require the provider network to have written agreements with its providers that comply with subdivision (1)(c) of this section.

(e) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered.

(2) Each discount medical plan organization shall maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The website address shall be prominently displayed on all of its advertisements, marketing materials, brochures, and discount medical plan cards. This subsection applies to those providers with which the discount medical plan organization has contracted directly as well as those providers that are members of a provider network with which the discount medical plan organization has contracted.

(3) Each discount medical plan organization shall maintain a toll-free telephone number for members to obtain additional information about and assistance on the discount medical plan and an up-to-date list of the names and addresses of the providers with which it has contracted directly or through a provider network. The toll-free telephone number shall be prominently displayed on all of its advertisements, marketing materials, brochures, and discount medical plan cards. Capable and competent personnel shall staff the toll-free telephone number.

Source: Laws 2008, LB855, § 41.

44-8310 Marketing; written agreement required; approval of advertising; powers of director.

(1) A discount medical plan organization may market directly or contract with other marketers for the distribution of its product.

(2)(a) The discount medical plan organization shall have an executed written agreement with each marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan.

(b) The agreement between the discount medical plan organization and the marketer shall prohibit the marketer from using advertising, marketing materials, brochures, and discount medical plan cards without the discount medical plan organization's approval in writing.

(c) The discount medical plan organization shall be bound by and responsible for the activities of a marketer that are within the scope of the marketer's agency relationship with the organization.

(3) A discount medical plan organization shall approve in writing all advertisements, marketing materials, brochures, and discount cards used by marketers to market, promote, sell, or distribute the discount medical plan prior to their use.

(4) Upon request, a discount medical plan organization shall submit to the director all advertising, marketing materials, and brochures regarding a discount medical plan.

Source: Laws 2008, LB855, § 42.

44-8311 Communications to prospective members and members; requirements; disclosures required; new member; terms and conditions of plan; information included.

(1)(a) All advertisements, marketing materials, brochures, discount medical plan cards, and any other communications of a discount medical plan organization provided to prospective members and members shall be truthful and not misleading in fact or in implication.

(b) Any advertisement, marketing material, brochure, discount medical plan card, or other communication is misleading in fact or in implication if it has a capacity or tendency to mislead or deceive based on the overall impression that it is reasonably expected to create within the segment of the public to which it is directed.

(2)(a) Except as otherwise provided in the Discount Medical Plan Organization Act, as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a description of an insurance product connected with a discount medical plan, a discount medical plan organization shall not use in its advertisements, marketing materials, brochures, or discount medical plan cards the term insurance.

(b) Except as otherwise provided in state law, a discount medical plan organization shall not describe or characterize the discount medical plan as being insurance whenever a discount medical plan is bundled with an insurance product and the insurance benefits are incidental to the discount medical plan benefits.

(c) A discount medical plan organization shall not:

(i) Use in its advertisements, marketing materials, brochures, or discount medical plan cards the terms health plan, coverage, copay, copayment, deductible, preexisting condition, guaranteed issue, premium, PPO, preferred provider organization, or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is health insurance;

(ii) Use language in its advertisements, marketing materials, brochures, or discount medical plan cards with respect to being licensed or registered by a state insurance department in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance or has been endorsed by a state;

(iii) Make misleading, deceptive, or fraudulent representations regarding the discount or range of discounts offered by the discount medical plan card or the access to any range of discounts offered by the discount medical plan card;

(iv) Have restrictions on access to discount medical plan providers, including waiting periods and notification periods, except for hospital services; or

(v) Pay providers any fees for medical or ancillary services or collect or accept money from a member to pay a provider for medical or ancillary services provided under the discount medical plan unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator in accordance with the Third-Party Administrator Act.

(3)(a) Each discount medical plan organization shall make the following general disclosures in writing in not less than twelve-point font on the first content page of any advertisement, marketing material, or brochure made available to the public relating to a discount medical plan together with any enrollment forms given to a prospective member:

(i) That the plan is a discount plan and is not insurance coverage;

(ii) That the range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received;

(iii) Unless the discount medical plan organization has an active certificate of authority to act as a third-party administrator as described in subdivision (2)(c)(v) of this section, that the plan does not make payments to providers for the medical or ancillary services received under the discount medical plan;

(iv) That the plan member is obligated to pay for all medical or ancillary services but will receive a discount from those providers that have contracted with the discount medical plan organization; and

(v) The toll-free telephone number and Internet website address for the registered discount medical plan organization for prospective members and members to obtain additional information about and assistance on the discount medical plan and an up-to-date list of providers participating in the discount medical plan.

(b) If the initial contact with a prospective member is by telephone, the disclosures required under subdivision (a) of this subsection shall be made orally and included in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

(4)(a) In addition to the general disclosures required under subsection (3) of this section, each discount medical plan organization shall provide to:

(i) Each prospective member, at the time of enrollment, information that describes the terms and conditions of the discount medical plan, including any limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan; and

(ii) Each new member a written document that contains the terms and conditions of the discount medical plan.

(b) The written document required under subdivision (a)(ii) of this subsection shall be clear and include the following information:

(i) The name of the member;

(ii) The benefits to be provided under the discount medical plan;

(iii) Any processing fees and periodic charges associated with the discount medical plan, including any limitations or restrictions on the refund of any processing fees and periodic charges;

(iv) The frequency of payment of any processing fees and periodic charges and procedures for changing the frequency of payment;

(v) Any limitations, exclusions, or exceptions regarding the receipt of discount medical plan benefits;

(vi) Any waiting periods for certain medical or ancillary services under the discount medical plan;

(vii) Procedures for obtaining discounts under the discount medical plan, such as requiring members to contact the discount medical plan organization to make an appointment with a provider on the member's behalf;

(viii) Cancellation procedures, including information on the member's thirty-day cancellation rights and refund requirements and procedures for obtaining refunds;

(ix) Renewal, termination, and cancellation terms and conditions;

(x) Procedures for adding new members to a family discount medical plan, if applicable;

(xi) Procedures for filing complaints under the discount medical plan organization's complaint system and information that, if the member remains dissatisfied after completing the organization's complaint system, the plan member may contact his or her state insurance department; and

(xii) The name, toll-free telephone number, and mailing address of the discount medical plan organization or other entity where the member can make inquiries about the plan, send cancellation notices, and file complaints.

Source: Laws 2008, LB855, § 43.

Cross References

Third-Party Administrator Act, see section 44-5801.

44-8312 Change in information; notice to director.

Each discount medical plan organization shall provide the director notice of any change in the discount medical plan organization's name, address, telephone number, principal business address or mailing address, or Internet website address no less than thirty days before such change is to occur.

Source: Laws 2008, LB855, § 44.

44-8313 Annual report; contents; failure to file; effect.

(1) If the information required in subsection (2) of this section is not provided at the time of renewal of a certificate of registration under section 44-8306, a discount medical plan organization shall file an annual report with the director in the form prescribed by the director within three months after the end of each fiscal year.

(2) The report shall include:

(a) If different from the initial application for a certificate of registration or at the time of renewal of a certificate of registration, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements with such persons and the discount medical plan organization, including any possible conflicts of interest;

(b) The number of discount medical plan members in the state; and

(c) Any other information relating to the performance of the discount medical plan organization that may be required by the director.

(3)(a) Any discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall forfeit:

(i) Up to five hundred dollars each day for the first ten days during which the violation continues; and

(ii) Up to one thousand dollars each day after the first ten days during which the violation continues.

(b) Upon notice by the director, the discount medical plan organization described in subdivision (a) of this subsection shall lose its authority to enroll new members or to do business in this state if the violation continues.

Source: Laws 2008, LB855, § 45.

44-8314 Violation; unfair trade practice; administrative penalty; fraudulent insurance act; restitution.

(1) A violation of the Discount Medical Plan Organization Act shall be an unfair trade practice under the Unfair Insurance Trade Practices Act.

(2) In addition to the penalties and other enforcement provisions of the Discount Medical Plan Organization Act, any person who willfully violates the act is subject to administrative penalties of up to one thousand dollars per violation.

(3) A person that willfully operates as or aids and abets another operating as a discount medical plan organization in violation of subsection (1) of section 44-8306 commits a fraudulent insurance act under section 28-631.

(4) A person that collects fees for purported membership in a discount medical plan but purposefully fails to provide the promised benefits commits a fraudulent insurance act under section 28-631. In addition, upon conviction, such person shall be ordered to pay restitution to persons aggrieved by the violation of the act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of such fine or imprisonment.

Source: Laws 2008, LB855, § 46.

Cross References

Unfair Insurance Trade Practices Act, see section 44-1521.

44-8315 Violations of act; cease and desist order; hearing; appeal; director; additional powers.

(1) The director may issue an order directing a discount medical plan organization to cease and desist from engaging in any action or practice in violation of the Discount Medical Plan Organization Act. Within ten days after service of the cease and desist order, the organization may request a hearing on the question of whether an action or practice in violation of the act has occurred. Such hearing shall be conducted as provided by the Administrative Procedure Act. The organization may appeal the decision of the director. Such appeal shall be in accordance with the Administrative Procedure Act.

(2)(a) In addition to the penalties and other enforcement provisions of the Discount Medical Plan Organization Act, the director may seek both temporary and permanent injunctive relief when:

(i) A discount medical plan is being operated by a person or entity that is not registered pursuant to the act; or

(ii) Any person, entity, or discount medical plan organization has engaged in any activity prohibited by the act or any rules or regulations adopted and promulgated pursuant to the act.

(b) The district court of Lancaster County shall have exclusive jurisdiction over any proceeding brought pursuant to this section.

(3) The director's authority to seek relief under this section is not conditioned upon having conducted any proceeding pursuant to the provisions of the Administrative Procedure Act.

Source: Laws 2008, LB855, § 47.

Cross References

Administrative Procedure Act, see section 84-920.

44-8316 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the provisions of the Discount Medical Plan Organization Act.

Source: Laws 2008, LB855, § 48.

ARTICLE 84

MANDATE OPT-OUT AND INSURANCE COVERAGE CLARIFICATION ACT

Section
44-8401. Act, how cited.
44-8402. Legislative findings.
44-8403. Qualified health insurance plan offered through health insurance exchange; abortion coverage; restriction; health insurance plan, contract, or policy; optional rider.
44-8404. Act; not construed as right to abortion.

44-8401 Act, how cited.

Sections 44-8401 to 44-8404 shall be known and may be cited as the Mandate Opt-Out and Insurance Coverage Clarification Act.

Source: Laws 2011, LB22, § 1.

44-8402 Legislative findings.

(1) The Legislature finds that:

(a) In the federal Patient Protection and Affordable Care Act, Public Law 111-148, federal tax dollars are routed via affordability credits to qualified health insurance plans offered through a health insurance exchange created under the act, including plans that provide coverage for abortion;

(b) Federal funding for health insurance plans that cover abortions is prohibited by the federal statutory restriction commonly known as the Hyde Amendment and the Federal Employees Health Benefits Program established under Chapter 89 of Title 5 of the United States Code, as amended;

(c) Section 1303 of the federal Patient Protection and Affordable Care Act explicitly permits each state to pass laws prohibiting qualified health insurance plans offered through a health insurance exchange created under the act in such state from offering abortion coverage. Such section allows a state to prohibit the use of public funds to subsidize health insurance plans that cover abortions within the state;

(d) The laws of the State of Nebraska provide that group health insurance plans or health maintenance agreements paid for with public funds shall not cover abortion unless necessary to prevent the death of the woman;

(e) Rust v. Sullivan, 500 U.S. 173 (1991), states that it is permissible for a state to engage in unequal subsidization of abortion and other medical services to encourage alternative activity deemed in the public interest; and

(f) A majority of the citizens of the State of Nebraska, like other Americans, oppose the use of public funds, both federal and state, to pay for abortions.

(2) Based on the findings in subsection (1) of this section, it is the purpose of the Mandate Opt-Out and Insurance Coverage Clarification Act to affirmatively opt out of allowing qualified health insurance plans that cover abortions to participate in health insurance exchanges within the State of Nebraska. Further, it is also the purpose of the act to limit the coverage of abortion in all health insurance plans, contracts, or policies delivered or issued for delivery in the State of Nebraska.

Source: Laws 2011, LB22, § 2.

44-8403 Qualified health insurance plan offered through health insurance exchange; abortion coverage; restriction; health insurance plan, contract, or policy; optional rider.

(1) No abortion coverage shall be provided by a qualified health insurance plan offered through a health insurance exchange created pursuant to the federal Patient Protection and Affordable Care Act, Public Law 111-148, within the State of Nebraska. This subsection shall not apply to coverage for an abortion which is verified in writing by the attending physician as necessary to prevent the death of the woman or to coverage for medical complications arising from an abortion.

(2) No health insurance plan, contract, or policy delivered or issued for delivery in the State of Nebraska shall provide coverage for an elective abortion except through an optional rider to the policy for which an additional premium is paid solely by the insured. This subsection applies to any health insurance plan, contract, or policy delivered or issued for delivery in the State of Nebraska by any health insurer, any nonprofit hospital, medical, surgical, dental, or health service corporation, any group health insurer, and any health maintenance organization subject to the laws of insurance in this state and any employer providing self-funded health insurance for his or her employees. This subsection also applies to any plan provision of hospital, medical, surgical, or funeral benefits or of coverage against accidental death or injury if such benefits or coverage are incidental to or a part of any other insurance plan delivered or issued for delivery in the State of Nebraska.

(3) The issuer of a health insurance plan, contract, or policy in the State of Nebraska shall not provide any incentive or discount to an insured if the insured elects abortion coverage.

(4) For purposes of this section, elective abortion means an abortion (a) other than a spontaneous abortion or (b) that is performed for any reason other than to prevent the death of the female upon whom the abortion is performed.

Source: Laws 2011, LB22, § 3.

44-8404 Act; not construed as right to abortion.

Nothing in the Mandate Opt-Out and Insurance Coverage Clarification Act shall be construed as creating a right to an abortion.

Source: Laws 2011, LB22, § 4.

ARTICLE 85
PORTABLE ELECTRONICS INSURANCE ACT

Section

44-8501 Act, how cited.

Sections 44-8501 to 44-8509 shall be known and may be cited as the Portable Electronics Insurance Act.

Source: Laws 2011, LB535, § 1.

44-8502 Terms, defined.

For purposes of the Portable Electronics Insurance Act:

(1) Customer means a person who purchases portable electronics;

(2) Covered customer means a customer who elects coverage pursuant to a portable electronics insurance policy issued to a vendor of portable electronics;

(3) Director means the Director of Insurance;

(4) Location means any physical location in this state or any website, call center, or other site or similar location to which Nebraska customers may be directed;

(5) Portable electronics means any nonstationary electronic equipment and its accessories capable of communications or data processing or utility including, but not limited to, a laptop, a tablet, a wearable computer, a personal communications device such as a cellular or mobile telephone, a hand-held smart phone, a media player, an e-reader, a personal digital assistant, devices used for data collection, global positioning, or monitoring, and other devices that may or may not incorporate wireless transmitters and receivers. Portable electronics does not include telecommunications switching equipment, transmission wires, cellular site transceiver equipment, or other equipment or system used by a telecommunications company to provide telecommunications service to consumers;

(6)(a) Portable electronics insurance means insurance that provides coverage for the repair or replacement of portable electronics and may provide coverage for portable electronics that are lost, stolen, damaged, or inoperable due to mechanical failure or malfunction or suffer other similar causes of loss; and

(b) Portable electronics insurance does not include:

(i) A service contract under the Motor Vehicle Service Contract Reimbursement Insurance Act;

(ii) A service contract or extended warranty providing coverage as described in subdivision (2) of section 44-102.01;

(iii) A policy of insurance providing coverage for a seller's or manufacturer's obligations under a warranty; or

(iv) A homeowner's, renter's, private passenger automobile, commercial multiperil, or other similar policy;

(7) Portable electronics transaction means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer;

(8) Supervising entity means a business entity that is a licensed insurance producer or insurer; and

(9) Vendor means a person in the business of engaging in portable electronics transactions directly or indirectly.

Source: Laws 2011, LB535, § 2; Laws 2017, LB306, § 1.

Cross References

Motor Vehicle Service Contract Reimbursement Insurance Act, see section 44-3520.

44-8503 Vendor; limited lines insurance license; issuance; application; contents.

(1) A vendor shall hold a limited lines insurance license issued under the Portable Electronics Insurance Act to sell or offer coverage under a policy of portable electronics insurance.

(2) The director may issue a limited lines insurance license under the act. Such license shall authorize an employee or authorized representative of a vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in a portable electronics transaction.

(3) The vendor shall submit an application for a limited lines insurance license pursuant to section 44-8504 to the director, and a list of all locations in this state at which the vendor intends to offer such insurance coverage shall accompany the application. A vendor shall maintain such list and make it available for the director upon request.

(4) Notwithstanding any other provision of law, a limited lines insurance license issued under the act shall authorize the vendor and its employees or authorized representatives to engage in the activities permitted by the act.

Source: Laws 2011, LB535, § 3.

44-8504 Limited lines insurance license; application; contents; period valid; fees.

(1) An application for a limited lines insurance license shall be made to and filed with the director on forms prescribed and furnished by the director.

(2) An application for an initial or a renewal license shall:

(a) Provide the name, residence address, and other information required by the director for an employee or authorized representative of the vendor that is designated by the vendor as the person responsible for the vendor's compliance with the Portable Electronics Insurance Act. If the vendor derives more than fifty percent of its revenue from the sale of portable electronics insurance, the information required by this subdivision shall be provided for all persons of record having beneficial ownership of ten percent or more of any class of securities of the vendor registered under federal securities law; and

(b) Provide the location of the vendor's home office.

(3) Any application for licensure under the act for an existing vendor shall be made within ninety days after the application is made available by the director.

(4) An initial license issued pursuant to the act shall be valid for one year and expires on April 30 of each year.

(5) Any vendor licensed under the act shall pay an initial license fee to the director in an amount prescribed by the director but not to exceed one hundred dollars and shall pay a renewal fee in an amount prescribed by the director but not to exceed one hundred dollars.

Source: Laws 2011, LB535, § 4.

44-8505 Brochure or written material; available to customer; contents; certificate of insurance; powers of insurer.

(1) At each location at which portable electronics insurance is offered to a customer, a brochure or other written material shall be available to the customer which:

(a) Discloses the fact that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other similar insurance coverage;

(b) States that the enrollment by the customer in a portable electronics insurance coverage program is not required in order to purchase or lease portable electronics or services;

(c) Summarizes the material terms of the portable electronics insurance, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) The benefits of the coverage; and

(v) The key terms and conditions of the coverage, including whether portable electronics may be repaired or replaced with a similar reconditioned make or model or with nonoriginal manufacturer parts or equipment;

(d) Summarizes the process for filing a claim, including a description of how to return the portable electronics and the maximum fee applicable if the customer fails to comply with any equipment return requirements; and

(e) States that the customer may cancel enrollment for portable electronics insurance coverage at any time and receive any applicable unearned premium refund on a pro rata basis.

(2) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor for its covered customers. A covered customer who elects to enroll for coverage shall receive a certificate of insurance and an explanation of coverage or instructions on how to obtain such materials upon request.

(3) Eligibility and underwriting standards for customers who elect to enroll in portable electronics insurance coverage shall be established by the insurer for each portable electronics insurance program.

Source: Laws 2011, LB535, § 5.

44-8506 Exemption from licensure as insurance producer; conditions; vendor; duties; treatment of funds.

(1) An employee or authorized representative of a vendor may sell or offer for sale portable electronics insurance to customers and shall not be subject to licensure as an insurance producer if:

(a) The vendor obtains a limited lines insurance license pursuant to section 44-8503 that authorizes its employees or authorized representatives to sell or offer for sale portable electronics insurance under this section;

(b) The insurer issuing the portable electronics insurance directly supervises or appoints a supervising entity to supervise the administration of the insurance program, including development of a training program for employees and authorized representatives of a vendor. The training required by this subdivision shall comply with the following:

(i) The training shall be delivered to employees and authorized representatives of a vendor who are directly involved in the activity of selling or offering for sale portable electronics insurance;

(ii) The training may be provided in electronic form. If the training is provided in electronic form, the supervising entity shall implement a supplemental education program that is conducted and overseen by licensed employees of the supervising entity; and

(iii) Each employee and authorized representative shall receive basic instruction on the portable electronics insurance offered to customers and the disclosures required by section 44-8505; and

(c) The vendor does not advertise, represent, or otherwise hold itself or any of its employees or authorized representatives out as authorized insurers or licensed insurance producers.

(2) The charges for portable electronics insurance coverage may be billed and collected by the vendor. Any charge to the customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics shall be separately itemized on the covered customer's bill. If the portable electronics insurance coverage is included in the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the customer that portable electronics insurance coverage is included with the portable electronics or related services. No vendor shall require the purchase of any kind of insurance specified in this section as a condition of the purchase or lease of portable electronics or services. If such insurance is purchased, the portable electronics insurance coverage offered by the limited lines insurance licensee to a customer is primary over any other insurance coverage applicable to the portable electronics. A vendor who bills and collects such charges shall not be required to maintain such funds in a segregated account if the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within sixty days after receipt. All funds received by a vendor from a covered customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. A vendor may receive compensation for billing and collection services.

Source: Laws 2011, LB535, § 6.

44-8507 Violations; director; powers; administrative fine.

If a vendor violates any provision of the Portable Electronics Insurance Act, the director may, after notice and a hearing:

(1) Revoke or suspend a limited lines insurance license issued under the act;

(2) Impose such other penalties, including suspension of the transaction of insurance at specific vendor locations where violations have occurred, as the director deems necessary or convenient to carry out the purposes of the act; and

(3) Impose an administrative fine of not more than one thousand dollars per violation or five thousand dollars in the aggregate.

Source: Laws 2011, LB535, § 7.

44-8508 Insurer; rights; duties; notice; policy; termination; vendor; duties.

Notwithstanding any other provision of law:

(1) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the vendor and enrolled customers with at least thirty days' notice, except that:

(a) An insurer may terminate an enrolled customer's insurance policy upon fifteen days' notice for:

(i) Discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under such policy; or

(ii) Nonpayment of premium; or

(b) An insurer may immediately terminate an enrolled customer's insurance policy:

(i) If the enrolled customer ceases to have active service with the vendor of portable electronics; or

(ii) If an enrolled customer exhausts the aggregate limit of liability, if any, under the portable electronics insurance policy and the insurer sends notice of termination to the customer within thirty days after exhaustion of the limit. If such notice is not sent within the thirty-day period, the customer shall continue to be enrolled in such insurance policy notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the customer;

(2) If the insurer changes the terms and conditions, the insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of the material changes;

(3) If a portable electronics insurance policy is terminated by a vendor, the vendor shall mail or deliver written notice to each enrolled customer at least thirty days prior to the termination advising the customer of such termination and of the effective date of termination; and

(4) If notice is required under this section, it shall be:

(a) In writing and may be mailed or delivered to a vendor at the vendor's mailing address and to an enrolled customer at such customer's last-known mailing address on file with the insurer. The insurer or vendor, as applicable, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or a commercial mail delivery service; or

(b) In electronic form. Disclosure of notice in electronic form to the enrolled customer shall be provided within thirty days after the purchase of the portable electronics. If notice is delivered in electronic form, the insurer or vendor, as applicable, shall maintain proof that the notice was sent.

Source: Laws 2011, LB535, § 8; Laws 2017, LB306, § 2.

44-8509 Records; maintenance.

Any records pertaining to transactions under the Portable Electronics Insurance Act shall be kept available and open to inspection by the director or his or her representatives with notice and during business hours. Records shall be maintained for three years following the completion of transactions under the act.

Source: Laws 2011, LB535, § 9.

ARTICLE 86

INSURED HOMEOWNERS PROTECTION ACT

Section

44-8601 Act, how cited.

Sections 44-8601 to 44-8608 shall be known and may be cited as the Insured Homeowners Protection Act.

Source: Laws 2012, LB943, § 1; Laws 2018, LB743, § 30.

44-8602 Terms, defined.

For purposes of the Insured Homeowners Protection Act:

(1) Residential contractor means a person in the business of contracting or offering to contract with an owner or possessor of residential real estate to:

(a) Repair or replace a roof system or perform any other exterior repair, replacement, construction, or reconstruction work on residential real estate;

(b) Perform interior or exterior cleanup services on residential real estate;

(c) Arrange for, manage, or process the work referred to in subdivision (1)(a) or (b) of this section; or

(d) Serve as a representative, agent, or assignee of the owner or possessor of residential real estate;

(2) Residential real estate means a new or existing building, including a detached garage, constructed for habitation by at least one but no more than four families; and

(3) Roof system means and includes roof coverings, roof sheathing, roof weatherproofing, and insulation.

Source: Laws 2012, LB943, § 2; Laws 2018, LB743, § 31.

44-8603 Contract to be paid from proceeds of property and casualty insurance policy; right to cancel; notice; residential contractor; duties.

(1) A person who has entered into a written contract with a residential contractor to provide goods or services to be paid from the proceeds of a property and casualty insurance policy may cancel the contract prior to midnight on the later of the third business day after the person has (a) entered into the written contract or (b) received written notice from the person's insurer that all or part of the claim or contract is not a covered loss under the insurance policy. Cancellation shall be evidenced by the person giving written notice of the cancellation to the residential contractor at the address of the residential contractor's place of business as stated in the contract. Written notice of cancellation may be given by delivering or mailing a signed and dated copy of the written notice of cancellation to the residential contractor at the address of the residential contractor's place of business as stated in the contract. The notice of cancellation shall include a copy of the written notice from the person's insurer, if applicable, to the effect that all or part of the claim or contract is not a covered loss under the insurance policy. Notice of cancellation given by mail shall be effective upon deposit in the United States mail, postage prepaid, if properly addressed to the residential contractor. Notice of cancellation is not required to be in any particular form and is sufficient if the notice indicates, by any form of written expression, the intent of the insured not to be bound by the contract.

(2) Within ten days after a contract to provide goods or services to be paid from the proceeds of a property and casualty insurance policy has been canceled by notification pursuant to this section, the residential contractor shall tender to the person canceling the contract any payments, partial payments, or deposits made by the person and any note or other evidence of indebtedness, except that if the residential contractor has provided any goods or services agreed to by such person in writing to be necessary to prevent damage to the premises, the residential contractor shall be entitled to be paid the reasonable value of such goods or services. Any provision in a contract to provide goods or services to be paid from the proceeds of a property and casualty insurance policy that requires the payment of any fee which is not for such goods or services shall not be enforceable against any person who has canceled a contract pursuant to this section.

Source: Laws 2012, LB943, § 3.

44-8604 Residential contractor; prohibited acts.

A residential contractor shall not promise to rebate any portion of an insurance deductible as an inducement to the sale of goods or services. A promise to rebate any portion of an insurance deductible includes granting any allowance or offering any discount against the fees to be charged or paying an insured or a person directly or indirectly associated with the residential real estate any form of compensation, except for any item of nominal value.

Source: Laws 2012, LB943, § 4.

44-8605 Post-loss assignment of rights or benefits; requirements; Department of Insurance; duties.

(1) A post-loss assignment of rights or benefits to a residential contractor under a property and casualty insurance policy insuring residential real estate shall comply with the following:

(a) The assignment may authorize a residential contractor to be named as a copayee for the payment of benefits under a property and casualty insurance policy covering residential real estate;

(b) The assignment shall be provided to the insurer of the residential real estate within five business days after execution;

(c) The assignment shall include a statement that the residential contractor has made no assurances that the claimed loss will be fully covered by an insurance contract and shall include the following notice in capitalized fourteen-point type:

YOU ARE AGREEING TO ASSIGN CERTAIN RIGHTS YOU HAVE UNDER YOUR INSURANCE POLICY. WITH AN ASSIGNMENT, THE RESIDENTIAL CONTRACTOR SHALL BE ENTITLED TO PURSUE ANY RIGHTS OR REMEDIES THAT YOU, THE INSURED HOMEOWNER, HAVE UNDER YOUR INSURANCE POLICY. PLEASE READ AND UNDERSTAND THIS DOCUMENT BEFORE SIGNING.

THE INSURER MAY ONLY PAY FOR THE COST TO REPAIR OR REPLACE DAMAGED PROPERTY CAUSED BY A COVERED PERIL, SUBJECT TO THE TERMS OF THE POLICY.

(d) The assignment shall not impair the interest of a mortgagee listed on the declarations page of the property and casualty insurance policy which is the subject of the assignment; and

(e) The assignment shall not prevent or inhibit an insurer from communicating with the named insured or mortgagee listed on the declarations page of the property and casualty insurance policy that is the subject of the assignment.

(2) The Department of Insurance shall strictly enforce the provisions of subdivision (13) of section 44-1540, which requires insurers to provide a named insured a reasonable and accurate explanation of the basis for the denial of a claim or an offer of a compromise settlement.

Source: Laws 2018, LB743, § 32.

44-8606 Residential contractor; furnish itemized description; contents.

Prior to commencement of repair or replacement work, a residential contractor shall furnish the insured and insurer with an itemized description of the work to be done and the materials, labor, and fees for repair or replacement of the damaged residential real estate and the total itemized amount agreed to be paid for the work to be performed, except that the description shall not limit the insured or residential contractor from identifying other goods and services necessary to complete repairs or replacement associated with a covered loss.

Source: Laws 2018, LB743, § 33.

44-8607 Notice required.

Any written contract, repair estimate, or work order prepared by a residential contractor to provide goods or services to be paid from the proceeds of a

property and casualty insurance policy shall include the following notice of the prohibition contained in section 44-8604 in capitalized fourteen-point type which shall be signed by the named insured and sent to the named insured's insurer prior to payment of proceeds under the applicable insurance policy:

IT IS A VIOLATION OF THE INSURANCE LAWS OF NEBRASKA TO REBATE ANY PORTION OF AN INSURANCE DEDUCTIBLE AS AN INDUCEMENT TO THE INSURED TO ACCEPT A RESIDENTIAL CONTRACTOR'S PROPOSAL TO REPAIR DAMAGED PROPERTY. REBATE OF A DEDUCTIBLE INCLUDES GRANTING ANY ALLOWANCE OR OFFERING ANY DISCOUNT AGAINST THE FEES TO BE CHARGED FOR WORK TO BE PERFORMED OR PAYING THE INSURED HOMEOWNER THE DEDUCTIBLE AMOUNT SET FORTH IN THE INSURANCE POLICY.

THE INSURED HOMEOWNER IS PERSONALLY RESPONSIBLE FOR PAYMENT OF THE DEDUCTIBLE. THE INSURANCE FRAUD ACT AND NEBRASKA CRIMINAL STATUTES PROHIBIT THE INSURED HOMEOWNER FROM ACCEPTING FROM A RESIDENTIAL CONTRACTOR A REBATE OF THE DEDUCTIBLE OR OTHERWISE ACCEPTING ANY ALLOWANCE OR DISCOUNT FROM THE RESIDENTIAL CONTRACTOR TO COVER THE COST OF THE DEDUCTIBLE. VIOLATIONS MAY BE PUNISHABLE BY CIVIL OR CRIMINAL PENALTIES.

Source: Laws 2018, LB743, § 34.

Cross References

Insurance Fraud Act, see section 44-6601.

44-8608 Violation of act; void contract.

A contract entered into with a residential contractor is void if the residential contractor violates any provision of the Insured Homeowners Protection Act.

Source: Laws 2018, LB743, § 35.

ARTICLE 87

NEBRASKA EXCHANGE TRANSPARENCY ACT

Section
44-8701. Repealed. Laws 2017, LB644, § 21.
44-8702. Repealed. Laws 2017, LB644, § 21.
44-8703. Repealed. Laws 2017, LB644, § 21.
44-8704. Repealed. Laws 2017, LB644, § 21.
44-8705. Repealed. Laws 2017, LB644, § 21.
44-8706. Repealed. Laws 2017, LB644, § 21.

44-8701 Repealed. Laws 2017, LB644, § 21.

44-8702 Repealed. Laws 2017, LB644, § 21.

44-8703 Repealed. Laws 2017, LB644, § 21.

44-8704 Repealed. Laws 2017, LB644, § 21.

44-8705 Repealed. Laws 2017, LB644, § 21.

44-8706 Repealed. Laws 2017, LB644, § 21.

ARTICLE 88

HEALTH INSURANCE EXCHANGE NAVIGATOR REGISTRATION ACT

Section

44-8801 Act, how cited.

Sections 44-8801 to 44-8808 shall be known and may be cited as the Health Insurance Exchange Navigator Registration Act.

Source: Laws 2013, LB568, § 1.

44-8802 Terms, defined.

For purposes of the Health Insurance Exchange Navigator Registration Act:

(1) Director means the Director of Insurance;

(2) Exchange means any health insurance exchange established or operating in this state, including any exchange established or operated by the United States Department of Health and Human Services; and

(3) Navigator means any individual or entity, other than an insurance producer or consultant, that receives any funding, directly or indirectly, from an exchange, the state, or the federal government to perform the duties identified in 42 U.S.C. 18031(i)(3), as such section existed on January 1, 2013.

Source: Laws 2013, LB568, § 2.

44-8803 Navigator; registration required; prohibited acts.

(1) No individual or entity shall perform, offer to perform, or advertise any service as a navigator in this state unless registered as a navigator by the director.

(2) A navigator shall not:

(a) Engage in any activities that would require an insurance producer license;

(b) Violate section 44-4050;

(c) Recommend or endorse a particular health plan;

(d) Accept any compensation or consideration from an insurance company, broker, or consultant that is dependent, in whole or in part, on whether a person enrolls in or purchases a qualified health plan; or

(e) Fail to respond to any written inquiry from the director regarding the navigator's duties as a navigator or fail to request additional reasonable time to respond within fifteen working days.

Source: Laws 2013, LB568, § 3.

44-8804 Individual navigator registration; application; form; contents; fee; entity navigator registration; application; form; contents; fee; notice of federal action; list of employees.

(1) An individual applying for an individual navigator registration shall make application to the director on a form developed by the director which, unless preempted by federal law, is accompanied by the initial individual registration fee in an amount not to exceed twenty-five dollars as established by the director. The individual shall declare in the application under penalty of refusal, suspension, or revocation of the registration that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the director shall find that the individual:

(a) Is at least eighteen years of age;

(b) Has successfully passed an examination prescribed by an exchange established or operating in this state and has been authorized to act as a navigator; and

(c) Has identified any entity navigator with which he or she is affiliated and supervised.

(2) An entity applying for an entity navigator registration shall make application on a form developed by the director and which contains the information prescribed by the director and which, unless preempted by federal law, is accompanied by the initial entity registration fee in an amount not to exceed fifty dollars as established by the director.

(3) The director may require any documents deemed necessary to verify the information contained in an application submitted in accordance with subsections (1) and (2) of this section.

(4) A registered navigator shall, in a manner prescribed by the director, notify the director within thirty days of any federal action that restricts or terminates the navigator's authorization to act as a navigator.

(5) A registered entity navigator shall, in a manner prescribed by the director, provide the director with a list of all individual navigators that it employs, supervises, or is affiliated with.

Source: Laws 2013, LB568, § 4.

44-8805 Registrations; term; renewal; application; fee; federal training and continuing education requirements.

(1) Individual and entity registrations shall expire one year after the date of issuance.

(2) An individual navigator may file an application for renewal of a registration on a form developed by the director and, unless preempted by federal law, shall pay the renewal fee in an amount not to exceed twenty-five dollars as established by the director, and an entity navigator may file an application for renewal of a registration on a form developed by the director and, unless

preempted by federal law, shall pay the renewal fee in an amount not to exceed fifty dollars as established by the director. An individual navigator who fails to file prior to the expiration of the current registration for registration renewal, unless preempted by federal law, shall pay a late fee in an amount not to exceed fifty dollars as established by the director, and an entity navigator that fails to file prior to the expiration of the current registration for registration renewal, unless preempted by federal law, shall pay a late fee in an amount not to exceed fifty dollars as established by the director.

(3) Any failure to fulfill the federal ongoing training and continuing education requirements shall result in the expiration of the registration.

Source: Laws 2013, LB568, § 5.

44-8806 Navigator; individual with existing health insurance coverage; information.

On contact with an individual who acknowledges having existing health insurance coverage obtained through a licensed insurance producer, a navigator shall make a reasonable effort to inform the individual that he or she may, but is not required to, seek further assistance from that producer or another licensed producer for information, assistance, and any other services and that tax credits may not be available to offset the premium cost of plans that are marketed outside of the exchange.

Source: Laws 2013, LB568, § 6.

44-8807 Director; disciplinary actions authorized; powers to examine business affairs and records; notice; hearing.

(1) The director, after notice and hearing, may place on probation, suspend, revoke, or refuse to issue, renew, or reinstate a navigator registration for violation of the Health Insurance Exchange Navigator Registration Act.

(2) Except as otherwise provided by law, the director may examine and investigate the business affairs and records of any navigator as such business affairs and records regard the navigator's duties as a navigator to determine whether the navigator has engaged or is engaging in any violation of the act.

(3) An entity navigator registration may be suspended or revoked or renewal or reinstatement thereof may be refused if the director finds, after notice and hearing, that an individual navigator's violation was known by the employing or supervising entity navigator and the violation was not reported to the director and no corrective action was undertaken.

Source: Laws 2013, LB568, § 7.

44-8808 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Health Insurance Exchange Navigator Registration Act.

Source: Laws 2013, LB568, § 8.

ARTICLE 89
STANDARD VALUATION ACT

Section
44-8901. Act, how cited.

Section

44-8901 Act, how cited.

Sections 44-8901 to 44-8912 shall be known and may be cited as the Standard Valuation Act.

Source: Laws 2014, LB755, § 1.

44-8902 Applicability of act.

Except as provided in sections 44-8905, 44-8906, and 44-8907, the Standard Valuation Act applies to those policies and contracts issued on or after the operative date of the valuation manual designated in subsection (2) of section 44-8908.

Source: Laws 2014, LB755, § 2.

44-8903 Terms, defined.

For the purposes of the Standard Valuation Act:

(1) Accident and health insurance contract means a contract that incorporates morbidity risk and provides protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual;

(2) Appointed actuary means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in sections 44-421 to 44-425 and 44-8905;

(3) Company means an entity which has (a) written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one such policy in force or on claim or (b) written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state;

(4) Deposit-type contract means a contract that does not incorporate mortality or morbidity risks and as may be specified in the valuation manual;

(5) Director means the Director of Insurance;

(6) Life insurance contract means a contract that incorporates mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual;

(7) Policyholder behavior means any action a policyholder, a contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to the act including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract;

(8) Principle-based valuation means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with section 44-8909 as specified in the valuation manual;

(9) Qualified actuary means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual;

(10) Reserves means reserve liabilities;

(11) Tail risk means a risk that occurs either when the frequency of low probability events is higher than expected under a normal probability distribution or when there are observed events of very significant size or magnitude; and

(12) Valuation manual means the valuation manual prescribed by the director which conforms substantially to the valuation manual developed and adopted by the National Association of Insurance Commissioners.

Source: Laws 2014, LB755, § 3.

44-8904 Director; valuation of reserves; duties; powers.

The director shall annually value, or cause to be valued, the reserves for all outstanding life insurance contracts, accident and health insurance contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the director may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in the Standard Valuation Act.

Source: Laws 2014, LB755, § 4.

Cross References

For operative date of valuation manual, see section 44-8908.

44-8905 Company; opinion of actuary; contents; standards; liability; confidentiality; director; powers; release of material; when.

(1) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the director shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported

amounts, and comply with applicable laws of this state. The valuation manual shall prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(2) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the director, except as exempted in the valuation manual, shall also annually include in the opinion required by subsection (1) of this section an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(3) Each opinion required by subsection (2) of this section shall be governed by the following provisions:

(a) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the director, shall be prepared to support each actuarial opinion; and

(b) If the company fails to provide a supporting memorandum at the request of the director within a period specified in the valuation manual or the director determines that the supporting memorandum provided by the company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the director, the director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the director.

(4) Every opinion shall be governed by the following provisions:

(a) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the director;

(b) The opinion shall be submitted with the annual statement reflecting the valuation of the reserves for each year ending on or after the operative date of the valuation manual;

(c) The opinion shall apply to all policies and contracts subject to subsection (2) of this section, plus other actuarial liabilities as may be specified in the valuation manual;

(d) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor and on such additional standards as may be prescribed in the valuation manual;

(e) In the case of an opinion required to be submitted by a foreign or alien company, the director may accept the opinion filed by that company with the insurance supervisory official of another state if the director determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(f) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person other than the insurance company and the director for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion; and

(g) Disciplinary action by the director against the company or the appointed actuary shall be as set forth in rules and regulations adopted and promulgated by the director.

(5)(a) Documents, materials, or other information in the possession or control of the director that are a memorandum in support of the opinion and any other material provided by the company to the director in connection with the memorandum shall be confidential by law and privileged, shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The director may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. Neither the director nor any person who received documents, materials, or other information while acting under the authority of the director shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or other information.

(b) In order to assist in the performance of the director's duties, the director:

(i) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities if the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information; and

(ii) May receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(c) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the director under this section or as a result of sharing information pursuant to this subsection.

(d) A memorandum in support of the opinion, and any other material provided by the company to the director in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this section or by rules and regulations.

(e) The memorandum or other material may otherwise be released by the director with the written consent of the company or to the American Academy of Actuaries pursuant to a request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the director for preserving the confidentiality of the memorandum or other material.

(f) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a governmental agency other than a state

insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

Source: Laws 2014, LB755, § 5.

Cross References

For operative date of valuation manual, see section 44-8908.

44-8906 Minimum standard of valuation; applicability to contracts; when.

For accident and health insurance contracts issued on or after the operative date of the valuation manual designated in subsection (2) of section 44-8908, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 44-8904. For disability and sickness and accident insurance contracts issued on or after the operative date defined in section 44-407.07 and prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted and promulgated by the director by rule and regulation.

Source: Laws 2014, LB755, § 6.

44-8907 Life insurance; standards of valuation; policies issued on or after operative date of law; reserves required.

(1) This section shall apply to only those policies and contracts issued on or after the operative date defined in section 44-407.07 (the Standard Nonforfeiture Law for Life Insurance), except as otherwise provided in subsection (3) of this section for all annuities and pure endowments purchased on or after the operative date of such subsection (3) under group annuity and pure endowment contracts issued prior to such operative date defined in section 44-407.07. This section shall apply to all policies and contracts issued prior to the operative date of the valuation manual designated in subsection (2) of section 44-8908, and sections 44-8908 and 44-8909 shall not apply to any such policies and contracts.

(2) Except as otherwise provided in subsections (3) and (4) of this section, the minimum standard for the valuation of all such policies and contracts issued prior to August 30, 1981, shall be that provided by the laws in effect immediately prior to such date. Except as otherwise provided in subsections (3) and (4) of this section, the minimum standard for the valuation of all such policies and contracts shall be the Commissioners Reserve Valuation Methods defined in subsections (5), (6), and (9) of this section; five percent interest for group annuity and pure endowment contracts and three and one-half percent interest for all other such policies and contracts, or in the cases of policies and contracts, other than annuity and pure endowment contracts, issued on or after September 2, 1973, four percent interest for such policies issued prior to August 24, 1979, and four and one-half percent interest for such policies issued on or after August 24, 1979; and the following tables: (a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies,—the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of section 44-407.08 (Standard Nonforfeiture Law for Life Insurance), the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after such operative date and prior to the operative date of section 44-407.24, except that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this section may be

calculated according to an age not more than six years younger than the actual age of the insured; and for such policies on or after the operative date of section 44-407.24 (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the company for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Department of Insurance for use in determining the minimum standard of valuation for such policies; (b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies,—the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of section 44-407.09 (Standard Nonforfeiture Law for Life Insurance), and for such policies issued on or after such operative date, the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Department of Insurance for use in determining the minimum standard of valuation for such policies; (c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies,—the 1937 Standard Annuity Mortality Table, or at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the Department of Insurance; (d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies,—the Group Annuity Mortality Table for 1951, any modification of such table approved by the Department of Insurance, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts; (e) for total and permanent disability benefits in or supplementary to ordinary policies or contracts—for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Department of Insurance for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies; (f) for accidental death benefits in or supplementary to policies—for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and (g) for group life insurance, life insurance issued on the substandard basis and other special benefits—such tables as may be approved by the Department of Insurance.

(3) Except as provided in subsection (4) of this section, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this subsection, as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the Commissioners Reserve Valuation Methods defined in subsections (5) and (6) of this section and the following tables and interest rates:

(a) For individual annuity and pure endowment contracts issued prior to August 24, 1979, excluding any disability and accidental death benefits in such contracts—the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the Department of Insurance, and six percent interest for single premium immediate annuity contracts, and four percent interest for all other individual annuity and pure endowment contracts;

(b) For individual single premium immediate annuity contracts issued on or after August 24, 1979, excluding any disability and accidental death benefits in such contracts—the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Department of Insurance for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the director, and seven and one-half percent interest;

(c) For individual annuity and pure endowment contracts issued on or after August 24, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts—the 1971 Individual Annuity Table, or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Department of Insurance for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the director, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts;

(d) For all annuities and pure endowments purchased prior to August 24, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts—the 1971 Group Annuity Mortality Table, or any modification of this table approved by the Department of Insurance, and six percent interest; and

(e) For all annuities and pure endowments purchased on or after August 24, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts—the 1971 Group Annuity Mortality Table, or any group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Department of Insurance for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the director, and seven and one-half percent interest.

(4)(a) The calendar year statutory valuation interest rates as defined in this subsection shall be used in determining the minimum standard for the valuation of all life insurance policies issued in a particular calendar year, on or after the operative date of section 44-407.02; all individual annuity and pure endow-

ment contracts issued in a particular calendar year on or after January 1 of the calendar year next following August 30, 1981; all annuities and pure endowments purchased in a particular calendar year on or after January 1 of the calendar year next following August 30, 1981, under group annuity and pure endowment contracts; and the net increase, if any, in a particular calendar year after January 1 of the calendar year next following August 30, 1981, in amounts held under guaranteed interest contracts.

(b)(i) The calendar year statutory valuation interest rates shall be determined as provided in subdivision (4)(b)(i) of this section and the results rounded to the nearer one-quarter of one percent: (A) For life insurance, the calendar year statutory valuation interest rate shall be equal to the sum of (I) three percent; (II) the weighting factor defined in this subsection multiplied by the difference between the lesser of the reference interest rate defined in this subsection and nine percent, and three percent; and (III) one-half the weighting factor defined in this subsection multiplied by the difference between the greater of the reference interest rate defined in this subsection and nine percent, and nine percent. (B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options, the calendar year statutory valuation interest rates shall be equal to the sum of (I) three percent and (II) the weighting factor defined in this subsection multiplied by the difference between the reference interest rate defined in this subsection and three percent. (C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue-year basis, except as stated in subdivision (4)(b)(i)(B) of this section, the formula for life insurance in subdivision (4)(b)(i)(A) of this section shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years, and the formula for single premium immediate annuities in subdivision (4)(b)(i)(B) of this section shall apply to annuities and guaranteed interest contracts with guarantee duration of ten years or less. (D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities in subdivision (4)(b)(i)(B) of this section shall apply. (E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities in subdivision (4)(b)(i)(B) of this section shall apply. (F) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when section 44-407.24 becomes operative.

(ii) The weighting factors referred to in the formulas stated in this subsection are as follows: (A) For life insurance, with a guarantee duration of ten years or less, the weighting factor is .50; with a guarantee duration of more than ten

years but not more than twenty years, the weighting factor is .45; and with a guarantee duration of more than twenty years, the weighting factor is .35. For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy. (B) The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options is .80. (C) The weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision (4)(b)(ii)(B) of this section, are as follows, according to plan type as defined in this subdivision: (I) For annuities and guaranteed interest contracts valued on an issue-year basis with a guarantee duration of five years or less, the weighting factor is .80 for plan type A, .60 for plan type B, and .50 for plan type C; with a guarantee duration of more than five years but not more than ten years, the weighting factor is .75 for plan type A, .60 for plan type B, and .50 for plan type C; with a guarantee duration of more than ten years but not more than twenty years, the weighting factor is .65 for plan type A, .50 for plan type B, and .45 for plan type C; and with more than twenty years guarantee duration the weighting factor is .45 for plan type A, .35 for plan type B, and .35 for plan type C. (II) For annuities and guaranteed interest contracts valued on an issue-year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase, the weighting factors are the factors shown in subdivision (4)(b)(ii)(C)(I) of this section increased by .05 for all plan types. (III) For annuities and guaranteed interest contracts valued on a change in fund basis, the weighting factors are the factors as computed in subdivision (4)(b)(ii)(C)(II) of this section increased by .10 for plan type A, increased by .20 for plan type B, and not increased for plan type C. (IV) For annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the weighting factors are the factors as computed in subdivision (4)(b)(ii)(C)(III) of this section increased by .05 for all plan types. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(c) Plan types used in this subsection are defined as follows: Under plan type A, at any time a policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, without such an adjustment but in installments over five years or more, or as an immediate life annuity, or no withdrawal may be permitted. Under plan type B, before expiration of the interest rate guarantee, a policyholder may withdraw funds only with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company or without such an adjustment but in installments over five years or

more, or no withdrawal may be permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years. Under plan type C, a policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than five years either without an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(d) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue-year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue-year basis. As used in this subsection, an issue-year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(e) The reference interest rate referred to in this subsection shall be defined as follows: (i) For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year next preceding the year of issue, of the reference monthly average as defined in this subsection. (ii) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or year of purchase, of the reference monthly average as defined in this subsection. (iii) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision (4)(e)(ii) of this section, with guarantee duration in excess of ten years the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the reference monthly average as defined in this subsection. (iv) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision (4)(e)(ii) of this section, with guarantee duration of ten years or less, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the reference monthly average as defined in this subsection. (v) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June 30 of the calendar year of issue or purchase, of the reference monthly average as defined in this subsection. (vi) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subdivision (4)(e)(ii) of this section, the average over a

period of twelve months, ending on June 30 of the calendar year of the change in the fund, of the reference monthly average as defined in this subsection.

(f) The reference monthly average referred to in this subsection shall mean a monthly bond yield average which is published by a national financial statistical organization, recognized by the National Association of Insurance Commissioners, in current general use in the insurance industry, and designated by the Director of Insurance. In the event that the National Association of Insurance Commissioners determines that an alternative method for determination of the reference interest rate is necessary, an alternative method, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the Department of Insurance, may be substituted.

(5)(a) Except as otherwise provided in subsections (6) and (9) of this section and section 44-8906, reserves according to the Commissioners Reserve Valuation Methods, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (i) over (ii), as follows: (i) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due, except that such net level annual premium shall not exceed the net level annual premium on the nineteen year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy; (ii) a net one year term premium for such benefits provided for in the first policy year.

(b) For any life insurance policy issued on or after January 1 of the fourth calendar year commencing after August 30, 1981, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the Commissioners Reserve Valuation Methods as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (9) of this section, be the greater of the reserve as of such policy anniversary calculated as described in subdivision (5)(a) of this section, and the reserve as of such policy anniversary calculated as described in subdivision (5)(a) of this section but with (i) the net level annual premium calculated as described in subdivision (5)(a) of this section being reduced by fifteen percent of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being

considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in subsections (2) and (4) of this section shall be used.

(c) Reserves according to the Commissioners Reserve Valuation Methods for (i) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums, (ii) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership, limited liability company, or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, (iii) disability and accidental death benefits in all policies and contracts, and (iv) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection, except that any extra premiums charged because of impairments or special hazards shall be disregarded in the determination of modified net premiums.

(6) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership, limited liability company, or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code.

Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations shall be the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(7)(a) In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (5), (6), (9), and (10) of this section and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(b) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by sections 44-420 to 44-427.

(8)(a) Reserves for all policies and contracts issued prior to August 30, 1981, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.

(b) Reserves for any category of policies, contracts, or benefits as established by the Department of Insurance, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard provided under the Standard Valuation Act, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for therein.

(c) A company which adopts at any time a standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided under the Standard Valuation Act may adopt a lower standard of valuation with the approval of the director, but not lower than the minimum standard provided under the act. For the purposes of this subdivision, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by section 44-8905 shall not be deemed to be the adoption of a higher standard of valuation.

(9) If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract, but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this subsection are those standards stated in subsections (2) and (4) of this section.

For any life insurance policy issued on or after January 1 of the fourth calendar year commencing after August 30, 1981, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (5) of this section, ignoring subdivision (5)(b) of this section. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (5) of this section, including subdivision (5)(b) of this section, and the minimum reserve calculated in accordance with this subsection.

(10) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the

insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (5), (6), and (9) of this section, the reserves which are held under any such plan must (a) be appropriate in relation to the benefits and the pattern of premiums for that plan, and (b) be computed by a method which is consistent with the principles of this section as determined by regulations promulgated by the Department of Insurance.

Source: Laws 1913, c. 154, § 94, p. 437; R.S.1913, § 3231; Laws 1919, c. 190, tit. V, art. VI, § 2, p. 618; C.S.1922, § 7830; C.S.1929, § 44-502; Laws 1943, c. 106, § 1(3), p. 356; R.S.1943, § 44-404; Laws 1959, c. 205, § 1, p. 715; Laws 1961, c. 221, § 2, p. 655; Laws 1963, c. 266, § 2, p. 796; Laws 1965, c. 262, § 1, p. 732; Laws 1967, c. 270, § 1, p. 730; Laws 1973, LB 309, § 2; Laws 1979, LB 354, § 2; Laws 1981, LB 355, § 1; Laws 1993, LB 121, § 224; Laws 1995, LB 574, § 43; R.S.1943, (2010), § 44-404; Laws 2014, LB755, § 7.

Cross References

For determination of operative date, see section 44-407.23.
Mortality tables, see Appendix, Nebraska Revised Statutes, Volume 2A.

44-8908 Valuation manual; director prescribe; designate operative date; when effective; contents; director; powers.

(1) For policies issued on or after the operative date of the valuation manual designated in subsection (2) of this section, the standard prescribed in the valuation manual is the minimum standard of valuation required under section 44-8905 except as provided under subsections (5) and (7) of this section.

(2) The director shall prescribe the valuation manual no later than July 1, 2017. The director shall designate the operative date of the valuation manual as of January 1 after the date on which the director prescribes the valuation manual.

(3) Unless a change in the valuation manual specifies a later effective date, the changes adopted by the director to the valuation manual shall be effective on January 1 following the adoption of the change by the director.

(4) The valuation manual must specify all of the following:

(a) Minimum valuation standards for and definitions of the policies or contracts subject to section 44-8904. Such minimum valuation standards shall be:

(i) The director's reserve valuation method for life insurance contracts, other than annuity contracts, subject to section 44-8904;

(ii) The director's annuity reserve valuation method for annuity contracts subject to section 44-8904; and

(iii) Minimum reserves for all other policies or contracts subject to section 44-8904;

(b) Which policies or contracts or types of policies or contracts are subject to the requirements of a principle-based valuation in subsection (1) of section 44-8909 and the minimum valuation standards consistent with those requirements;

(c) For policies and contracts subject to a principle-based valuation under section 44-8909:

(i) Requirements for the format of reports to the director under subdivision (2)(c) of section 44-8909 which shall include information necessary to determine if the valuation is appropriate and in compliance with the Standard Valuation Act;

(ii) Assumptions shall be prescribed for risks over which the company does not have significant control or influence; and

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(d) For policies not subject to a principle-based valuation under section 44-8909, the minimum valuation standard shall either:

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual designated in subsection (2) of this section; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(e) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(f) The data and form of the data required under section 44-8910 and with whom the data must be submitted.

The valuation manual may specify other requirements, including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the director, in compliance with the act, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the director by rule and regulation.

(6) The director may employ or contract with a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company or to review and opine on a company's compliance with any requirement set forth in the act. The director may rely upon the opinion, regarding provisions contained within the act, of a qualified actuary engaged by the insurance commissioner of another state, district, or territory of the United States.

(7) The director may require a company to change any assumption or method that in the opinion of the director is necessary in order to comply with the requirements of the valuation manual or the act and the company shall adjust the reserves as required by the director. The director may take other disciplinary action pursuant to law.

Source: Laws 2014, LB755, § 8.

44-8909 Reserves; company; duties.

(1) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(a) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with significant tail risk, the valuation must reflect conditions appropriately adverse to quantify the tail risk;

(b) Incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(c) Incorporate assumptions that are derived in one of the following manners:

(i) The assumption is prescribed in the valuation manual; or

(ii) For assumptions that are not prescribed, the assumptions shall:

(A) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(B) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience; and

(d) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this section as specified in the valuation manual shall:

(a) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(b) Provide to the director and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year; and

(c) Develop, and file with the director upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3) A principle-based valuation may include a prescribed formulaic reserve component.

Source: Laws 2014, LB755, § 9.

44-8910 Company; submit data.

A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

Source: Laws 2014, LB755, § 10.

44-8911 Confidential information; how treated; director; powers; release of material; when.

(1) For purposes of this section, confidential information means:

(a) A memorandum in support of an opinion submitted under section 44-8905 and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the director or any other person in connection with such memorandum;

(b) All documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the director or any other person in the course of an examination made under subsection (6) of section 44-8908, except that if an examination report or other material prepared in connection with an examination made under the Insurers Examination Act is not held as private and confidential information under the act, an examination report or other material prepared in connection with an examination made under subsection (6) of section 44-8908 shall not be confidential information to the same extent as if such examination report or other material had been prepared under the Insurers Examination Act;

(c) Any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under subdivision (2)(b) of section 44-8909 evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the director or any other person in connection with such reports, documents, materials, and other information;

(d) Any principle-based valuation report developed under subdivision (2)(c) of section 44-8909 and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the director or any other person in connection with such report; and

(e) Any data, documents, materials, and other information submitted by a company under section 44-8910, known as experience data, and any other data, documents, materials, and information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, known as experience materials, in each case that includes any potentially company-identifying or personally identifiable information, that is provided to or obtained by the director and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the director or any other person in connection with such experience data and experience materials.

(2)(a) Except as provided in this section, a company's confidential information is confidential by law and privileged and shall not be a public record

subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action, except that the director may use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the director's official duties.

(b) Neither the director nor any person who received confidential information while acting under the authority of the director shall be permitted or required to testify in any private civil action concerning any confidential information.

(c) In order to assist in the performance of the director's duties, the director may share confidential information (i) with other state, federal, and international regulatory agencies and with the National Association of Insurance Commissioners and its affiliates and subsidiaries and (ii) in the case of confidential information specified in subdivisions (1)(a) and (b) of this section, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings. The recipient must agree, and must have the legal authority to agree, to maintain the confidentiality and privileged status of such data, documents, materials, and other information in the same manner and to the same extent as required for the director.

(d) The director may receive data, documents, materials, and other information, including otherwise confidential and privileged data, documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any data, document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the data, document, material, or other information.

(e) The director may enter into agreements governing sharing and use of information consistent with this subsection.

(f) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the director under this section or as a result of sharing as authorized in subdivision (2)(c) of this section.

(g) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under subsection (2) of this section shall be available and enforced in any proceeding in, and in any court of, this state.

(h) Regulatory agency, law enforcement agency, and the National Association of Insurance Commissioners include employees, agents, consultants, and contractors of such entities.

(3) Notwithstanding subsection (2) of this section, any confidential information specified in subdivisions (1)(a) and (d) of this section:

(a) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under section 44-8905 or principle-based valuation report developed under subdivision (2)(c) of section 44-8909 by

reason of an action required by the Standard Valuation Act or by rule and regulation;

(b) May otherwise be released by the director with the written consent of the company; and

(c) Once any portion of a memorandum in support of an opinion submitted under section 44-8905 or a principle-based valuation report developed under subdivision (2)(c) of section 44-8909 is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

Source: Laws 2014, LB755, § 11.

Cross References

Insurers Examination Act, see section 44-5901.

44-8912 Director; exempt specific product forms or product lines; provisions applicable.

(1) The director may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this state from the requirements of section 44-8908 if:

(a) The director has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(b) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual designated in subsection (2) of section 44-8908 in addition to any requirements established by the director and by rule and regulation.

(2) For any company granted an exemption under this section, sections 44-420 to 44-427, 44-8906, and 44-8907 shall be applicable. With respect to any company applying this exemption, any reference to section 44-8908 found in such sections shall not be applicable.

Source: Laws 2014, LB755, § 12.

ARTICLE 90

RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT ACT

Section

44-9001 Act, how cited.

Sections 44-9001 to 44-9011 shall be known and may be cited as the Risk Management and Own Risk and Solvency Assessment Act.

Source: Laws 2014, LB700, § 1.

44-9002 Purposes of act; applicability.

(1) The purposes of the Risk Management and Own Risk and Solvency Assessment Act are to provide requirements for maintaining a risk management framework and completing an own risk and solvency assessment and to provide guidance and instructions for filing an own risk and solvency assessment summary report with the director.

(2) The requirements of the act apply to all insurers domiciled in this state unless exempt pursuant to section 44-9008.

Source: Laws 2014, LB700, § 2.

44-9003 Legislative findings and declaration.

The Legislature finds and declares that the own risk and solvency assessment summary report will contain confidential and sensitive information related to an insurer's or insurance group's identification of risks that is material and relevant to the insurer or insurance group filing the report. The information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public. It is the intent of the Legislature that the own risk and solvency assessment summary report shall be a confidential document filed with the director, that the own risk and solvency assessment summary report shall be shared only as provided in the Risk Management and Own Risk and Solvency Assessment Act and to assist the director in the performance of his or her duties, and that in no event shall the own risk and solvency assessment summary report be subject to public disclosure.

Source: Laws 2014, LB700, § 3.

44-9004 Terms, defined.

For purposes of the Risk Management and Own Risk and Solvency Assessment Act:

(1) Director means the Director of Insurance;

(2) Insurance group means those insurers and affiliates included within an insurance holding company system as defined in subdivision (6) of section 44-2121;

(3) Insurer has the same meaning as in section 44-103, except that it does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(4) Own risk and solvency assessment means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by the insurer or insurance group, of the material and relevant risks associated with the insurer's or insurance group's current business plan and the sufficiency of capital resources to support those risks;

(5) Own risk and solvency assessment guidance manual means the own risk and solvency assessment guidance manual prescribed by the director which

conforms substantially to the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners. A change in the own risk and solvency assessment guidance manual shall be effective on the January 1 following the calendar year in which the change has been adopted by the director; and

(6) Own risk and solvency assessment summary report means a confidential, high-level summary of an insurer's or insurance group's own risk and solvency assessment.

Source: Laws 2014, LB700, § 4; Laws 2016, LB772, § 16.

44-9005 Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement is satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Source: Laws 2014, LB700, § 5.

44-9006 Own risk and solvency assessment.

Subject to section 44-9008, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an own risk and solvency assessment consistent with a process comparable to the own risk and solvency assessment guidance manual. The own risk and solvency assessment shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

Source: Laws 2014, LB700, § 6.

44-9007 Own risk and solvency assessment summary report; submission; contents; similar report accepted; when.

(1) Upon the director's request, and no more than once each year, an insurer shall submit to the director an own risk and solvency assessment summary report or any combination of reports that together contain the information described in the own risk and solvency assessment guidance manual applicable to the insurer or the insurance group of which the insurer is a member. Notwithstanding any request from the director, if the insurer is a member of an insurance group, the insurer shall submit the report required by this subsection if the director is the lead state insurance commissioner of the insurance group.

(2) The report shall include a signature of the insurer's or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the own risk and solvency assessment summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer may comply with subsection (1) of this section by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to the insurance commissioner of another state or to a supervisor or regulator of a

foreign jurisdiction if that report provides information that is comparable to the information described in the own risk and solvency assessment guidance manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

(4) The first filing of the own risk and solvency assessment summary report shall be in 2015.

Source: Laws 2014, LB700, § 7.

44-9008 Act; exemptions; waiver; director; considerations; director; powers.

(1) An insurer shall be exempt from the requirements of the Risk Management and Own Risk and Solvency Assessment Act if:

(a) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, of less than five hundred million dollars; and

(b) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and National Flood Insurance Program, of less than one billion dollars.

(2) If an insurer qualifies for exemption pursuant to subdivision (1)(a) of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subdivision (1)(b) of this section, then the own risk and solvency assessment summary report required pursuant to section 44-9007 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one own risk and solvency assessment summary report for any combination of insurers if the combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to subdivision (1)(a) of this section, but the insurance group of which the insurer is a member qualifies for exemption pursuant to subdivision (1)(b) of this section, then the only own risk and solvency assessment summary report required pursuant to section 44-9007 shall be the report applicable to that insurer.

(4) An insurer that does not qualify for exemption pursuant to subsection (1) of this section may apply to the director for a waiver from the requirements of the act based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the director may consider the type and volume of business written, ownership and organizational structure, and any other factor the director considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the director shall coordinate with the lead state insurance commissioner and with the other domiciliary insurance commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions stated in this section:

(a) The director may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment, and file an own risk and solvency assessment summary report based on unique circumstances, including, but not limited to, the type and volume of business written, owner-

ship and organizational structure, federal agency requests, and international supervisor requests; and

(b) The director may require that an insurer maintain a risk management framework, conduct an own risk and solvency assessment, and file an own risk and solvency assessment summary report if the insurer has risk-based capital for a company action level event as set forth in section 44-6016, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined by rule and regulation adopted and promulgated by the director to define standards for companies deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer as determined by the director.

(6) If an insurer that qualified for an exemption pursuant to subsection (1) of this section no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year after the year the threshold is exceeded to comply with the requirements of the act.

Source: Laws 2014, LB700, § 8.

44-9009 Own risk and solvency assessment summary report; documentation and supporting information.

(1) An own risk and solvency assessment summary report shall be prepared consistent with the own risk and solvency assessment guidance manual, subject to the requirements of subsection (2) of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the director.

(2) The review of the own risk and solvency assessment summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

Source: Laws 2014, LB700, § 9.

44-9010 Confidentiality; director; powers; sharing and use of information; written agreement; contents.

(1) Documents, materials, or other information, including the own risk and solvency assessment summary report, in the possession or control of the director that are obtained by, created by, or disclosed to the director or any other person under the Risk Management and Own Risk and Solvency Assessment Act, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The director may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(2) Neither the director nor any person who received documents, materials, or other own risk and solvency assessment related information through examination or otherwise while acting under the authority of the director or with whom such documents, materials, or other information are shared pursuant to the act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the director's regulatory duties, the director:

(a) May, upon request, share documents, materials, or other own risk and solvency assessment information, including the confidential and privileged documents, materials, or information subject to subsection (1) of this section, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including members of any supervisory college under section 44-2137.01, with the National Association of Insurance Commissioners, and with any third-party consultants designated by the director, if the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) May receive documents, materials, or other own risk and solvency assessment information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret documents and materials, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college under section 44-2137.01, and from the National Association of Insurance Commissioners, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) The director shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to the act that:

(a) Specifies procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to the act, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(b) Specifies that ownership of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to the act remains with the director and that the National Association of Insurance Commissioners' or a third-party consultant's use of the information is subject to the direction of the director;

(c) Prohibits the National Association of Insurance Commissioners or a third-party consultant from storing the information shared pursuant to the act in a permanent database after the underlying analysis is completed;

(d) Requires prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners or a third-party consultant pursuant to the act is subject to a request or subpoena to the National Association of Insurance Commissioners or a third-party consultant for disclosure or production;

(e) Requires the National Association of Insurance Commissioners or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to the act; and

(f) As part of the retention process, requires a third-party consultant to verify to the director, with notice to the insurer, that it is free of any conflict of interest and that it has internal procedures in place to monitor compliance with any conflicts and to comply with the act's confidentiality standards and requirements. The retention agreement with a third-party consultant shall require prior written consent of the insurer before making public any information provided pursuant to the act as required in subsection (1) of this section.

(5) The sharing of information and documents by the director pursuant to the act shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution, and enforcement of the provisions of the act.

(6) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other own risk and solvency assessment information shall occur as a result of disclosure of such documents, materials, or other information to the director under this section or as a result of sharing as authorized in the act.

(7) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant pursuant to the act shall be confidential by law and privileged, shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

Source: Laws 2014, LB700, § 10.

44-9011 Failure to file own risk and solvency assessment summary report; penalty.

Any insurer failing, without just cause, to timely file its own risk and solvency assessment summary report as required in the Risk Management and Own Risk and Solvency Assessment Act shall be required, after notice and hearing, to pay a penalty of not to exceed two hundred dollars for each day's delay. The maximum penalty under this section is ten thousand dollars. The director may reduce the penalty if the insurer demonstrates to the director that the imposition of the penalty would constitute a financial hardship to the insurer. The director shall remit any penalties collected under this section to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Source: Laws 2014, LB700, § 11.

ARTICLE 91
CORPORATE GOVERNANCE ANNUAL DISCLOSURE ACT

Section

44-9101 Act, how cited.

Sections 44-9101 to 44-9109 shall be known and may be cited as the Corporate Governance Annual Disclosure Act.

Source: Laws 2016, LB772, § 1.

44-9102 Purposes of act.

(1) The purposes of the Corporate Governance Annual Disclosure Act are to:

(a) Provide the director a summary of an insurer's or insurance group's corporate governance structure, policies, and practices to permit the director to gain and maintain an understanding of the insurer's or insurance group's corporate governance framework;

(b) Outline the requirements for completing a corporate governance annual disclosure with the director; and

(c) Provide for the confidential treatment of the corporate governance annual disclosure and related information that contains confidential and sensitive information related to an insurer's or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(2) Nothing in the Corporate Governance Annual Disclosure Act shall be construed (a) to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law or (b) to limit the director's authority, or the rights or obligations of third parties, under the Insurers Examination Act.

(3) The requirements of the Corporate Governance Annual Disclosure Act shall apply to all insurers that are domiciled in this state.

Source: Laws 2016, LB772, § 2.

Cross References

Insurers Examination Act, see section 44-5901.

44-9103 Terms, defined.

For purposes of the Corporate Governance Annual Disclosure Act:

(1) Corporate governance annual disclosure means a confidential report filed by an insurer or insurance group made in accordance with the requirements of the Corporate Governance Annual Disclosure Act;

(2) Director means the Director of Insurance;

(3) Insurance group means those insurers and affiliates included within an insurance holding company system as defined in section 44-2121; and

(4) Insurer has the same meaning as in section 44-103, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

Source: Laws 2016, LB772, § 3.

44-9104 Corporate governance annual disclosure; submission to director; review; cross reference to other documents.

(1) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the director a corporate governance annual disclosure that contains the information described in section 44-9105. Notwithstanding any request from the director made pursuant to subsection (3) of this section, if the insurer is a member of an insurance group, the insurer shall submit the disclosure required by this section to the director of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(2) The corporate governance annual disclosure must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices contained in the corporate governance annual disclosure and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer not required to submit a corporate governance annual disclosure under this section shall do so upon the director's request.

(4) For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the corporate governance annual disclosure at the level at which the insurer's or insurance group's risk appetite is determined, the level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on one of these three criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(5) The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(6) Insurers providing information substantially similar to the information required by the Corporate Governance Annual Disclosure Act in other documents provided to the director, including proxy statements filed in conjunction with the requirements of section 44-2132 or other state or federal filings provided to the director, shall not be required to duplicate such information in the corporate governance annual disclosure, but shall only be required to cross reference the document in which such information is included.

Source: Laws 2016, LB772, § 4.

44-9105 Corporate governance annual disclosure; contents; request for additional information.

The corporate governance annual disclosure shall be prepared in a manner prescribed by the director. The insurer or insurance group shall have discretion over the responses to the corporate governance annual disclosure inquiries, except that the corporate governance annual disclosure shall contain the material information necessary to permit the director to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices. The director may request additional information that he or she deems material and necessary to provide the director with a clear understanding of the corporate governance policies, reporting or information systems, or controls implementing the corporate governance policies. Documentation and supporting information shall be maintained and made available upon examination or upon request of the director.

Source: Laws 2016, LB772, § 5.

44-9106 Documents, materials, and other information; proprietary and trade secrets; confidential; use by director; director; powers.

(1) Documents, materials, or other information, including the corporate governance annual disclosure, in the possession or control of the Department of Insurance that are obtained by, created by, or disclosed to the director or any other person under the Corporate Governance Annual Disclosure Act are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be a public record subject to disclosure by the director pursuant to sections 84-712 to 84-712.09, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the director is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the director's official duties. The director shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the director may share or receive confidential documents, materials, or other information related to the corporate governance annual disclosure pursuant to subsection (3) of this section to assist in the performance of the director's regular duties.

(2) Neither the director nor any person who received documents, materials, or other information related to the corporate governance annual disclosure, through examination or otherwise, while acting under the authority of the director, or with whom such documents, materials, or other information are shared pursuant to the Corporate Governance Annual Disclosure Act, shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or other information subject to subsection (1) of this section.

(3) In order to assist in the performance of the director's regulatory duties, the director:

(a) May, upon request, share documents, materials, or other information related to the corporate governance annual disclosure, including the confidential and privileged documents, materials, or other information subject to subsection (1) of this section, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including members of any supervisory college as described in section 44-2137.01, with the National Association of Insurance Commissioners, and with third-party consultants pursuant to section 44-9107 if the recipient agrees in writing to maintain the confidentiality and privileged status of such documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) May receive documents, materials, or other information related to the corporate governance annual disclosure, including otherwise confidential and privileged documents, materials, or other information, including proprietary and trade secret documents and materials, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as described in section 44-2137.01 and from the National Association of Insurance Commissioners, and shall maintain as confidential or privileged any documents, materials, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(4) The sharing of information and documents by the director pursuant to the Corporate Governance Annual Disclosure Act shall not constitute a delegation of regulatory authority or rulemaking, and the director is solely responsible for the administration, execution, and enforcement of the provisions of the act.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information related to the corporate governance annual disclosure shall occur as a result of disclosure of such documents, materials, or other information to the director under this section or as a result of sharing as authorized in the Corporate Governance Annual Disclosure Act.

Source: Laws 2016, LB772, § 6.

44-9107 Review of corporate governance annual disclosure; third-party consultants; National Association of Insurance Commissioners; written agreement; contents.

(1) The director may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the director's staff, as may be reasonably necessary to assist the director in reviewing the corporate governance annual disclosure and related informa-

tion or the insurer's compliance with the Corporate Governance Annual Disclosure Act.

(2) Any persons retained under subsection (1) of this section shall be under the direction and control of the director and shall act in a purely advisory capacity.

(3) The National Association of Insurance Commissioners and third-party consultants shall be subject to the same confidentiality standards and requirements as the director.

(4) As part of the retention process, a third-party consultant shall verify to the director, with notice to the insurer, that the third-party consultant is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict of interest and to comply with the confidentiality standards and requirements of the Corporate Governance Annual Disclosure Act.

(5) A written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to the Corporate Governance Annual Disclosure Act shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under the act:

(a) Specific procedures and protocols for maintaining the confidentiality and security of information related to the corporate governance annual disclosure that is shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to the act;

(b) Procedures and protocols for sharing by the National Association of Insurance Commissioners only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information related to the corporate governance annual disclosure and has verified in writing the legal authority to maintain confidentiality.

(c) A provision specifying that (i) ownership of the information related to the corporate governance annual disclosure that is shared with the National Association of Insurance Commissioners or a third-party consultant remains with the Department of Insurance and (ii) the National Association of Insurance Commissioners' or third-party consultant's use of the information is subject to the direction of the director;

(d) A provision that prohibits the National Association of Insurance Commissioners or a third-party consultant from storing the information shared pursuant to the Corporate Governance Annual Disclosure Act in a permanent database after the underlying analysis is completed;

(e) A provision requiring the National Association of Insurance Commissioners or third-party consultant to provide prompt notice to the director and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's or insurance group's information related to the corporate governance annual disclosure; and

(f) A requirement that the National Association of Insurance Commissioners or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential

information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to the Corporate Governance Annual Disclosure Act.

Source: Laws 2016, LB772, § 7.

44-9108 Failure to file corporate governance annual disclosure; forfeiture; suspension of certificate of authority.

Any insurer failing, without just cause, to timely file the corporate governance annual disclosure as required in the Corporate Governance Annual Disclosure Act shall forfeit fifty dollars each day thereafter such failure continues. The maximum forfeit shall not exceed ten thousand dollars. In addition to the forfeiture, the director may suspend, after notice and hearing, the certificate of authority of the insurer until it has complied with the act. The director may reduce the forfeiture if the insurer demonstrates to the director that the forfeiture would constitute a financial hardship to the insurer. The director shall remit any forfeiture collected pursuant to this section to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Source: Laws 2016, LB772, § 8.

44-9109 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Corporate Governance Annual Disclosure Act.

Source: Laws 2016, LB772, § 9.

ARTICLE 92

PUBLIC ADJUSTERS LICENSING ACT

Section

44-9201 Act, how cited.

Sections 44-9201 to 44-9219 shall be known and may be cited as the Public Adjusters Licensing Act.

Source: Laws 2018, LB743, § 1.

44-9202 Purpose of act.

The purpose of the Public Adjusters Licensing Act is to govern the qualifications and procedures for licensing public adjusters in this state and to specify the duties of and restrictions on public adjusters, including limitation of such licensure to assisting only insureds with first-party claims.

Source: Laws 2018, LB743, § 2.

44-9203 Terms, defined.

As used in the Public Adjusters Licensing Act, unless the context otherwise requires:

(1) Business entity means a corporation, association, partnership, limited liability company, limited liability partnership, or any other legal entity;

(2) Catastrophic disaster means an event declared to be a catastrophic disaster by the President of the United States or the governor of the state in which the disaster occurred that (a) results in large numbers of deaths and injuries, (b) causes extensive damage or destruction of facilities that provide and sustain human needs, (c) produces an overwhelming demand on state and local response resources and mechanisms, (d) causes a severe long-term effect on general economic activity, and (e) severely affects state, local, and private sector capabilities to begin and sustain response activities;

(3) Department means the Department of Insurance;

(4) Director means the Director of Insurance;

(5) Home state means the District of Columbia or any state or territory of the United States in which the principal place of residence or principal place of business of the public adjuster is located;

(6) Individual means a natural person;

(7) Insured means a person insured under the insurance policy against which the claim is made;

(8) Person means an individual or a business entity;

(9) Public adjuster means any person who, for compensation, does any of the following:

(a) Acts for or aids an insured in negotiating for or effecting the settlement of a first-party claim for loss or damage to real or personal property of the insured;

(b) Advertises for employment as a public adjuster of first-party claims or otherwise solicits business or represents to the public that the person is a public adjuster of first-party claims for loss or damage to real or personal property of an insured; or

(c) Directly or indirectly solicits the business of investigating or adjusting losses or of advising an insured about first-party claims for loss or damage to real or personal property of the insured;

(10) Uniform business entity application means the uniform business entity application prescribed by the director which conforms substantially to the uniform business entity application for resident and nonresident business entities adopted by the National Association of Insurance Commissioners; and

(11) Uniform individual application means the uniform individual application prescribed by the director which conforms substantially to the uniform application for individual adjuster licensing adopted by the National Association of Insurance Commissioners.

Source: Laws 2018, LB743, § 3.

44-9204 License required; exceptions.

(1) A person shall not operate as or represent that such person is a public adjuster in this state unless such person is licensed as a public adjuster in accordance with the Public Adjusters Licensing Act.

(2) A public adjuster shall not misrepresent to any insured that such public adjuster is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or acting as an independent adjuster unless so appointed by an insurer in writing to act on behalf of the insurer for that specific claim or purpose. A public adjuster is prohibited from charging any insured a fee when appointed by the insurer and the appointment is accepted by the public adjuster.

(3) A public adjuster shall not, directly or indirectly, solicit, or enter into, an agreement for the repair or replacement of damaged property on which such public adjuster has engaged to adjust or settle claims for losses or damages of the insured.

(4) Notwithstanding subsection (1) of this section, licensing as a public adjuster shall not be required for:

(a) An attorney admitted to practice in this state, when acting in the attorney's professional capacity as an attorney;

(b) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

(c) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including, but not limited to, a photographer, estimator, private investigator, engineer, or handwriting expert;

(d) A licensed health care provider, or an employee of a licensed health care provider, who prepares or files a health claim form on behalf of a patient; or

(e) A person who settles subrogation claims between insurers.

Source: Laws 2018, LB743, § 4.

44-9205 Resident public adjuster license; application; qualifications; fee; examination.

An individual applying for a resident public adjuster license shall make application to the director on the uniform individual application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of such individual's knowledge and belief. Before approving an application for a resident public adjuster license, the director shall find that such individual:

(1) Is at least eighteen years of age. Notwithstanding the provisions of section 43-2101, if an individual is issued a license pursuant to the Public Adjusters Licensing Act, his or her minority ends;

(2) Has his or her principal place of residence or principal place of business in this state;

(3) Has not committed any act that is a ground for denial, suspension, or revocation set forth in section 44-9211;

(4) Has paid the resident licensing fee, not to exceed one hundred dollars, prescribed by the director;

(5) Except as otherwise provided under the act, has passed the examinations required by section 44-9208;

(6) Is trustworthy, reliable, and of good reputation, evidence of which may be determined by the director;

(7) Is financially responsible to exercise the license and has provided proof of financial responsibility as required in section 44-9212; and

(8) Maintains an office in this state with public access to such office by reasonable appointment or regular business hours.

Source: Laws 2018, LB743, § 5.

44-9206 Nonresident public adjuster license; application; qualifications; fee; director; verify status; termination of license; when.

(1) An individual applying for a nonresident public adjuster license shall make application to the director in the manner prescribed by the director and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of such individual's knowledge and belief. Before approving an application for a nonresident public adjuster license, the director shall find that the applicant:

(a) Is licensed as a resident public adjuster and in good standing in such individual's home state and that such home state awards nonresident public adjuster licenses to residents of this state on the same basis as provided for in the Public Adjusters Licensing Act; and

(b) Has paid the nonresident licensing fee, not to exceed one hundred dollars, prescribed by the director.

(2) The director may verify the licensing status of a nonresident public adjuster through the producer database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(3) As a condition to continuation of a nonresident public adjuster license, a licensed nonresident public adjuster shall maintain a resident public adjuster license in good standing in his or her home state.

(4) A nonresident public adjuster license issued pursuant to this section shall terminate and be surrendered immediately to the director if the home state public adjuster license terminates for any reason, unless the individual has been issued a license as a resident public adjuster in a new home state and such new home state has reciprocity with this state. A licensed nonresident public adjuster shall notify the director of any change to a new home state as soon as possible, but no later than thirty days after receiving a license as a resident

public adjuster from the new home state. The nonresident public adjuster shall include both the new and the old addresses in the notice to the director.

Source: Laws 2018, LB743, § 6.

44-9207 Business entity acting as public adjuster; license; application; qualifications; fee; director; powers.

(1) A business entity acting as a public adjuster in this state is required to obtain a public adjuster license and shall make application to the director on the uniform business entity application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the knowledge and belief of such entity. Before approving an application for a business entity public adjuster license, the director shall find that the applicant:

(a) Has paid the business entity licensing fee, not to exceed one hundred fifty dollars, prescribed by the director; and

(b) Has designated a resident public adjuster or a nonresident public adjuster licensed pursuant to the Public Adjusters Licensing Act to be responsible for compliance with the insurance laws, rules, and regulations of this state for such business entity.

(2) The director may require any documents reasonably necessary to verify the information contained in any application submitted pursuant to this section.

Source: Laws 2018, LB743, § 7.

44-9208 Examination; fee.

(1) An individual applying for a resident public adjuster license shall pass a written examination, unless exempt pursuant to section 44-9209. Such examination shall test the knowledge of the individual concerning the duties and responsibilities of a public adjuster and the insurance laws and regulations of this state and shall be conducted as prescribed by the director.

(2) The director may make arrangements, including contracting with an outside testing service, for administering the written examination required pursuant to subsection (1) of this section and collecting a fee prescribed by the director. The fee shall not exceed one hundred dollars.

Source: Laws 2018, LB743, § 8.

44-9209 Exemption from examination.

(1) An individual who moves to this state, was previously licensed as a public adjuster in another state based on a public adjuster examination, and applies for a resident public adjuster license in this state within ninety days of establishing legal residence shall not be required to pass an examination pursuant to section 44-9208 in this state if:

(a) Such individual is currently licensed in the other state or if an application for a resident public adjuster license is received within twelve months of the cancellation of his or her previous license; and

(b) The other state issues a certification that such individual is licensed and in good standing in that state or was licensed and in good standing at the time of cancellation.

(2) An individual who applies for a resident public adjuster license and who was previously licensed as either a resident public adjuster or a nonresident public adjuster in this state shall not be required to complete an examination if the application is received within twelve months of the termination of such previous license in this state and if, at the time of such termination, the applicant was in good standing in this state.

Source: Laws 2018, LB743, § 9.

44-9210 Individual; issuance of license; expiration; renewal; fee; lapsed license; reinstatement; business entity; license; expiration; renewal; fee; lapsed license; reinstatement; license; contents; licensee; duties; director; powers; renewal procedures.

(1)(a) An individual who meets the requirements for a resident public adjuster license shall be issued such license. An individual who meets the requirements for a nonresident public adjuster license shall be issued such license.

(b) Each resident public adjuster license and each nonresident public adjuster license shall expire on the last day of the month of such public adjuster's birthday in the first year after issuance of such license in which his or her age is divisible by two.

(c) Each resident public adjuster license and each nonresident public adjuster license may be renewed within the ninety-day period immediately preceding the expiration date upon payment of the renewal fee, not to exceed one hundred dollars, prescribed by the director. A resident public adjuster or nonresident public adjuster who allows his or her license to lapse may, within the twelve-month period immediately following the expiration date, reinstate the same license without the necessity of passing a written examination upon payment of a reinstatement fee, not to exceed one hundred twenty-five dollars, prescribed by the director in addition to the renewal fee.

(d) The director may grant an individual licensee who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance, including, but not limited to, a long-term medical disability, a waiver of any examination requirement or any other fine, fee, or sanction imposed for failure to comply with renewal procedures.

(2)(a) A business entity that has met the requirements of the Public Adjusters Licensing Act shall be issued a business entity public adjuster license.

(b) Each business entity public adjuster license shall expire on April 30 of each year.

(c) A business entity public adjuster license may be renewed within the ninety-day period immediately preceding the expiration date upon payment of the renewal fee, not to exceed one hundred fifty dollars, prescribed by the director. A business entity public adjuster that allows its license to lapse may, within the thirty-day period immediately following the expiration date, renew the same license upon payment of a late renewal fee, not to exceed one hundred twenty-five dollars, prescribed by the director in addition to the renewal fee.

(d) Any business entity public adjuster license renewed within the thirty-day period immediately following the expiration date pursuant to this subsection shall be deemed to have been renewed before the expiration date.

(3)(a) Each license issued pursuant to the Public Adjusters Licensing Act shall contain the licensee's name, address, and license number, the date of issuance,

the lines of authority, the expiration date, and any other information the director deems necessary.

(b) Each licensee shall inform the director, by any means acceptable to the director, of any change of legal name, address, or other information submitted on the application within thirty days after the change. Any licensee failing to provide such notification shall be subject to a fine by the director of not more than five hundred dollars per violation, suspension of the license until the change is reported to the director, or both.

(c) Each licensee doing business under any name other than the licensee's legal name shall notify the director prior to using the assumed name.

(d) Each licensee shall be subject to the Unfair Insurance Trade Practices Act and the Unfair Insurance Claims Settlement Practices Act.

(e) Each licensee shall report to the director any administrative action taken against such licensee in another jurisdiction or by another governmental agency in this state within thirty days of the final disposition of the matter. This report shall include a copy of the order, consent to order, or other relevant legal documents.

(f) Each licensee shall report to the director any criminal prosecution of such licensee taken in any jurisdiction within thirty days of arraignment. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

(4) The director may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions, including the collection of fees, related to the administration of the Public Adjusters Licensing Act.

(5) The director may establish license renewal procedures by rule and regulation adopted and promulgated pursuant to the Administrative Procedure Act.

Source: Laws 2018, LB743, § 10.

Cross References

Administrative Procedure Act, see section 84-920.
Unfair Insurance Claims Settlement Practices Act, see section 44-1536.
Unfair Insurance Trade Practices Act, see section 44-1521.

44-9211 Director; powers; nonrenewal or denial of application; notice; hearing; administrative fine; director; enforce act.

(1) The director may suspend, revoke, or refuse to issue or renew a resident public adjuster license, nonresident public adjuster license, or business entity public adjuster license or may levy an administrative fine in accordance with subsection (4) of this section, or any combination of such actions, for any one or more of the following causes:

(a) Providing incorrect, misleading, incomplete, or materially untrue information in the license application;

(b) Violating any insurance law or violating any rule, regulation, subpoena, or order of the director or of another state's insurance commissioner or director;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating, or converting any money or property received in the course of doing business;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony or a Class I, II, or III misdemeanor;

(g) Having admitted or been found to have committed any insurance unfair trade practice, any unfair claims settlement practice, or any fraud;

(h) Using fraudulent, coercive, or dishonest practices or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this state or elsewhere or failing to comply with section 44-9217;

(i) Having an insurance or public adjuster license, or the equivalent thereof, denied, suspended, placed on probation, or revoked in Nebraska or in any other state, province, district, or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(l) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation pursuant to the License Suspension Act;

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax; or

(o) Failing to maintain in good standing a resident license in the public adjuster's home state.

(2) If the director does not renew or denies an application for a public adjuster license, the director shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the director within thirty days for a hearing before the director to determine the reasonableness of the director's action. The hearing shall be held within thirty days and shall be held pursuant to the Administrative Procedure Act.

(3) A business entity public adjuster license may be suspended, revoked, or refused if the director finds, after notice and hearing, that a violation committed by an individual licensee providing services through the business entity was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the business entity and the violation was neither reported to the director nor corrective action taken.

(4) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person violating the act may, after notice and hearing, be subject to an administrative fine of not more than one thousand dollars per violation. Such fine may be enforced in the same manner as civil judgments. Any person charged with a violation of the Public Adjusters Licensing Act may waive his or her right to a hearing and consent to such discipline as the director determines is appropriate. The Administrative Procedure Act shall govern all hearings held pursuant to this subsection.

(5) The director shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by the Public Adjusters Licensing Act against any person who is under investigation for or charged with a violation of the act even if the person's license or registration has been surrendered or has lapsed by operation of law. No disciplinary proceeding shall be instituted against any licensed person after the expiration of three years from the termination of such license.

Source: Laws 2018, LB743, § 11.

Cross References

Administrative Procedure Act, see section 84-920.
License Suspension Act, see section 43-3301.

44-9212 Financial responsibility; surety bond; director; powers.

(1) Prior to the issuance of a resident public adjuster license or a nonresident public adjuster license and for the duration of such license, an applicant shall secure evidence of financial responsibility in a format prescribed by the director through a surety bond. The surety bond shall be executed and issued by an insurer authorized to issue surety bonds in this state, which bond:

(a) Shall be in the minimum amount of twenty thousand dollars; and

(b) Shall not be terminated unless written notice has been filed with the director and submitted to such public adjuster at least thirty days prior to such termination.

(2) The director may request the evidence of financial responsibility at any time the director deems relevant.

(3) A public adjuster shall immediately notify the director if evidence of financial responsibility terminates or becomes impaired. The authority to act as a public adjuster shall automatically terminate if the evidence of financial responsibility terminates or becomes impaired.

Source: Laws 2018, LB743, § 12.

44-9213 Continuing education.

(1) Except as otherwise provided in this section, an individual who holds a resident public adjuster license or a nonresident public adjuster license shall satisfactorily complete a minimum of twenty-four credits of continuing education, including three credits of ethics, reported on a biennial basis in conjunction with the license renewal cycle.

(2) The requirements of subsection (1) of this section shall not apply to a nonresident public adjuster who has met the continuing education requirements of the adjuster's home state and whose home state gives credit to residents of this state on the same basis.

(3) Only continuing education activities approved by the director pursuant to sections 44-3901 to 44-3908 shall be used to satisfy the requirements of this section.

Source: Laws 2018, LB743, § 13.

44-9214 Contracts; contents; prohibited terms; separate disclosure document; public adjuster; duties; written notice of rights; right to rescind.

(1) Public adjusters shall ensure that all contracts for their services are in writing and contain the following terms:

(a) Legible full name of the public adjuster signing the contract, as specified in director records;

(b) Home state, business address, and telephone number;

(c) Public adjuster license number;

(d) Title of ''Public Adjuster Contract'';

(e) Insured's full name, street address, insurer name, and insurance policy number, if known or upon notification;

(f) Description of the loss and its location, if applicable;

(g) Description of services to be provided to the insured;

(h) Signatures of the public adjuster and the insured;

(i) Date contract was signed by the public adjuster and date the contract was signed by the insured;

(j) Attestation language stating that the public adjuster is fully bonded pursuant to state law; and

(k) The specific amount of compensation, including, but not limited to, the full salary, fee, commission, or other consideration the public adjuster is to receive for services.

(2)(a) The contract may specify that the public adjuster shall be named as a co-payee on an insurer's payment of a claim.

(b) If the compensation is based on a share of the insurance settlement, the exact percentage shall be specified.

(c) Initial expenses to be reimbursed to the public adjuster from the proceeds of the claim payment shall be specified by type and the dollar estimates shall be set forth in the contract. Any additional expenses shall be approved in writing by the insured.

(d) Compensation provisions in a public adjuster contract shall not be redacted in any copy of the contract provided to the director.

(3) If the insurer, not later than seventy-two hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy, the public adjuster shall:

(a) Not receive a commission that consists of a percentage of the total amount paid by an insurer to resolve a claim;

(b) Inform the insured that the loss recovery amount might not be increased by the insurer; and

(c) Be entitled only to reasonable compensation from the insured for services provided by the public adjuster on behalf of the insured, based on the time spent on a claim and expenses incurred by the public adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(4) A public adjuster contract may not contain any contract term that:

(a) Allows a percentage fee to be collected by the public adjuster when money is due from an insurer, but not paid, or that allows a public adjuster to collect the entire fee from the first check issued by an insurer, rather than as a percentage of each check issued by an insurer;

(b) Requires the insured to authorize an insurer to issue a check only in the name of the public adjuster;

(c) Imposes collection costs or late fees; or

(d) Precludes a public adjuster from pursuing civil remedies.

(5) Prior to the signing of the contract the public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states:

(a) Property insurance policies obligate the insured to present a claim to his or her insurer for consideration;

(b) There are three types of adjusters that could be involved in the claim process. The definitions of the three types are as follows:

(i) Company adjuster means an insurance adjuster who is an employee of an insurer. He or she represents the interest of the insurer, is paid by the insurer, and will not charge the insured a fee;

(ii) Independent adjuster means an insurance adjuster who is hired on a contract basis by an insurer to represent the interest of the insurer in the settlement of the claim. He or she is paid by the insurer and will not charge the insured a fee; and

(iii) Public adjuster means an insurance adjuster who does not work for any insurer. He or she works for the insured to assist in the preparation, presentation, and settlement of the claim. The insured hires a public adjuster by signing a contract agreeing to pay a fee or commission based on a percentage of the settlement or other method of compensation;

(c) The insured is not required to hire a public adjuster to help the insured meet the insured's obligations under the policy, but has the right to do so;

(d) The insured has the right to initiate direct communications with the insured's attorney, the insurer, the company adjuster, and the insurer's attorney, or any other person regarding the settlement of the insured's claim;

(e) The public adjuster is not a representative or employee of the insurer; and

(f) The salary, fee, commission, or other consideration to be paid to a public adjuster is the obligation of the insured, not the insurer.

(6) The contract shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The original contract retained by the public adjuster shall be available at all times for inspection without notice by the department.

(7) The public adjuster shall provide the insurer a notification letter, which has been signed by the insured, authorizing the public adjuster to represent the insured's interest.

(8) The public adjuster shall give the insured written notice of the insured's rights as provided in this section.

(9) The insured has the right to rescind the contract within three business days after the date the contract was signed. The rescission shall be in writing and mailed or delivered to the public adjuster at the address in the contract within the three-business-day period.

(10) If the insured exercises the right to rescind the contract, anything of value given by the insured under the contract will be returned to the insured

within fifteen days following the receipt by the public adjuster of the rescission notice.

(11) The director may require a public adjuster to file a contract with the department in a manner prescribed by the director.

Source: Laws 2018, LB743, § 14.

44-9215 Escrow account.

A public adjuster who receives, accepts, or holds, on behalf of an insured, any funds toward the settlement of a claim for loss or damage shall deposit the funds in a non-interest-bearing escrow account in a financial institution that is insured by an agency of the federal government in the home state of such public adjuster or the state where the loss occurred.

Source: Laws 2018, LB743, § 15.

44-9216 Records; contents; retention; inspection.

(1) A public adjuster shall maintain a complete record of each transaction as a public adjuster. The records required by this section shall include the following:

(a) The name of the insured;

(b) The date, location, and amount of the loss;

(c) A copy of the contract between the public adjuster and the insured;

(d) The name of the insurer, amount, expiration date, and policy number for each policy carried with respect to the loss;

(e) An itemized statement of the amount recovered for the insured;

(f) An itemized statement of all compensation received by the public adjuster, from any source whatsoever, in connection with the loss;

(g) A register of all money received, deposited, disbursed, or withdrawn in connection with a transaction with an insured, including fees, transfers, and disbursements from a trust account and all transactions concerning all interest-bearing accounts;

(h) The name of the public adjuster who executed the contract;

(i) The name of the attorney representing the insured, if applicable, and the name of the claims representative of the insurer; and

(j) Evidence of financial responsibility in a format prescribed by the director.

(2) Records shall be maintained for at least five years after the termination of the transaction with an insured and shall be open to examination by the department at all times.

(3) Records submitted to the department in accordance with this section that contain information identified in writing as proprietary by the public adjuster shall be treated as confidential by the department.

Source: Laws 2018, LB743, § 16.

44-9217 Public adjuster; loyalty; prohibited acts.

(1) A public adjuster shall serve with objectivity and complete loyalty to the interest of the insured and shall, in good faith, render to the insured such information, counsel, and service, as within the knowledge, understanding, and

opinion of such public adjuster will best serve the insurance claim needs and interest of the insured.

(2) A public adjuster shall not solicit, nor attempt to solicit, an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract.

(3) A public adjuster shall not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required under the Public Adjusters Licensing Act.

(4) A public adjuster shall not have a direct or indirect financial interest in any aspect of the claim, other than the salary, fee, commission, or other consideration established in the written contract with the insured. Direct or indirect financial interest includes, but is not limited to, ownership of, employment by, or other consideration received from any business entity or individual that performs any work pertaining to damage related to the insured loss.

(5) A public adjuster shall not acquire any interest in salvage of property subject to the contract with the insured unless the public adjuster obtains written permission from the insured after settlement of the claim with the insurer.

(6) A public adjuster shall abstain from referring or directing the insured to obtain needed repairs or services in connection with a loss from any person:

(a) With whom the public adjuster has a direct or indirect financial interest; or

(b) From whom the public adjuster may receive direct or indirect compensation or other consideration for the referral.

(7) A public adjuster shall not undertake the adjustment of any claim if such public adjuster is not competent and knowledgeable as to the terms and conditions of the insurance coverage or if the loss or coverage otherwise exceeds the current expertise of the public adjuster.

(8) A public adjuster shall not knowingly make any false oral or written material statements regarding any person engaged in the business of insurance to any insured client or potential insured client.

(9) A public adjuster, while so licensed pursuant to the Public Adjusters Licensing Act, shall not represent or act as a company adjuster or independent adjuster in any circumstance.

(10) A public adjuster shall not enter into a contract or accept a power of attorney that vests in such public adjuster the effective authority to choose the persons who shall perform repair work.

(11) A public adjuster shall not agree to any loss settlement without the knowledge and consent of the insured.

Source: Laws 2018, LB743, § 17.

44-9218 Fee; catastrophic fees.

(1) A public adjuster may charge the insured a reasonable fee for public adjuster services.

(2) A person shall not accept a commission, service fee, or other valuable consideration for investigating or settling claims in this state if that person is required to be licensed under the Public Adjusters Licensing Act and is not so licensed.

(3) In the event of a catastrophic disaster, there shall be limits on catastrophic fees. No public adjuster shall charge, agree to, or accept as compensation or reimbursement any payment, commission, fee, or other thing of value equal to or more than ten percent of any insurance settlement or proceeds resulting from a catastrophic disaster.

(4) No public adjuster shall require, demand, or accept any fee, retainer, compensation, deposit, or other thing of value prior to settlement of a claim unless the loss is being handled by the public adjuster on a time-plus-expense basis.

Source: Laws 2018, LB743, § 18.

44-9219 Rules and regulations.

The director may adopt and promulgate rules and regulations to carry out the Public Adjusters Licensing Act.

Source: Laws 2018, LB743, § 19.

CHAPTER 45
INTEREST, LOANS, AND DEBT

Article.

Cross References

Credit Report Protection Act, see section 8-2601.

ARTICLE 1
INTEREST RATES AND LOANS

(a) GENERAL PROVISIONS

Section

Section
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45-145. Transferred to section 45-1031.
45-146. Repealed. Laws 2001, LB 53, § 115.
45-147. Repealed. Laws 2001, LB 53, § 115.
45-148. Transferred to section 45-1034.
45-149. Transferred to section 45-1035.
45-150. Transferred to section 45-1036.
45-151. Repealed. Laws 1988, LB 352, § 190.
45-152. Repealed. Laws 1988, LB 352, § 190.
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45-155.01. Repealed. Laws 1989, LB 3, § 2.
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(c) LOAN AGENCIES

45-159. Repealed. Laws 1982, LB 592, § 2.

(a) GENERAL PROVISIONS

45-101 Repealed. Laws 1975, LB 349, § 6.

45-101.01 Unconstitutional.

This section enacted by 1963 Special Session as a part of Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

45-101.02 Terms, defined.

As used in sections 45-101.02 to 45-101.04, 45-102, and 45-105, unless the context otherwise requires:

(1) Interest means the compensation agreed upon or allowed by law upon any loan or forbearance of money, goods, or things in action but does not include loan service costs;

(2) Loan service costs means reasonable and necessary costs and charges incurred in connection with the making, closing, disbursing, servicing, extending, transferring, or renewing of a loan, including but not limited to (a) prepayment charges, (b) delinquency charges, (c) premiums for hazard, private mortgage, disability, life, or title insurance, (d) fees for escrow, appraisal, abstracting, title examination, surveys, inspections, credit reports, and recording of documents, (e) origination fees, (f) interest on interest after default, and (g) costs and charges incurred for determining qualification for the loan proceeds and disbursement of the loan proceeds; and

(3) Discount points means any charges except actual loan service costs whether or not actually denominated as discount points paid to a lender which directly or indirectly affect the ability of the borrower to secure a loan. For the

purpose of determining the rate of interest on any loan, discount points, if any, shall be amortized over the original term of the loan.

Source: Laws 1975, LB 349, § 1; Laws 1997, LB 137, § 19.

45-101.03 General interest rate; maximum; variable rate authorized; conditions.

(1) Except as provided in section 45-101.04, any rate of interest which may be agreed upon, not exceeding sixteen percent per annum on the unpaid principal balance, shall be valid upon any loan or forbearance of money, goods, or things in action and may be taken yearly, for any shorter period, or in advance, if so expressly agreed.

(2) Such rate of interest so long as it does not violate sections 45-101.02 to 45-113 or any federal usury law may be charged on a variable rate basis, except that if the lender proposes to increase the interest rate during the term of a loan on consumer goods notice of such proposed increase shall be communicated in writing to the person or persons primarily obligated on such loan at least ten days prior to the proposed increase. Deposit of such notice in the United States mails, postage prepaid, shall be deemed communication for the purpose of this section.

Source: Laws 1975, LB 349, § 2; Laws 1979, LB 390, § 1; Laws 1980, LB 276, § 6; Laws 1982, LB 778, § 1.

Notwithstanding limitations on interest rates imposed on state banks by Nebraska law, national bank in Nebraska can charge, with respect to credit card transactions, rates allowed by Nebraska law for ''small loan companies''. Fisher v. First Nat. Bank of Omaha, 548 F.2d 255 (8th Cir. 1977).

45-101.04 General interest rate; maximum; when not applicable.

The limitation on the rate of interest provided in section 45-101.03 shall not apply to:

(1) Other rates of interest authorized for loans made by any licensee or permittee operating under a license or permit duly issued by the Department of Banking and Finance pursuant to the Credit Union Act, the Nebraska Installment Loan Act, subsection (4) of section 8-319, or sections 8-815 to 8-829;

(2) Loans made to any corporation, partnership, limited liability company, or trust;

(3) The guarantor or surety of any loan to a corporation, partnership, limited liability company, or trust;

(4) Loans made when the aggregate principal amount of the indebtedness is twenty-five thousand dollars or more of the borrower to any one financial institution, licensee, or permittee;

(5) Loans insured, guaranteed, sponsored, or participated in, either in whole or part, by any agency, department, or program of the United States or state government;

(6) Loans or advances of money, repayable on demand, which are made solely upon securities, as defined in subdivision (15) of section 8-1101, pledged as collateral for such repayment and in which such loans or advances are used by the borrower only for the purchase of securities as so defined. It shall be lawful to contract for and receive any rate of interest on such transaction as the parties thereto may expressly agree;

(7) Interest charges made on open credit accounts by a person who sells goods or services on credit when the interest charges do not exceed one and one-third percent per month for any charges which remain unpaid for more than thirty days following rendition of the statement of account;

(8) A minimum charge of ten dollars per loan which may be charged by the lender in lieu of all interest charges;

(9) Loans described in subsection (4) of section 8-319 made by a state or federal savings and loan association at a rate not to exceed nineteen percent per annum;

(10) Loans made primarily for business or agricultural purposes or secured by real property when such loans are made (a) by a licensee, registrant, or permittee operating under a license, registration, or permit duly issued by the Department of Banking and Finance except for licensees operating under the Nebraska Installment Loan Act, (b) by any financial institution insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration, or (c) by any insurance company organized under the laws of this state and subject to regulation by the Department of Insurance;

(11) Loans secured solely by real property when such loans are (a) made by licensees operating under the Nebraska Installment Loan Act and (b) made to finance or refinance the purchase of the property or construction on or improvements to the property, if the Department of Banking and Finance has the authority to examine such loans for compliance with sections 45-101.02 and 45-101.03. A licensee making a loan pursuant to this subdivision may obtain an interest in any fixtures attached to such real property and any insurance proceeds payable in connection with such real property or the loan;

(12) Loans secured by a reverse mortgage pursuant to section 45-702.01;

(13) Interest charges made on any goods or services sold under an installment contract pursuant to the Nebraska Installment Sales Act. Subject to section 45-338, it shall be lawful to contract for and receive any rate of interest on such contract as the parties may expressly agree to in writing; or

(14) Fees which may be charged by a licensee for services pursuant to the Delayed Deposit Services Licensing Act.

Source: Laws 1975, LB 349, § 3; Laws 1976, LB 616, § 1; Laws 1979, LB 390, § 2; Laws 1980, LB 276, § 7; Laws 1980, LB 279, § 4; Laws 1982, LB 623, § 1; Laws 1986, LB 143, § 1; Laws 1988, LB 795, § 5; Laws 1989, LB 272, § 2; Laws 1993, LB 121, § 263; Laws 1993, LB 216, § 11; Laws 1994, LB 967, § 30; Laws 1994, LB 979, § 7; Laws 1995, LB 397, § 1; Laws 1996, LB 948, § 124; Laws 1997, LB 335, § 12; Laws 1999, LB 396, § 24; Laws 2001, LB 53, § 28; Laws 2003, LB 131, § 25; Laws 2004, LB 999, § 31; Laws 2010, LB892, § 2.

Cross References

Credit Union Act, see section 21-1701.
Delayed Deposit Services Licensing Act, see section 45-901.
Nebraska Installment Loan Act, see section 45-1001.
Nebraska Installment Sales Act, see section 45-334.

A corporation may agree to pay any rate of interest by an agreement in writing which sets out the amount or rate charged. Such interest is not usurious. Classen v. Becton, Dickinson & Co., 214 Neb. 543, 334 N.W.2d 644 (1983).

The exemptions specified in subdivisions (2), (3), and (4) of this section exempt the specified transactions from the installment loan act, sections 8-435 et seq., as well as from the interest rate limitations of section 45-101.03. McCaul v. American Savings Co., 213 Neb. 841, 331 N.W.2d 795 (1983).

45-101.05 Mortgage loan; escrow account; how established and maintained.

No lender, in connection with a mortgage loan, shall require the borrower or prospective borrower:

(1) To deposit in any escrow account which may be established in connection with such loan for the purpose of assuring payment of taxes, insurance premiums, or other charges with respect to the property, prior to or upon the date of settlement, an aggregate sum in excess of the total amount of such taxes, insurance premiums, and other charges which are attributable to the period beginning on the last date on which each such charge would have been paid under the normal lending practice of the lender if the selection of each such date constitutes prudent lending practice and ending on the due date of its first full installment payment under the mortgage plus a cushion that shall be no greater than one-sixth of the estimated total annual payments to be made from the escrow account for such taxes, insurance premiums, and other charges during the twelve-month period beginning on the date of settlement; or

(2) To deposit in any such escrow account in any month beginning after the date of settlement a sum for the purpose of assuring payment of taxes, insurance premiums, or other charges with respect to the property in excess of one-twelfth of the total annual escrow account payments which the lender reasonably anticipates paying from the escrow account for such taxes, insurance premiums, and other charges plus a cushion that shall be no greater than one-sixth of the estimated total annual payments to be made from the escrow account for such taxes, insurance premiums, and other charges, except that if the lender determines that a shortage exists or that there will be a deficiency on the due date the lender shall not be prohibited from requiring additional monthly deposits in such escrow account of pro rata portions of the shortage or deficiency corresponding to the number of months from the date of the lender's determination of such shortage or deficiency to the date upon which such taxes, insurance premiums, and other charges would be paid under the normal lending practice of the lender if the selection of each such date constitutes prudent lending practice.

Source: Laws 1976, LB 502, § 1; Laws 1997, LB 554, § 1.

45-101.06 Escrow accounts; not required.

It is not the intent of sections 45-101.05 to 45-101.07 to require that escrow accounts be required or established.

Source: Laws 1976, LB 502, § 2.

45-101.07 Violations; penalty.

Any lender who violates any of the provisions of section 45-101.05 shall be guilty of a Class IV misdemeanor.

Source: Laws 1976, LB 502, § 3; Laws 1977, LB 41, § 39.

45-102 Interest; legal rate; exception.

Interest upon the loan or forbearance of money, goods or things in action shall be at the rate of twelve percent per annum for the period commencing on March 19, 1980, through August 31, 1983, and at the rate of six percent per annum commencing on September 1, 1983, on the unpaid principal balance,

unless a greater rate, not exceeding the rate of interest provided in section 45-101.03, be contracted for by the parties.

Source: Laws 1879, § 2, p. 113; R.S.1913, § 3347; C.S.1922, § 2837; C.S.1929, § 45-104; Laws 1933, c. 85, § 2, p. 336; Laws 1941, c. 90, § 3, p. 345; C.S.Supp.,1941, § 45-102; Laws 1943, c. 108, § 2, p. 376; R.S.1943, § 45-102; Laws 1961, c. 17, § 3, p. 118; Laws 1963, c. 272, § 2, p. 819; Laws 1963, Spec. Sess., c. 8, § 5, p. 101; Laws 1963, Spec. Sess., c. 7, § 4, p. 90; Laws 1967, c. 276, § 2, p. 744; Laws 1975, LB 349, § 4; Laws 1980, LB 279, § 5.

1. Rate
2. Miscellaneous
3. Unconstitutional

1. Rate

This section is not the only section fixing maximum rate of interest. Lefferdink v. Schmutte, 149 Neb. 695, 32 N.W.2d 194 (1948).

Statutory rate of interest was not applicable in absence of contract. Moore v. Schank, 148 Neb. 228, 27 N.W.2d 165 (1947).

Where joint debtor has paid more than proportionate share of debt and seeks contribution, he is entitled to interest at legal rate and not at rate provided in original debt. Exchange Elevator Co. v. Marshall, 147 Neb. 48, 22 N.W.2d 403 (1946).

Guardian is surcharged with the legal rate of interest where an unauthorized loan is made by him. In re Guardianship of Morris, 145 Neb. 319, 16 N.W.2d 442 (1944).

In suit on fire insurance policy, where proof of loss was made June 1, 1933, when legal interest rate was seven percent, interest was allowed on judgment at seven percent and not six percent as provided by law at time judgment entered. Wheaton v. Aetna Life Ins. Co., 128 Neb. 583, 259 N.W. 753 (1935).

Note providing interest from date without specified rate bears interest at legal rate. Praest v. Quesner, 113 Neb. 485, 203 N.W. 549 (1925).

A judgment upon a note and mortgage draws interest at the same rate as contract. Rafert v. Federal Farm Mortgage Corporation, 152 F.2d 193 (8th Cir. 1945).

2. Miscellaneous

In order to receive prejudgment interest, a litigant must comply with section 45-103.02. Sayer v. Bowley, 243 Neb. 801, 503 N.W.2d 166 (1993).

A devise under a will is neither a loan nor a forbearance. In re Estate of Peterson, 230 Neb. 744, 433 N.W.2d 500 (1988).

Potentially conflicting interests within a class are incompatible with the maintenance of a true class action and this aspect may be disposed of upon motion for summary judgment. Blankenship v. Omaha P. P. Dist., 195 Neb. 170, 237 N.W.2d 86 (1976).

Assignment of interest under insurance policy does not bear interest until death of insured and collection on policy. In re Estate of Dalbey, 143 Neb. 32, 8 N.W.2d 512 (1943).

A dealer in automobiles may in good faith sell a car on time for a price in excess of the cash price without tainting the transaction with usury, though the difference in prices may exceed lawful interest for a loan. American Loan Plan v. Frazell, 135 Neb. 718, 283 N.W. 836 (1939).

Proper method of computing interest on certificate of deposit in insolvent state bank is stated. State ex rel. Spillman v. Farmers State Bank, 113 Neb. 679, 204 N.W. 795 (1925).

In awarding damages for breach of contract, court could not allow interest on unliquidated claim at a rate exceeding six percent after statute reducing legal rate from seven to six percent became effective. Otoe County Nat. Bank v. Delany, 88 F.2d 238 (8th Cir. 1945).

Alleged error in calculating interest on allowance of attorney's fee is not reviewable in absence of motion, objection or exception, or assignment of error at trial. Metropolitan Life Ins. Co. v. Armstrong, 85 F.2d 187 (8th Cir. 1936).

Where the interest charged on delinquent taxes did not exceed the maximum lawful rate that could be charged by agreement, such charge was not a penalty but was interest allowable under the federal bankruptcy act. Horn v. Boone County, 44 F.2d 920 (8th Cir. 1930).

Federally chartered lending institution designed to serve particular, limited purpose and which was not engaged in banking was not bound by Nebraska usury law. Beatrice Production Credit Assn. v. Vieselmeyer, 376 F.Supp. 1391 (D. Neb. 1973).

3. Unconstitutional

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

Amendment to this section in 1963 Special Session by Legislative Bill 16 was unconstitutional as special legislation. Davis v. General Motors Acceptance Corp., 176 Neb. 865, 127 N.W.2d 907 (1964).

45-103 Interest; judgments; decrees; rate; exceptions.

For decrees and judgments rendered before July 20, 2002, interest on decrees and judgments for the payment of money shall be fixed at a rate equal to one percentage point above the bond equivalent yield, as published by the Secretary of the Treasury of the United States, of the average accepted auction price for the last auction of fifty-two-week United States Treasury bills in effect on the date of entry of the judgment. For decrees and judgments rendered on and after July 20, 2002, interest on decrees and judgments for the payment of money

shall be fixed at a rate equal to two percentage points above the bond investment yield, as published by the Secretary of the Treasury of the United States, of the average accepted auction price for the first auction of each annual quarter of the twenty-six-week United States Treasury bills in effect on the date of entry of the judgment. The State Court Administrator shall distribute notice of such rate and any changes to it to all Nebraska judges to be in effect two weeks after the date the auction price is published by the Secretary of the Treasury of the United States. This interest rate shall not apply to:

(1) An action in which the interest rate is specifically provided by law; or

(2) An action founded upon an oral or written contract in which the parties have agreed to a rate of interest other than that specified in this section.

Source: Laws 1879, § 3, p. 113; R.S.1913, § 3348; C.S.1922, § 2836; C.S.1929, § 45-103; Laws 1933, c. 85, § 1, p. 336; C.S.Supp.,1941, § 45-103; R.S.1943, § 45-103; Laws 1972, LB 1330, § 1; Laws 1980, LB 279, § 6; Laws 1981, LB 42, § 24; Laws 1981, LB 167, § 32; Laws 1986, LB 298, § 1; Laws 1994, LB 1183, § 1; Laws 2000, LB 921, § 35; Laws 2002, LB 876, § 78.

Cross References

For provisions for interest on judgments against the state, see section 25-21,211.

1. Contract rate
2. Judgments and decrees generally
3. Installment judgment
4. Verdict
5. Miscellaneous

1. Contract rate

This section allows parties to contractually agree to a rate of prejudgment interest that will apply to an unliquidated claim. Folgers Architects v. Kerns, 262 Neb. 530, 633 N.W.2d 114 (2001).

Under security agreements providing for interest at highest legal rate, secured party was entitled to nine percent a year on amounts due from date of default and nine percent on part of judgment covering amounts due for repossession, repair, and cleaning of trucks from date judgment was entered. Cornett v. White Motor Corp., 190 Neb. 496, 209 N.W.2d 341 (1973).

Lawful interest, where rate is not fixed by statute, is subject of contract as limited by law, and is not allowable at a different rate by court of equity. Johnson v. Kindig, 127 Neb. 360, 255 N.W. 236 (1934).

Judgment on note held to draw same rate of interest as note from its date, if the rate is equal to or exceeds the legal rate and does not exceed the maximum lawful rate. Calloway v. Doty, 108 Neb. 319, 188 N.W. 104 (1922).

Judgments should draw interest at seven percent from date of rendition when founded upon contract providing for less rate. Portsmouth Savings Bank v. Yeiser, 81 Neb. 343, 116 N.W. 38 (1908).

Where contract provides for payment at legal rate until maturity and higher rate thereafter, judgment will draw higher rate. Conn. Mut. Life Ins. Co. v. Westerhoff, 58 Neb. 379, 78 N.W. 724, 79 N.W. 731 (1899).

Contract to pay ten percent instead of seven, as provided in contract, to gain extension of time, is valid, and interest is not payable till principal is due. Greenwood v. Fenton, 54 Neb. 573, 74 N.W. 843 (1898).

Where contract bears interest at six percent before maturity and ten thereafter, decree will draw ten. Havemeyer v. Paul, 45 Neb. 373, 63 N.W. 932 (1895).

2. Judgments and decrees generally

Judgment interest accrues on the judgment, even if that judgment is made up in part of interest already accrued. Heritage Bank v. Bruha, 283 Neb. 263, 812 N.W.2d 260 (2012).

It is not mandatory that interest be charged on a marital deferred property distribution. It is, however, within the discretionary power of a district court to award interest on deferred installments payable as part of a marital property distribution. When utilizing this discretionary power, a factor the district court or the Court of Appeals should take into consideration is the burden of the payor spouse. Priest v. Priest, 251 Neb. 76, 554 N.W.2d 792 (1996).

When a judgment is to be paid in installments, interest begins to accrue on each individual installment only from the date it becomes due and payable. Thiltges v. Thiltges, 247 Neb. 371, 527 N.W.2d 853 (1995).

Plaintiff was entitled to six percent interest on claim allowed against receiver until amendment increased it to eight percent from July 6, 1972. Colburn v. Ley, 191 Neb. 427, 215 N.W.2d 869 (1974).

Provision for interest on decrees and judgments relates to money immediately due and collectible where its nonpayment is a breach of duty. Patterson v. Spelts Lumber Co., 166 Neb. 692, 90 N.W.2d 283 (1958).

Order of court establishing trust fund in sum certain, entitled to priority of payment from assets of failed bank before claims of depositors and creditors are paid, bears interest at legal rate from date of decree until paid, and accrued interest is preferred claim over claims of depositors and creditors. State ex rel. Spillman v. First State Bank, 124 Neb. 786, 248 N.W. 383 (1933).

Where court in receivership proceeding allows depositor of insolvent bank preferred claim payable from guaranty fund, the order is a judgment and such judgment draws interest at legal rate until paid. Bliss v. Bryan, 123 Neb. 461, 243 N.W. 625 (1932).

In liquidation of insolvent bank, allowance of trust fund is decree in the nature of judgment for payment of money, and hereunder, bears interest at legal rate from date of judgment until paid. Hall v. Citizens State Bank, 122 Neb. 636, 241 N.W. 123 (1932).

Insolvent state bank is liable for interest at seven percent on deposit after allowance of claim. State ex rel. Spillman v. Nebraska State Bank of Harvard, 118 Neb. 660, 225 N.W. 778 (1929).

Judgments, when revived, draw interest at legal rate from date of rendition. McDonald v. Thomas Co., 89 Neb. 494, 131 N.W. 1021 (1911).

Decree in favor of heirs, against trustee of estate, draws interest at seven percent. Smullin v. Wharton, 86 Neb. 553, 125 N.W. 1112 (1910).

Interest on judgment should be computed from date of rendition. Tobler v. Union Stock Yards Co., 85 Neb. 413, 123 N.W. 461 (1909).

Decree in suit on creditor's bill, ordering defendant to pay money into court forthwith, draws interest, though not provided in decree. Stuart v. Burcham, 62 Neb. 84, 86 N.W. 898 (1901).

Decree foreclosing mortgage draws interest from date of rendition until paid. Stenger v. Carrig, 61 Neb. 753, 86 N.W. 475 (1901).

Judgments draw interest until paid. Trompen v. Hammond, 61 Neb. 446, 85 N.W. 436 (1901).

Deposit of money into court on decree of distribution; when to draw interest. Whitall v. Cressman, 18 Neb. 508, 26 N.W. 245 (1886).

Interest under this section shall accrue on decrees and judgments for the payment of money from the date of entry of judgment until satisfaction of judgment. Valley Cty. Sch. Dist. 88–0005 v. Ericson State Bank, 18 Neb. App. 624, 790 N.W.2d 462 (2010).

3. Installment judgment

Where a judgment is required to be paid in installments, interest begins to accrue on each individual installment from the date it becomes due and payable. Dryden v. Dryden, 205 Neb. 666, 289 N.W.2d 525 (1980).

Delinquent installments of child support bear interest at the legal rate from the date of delinquency. Ferry v. Ferry, 201 Neb. 595, 271 N.W.2d 450 (1978).

The trial court has the inherent power in adjusting the rights of the parties to provide that a money allowance to be paid in installments shall not draw interest until a certain date. Nickel v. Nickel, 201 Neb. 267, 267 N.W.2d 190 (1978).

Where judgment was rendered for specific amount against each of several defendants jointly and severally liable, and case continued for further decree in event any should fail to pay, interest on remaining amount begins from date of demand and refusal, not from original judgment. First Nat. Bank of Omaha v. Cooper, 91 Neb. 624, 136 N.W. 1023 (1912).

Section refers to judgments collectible at once. Installment judgments should draw interest from date of maturity of installment until paid. Dike v. Andrews, 80 Neb. 455, 114 N.W. 582 (1908).

4. Verdict

Interest is allowable on amount of verdict from date of rendition to entry of judgment thereon. Hilton v. State, 60 Neb. 421, 83 N.W. 354 (1900).

Interest on verdict in tort should be allowed up to rendition of judgment and become part thereof. Fremont, E. & M. V. R.R. Co. v. Root, 49 Neb. 900, 69 N.W. 397 (1896).

5. Miscellaneous

Based on the mandatory language contained herein, a court of equity does not have discretion to withhold interest on decrees or judgments for the payment of money. Welch v. Welch, 246 Neb. 435, 519 N.W.2d 262 (1994).

A court of equity has a reasonable discretion to allow or withhold interest as is reasonable and just, except in cases where it is recoverable as a matter of right. Kullbom v. Kullbom, 215 Neb. 148, 337 N.W.2d 731 (1983).

The provisions for interest in this section apply to sales conducted pursuant to statutory procedures relating to foreclosure sales. They do not apply as a matter of right to sales conducted under terms negotiated by the parties. In such situations, the court may exercise reasonable discretion in allocating interest between the parties. Bankers Union Life Ins. Co. v. Nebraska Corp., 211 Neb. 350, 318 N.W.2d 730 (1982).

Where usury is established, plaintiff is not entitled to interest on the judgment. Central Constr. Co. v. Blanchard, 180 Neb. 62, 141 N.W.2d 416 (1966).

Interest is not allowed on attorney's fee until claim is reduced to judgment. Metcalf v. Hartford Acc. & Ind. Co., 176 Neb. 468, 126 N.W.2d 471 (1964).

Representatives of estates should be surcharged with interest at legal rate when they have abused their trust. In re Estate of Wiley, 150 Neb. 898, 36 N.W.2d 483 (1949).

In action to rescind a contract, where certain money in hands of defendant is found to be an equitable trust fund in favor of plaintiff, plaintiff is entitled to interest thereon. Ericson v. Nebraska–Iowa Farm Investment Co., 134 Neb. 391, 278 N.W. 841 (1938).

Where payment is made upon judgment in excess of interest then due thereon, entire balance due on judgment bears interest as provided by law from date of such payment. Rawlings v. Anheuser–Busch Brewing Co., 69 Neb. 34, 94 N.W. 1001 (1903).

In all actions interest is recoverable for use or destruction of property when amount due plaintiff may be ascertained by reference to market values. Missouri, K. & T. Trust Co. v. Clark, 60 Neb. 406, 83 N.W. 202 (1900).

Note, providing for legal rate until maturity and higher legal rate thereafter, is not a penalty and not usurious. Crapo v. Hefner, 53 Neb. 251, 73 N.W. 702 (1898).

Where interest on note plus commission on loan taken together do not exceed legal rate for period, it is not usurious. Upton v. O'Donahue, 32 Neb. 565, 49 N.W. 267 (1891).

Unlike this section, which provides for postjudgment interest, section 45–104 allows for prejudgment interest. Farm & Garden Ctr. v. Kennedy, 26 Neb. App. 576, 921 N.W.2d 615 (2018).

In Frazier–Lemke proceedings, failure to file claim at time of application for extension does not prejudice holder of mortgage lien, and holder of lien is not required to offer proof of freedom from usury. Rafert v. Federal Farm Mortgage Corporation, 152 F.2d 193 (8th Cir. 1945).

In awarding damages for breach of contract, court could not allow interest on unliquidated claim at a rate exceeding six percent after statute reducing legal rate from seven to six percent became effective. Otoe County Nat. Bank v. Delany, 88 F.2d 238 (8th Cir. 1937).

Alleged error in calculating interest on allowance of attorney's fees is not reviewable in absence of motion, objection or exception, or assignment of error at trial. Metropolitan Life Ins. Co. v. Armstrong, 85 F.2d 187 (8th Cir. 1936).

45-103.01 Postjudgment interest; accrual; when.

Interest as provided in section 45-103 shall accrue on decrees and judgments for the payment of money from the date of entry of judgment until satisfaction of judgment.

Source: Laws 1986, LB 298, § 2; Laws 1994, LB 1183, § 2; Laws 1999, LB 43, § 20.

Judgment interest accrues on the judgment, even if that judgment is made up in part of interest already accrued. Heritage Bank v. Bruha, 283 Neb. 263, 812 N.W.2d 260 (2012).

This section allows parties to contractually agree to a rate of postjudgment interest and does not impose additional conditions for the recovery of such interest. Folgers Architects v. Kerns, 262 Neb. 530, 633 N.W.2d 114 (2001).

Interest accrues from the date the original judgment is due, regardless of whether an appeal is taken prior to that date. Gallner v. Gallner, 257 Neb. 158, 595 N.W.2d 904 (1999).

Based on the mandatory language contained herein, a court of equity does not have discretion to withhold interest on decrees or judgments for the payment of money. Welch v. Welch, 246 Neb. 435, 519 N.W.2d 262 (1994).

The court did not err in awarding postjudgment interest on the wife's fixed dollar amount share of her husband's profit-sharing plan from the date of entry of the decree, even though the qualified domestic relations order called for by the decree was not entered for over 2 years. Fry v. Fry, 18 Neb. App. 75, 775 N.W.2d 438 (2009).

When a judgment is modified upon appeal, interest runs on the full amount of the judgment as modified from the date the original judgment was rendered by the trial court. Ramaekers, McPherron & Skiles v. Ramaekers, 4 Neb. App. 733, 549 N.W.2d 662 (1996).

45-103.02 Prejudgment interest; accrual; when; conditions.

(1) Except as provided in section 45-103.04, interest as provided in section 45-103 shall accrue on the unpaid balance of unliquidated claims from the date of the plaintiff's first offer of settlement which is exceeded by the judgment until the entry of judgment if all of the following conditions are met:

(a) The offer is made in writing upon the defendant by certified mail, return receipt requested, to allow judgment to be taken in accordance with the terms and conditions stated in the offer;

(b) The offer is made not less than ten days prior to the commencement of the trial;

(c) A copy of the offer and proof of delivery to the defendant in the form of a receipt signed by the party or his or her attorney is filed with the clerk of the court in which the action is pending; and

(d) The offer is not accepted prior to trial or within thirty days of the date of the offer, whichever occurs first.

(2) Except as provided in section 45-103.04, interest as provided in section 45-104 shall accrue on the unpaid balance of liquidated claims from the date the cause of action arose until the entry of judgment.

Source: Laws 1986, LB 298, § 3; Laws 1994, LB 1183, § 3; Laws 1999, LB 43, § 21.

1. Liquidated claims
2. Unliquidated claims
3. Miscellaneous

1. Liquidated claims

Prejudgment interest is recoverable only when the claim is liquidated, that is, when there is no reasonable controversy as to the plaintiff's right to recover and the amount of such recovery. This determination requires a two-pronged inquiry. There must be no dispute as to the amount due and to the plaintiff's right to recover. Dutton–Lainson Co. v. Continental Ins. Co., 279 Neb. 365, 778 N.W.2d 433 (2010).

Prejudgment interest may be awarded only as provided in subsection (2) of this section. Dutton–Lainson Co. v. Continental Ins. Co., 279 Neb. 365, 778 N.W.2d 433 (2010).

Prejudgment interest under this section is recoverable only when the claim is liquidated, that is, when there is no reasonable controversy as to either the plaintiff's right to recover or the amount of such recovery. A two-pronged inquiry is required. There must be no dispute either as to the amount due or as to the plaintiff's right to recover, or both. Ferer v. Aaron Ferer & Sons, 272 Neb. 770, 725 N.W.2d 168 (2006).

Under this section, the proper date for prejudgment interest to begin accruing on a liquidated claim is the date in which the cause of action arose; it is important that a court awarding prejudgment interest disclose the precise date on which it determined the cause of action giving rise to an award of prejudgment interest arose. Blue Valley Co-op v. National Farmers Org., 257 Neb. 751, 600 N.W.2d 786 (1999).

A claim is liquidated when there is no reasonable controversy either as to the plaintiff's right to recover or as to the amount of such recovery. Cheloha v. Cheloha, 255 Neb. 32, 582 N.W.2d 291 (1998).

Prejudgment interest under subsection (2) of this section is recoverable only when the claim is liquidated, that is, when there is no reasonable controversy as to either the plaintiff's right to recover or the amount of such recovery. Farm & Garden Ctr. v. Kennedy, 26 Neb. App. 576, 921 N.W.2d 615 (2018).

2. Unliquidated claims

Under subsection (1) of this section, where the claim is unliquidated and the plaintiff's offer of settlement is exceeded by the judgment, prejudgment interest accrues on the full amount of the judgment starting on the date of the plaintiff's first offer of settlement, which offer is exceeded by the judgment. Martensen v. Rejda Bros., 283 Neb. 279, 808 N.W.2d 855 (2012).

The interest rate referenced in this section does not apply when the parties have contractually agreed to the rate of interest that will apply to an unliquidated claim. This section pre-

scribes the conditions for allowance of prejudgment interest on all causes of action, and the parties cannot contract out of the statutory conditions. Folgers Architects v. Kerns, 262 Neb. 530, 633 N.W.2d 114 (2001).

An offer to settle a claim pursuant to this section may be made either before or after the commencement of an action asserting the claim. This section does not differentiate between a judgment reached by agreement and one rendered following trial. Wortman By and Through Wortman v. Unger, 254 Neb. 544, 578 N.W.2d 413 (1998).

If there is a dispute as to either the amount due or the plaintiff's right to recover, the claim is generally considered to be unliquidated and prejudgment interest is not allowed. Farm & Garden Ctr. v. Kennedy, 26 Neb. App. 576, 921 N.W.2d 615 (2018).

3. Miscellaneous

This section and section 45–104 are alternate and independent sections authorizing the recovery of prejudgment interest. Weyh v. Gottsch, 303 Neb. 280, 929 N.W.2d 40 (2019).

This section provides the sole means for recovery of interest costs. Interest is not otherwise recoverable as a separate element of damages. R & D Properties v. Altech Constr. Co., 279 Neb. 74, 776 N.W.2d 493 (2009).

Prejudgment interest may be awarded only as provided in this section. IBP, Inc. v. Sands, 252 Neb. 573, 563 N.W.2d 353 (1997).

In order to be eligible to receive prejudgment interest in a cause of action accruing after January 1, 1987, a litigant must comply with the requirements of this section. Label Concepts v. Westendorf Plastics, 247 Neb. 560, 528 N.W.2d 335 (1995).

It was plain error for district court to award prejudgment interest where the requirements of this section were not complied with. Peterson v. Kellner, 245 Neb. 515, 513 N.W.2d 517 (1994).

In order to receive prejudgment interest, a litigant must comply with this section. Sayer v. Bowley, 243 Neb. 801, 503 N.W.2d 166 (1993).

Prejudgment interest may be recovered only as provided under this section. Elson v. Pool, 235 Neb. 469, 455 N.W.2d 783 (1990).

Prejudgment interest is not allowed on rent which accrued on or after January 1, 1987, unless the provisions of this section are complied with. Knox v. Cook, 233 Neb. 387, 446 N.W.2d 1 (1989).

45-103.03 Interest; how computed.

All payments made prior to trial by or on behalf of the defendant shall be subtracted from the judgment before interest as provided in subsection (1) of section 45-103.02 is added.

Source: Laws 1986, LB 298, § 4; Laws 1994, LB 1183, § 4.

45-103.04 Prejudgment interest; exceptions.

Interest as provided in section 45-103.02 shall not accrue prior to the date of entry of judgment for:

(1) Any action arising under Chapter 42; or

(2) Any action involving the state, a political subdivision of the state, or any employee of the state or any of its political subdivisions for any negligent or wrongful act or omission accruing within the scope of such employee's office or employment.

Source: Laws 1986, LB 298, § 5; Laws 1994, LB 1183, § 5; Laws 1999, LB 43, § 22.

Subsection (2) of this section prohibits prejudgment interest for (1) any action involving the state, (2) any action involving a political subdivision of the state, or (3) any action involving an employee of the state or political subdivision for any negligent or wrongful act or omission accruing within the scope of such employee's office or employment. Eikmeier v. City of Omaha, 280 Neb. 173, 783 N.W.2d 795 (2010).

Claims against political subdivisions which accrued on or after January 1, 1987, are not subject to prejudgment interest. Hammond v. City of Broken Bow, 239 Neb. 437, 476 N.W.2d 822 (1991).

45-104 Interest; other contract obligations.

Unless otherwise agreed, interest shall be allowed at the rate of twelve percent per annum on money due on any instrument in writing, or on settlement of the account from the day the balance shall be agreed upon, on money received to the use of another and retained without the owner's consent, express or implied, from the receipt thereof, and on money loaned or due and withheld by unreasonable delay of payment. Unless otherwise agreed or provided by law, each charge with respect to unsettled accounts between parties shall

bear interest from the date of billing unless paid within thirty days from the date of billing.

Source: Laws 1879, § 4, p. 114; R.S.1913, § 3349; C.S.1922, § 2837; C.S.1929, § 45-104; Laws 1933, c. 85, § 2, p. 336; C.S.Supp.,1941, § 45-104; R.S.1943, § 45-104; Laws 1980, LB 279, § 7.

Cross References

For other provisions for interest on claims of $4,000 or less, see section 25-1801.

1. Scope of section

Section 45–103.02 and this section are alternate and independent sections authorizing the recovery of prejudgment interest. Weyh v. Gottsch, 303 Neb. 280, 929 N.W.2d 40 (2019).

This section authorizes the recovery of prejudgment interest on four categories of contract-based claims without regard to whether the claim is liquidated or unliquidated. Weyh v. Gottsch, 303 Neb. 280, 929 N.W.2d 40 (2019).

This section only provides the interest rate on prejudgment interest in specific types of actions; it does not provide an alternative statute for recovery independent of section 45–103.02. Records v. Christensen, 246 Neb. 912, 524 N.W.2d 757 (1994).

In order to receive prejudgment interest, a litigant must comply with section 45–103.02. Sayer v. Bowley, 243 Neb. 801, 503 N.W.2d 166 (1993).

2. Instruments in writing

A will is an instrument in writing. Therefore, when interest is required to be paid on a pecuniary devise pursuant to section 30–24,102, the legal rate of interest called for is 12 percent per annum, as required by this section. In re Estate of Peterson, 230 Neb. 744, 433 N.W.2d 500 (1988).

Where the parties had ''otherwise agreed'' by a provision in their lease, this section was superseded. Prudential Ins. Co. v. Greco, 211 Neb. 342, 318 N.W.2d 724 (1982).

Where no interest rate is inserted in a form contract providing for interest and it appears from other matter typed into the form contract and parol evidence at trial that no interest payments were intended, this section does not require that interest be paid. Lovelace v. Stern, 207 Neb. 174, 297 N.W.2d 160 (1980).

Where under signed agreement defendant was to pay upon completion of subcontracts and date of completion was not proved, the account was not settled and interest was allowable from date of judgment only. Andrews Electric Co. v. Farm Automation, Inc., 188 Neb. 669, 198 N.W.2d 463 (1972).

Note providing interest from date, without specified rate, bears interest at legal rate. Praest v. Quesner, 113 Neb. 485, 203 N.W. 549 (1925).

In action on official bonds, interest runs from time, under terms of statute and bond, when funds should have been accounted for and turned over to successor. Thomssen v. County of Hall, 63 Neb. 777, 89 N.W. 389 (1902).

A written instrument whereby maker promises to pay a specified sum with interest at a specified rate per annum draws interest from date of instrument notwithstanding the instrument contains a condition that it shall not be due and payable until payee shall render an account of money received under bond. Jewett v. McGillicuddy, 55 Neb. 588, 75 N.W. 1099 (1898).

Demand certificates, in absence of agreement, draw interest at legal rate from demand, and, if no demand, then from commencement of suit. Morse v. Rice, 36 Neb. 212, 54 N.W. 308 (1893).

In action on executor's bond for money which he failed to pay, interest should be allowed at legal rate. Bell v. Arndt, 24 Neb. 261, 38 N.W. 750 (1888).

Due bills draw interest from date, unless there is some provision therein to the contrary. Estate of Bennett v. Taylor, 4 Neb. Unof. 800, 96 N.W. 669 (1903).

''[M]oney due on any instrument in writing'' under this section includes written invoices and billing statements sent by a business to a customer for products and services sold, and unless otherwise agreed or provided by law, such unsettled accounts between the parties shall bear interest from the date of billing unless paid within 30 days from the date of billing. Farm & Garden Ctr. v. Kennedy, 26 Neb. App. 576, 921 N.W.2d 615 (2018).

Where written contract provides that purchase price of goods shall be paid by a certain date, seller is entitled to interest from date buyer was obligated to make payment. City of Hastings v. Nebraska–Kansas Nat. Gas Co., 226 F.2d 419 (8th Cir. 1955).

3. Accounts

When a bank or savings institution is found liable for unauthorized withdrawal of funds from depositor's account, the depositor is entitled to interest from the date of such withdrawals to date of judgment. Edquist v. Commercial Sav. & Loan Assn., 191 Neb. 618, 217 N.W.2d 82 (1974).

A cotenant who collects rents and profits from real estate is required to pay interest on each year's rent to the other cotenants. Fraser v. Temple, 173 Neb. 367, 113 N.W.2d 319 (1962).

Trial court properly added to verdict interest on unsettled account from six months after date of last item. Heusser v. McAtee, 151 Neb. 828, 39 N.W.2d 802 (1949).

In absence of contract, unsettled accounts do not draw interest until six months after the date of the last item. Moore v. Schank, 148 Neb. 228, 27 N.W.2d 165 (1947).

Where mechanics' lien is based on book account, interest commences six months after date of last item, in absence of other agreement. Walker v. Collins Constr. Co., 121 Neb. 157, 236 N.W. 334 (1931).

Unsettled accounts draw interest at legal rate beginning six months from date of last item, whether it be debit or credit, but greater rate may be agreed upon. Woodbury Granite Co. v. Miller, 102 Neb. 304, 167 N.W. 68 (1918); Lindell v. Deere, Wells & Co., 66 Neb. 87, 92 N.W. 164 (1902); Garneau v. Omaha Printing Co., 52 Neb. 383, 72 N.W. 360 (1897).

In partnership accounts, interest may be allowed on an advancement, but not on withdrawals until replacement is demanded. Clark v. Warden, 10 Neb. 87, 4 N.W. 413 (1880).

Interest on claim against receiver was properly allowed from date of contract which amounted to an account stated. Lupton v. Chase National Bank of New York, 89 F.Supp. 393 (D. Neb. 1950).

4. Money retained

As used in this section, ''money received to the use of another'' indicates that the money is received on behalf of another person, such as an agent receiving money on behalf of his principal. Brook Valley Ltd. Part. v. Mutual of Omaha Bank, 285 Neb. 157, 825 N.W.2d 779 (2013).

Where delay in payment of a specific legacy is caused by litigation which precluded speedy administration of estate, executor is not ordinarily chargeable with interest until a reasonable time has elapsed after difficulty has ceased. In re Kierstead's Estate, 128 Neb. 654, 259 N.W. 740 (1935).

Money sought to be reclaimed as a trust fund from receiver of insolvent state bank bears interest at legal rate, as it is money received to the use of another and retained without the owner's consent. Hall v. Citizens State Bank of Superior, 122 Neb. 636, 241 N.W. 123 (1932).

Agent chargeable with interest at legal rate from time money was wrongfully withheld from principal. Pearlman v. Snitzer, 112 Neb. 135, 198 N.W. 879 (1924).

Interest may be allowed at legal rate on money due and withheld by unreasonable delay of payment. Mullally v. Dingman, 62 Neb. 702, 87 N.W. 543 (1901).

A claim against an insolvent bank for specific money deposited and adjudicated to be a trust fund draws interest as money received to the use of another and retained without the owner's consent. Capital Nat. Bank v. Coldwater Nat. Bank, 49 Neb. 786, 69 N.W. 115 (1896), 59 A.S.R. 572 (1896).

5. Money loaned or due

Where stockholders of a corporation resisted payment of additional judgment rendered on account of failure of same stockholders to pay share of original judgment, they were liable for interest on money due and withheld by unreasonable delay. First Nat. Bank of Omaha v. Cooper, 91 Neb. 624, 136 N.W. 1023 (1912).

Allowance of interest on purchase money refunded is in discretion of court and cannot exceed legal rate. State Bank of Nebraska v. Green, 10 Neb. 130, 4 N.W. 942 (1880).

Where, by express agreement, the amount of merchandise sold during each month was, at the end of the month, due and payable, sales for each month would draw interest from time account fell due. Beck v. Devereaux, 9 Neb. 109, 2 N.W. 365 (1879).

Where amount due is liquidated, and there is evidence that makes it possible to compute with exactness the amount owed, the prevailing party is entitled to prejudgment interest. Kaus v. Bideaux, 709 F.2d 1221 (8th Cir. 1983).

6. Date interest accrues

Under this section, an agent is chargeable with interest at the legal rate from the time that the money is wrongfully withheld from the principal. Cheloha v. Cheloha, 255 Neb. 32, 582 N.W.2d 291 (1998).

Interest properly allowed from date checks and warrants involved were deposited in treasurer's bank account. City of Bellevue v. Western Surety Co., 184 Neb. 678, 171 N.W.2d 772 (1969).

On rescission of contract, party rescinding is liable for interest on money withheld from date of rescission. James v. Hogan, 154 Neb. 306, 47 N.W.2d 847 (1951).

A claim adjudicated to be trust funds payable from assets of insolvent state bank in preference to depositors' claims is in effect a judgment, which bears interest at legal rate from date rendered. State ex rel. Sorensen v. Plateau State Bank, 126 Neb. 407, 253 N.W. 433 (1934).

Generally, prejudgment interest accrues on the unpaid balance of liquidated claims arising from an instrument in writing from the date the cause of action arose until the entry of judgment. Valley Cty. Sch. Dist. 88–0005 v. Ericson State Bank, 18 Neb. App. 624, 790 N.W.2d 462 (2010).

In a suit where amounts of debts and set-offs were known, prejudgment interest should have run from a date six months after the last transaction affecting the account. Ford Motor Co. v. Auto Supply Co., Inc., 615 F.2d 757 (8th Cir. 1980).

Where amount claimed is a matter of reasonable controversy and is unliquidated, interest runs from date of judgment. Socony Mobil Oil Co. v. Klapal, 205 F.Supp. 388 (D. Neb. 1962).

7. Contracted rate

This section allows parties to contractually agree to a rate of prejudgment interest that will apply to a liquidated claim. Folgers Architects v. Kerns, 262 Neb. 530, 633 N.W.2d 114 (2001).

Where the parties have contracted for a particular lawful rate of interest, a court should award the contract rate rather than the statutory rate. Lease Northwest v. Davis, 224 Neb. 617, 400 N.W.2d 220 (1987).

Amount due as interest prior to judgment by reason of agreement of the parties is not prejudgment interest as the term is used in this section. First Nat. Bank v. Bolzer, 221 Neb. 415, 377 N.W.2d 533 (1985).

8. Liquidated versus unliquidated

Prejudgment interest is allowed where the amount of the claim is liquidated; if reasonable controversy exists concerning the claimant's right to recover or the amount of such recovery, the claim is unliquidated, and prejudgment interest is not allowed. Knox v. Cook, 233 Neb. 387, 446 N.W.2d 1 (1989).

Prejudgment interest is allowable only when the amount of the claim is liquidated. Graff v. Burnett, 226 Neb. 710, 414 N.W.2d 271 (1987).

Prejudgment interest is properly disallowed where the claim is unliquidated. A claim is unliquidated when there exists a reasonable controversy as to plaintiff's right to recover and as to the amount of such a recovery, if any. Philip G. Johnson & Co. v. Salmen, 211 Neb. 123, 317 N.W.2d 900 (1982).

A claim is liquidated if the evidence furnishes data which if believed makes it possible to compute the amount with exactness without reliance on opinion or discretion and on a liquidated claim prejudgment interest is allowed as a matter of right. Abbott v. Abbott, 188 Neb. 61, 195 N.W.2d 204 (1972).

9. Miscellaneous

Applicant for attorney fees is not entitled to interest until fee is calculated and evaluated. State v. Ryan, 233 Neb. 151, 444 N.W.2d 656 (1989).

Holder of an agister's lien on cattle covered by security agreement is not protected as to amount of interest in excess of that permitted hereunder. Mousel v. Daringer, 190 Neb. 77, 206 N.W.2d 579 (1973).

Computation of interest by trial court was properly made. Western Pipe & Supply, Inc. v. Heart Mountain Oil Co., Inc., 179 Neb. 858, 140 N.W.2d 813 (1966).

This section has no application to situation where damages are allowed to be offset against cash payment due on completion of building contract. Jones v. Elliott, 172 Neb. 96, 108 N.W.2d 742 (1961).

In action based on quantum meruit, interest was not allowable until judgment. Umberger v. Sankey, 154 Neb. 881, 50 N.W.2d 346 (1951).

Provisions of United States Constitution do not forbid states to legislate on rates of interest. Klattenburg v. Qualsett, 114 Neb. 18, 205 N.W. 577 (1925).

Cities are liable for interest in default, same as other debtors. Murphy v. City of Omaha, 33 Neb. 402, 50 N.W. 265 (1891).

Section applies to barred claims revived by acknowledgment. Devereaux v. Henry, 16 Neb. 55, 19 N.W. 697 (1884).

Claims bear interest, as matter of law, without any contract therefor, and no express allegation of interest is required. Peterson v. Mannix, 2 Neb. Unof. 795, 90 N.W. 210 (1902).

Unlike section 45–103, which provides for postjudgment interest, this section allows for prejudgment interest. Farm & Garden Ctr. v. Kennedy, 26 Neb. App. 576, 921 N.W.2d 615 (2018).

This section provides the interest rate for prejudgment interest upon the happening of events outlined in this section. Valley Cty. Sch. Dist. 88–0005 v. Ericson State Bank, 18 Neb. App. 624, 790 N.W.2d 462 (2010).

Constructive trustee who usurps a corporate opportunity is not entitled to interest. I.P. Homeowners, Inc. v. Radtke, 5 Neb. App. 271, 558 N.W.2d 582 (1997).

The trial court was correct in denying prejudgment interest when the amount due and owing on plaintiff's claim depended upon the interpretation of several contract clauses. Omaha Paper Stock Co. v. Harbor Ins. Co., 596 F.2d 283 (8th Cir. 1979).

Excess judgment suit against insurer sounds in tort and no prejudgment interest is allowable. Lienemann v. State Farm Mut. Auto Fire & Cas. Co., 540 F.2d 333 (8th Cir. 1976).

Section cited in denying interest on items of drayage, etc., in corporate receiver's report. Brictson Mfg. Co. v. Close, 25 F.2d 794 (8th Cir. 1928).

45-104.01 Interest; political subdivisions; delinquent taxes; special assessments.

Unless otherwise specifically provided, the interest rate assessed on delinquent payments of any taxes or special assessments owing to any political subdivision of the State of Nebraska shall be assessed at a rate of fourteen percent per annum.

Source: Laws 1981, LB 167, § 1; Laws 1992, Fourth Spec. Sess., LB 1, § 4.

Under the former law, if an obligation to pay interest arises under section 67-405 and the rate is not specified, the rate is that specified in this section. Robertson v. Jacobs Cattle Co., 285 Neb. 859, 830 N.W.2d 191 (2013).

This statutory provision does not mandate the assessment of interest on delinquent taxes; rather, it sets the rate at which such interest will be assessed. Ameritas Life Ins. Corp. v. Balka, 257 Neb. 878, 601 N.W.2d 508 (1999).

45-104.02 Interest; State of Nebraska; delinquent taxes; special assessments; credits or refunds.

(1) Unless otherwise specifically provided, the interest rate assessed on delinquent payments of any taxes or special assessments owing to the State of Nebraska shall be assessed at a rate of fourteen percent per annum through December 31, 1992, and at the per annum rate determined pursuant to subsection (2) of this section after such date.

(2) Commencing January 1, 1993, the interest rate assessed pursuant to subsection (1) of this section shall be redetermined every other year. The rate shall be determined by the Tax Commissioner and shall be equal to the average short-term borrowing rate for the federal government during July of the previous year rounded to the nearest whole percentage point plus three percentage points. If the new rate does not increase or decrease the old rate by at least two percentage points, the old rate shall continue in effect.

(3)(a) The rate determined pursuant to subsection (2) of this section shall apply for the period from its effective date through the date of payment or up to the effective date of the succeeding new rate, whichever is earlier.

(b) Interest on taxes or special assessments shall be calculated using the different rates which are effective over the period of delinquency.

(c) For any taxes or special assessments that were delinquent and unpaid on or before December 31, 1992, the interest rate shall be fourteen percent per annum through December 31, 1992.

(4) For any credits or refunds of taxes or special assessments on which interest is to be determined at the rate specified in this section, the calculation of interest shall use the same rates for the same periods that are used for interest on delinquent payments.

(5) For refunds applied for on or after May 1, 1993, for any taxes that were overpaid as of December 31, 1992, the interest rate shall be seven percent per annum from the date of overpayment through December 31, 1992.

Source: Laws 1992, Fourth Spec. Sess., LB 1, § 5; Laws 1993, LB 345, § 2.

Absent evidence in the record about what the rate should be, an appellate court cannot rule that the rate used by the trial judge was wrong. Holman v. Papio-Missouri River Nat. Resources Dist., 246 Neb. 787, 523 N.W.2d 510 (1994).

45-105 Usury; penalty.

If a greater rate of interest than is allowed in section 45-101.03 shall be contracted for or received or reserved, the contract shall not on that account be void, but if in any action on such contract, proof be made that illegal interest has been directly or indirectly contracted for, or taken, or reserved, the plaintiff shall recover only the principal, without interest, and the defendant shall recover costs; and if interest shall have been paid thereon, judgment shall be for the principal, deducting interest paid; *Provided,* the acts and dealings of an agent in loaning money shall bind the principal, and in all cases where there is illegal interest by the transaction of the agent, the principal will be held thereby as if he had done the same in person. Where the same person acts as agent for the borrower who obtains the money from the lender, he shall be deemed to be the agent of the lender also.

Source: Laws 1879, § 5, p. 114; R.S.1913, § 3350; C.S.1922, § 2838; C.S.1929, § 45-105; R.S.1943, § 45-105; Laws 1975, LB 349, § 5.

1. Definition

Elements of usury are (1) a loan, express or implied; (2) an understanding that the money will be returned; (3) for such loan, a greater rate of interest than allowed by law shall be paid or agreed to be paid; and (4) a corrupt intent to take more than the legal rate of interest for the money loaned. Farmland Enterprises, Inc. v. Schueman, 212 Neb. 342, 322 N.W.2d 665 (1982).

Usurious intent need not be implied where variable interest rate at time of contracting was below legal limit but where it exceeded the limit because of increase in the prime rate to which contract referred. Farmland Enterprises, Inc. v. Schueman, 212 Neb. 342, 322 N.W.2d 665 (1982).

A nonlicensee may make an installment loan where interest not in excess of nine percent per annum is charged. Pattavina v. Pignotti, 177 Neb. 217, 128 N.W.2d 817 (1964).

What constitutes usury is defined. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 298, 96 N.W.2d 55 (1959).

Usury is intent, under contract, on part of borrower to give and of lender to receive interest in excess of legal limit. Menzie v. Smith, 63 Neb. 666, 88 N.W. 855 (1902).

To constitute usury, there must be a contract by which lender receives or reserves a greater rate of interest than maximum allowed by law. Richards v. Kountze, 4 Neb. 200 (1876).

2. Transactions usurious

Usurious loan disguised as conditional or time sale is subject to forfeiture of interest. Midstates Acceptance v. Voss, 189 Neb. 411, 202 N.W.2d 822 (1972).

Usurious contract not void, but recovery limited to amount of principal without interest less interest paid. Baker v. A. C. Nelson Co., 185 Neb. 128, 174 N.W.2d 197 (1970).

Where defense of usury is established, plaintiff is not entitled to recover interest on the principal. Central Constr. Co. v. Blanchard, 180 Neb. 62, 141 N.W.2d 416 (1966).

Where sum named in promissory note exceeds sum actually loaned, such excess being a commission to payee, which added to interest aggregates more than legal rate of interest, the note is usurious. Detweiler v. Forman, 120 Neb. 780, 235 N.W. 330 (1931).

Prior to 1927, mortgage requiring mortgagor to pay maximum legal interest plus taxes on mortgagee's interest in mortgaged premises was usurious. War Finance Corp. v. Thornton, 118 Neb. 797, 226 N.W. 454 (1929); Stuart v. Durland, 115 Neb. 211, 212 N.W. 31 (1927), 53 A.L.R. 739 (1927).

Sale or purchase of property at price beyond its value as condition for making loan, with intent that lender receive more than lawful rate is usurious. Sanford v. Hawthorne, 103 Neb. 867, 174 N.W. 863 (1919).

Taking interest for more than one year in advance is unauthorized by statute and is usurious. Allen v. Dunn, 71 Neb. 831, 99 N.W. 680 (1904).

Exacting bonus in addition to highest legal rate renders transaction usurious. Hare v. Winterer, 64 Neb. 551, 90 N.W. 544 (1902).

Where debtor executes note and mortgage at lawful rate, and at maturity enters into new usurious contract for extension under which lender retains note and mortgage as collateral, all interest is forfeited after date of usurious contract. Chicago Lumber Co. v. Bancroft, 64 Neb. 176, 89 N.W. 780 (1902).

Stipulation for legal rate until maturity, and if not then paid, for higher legal rate from date, is penalty and not enforceable. Stipulation that past due installments of interest shall draw interest, if total interest does not exceed ten percent, is valid. Hallam v. Telleren, 55 Neb. 255, 75 N.W. 560 (1898).

Usury law cannot be evaded by antedating note bearing highest legal rate from date. Vail v. Van Doren, 45 Neb. 450, 63 N.W. 787 (1895).

Usurious note given for extension of legal note is usurious. McDonald v. Beer, 42 Neb. 437, 60 N.W. 868 (1894).

Loan, made at twelve percent for one year, is not purged of usury by extension for another year at eight percent. Doyle v. Holland, 39 Neb. 87, 57 N.W. 989 (1894).

Agreement to pay attorney's fee for extension of time is usurious, and amount must be applied on principal. Rosa v. Doggett, 8 Neb. 48 (1878).

Where purported lease and farm equipment dealer's guaranty was found to be a usurious loan transaction but was not found to have been fraudulently obtained, seller of farm equipment was entitled to avoid guaranty only to extent of usurious interest and his right to reimbursement from farmer was vitiated only to extent of usurious interest. McKeeman v. Commercial Credit Equipment Corp., 320 F.Supp. 938 (D. Neb. 1970).

3. Transactions not usurious

Prior to 1941, contract for payment of interest at rate of ten percent was not usurious. Lefferdink v. Schmutte, 149 Neb. 695, 32 N.W.2d 194 (1948).

A clause in a mortgage upon real estate located in a foreign state, that the mortgagor will pay the tax on the note secured thereby, does not render such note usurious though the note bears interest at the maximum legal rate and is taxable to the mortgagor. Pierson v. Faulkner, 134 Neb. 865, 279 N.W. 813 (1938).

To constitute usury, brokerage charge and interest for term of loan must exceed legal maximum. Western Securities Co. v. Naughton, 124 Neb. 702, 248 N.W. 56 (1933).

A dealer in automobiles may in good faith sell a car on time in excess of the cash price without tainting the transaction with usury, though the difference in prices may exceed the maximum legal rate of interest. Grand Island Finance Co. v. Fowler, 124 Neb. 514, 247 N.W. 429 (1933).

A mortgage is not void because usurious interest is exacted thereunder, and mortgagor's covenant to pay taxes is invalidated only to extent of usury involved. Matthews v. Guenther, 120 Neb. 742, 235 N.W. 98 (1931).

Interest upon interest cannot be stipulated for, but agreement made after interest is due, that it shall bear maximum rate, is valid, and extending time is sufficient consideration for such agreement. Sanford v. Lundquist, 80 Neb. 414, 118 N.W. 129 (1908).

Officer of bank cannot make contract with corporation of which he is officer to pay usurious rate on money owing by him to bank, thereby escaping payment of all interest. Gund v. Ballard, 73 Neb. 547, 103 N.W. 309 (1905).

Mistake in computing interest will not render contract usurious. Dodds v. McCormick Harv. Machine Co., 62 Neb. 759, 87 N.W. 911 (1901).

Contract for legal rate is not rendered usurious by oral agreement to pay more than legal rate, unless carried out. Koehler v. Dodge, 31 Neb. 328, 47 N.W. 913 (1891).

Interest taken in advance is not usurious, unless total amount of interest exceeds ten percent. Foster v. Pitman, 2 Neb. Unof. 672, 89 N.W. 763 (1902).

4. National banks

Exemption of national banks from state usury laws owes existence to acts of Congress, and will not cover note and mortgage collateral to note in national bank. Gadsden v. Thrush, 58 Neb. 340, 78 N.W. 632 (1899).

Prohibition of federal law against taking usury applies to artificial as well as natural persons, is not penal statute and not strictly construed. Albion Nat. Bank v. Montgomery, 54 Neb. 681, 74 N.W. 1102 (1898).

Defense of usury is available in action by national bank to recover unpaid interest where rate contracted for is in excess of that prescribed by Act of Congress. Tomblin v. Higgins, 53 Neb. 92, 73 N.W. 461 (1897).

State law relating to usury does not apply to national banks so far as the penalty and remedy are concerned, which are governed by federal law. First Nat. Bank of Tobias v. Barnett, 51 Neb. 397, 70 N.W. 937 (1897).

Usurious interest paid on loan cannot be set off in suit to recover principal more than two years after payment, as federal statute governs. Montgomery v. Albion Nat. Bank, 50 Neb. 652, 70 N.W. 239 (1897).

Payment of loan made by national bank is not a condition precedent to maintain suit to recover double amount of usurious interest paid. Exeter Nat. Bank v. Orchard, 43 Neb. 579, 61 N.W. 833 (1895).

Limitation of two years in which to recover penalty under federal statute dated from actual payment of such usurious interest. Lanham v. First Nat. Bank of Crete, 42 Neb. 757, 60 N.W. 1041 (1894); First Nat. Bank of Dorchester v. Smith, 36 Neb. 199, 54 N.W. 254 (1893).

Courts of this state have jurisdiction in actions to recover from national banks the penalty provided by federal statute for taking usury. Schuyler Nat. Bank v. Bollong, 37 Neb. 620, 56 N.W. 209 (1893).

National bank cannot collect usurious interest, but usurious interest charged but not paid, cannot be recovered. Hall v. Bank of Fairfield, 30 Neb. 99, 46 N.W. 150 (1890).

5. Foreign building and loan associations

Requirement that borrower subscribe to capital stock as a condition to obtaining loan, the stock to be paid for in monthly installments, made the transaction usurious. Clarke v. Woodruff, 72 Neb. 286, 100 N.W. 314 (1904).

Foreign building and loan associations doing business in Nebraska are subject to penalties of statute against usury. Anselme v. American S. & L. Assn., 66 Neb. 520, 92 N.W. 745 (1902); Interstate S. & L. Assn. v. Strine, 59 Neb. 27, 80 N.W. 45 (1899).

Special terms and exemptions given to domestic building and loan associations by general law, are constitutional and not in conflict with general interest law. Livingston L. & B. Assn. v. Drummond, 49 Neb. 200, 68 N.W. 375 (1896).

6. Acts of agents

Agent of lender exacting, directly or indirectly, interest in excess of legal rate, renders transaction usurious. Hare v. Hooper, 56 Neb. 480, 76 N.W. 1055 (1898); Courtnay v. Price, 12 Neb. 188, 10 N.W. 698 (1881).

Broker, receiving bonus for procuring loan as agent of borrowers, does not render transaction usurious. Davis v. Sloman, 27 Neb. 877, 44 N.W. 41 (1889).

7. Conflict of laws

Notes made and payable in foreign state calling for rate higher than legal in this state will be enforced in absence of plea of usury. McCready v. Phillips, 56 Neb. 446, 76 N.W. 885 (1898).

Where contract is made in Nebraska, payable in New York, validity is to be determined by laws of Nebraska. Bascom v. Zediker, 48 Neb. 380, 67 N.W. 148 (1896).

Presumption is that laws of other state are same as our own, unless pleaded and proved. People's B., L. & S. Assn. v. Backus, 2 Neb. Unof. 463, 89 N.W. 315 (1902).

8. Usury as defense

Although variable interest rate caused interest in excess of the then legal limit to be paid for a period, usury is not available as a defense because the action on the loan was not brought until after Legislature exempted the transaction from the interest limitation. Farmland Enterprises, Inc. v. Schueman, 212 Neb. 342, 322 N.W.2d 665 (1982).

Purchaser of equity of redemption may set up defense of usury against mortgage where he deducted from purchase money only legal interest. Nat. Mut. B. & L. Assn. v. Retzman, 69 Neb. 667, 96 N.W. 204 (1903).

Mortgagor, who has conveyed lands by warranty deed, is entitled to intervene for purpose of pleading usury in foreclosure action. Pitman v. Ireland, 64 Neb. 675, 90 N.W. 540 (1902).

Where usury is established, plaintiff is only entitled to actual amount loaned less all payments of interest and principal on debt. Male v. Wink, 61 Neb. 748, 86 N.W. 472 (1901).

Defense is available in action on account, without alleging fraud or mistake. Jorgensen v. Kingsley, 60 Neb. 44, 82 N.W. 104 (1900).

Defense of usury is personal to borrower and his sureties and privies, and not available to purchaser of equity of redemption of mortgaged premises. Bldg. & Loan Assn. of Dakota v. Walker, 59 Neb. 456, 81 N.W. 308 (1899); People's B., L. & S. Assn. v. Pickard, 2 Neb. Unof. 144, 96 N.W. 337 (1901).

Where usurious note has been repeatedly renewed, notes being taken in name of bank or cashier and transferred after due, holder of final note takes subject to defense of usury. Farmers Bank of Kearney v. Oliver, 55 Neb. 774, 76 N.W. 449 (1898).

Where debtor delivered accommodation note in payment of usurious note, accommodation note was not renewal of usurious loan, and maker could not raise defense of usury. Palmer v. Carpenter, 53 Neb. 394, 73 N.W. 690 (1898).

Every renewal of a note given for a usurious loan of money is subject to the defense of usury between the original parties and purchasers with notice. McDonald v. Aufdengarten, 41 Neb. 40, 59 N.W. 762 (1894).

Innocent purchaser of note for value before maturity and without notice takes note free from defense of usury. Van Etten v. Howell, 40 Neb. 850, 59 N.W. 389 (1894).

If usurious interest is received and deposited in bank by officers of bank as agent of depositor, bank cannot raise defense of usury against depositor. Porter v. Sherman County Banking Co., 40 Neb. 274, 58 N.W. 721 (1894).

Where usury is shown in original transaction, every subsequent security given on same is usurious and holder must show that he is bona fide holder, before maturity, without notice. Knox v. Williams, 24 Neb. 630, 39 N.W. 786 (1888).

Defense is available to maker against assignee of mortgage alone, note not being endorsed though transferred for value before maturity and without notice. Doll v. Hollenbeck, 19 Neb. 639, 28 N.W. 286 (1886).

Usury is personal defense, except where contract for usury is separable from agreement to pay interest, when it may be pleaded by anyone. Bean v. People's B., L. & S. Assn., 2 Neb. Unof. 810, 90 N.W. 222 (1902).

Usury cannot be asserted by purchaser of mortgaged premises who has assumed mortgage. People's B., L. & S. Assn. of Geneva v. Palmer, 2 Neb. Unof. 460, 89 N.W. 316 (1902).

9. Pleading and proof

The claim of usury in this state is a defense to a cause of action. Usury must be pleaded to be available as a defense. General Fiberglass Supply, Inc. v. Roemer, 256 Neb. 810, 594 N.W.2d 283 (1999).

Burden is on one pleading usury, but, when proved, holder of note must prove that he is bona fide purchaser before maturity, for value, without notice. Male v. Wink, 61 Neb. 748, 86 N.W. 472 (1901); Blackwell v. Wright, 27 Neb. 269, 43 N.W. 116 (1889); Olmsted v. New Eng. Mtg. Sec. Co., 11 Neb. 487, 9 N.W. 650 (1881); Bovier v. McCarthy, 4 Neb. Unof. 490, 94 N.W. 965 (1903).

Usury may be proved by defendant under general denial in replevin. Davis v. Culver, 58 Neb. 265, 78 N.W. 504 (1899).

In action to foreclose a mortgage, answer was sufficient to plead defense of usury where it alleged execution of note and mortgage in excess of the money loaned so that interest in excess of the maximum lawful rate on the amount loaned was reserved and to be paid to the lender. FarmLand Sec. Co. v. Nelson, 52 Neb. 624, 72 N.W. 1048 (1897).

Plea must show contract by which there was reserved or received a rate in excess of highest legal rate. McKinley-Lanning L. & T. Co. v. Aldrich, 50 Neb. 785, 70 N.W. 399 (1897).

It is essential to a plea of usury that it state with whom the agreement alleged to be usurious was made, when made, where made, and the facts which it is alleged make the transaction usurious. Rainbolt v. Strang, 39 Neb. 339, 58 N.W. 96 (1894); Hare v. Winterer, 1 Neb. Unof. 854, 96 N.W. 179 (1901).

Plea should state with whom contract was made, its nature, and amount of usurious interest agreed upon or received. New Eng. Co. Mtg. Sec. v. Sandford, 16 Neb. 689, 21 N.W. 394 (1884).

Plea of usury is defense in action on usurious contract, but cannot be retained as set-off or counterclaim after action is dismissed. New Eng. Mtg. Sec. Co. v. Aughe, 12 Neb. 504, 11 N.W. 753 (1882).

10. Costs

Where defense is established, plaintiff is not entitled to costs nor interest on judgment awarded him. Interstate S. & L. Assn. v. Strine, 58 Neb. 133, 78 N.W. 377 (1899).

Where defense of usury is sustained, defendant is entitled to costs, and also costs on attachment sued out to recover usurious debt. Montgomery v. Albion Nat. Bank, 50 Neb. 652, 70 N.W. 239 (1897).

11. Miscellaneous

Remedy for recovery of usury under this section contrasted with remedy under Installment Loan Act. Dailey v. A. C. Nelsen Co., 178 Neb. 881, 136 N.W.2d 186 (1965).

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

Amendment to this section in 1963 Special Session by Legislative Bill 16 was unconstitutional as special legislation. Davis v. General Motors Acceptance Corp., 176 Neb. 865, 127 N.W.2d 907 (1964).

The scope of the effect of usury on installment loans has been broadened in comparison to what it is on ordinary loans. Commonwealth Trailer Sales, Inc. v. Bradt, 166 Neb. 1, 87 N.W.2d 705 (1958).

Statute does not make contract void where a usurious rate of interest is charged. McNish v. General Credit Corp., 164 Neb. 526, 83 N.W.2d 1 (1957).

Installment Loan Act was independent act and not unconstitutional for failure to amend this section. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

Payee loses only interest for violation of general usury law. Fidelity Finance Co. v. Westfall, 127 Neb. 56, 254 N.W. 710 (1934).

Where a note has been paid, an action cannot be maintained to recover usurious interest. Waller v. First Trust Co., 126 Neb. 403, 255 N.W. 29 (1934).

Borrower under usurious contract is entitled to possession of mortgaged property divested of lien upon payment or tender of

principal. Frenzer v. Richards, 60 Neb. 131, 82 N.W. 317 (1900).

Usury once paid cannot be recovered in independent action. Blain v. Willson, 32 Neb. 302, 49 N.W. 224 (1891); New Eng. Mtg. Sec. Co. v. Aughe, 12 Neb. 504, 11 N.W. 753 (1882).

Where there are unmatured renewal notes, a greater part of which represent usurious interest on former notes, and where there is reason to fear that the notes will be transferred to a bona fide holder for value, the debtor may obtain relief by injunction. Wilhelmson v. Bentley, 25 Neb. 473, 41 N.W. 387 (1889).

Borrower seeking relief from usurious contract in equity must tender amount of principal and lawful interest and court will render decree for principal with seven percent interest. Eiseman v. Gallagher, 24 Neb. 79, 37 N.W. 941 (1888).

45-105.01 Unconstitutional.

This section enacted by 1963 Special Session as a part of Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

45-106 Interest; warrants or orders.

All warrants or orders issued by the proper authorities of any county, city, township, school district, other municipal subdivision less than a county, or sanitary district, whose area is located partly within a municipality, shall draw interest from and after the date of presentation for payment at such rate as is fixed by the issuing authority and endorsed on the warrant. All warrants issued by the state shall draw interest at the rate of four percent per annum from the date the same are presented for payment.

Source: Laws 1879, § 10, p. 115; Laws 1895, c. 43, § 1, p. 185; Laws 1895, c. 44, § 1, p. 186; Laws 1899, c. 48, § 1, p. 260; Laws 1903, c. 54, § 1, p. 345; R.S.1913, § 3355; Laws 1919, c. 108, § 1, p. 264; C.S.1922, § 2843; Laws 1929, c. 125, § 1, p. 472; C.S.1929, § 45-110; R.S.1943, § 45-106; Laws 1945, c. 110, § 1, p. 354; Laws 1947, c. 171, § 2, p. 519; Laws 1969, c. 51, § 109, p. 340.

Cross References

For other provisions as to interest on warrants:
Counties, see section 23-1602.
Drainage districts, see section 31-416.

45-107 Interest; effect on purchase of certain lands.

The rate of interest fixed by sections 45-101.02 to 45-106 shall not affect interest on purchase money of school, university, and agricultural college lands, or on lands delinquent or sold for the nonpayment of taxes.

Source: Laws 1879, § 11, p. 115; R.S.1913, § 3356; C.S.1922, § 2844; C.S.1929, § 45-111; R.S.1943, § 45-107.

Cross References

For provisions for payment of interest on redemption from sale for taxes, see sections 77-1824 and 77-1830.

45-108 Interest; rate; when calculated by the year.

When in any law, or in any instrument in writing specifying a rate of interest, no period of time is mentioned for which such rate is to be calculated, it shall be deemed to be by the year.

Source: Laws 1879, § 9, p. 115; R.S.1913, § 3354; C.S.1922, § 2842; C.S.1929, § 45-109; R.S.1943, § 45-108.

45-109 Contracts for payment of money or indebtedness; when usurious.

Any contract for the payment of money in satisfaction of indebtedness which seeks, directly or indirectly, to prevent the debtor from discharging his obligation in full in any lawful money of the United States with the same number of

dollars he originally contracted to pay, plus interest not in excess of the maximum legal contract rate, is hereby declared to constitute usury, the same as if the contract sought to bind the debtor to pay more than the maximum legal rate of interest.

Source: Laws 1935, c. 126, § 1, p. 452; C.S.Supp.,1941, § 45-128; R.S. 1943, § 45-109.

45-110 Usurious contracts; limit of recovery.

All such contracts are hereby declared contrary to public policy and usurious, and in any action therefor the plaintiff shall recover only the same number of dollars in any lawful money of the United States as the number of dollars contracted for at the time the original contract was entered into, plus interest not exceeding the maximum legal contract rate and costs, and no more.

Source: Laws 1935, c. 126, § 2, p. 452; C.S.Supp.,1941, § 45-129; R.S. 1943, § 45-110.

45-111 Usury; civil proceedings; testimony of lender compellable.

Any person charged with taking illegal interest may be required to answer touching the same, on oath, in any civil proceeding.

Source: Laws 1879, § 6, p. 114; R.S.1913, § 3351; C.S.1922, § 2839; C.S.1929, § 45-106; R.S.1943, § 45-111.

45-112 Usury; relief; tender of principal unnecessary.

Relief to the complaining party in case of an usurious loan may be given without payment or tender by him of the principal sum.

Source: Laws 1879, § 7, p. 115; R.S.1913, § 3352; C.S.1922, § 2840; C.S.1929, § 45-107; R.S.1943, § 45-112.

45-113 Usury; witness; testimony not evidence in criminal proceeding, when.

Any officer or agent of a person or a corporation, whether interested or not, may be summoned as a witness in any action for usury against such person or corporation, and required to disclose all the facts of the case, but the testimony of such witness, or the answer of the party as required in section 45-111, shall not be used against such witness or party in any criminal prosecution for perjury.

Source: Laws 1879, § 8, p. 115; R.S.1913, § 3353; C.S.1922, § 2841; C.S.1929, § 45-108; R.S.1943, § 45-113.

(b) INSTALLMENT LOANS

45-114 Transferred to section 45-1002.

45-115 Transferred to section 45-1003.

45-116 Transferred to section 45-1004.

45-117 Transferred to section 45-1005.

45-118 Transferred to section 45-1006.

45-119 Transferred to section 45-1007.

45-120 Transferred to section 45-1008.

45-121 Transferred to section 45-1009.

45-122 Transferred to section 45-1010.

45-123 Transferred to section 45-1011.

45-124 Transferred to section 45-1012.

45-125 Repealed. Laws 1983, LB 447, § 104.

45-126 Transferred to section 45-1013.

45-127 Transferred to section 45-1014.

45-128 Transferred to section 45-1015.

45-129 Transferred to section 45-1016.

45-130 Transferred to section 45-1017.

45-131 Transferred to section 45-1018.

45-132 Transferred to section 45-1019.

45-133 Transferred to section 45-1020.

45-134 Transferred to section 45-1021.

45-135 Transferred to section 45-1022.

45-136 Transferred to section 45-1023.

45-137 Transferred to section 45-1024.

45-138 Transferred to section 45-1025.

45-139 Transferred to section 45-1026.

45-140 Transferred to section 45-1027.

45-141 Repealed. Laws 1957, c. 185, § 5.

45-142 Transferred to section 45-1028.

45-143 Transferred to section 45-1029.

45-144 Transferred to section 45-1030.

45-145 Transferred to section 45-1031.

45-146 Repealed. Laws 2001, LB 53, § 115.

45-147 Repealed. Laws 2001, LB 53, § 115.

45-148 Transferred to section 45-1034.

45-149 Transferred to section 45-1035.

45-150 Transferred to section 45-1036.

45-151 Repealed. Laws 1988, LB 352, § 190.

45-152 Repealed. Laws 1988, LB 352, § 190.

45-153 Transferred to section 45-1037.

45-154 Transferred to section 45-1038.

45-155 Transferred to section 45-1039.

45-155.01 Repealed. Laws 1989, LB 3, § 2.

45-156 Transferred to section 45-1040.

45-157 Transferred to section 45-1041.

45-158 Transferred to section 45-1042.

(c) LOAN AGENCIES

45-159 Repealed. Laws 1982, LB 592, § 2.

45-160 Repealed. Laws 1982, LB 592, § 2.

45-161 Repealed. Laws 1982, LB 592, § 2.

45-162 Repealed. Laws 1982, LB 592, § 2.

(d) PURCHASE OF INSTALLMENT PAPER

45-163 Repealed. Laws 1971, LB 684, § 1.

45-164 Repealed. Laws 1971, LB 684, § 1.

45-165 Repealed. Laws 1971, LB 684, § 1.

45-165.01 Repealed. Laws 1971, LB 684, § 1.

45-165.02 Repealed. Laws 1971, LB 684, § 1.

45-166 Repealed. Laws 1971, LB 684, § 1.

45-167 Repealed. Laws 1971, LB 684, § 1.

45-168 Repealed. Laws 1971, LB 684, § 1.

45-169 Repealed. Laws 1971, LB 684, § 1.

45-170 Repealed. Laws 1959, c. 264, § 1, p. 952.

45-171 Repealed. Laws 1971, LB 684, § 1.

45-172 Repealed. Laws 1971, LB 684, § 1.

(e) COLLECTION PROCEDURES

45-173 Transferred to section 45-1043.

45-174 Transferred to section 45-1044.

45-175 Transferred to section 45-1045.

45-176 Transferred to section 45-1046.

45-177 Transferred to section 45-1047.

45-178 Transferred to section 45-1048.

45-179 Transferred to section 45-1049.

45-180 Transferred to section 45-1050.

45-181 Transferred to section 45-1051.

45-182 Transferred to section 45-1052.

45-183 Transferred to section 45-1053.

45-184 Transferred to section 45-1054.

45-185 Transferred to section 45-1055.

45-186 Transferred to section 45-1056.

45-187 Transferred to section 45-1057.

45-188 Transferred to section 45-1058.

45-188.01 Repealed. Laws 2001, LB 53, § 115.

(f) LOAN BROKERS

45-189 Loan brokers; legislative findings.

The Legislature finds that:

(1) Many professional groups are presently licensed or otherwise regulated by the State of Nebraska in the interest of public protection;

(2) Certain questionable business practices, such as the collection of an advance fee prior to the performance of the service, misleads the public;

(3) Such practices are avoided by many professional groups and many professional groups are regulated by the state to restrict practices which tend to mislead or deceive the public;

(4) Loan brokers in Nebraska have engaged in the practice of collecting an advance fee from borrowers in consideration for attempting to procure a loan of money;

(5) Such practice, as well as others, by loan brokers has led the public to believe that the loan broker has agreed to procure a loan for the borrower when in fact the loan broker has merely promised to attempt to procure a loan; and

(6) Regulation of loan brokers by the state, in similar fashion to that of other professions, is necessary in order to protect the public welfare and to promote the use of fair and equitable business practices.

Source: Laws 1981, LB 154, § 1; Laws 2011, LB75, § 2.

45-190 Terms, defined.

For purposes of sections 45-189 to 45-191.11, unless the context otherwise requires:

(1) Advance fee means any fee, deposit, or consideration which is assessed or collected, prior to the closing of a loan, by a loan broker and includes, but is not limited to, any money assessed or collected for processing, appraisals, credit checks, consultations, or expenses;

(2) Borrower means a person obtaining or desiring to obtain a loan of money;

(3) Department means the Department of Banking and Finance;

(4) Director means the Director of Banking and Finance;

(5)(a) Loan broker means any person who:

(i) For or in expectation of consideration from a borrower, procures, attempts to procure, arranges, or attempts to arrange a loan of money for a borrower;

(ii) For or in expectation of consideration from a borrower, assists a borrower in making an application to obtain a loan of money;

(iii) Is employed as an agent for the purpose of soliciting borrowers as clients of the employer; or

(iv) Holds himself or herself out, through advertising, signs, or other means, as a loan broker; and

(b) Loan broker does not include: (i) A bank, bank holding company, trust company, savings and loan association or subsidiary of a savings and loan association, building and loan association, or credit union which is subject to regulation or supervision under the laws of the United States or any state; (ii) a mortgage banker or an installment loan company licensed or registered under the laws of the State of Nebraska; (iii) a credit card company; (iv) an insurance company authorized to conduct business under the laws of the State of Nebraska; or (v) a lender approved by the Federal Housing Administration or the United States Department of Veterans Affairs, if the loan is secured or covered by guarantees, commitments, or agreements to purchase or take over the same by the Federal Housing Administration or the United States Department of Veterans Affairs;

(6) Loan brokerage agreement means any agreement for services between a loan broker and a borrower; and

(7) Person means natural persons, corporations, trusts, unincorporated associations, joint ventures, partnerships, and limited liability companies.

Source: Laws 1981, LB 154, § 2; Laws 1982, LB 751, § 1; Laws 1985, LB 86, § 1; Laws 1989, LB 272, § 3; Laws 1993, LB 121, § 271; Laws 1993, LB 270, § 1; Laws 1995, LB 599, § 11; Laws 2001, LB 53, § 87; Laws 2003, LB 131, § 26; Laws 2009, LB327, § 16; Laws 2011, LB75, § 3; Laws 2013, LB279, § 1; Laws 2017, LB184, § 1.

45-191 Loan brokers; prohibited acts.

No loan broker shall:

(1) Assess or collect an advance fee from a borrower under a contract to provide services for the procurement of a loan of money;

(2) Willfully, either orally or in writing, misrepresent the terms, benefits, privileges, or provisions of any service contract issued or to be issued by the loan broker or by any lender; or

(3) Represent or imply that the loan broker has been sponsored, recommended, or approved by the department or that the loan broker's abilities or qualifications have been passed upon by the department.

Source: Laws 1981, LB 154, § 3; Laws 1993, LB 270, § 2.

45-191.01 Loan brokerage agreement; written disclosure statement; requirements.

(1) Prior to a borrower signing a loan brokerage agreement, the loan broker shall give the borrower a written disclosure statement. The cover sheet of the disclosure statement shall have printed, in at least ten-point boldface capital letters, the title DISCLOSURES REQUIRED BY NEBRASKA LAW. The following statement, printed in at least ten-point type, shall appear under the title:

THE STATE OF NEBRASKA HAS NOT REVIEWED AND DOES NOT APPROVE, RECOMMEND, ENDORSE, OR SPONSOR ANY LOAN BROKERAGE AGREEMENT. THE INFORMATION CONTAINED IN THIS DISCLOSURE DOCUMENT HAS NOT BEEN VERIFIED BY THE STATE. IF YOU HAVE QUESTIONS, SEEK LEGAL ADVICE BEFORE YOU SIGN A LOAN BROKERAGE AGREEMENT.

Only the title and the statement shall appear on the cover sheet.

(2) The body of the disclosure statement shall contain the following information:

(a) The name, street address, and telephone number of the loan broker, the names under which the loan broker does, has done, or intends to do business, the name and street address of any parent or affiliated company, and the electronic mail and Internet address of the loan broker, if any;

(b) A statement as to whether the loan broker does business as an individual, a partnership, a corporation, or another organizational form, including identification of the state of incorporation or formation;

(c) How long the loan broker has done business;

(d) The number of loan brokerage agreements the loan broker has entered into in the previous twelve months;

(e) The number of loans the loan broker has obtained for borrowers in the previous twelve months;

(f) A description of the services the loan broker agrees to perform for the borrower;

(g) The conditions under which the borrower is obligated to pay the loan broker. This disclosure shall be in boldface type;

(h) The names, titles, and principal occupations for the past five years of all officers, directors, or persons occupying similar positions responsible for the loan broker's business activities;

(i) A statement whether the loan broker or any person identified in subdivision (h) of this subsection:

(i) Has been convicted of a felony or misdemeanor or pleaded nolo contendere to a felony or misdemeanor charge if such felony or misdemeanor involved fraud, embezzlement, fraudulent conversion, or misappropriation of property;

(ii) Has been held liable in a civil action by final judgment or consented to the entry of a stipulated judgment if the civil action alleged fraud, embezzlement, fraudulent conversion, or misappropriation of property or the use of untrue or misleading representations in an attempt to sell or dispose of real or personal property or the use of unfair, unlawful, or deceptive business practices; or

(iii) Is subject to any currently effective injunction or restrictive order relating to business activity as the result of an action brought by a public agency or department including, but not limited to, action affecting any vocational license; and

(j) Any other information the director requires.

Source: Laws 1993, LB 270, § 3; Laws 2007, LB124, § 29; Laws 2017, LB184, § 2.

45-191.02 Loan brokers; filings with department required; filing fees.

(1) Before advertising or making any oral or written representation or acting as a loan broker in this state a loan broker shall file with the department one copy of the disclosure statement and one copy of any loan brokerage agreement.

(2) The loan broker shall renew these filings no less than annually and shall also file any amendment to the disclosure statement within forty-five days after any material change in information required to be disclosed in the disclosure statement.

(3) The loan broker shall pay a one-hundred-fifty-dollar filing fee upon filing the initial disclosure statement and a one-hundred-dollar filing fee upon the filing of a renewal of the disclosure statement. The loan broker shall pay a fifty-dollar filing fee for each amendment filed. All funds collected by the department under this section shall be remitted to the State Treasurer for credit to the Securities Act Cash Fund.

(4) The information contained or filed under this section may be made available to the public under such rules and regulations as the department may prescribe.

Source: Laws 1993, LB 270, § 4; Laws 2001, LB 53, § 88; Laws 2003, LB 217, § 33; Laws 2020, LB909, § 23.

45-191.03 Prohibited acts; violations; penalties.

(1) A loan broker who fails to make accurate and timely filings as required by section 45-191.02 shall be guilty of a Class I misdemeanor.

(2) A loan broker who willfully violates subdivision (1) of section 45-191 shall be guilty of:

(a) A Class IV felony if the advance fee assessed or collected is greater than three hundred dollars; or

(b) A Class I misdemeanor if the advance fee assessed or collected is three hundred dollars or less.

(3) A willful violation of any other provision of sections 45-189 to 45-191.11 by a loan broker shall be a Class IV felony.

Source: Laws 1993, LB 270, § 5.

45-191.04 Loan brokerage agreement; requirements; right to cancel.

(1) A loan brokerage agreement shall be in writing and shall be signed by the loan broker and the borrower. The loan broker shall furnish the borrower a copy of such signed loan brokerage agreement at the time the borrower signs it.

(2) The borrower has the right to cancel a loan brokerage agreement for any reason at any time within five business days after the date the parties sign the agreement. The loan brokerage agreement shall set forth the borrower's right to cancel and the procedures to be followed when an agreement is canceled.

(3) A loan brokerage agreement shall set forth in at least ten-point type, or handwriting of at least equivalent size, the following:

(a) The terms and conditions of payment;

(b) A full and detailed description of the acts or services the loan broker will undertake to perform for the borrower;

(c) The loan broker's principal business address, telephone number, and electronic mail and Internet address, if any, and the name, address, telephone number, and electronic mail and Internet address, if any, of its agent in the State of Nebraska authorized to receive service of process;

(d) The business form of the loan broker, whether a corporation, partnership, limited liability company, or otherwise; and

(e) The following notice of the borrower's right to cancel the loan brokerage agreement pursuant to this section:

''You have five business days in which you may cancel this agreement for any reason by mailing or delivering written notice to the loan broker. The five business days shall expire on . . . . . (last date to mail or deliver notice), and notice of cancellation should be mailed to . . . . . (loan broker's name and business street address). If you choose to mail your notice, it must be placed in the United States mail properly addressed, first-class postage prepaid, and postmarked before midnight of the above date. If you choose to deliver your notice to the loan broker directly, it must be delivered to the loan broker by the end of the normal business day on the above date. Within five business days after receipt of the notice of cancellation, the loan broker shall return to you all sums paid by you to the loan broker pursuant to this agreement.''

The notice shall be set forth immediately above the place at which the borrower signs the loan brokerage agreement.

Source: Laws 1993, LB 270, § 6; Laws 2001, LB 53, § 89; Laws 2007, LB124, § 30; Laws 2017, LB184, § 3.

45-191.05 Waiver of sections; attempt; prohibited.

A waiver of sections 45-189 to 45-191.11 by a borrower prior to or at the time of entering into a loan brokerage agreement is contrary to public policy and shall be void. Any attempt by a loan broker to have a borrower waive any rights pursuant to sections 45-189 to 45-191.11 shall be a violation of such sections.

Source: Laws 1993, LB 270, § 7.

45-191.06 Department; adopt rules and regulations.

The department may adopt, promulgate, amend, and rescind such rules and regulations as necessary or appropriate to implement the purposes of sections 45-189 to 45-191.11.

Source: Laws 1993, LB 270, § 8.

45-191.07 Violation of loan brokerage agreement by loan broker; effect.

(1) If a loan broker materially violates the loan brokerage agreement, the borrower may upon written notice void such loan brokerage agreement. In addition, the borrower may recover all money paid to the loan broker and any other damages, including reasonable attorney's fees. The loan broker shall be deemed to have materially violated the loan brokerage agreement if the loan broker does any of the following:

(a) Makes false or misleading statements relating to the loan brokerage agreement;

(b) Does not comply with the loan brokerage agreement or any obligations arising from the loan brokerage agreement;

(c) Does not grant the borrower a loan or diligently attempt to obtain a loan for the borrower; or

(d) Does not comply with the requirements of sections 45-189 to 45-191.11.

(2) Remedies under this section shall be in addition to any other remedies available in law or equity.

Source: Laws 1993, LB 270, § 9.

45-191.08 Director; enforcement powers.

(1)(a) The director in his or her discretion may make such investigations within or without this state as necessary to determine whether any person has violated or is about to violate sections 45-189 to 45-191.11 or to aid in the enforcement of such sections or in the adopting or promulgating of rules, regulations, and forms under such sections. In the discretion of the director, the actual expense of any such investigation may be charged to any person who is the subject of such investigation.

(b) The department may publish information concerning any violation of such sections or any rule, regulation, or order of the department.

(c) For purposes of any investigation or proceeding under such sections, the director or any officer designated by him or her may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records which the director deems relevant or material to the inquiry.

(2)(a) In case of contumacy by or refusal to obey a subpoena issued to any person, any court of competent jurisdiction, upon application by the director, may issue an order to that person requiring him or her to appear before the director or an officer designated by the director to produce documentary evidence or to give evidence touching on a matter under investigation or in question. Any failure to obey an order of the court may be punished by the court as a contempt of court.

(b) The request for order of compliance may be addressed to either (i) the district court of Lancaster County or the district court in the county where service may be obtained on the person refusing to testify or produce, if the person is within this state, or (ii) the appropriate district court of this state having jurisdiction over the person refusing to testify or produce, if the person is outside this state.

Source: Laws 1993, LB 270, § 10.

45-191.09 Director; summary cease and desist order; when; other enforcement measures; collection of fines and costs; hearing; procedure; appeal.

(1) The director may summarily order a loan broker to cease and desist from acting as a loan broker or from the use of certain forms or practices relating to the loan broker's activities if the order is in the public interest and the director finds:

(a) The disclosure statement on file is incomplete in any material respect or contains any statement which was, in light of the circumstances under which it was made, false or misleading with respect to any material fact;

(b) The loan broker has willfully violated or willfully failed to comply with any provision of sections 45-189 to 45-191.11;

(c) There has been a substantial failure to comply with any of the provisions of such sections;

(d) The continued use of certain forms or practices relating to the loan broker's activity would constitute a misrepresentation, deceit, or fraud upon the consumer; or

(e) Any person identified in the required disclosure statement has been convicted of an offense described in subdivision (2)(i)(i) of section 45-191.01 or is subject to an order or has had a civil judgment entered against him or her as described in subdivision (2)(i)(ii) or (2)(i)(iii) of section 45-191.01 and the involvement of such person in the loan broker's business creates an unreasonable risk to prospective borrowers.

(2) If the director believes, whether or not based upon an investigation conducted under section 45-191.08, that any person or loan broker has engaged in or is about to engage in any act or practice constituting a violation of any provision of sections 45-189 to 45-191.11 or any rule, regulation, or order under such sections, the director may:

(a) Issue a cease and desist order;

(b) Impose a fine not to exceed one thousand dollars per violation, in addition to costs of the investigation; or

(c) Initiate an action in any court of competent jurisdiction to enjoin such acts or practices and to enforce compliance with such sections or any order under such sections.

(3) Upon a proper showing a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted. The director shall not be required to post a bond.

(4)(a) Any fines and costs imposed pursuant to this section shall be in addition to all other penalties imposed by the laws of this state. The department shall collect the fines and costs and remit them to the State Treasurer. The State Treasurer shall credit the costs to the Securities Act Cash Fund and

distribute the fines in accordance with Article VII, section 5, of the Constitution of Nebraska.

(b) If a person fails to pay the fine or costs of the investigation referred to in this subsection, a lien in the amount of the fine and costs may be imposed upon all of the assets and property of such person in this state and may be recovered by suit by the department. Failure of the person to pay a fine and costs shall constitute a separate violation of sections 45-189 to 45-191.11.

(5) Upon entry of an order pursuant to this section, the director shall promptly notify all persons to whom such order is directed that it has been entered and of the reasons for such order and that any person to whom the order is directed may request a hearing in writing within fifteen business days of the issuance of the order. Upon receipt of a written request, the matter shall be set down for hearing to commence within thirty business days after the receipt unless the parties consent to a later date or the hearing officer sets a later date for good cause. If a hearing is not requested within fifteen business days from the issuance of the order and none is ordered by the director, the order shall automatically become final and shall remain in effect until it is modified or vacated by the director. If a hearing is requested or ordered, the director, after notice and hearing, shall enter his or her written findings of fact and conclusions of law and may affirm, modify, or vacate the order.

(6) The director may vacate or modify a cease and desist order if he or she finds that the conditions which caused its entry have changed or that it is otherwise in the public interest to do so.

(7) Any person aggrieved by a final order of the director may appeal the order. The appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1993, LB 270, § 11; Laws 2001, LB 53, § 90; Laws 2020, LB909, § 24.

Cross References

Administrative Procedure Act, see section 84-920.

45-191.10 Persons exempt.

The following persons are exempt from sections 45-189 to 45-191.11 if such person does not hold himself or herself out, through advertising, signs, or other means, as a loan broker: Securities broker-dealer, real estate broker or salesperson, attorney, certified public accountant, or investment adviser.

Source: Laws 1993, LB 270, § 12; Laws 1995, LB 599, § 12; Laws 2013, LB279, § 2.

45-191.11 Burden of proof.

In any proceeding under the provisions of sections 45-189 to 45-191.11, the burden of proving an exemption or an exception from a definition shall be upon the person claiming it.

Source: Laws 1993, LB 270, § 13.

45-192 Repealed. Laws 1993, LB 270, § 15.

45-193 Repealed. Laws 1993, LB 270, § 15.

(g) PREAUTHORIZED LOANS

45-194 Transferred to section 45-1059.

45-195 Transferred to section 45-1060.

45-196 Transferred to section 45-1061.

45-197 Repealed. Laws 2001, LB 53, § 115.

45-198 Transferred to section 45-1062.

45-199 Transferred to section 45-1063.

45-1,100 Transferred to section 45-1064.

45-1,101 Transferred to section 45-1065.

45-1,102 Transferred to section 45-1066.

45-1,103 Transferred to section 45-1067.

(h) REJECTION OF FEDERAL LIMITS

45-1,104 Federal interest rate limitations; rejected by state.

The federal limits on interest rates as provided in sections 501(a)(1), 511, and 524 of Public Law 96-221 shall not apply to loans, mortgages, credit sales, and advances made in Nebraska and are hereby rejected by the State of Nebraska pursuant to this section. Sections 521 to 523 of Public Law 96-221 are not rejected. Subject to the foregoing, the State of Nebraska elects to retain the power to establish or not establish usury limits provided under the Nebraska statutes and the Nebraska Constitution and retains the power to have such limits, if any, apply to any loan, mortgage, credit sale, or advance made in this state after July 17, 1982.

Source: Laws 1982, LB 623, § 2; Laws 1988, LB 913, § 2.

(i) CONSUMER CREDIT DEFAULT PROCEDURES

45-1,105 Terms, defined.

As used in sections 45-1,105 to 45-1,110, unless the context otherwise requires:

(1) Collateral shall mean the property subject to a security interest as defined by the Uniform Commercial Code;

(2) Consumer shall mean a natural person to whom credit is offered or extended by way of a transaction if the money, property, or services of the transaction are primarily for personal, family, or household purposes;

(3) Credit shall mean the right granted by a creditor to a debtor to defer payment of debt or to incur debt and defer its payment;

(4) Creditor shall mean creditors who regularly extend, or arrange for the extension of, credit which is payable by agreement in more than four installments or for which payment of a finance charge is or may be required, whether in connection with loans, sale of property or services, or otherwise; and

(5) Default shall mean either of the following, if without justification under any law:

(a) The consumer fails to make a payment required by the agreement; or

(b) The prospect of payment, performance, or realization of collateral is significantly impaired. The burden of establishing the prospect of significant impairment shall be on the creditor.

Source: Laws 1983, LB 111, § 1.

45-1,106 Consumer credit transaction; default; notice required.

(1) With respect to a consumer credit transaction, after a consumer has been in default for ten days, a creditor may give the consumer the notice described in this section. A creditor gives notice to the consumer under this section when he or she delivers the notice to the consumer or delivers or mails the notice to the consumer's last-known residence address.

(2) The notice shall be in writing and shall conspicuously state: The name, address, and telephone number of the creditor to which payment is to be made; a brief identification of the credit transaction; the consumer's right to cure the default; and the amount of payment and date by which payment must be made to cure the default, or any other performance necessary to cure the default and the date by which such performance must be tendered.

Source: Laws 1983, LB 111, § 2.

45-1,107 Consumer credit transaction; default; consumer's right to cure.

(1) With respect to a consumer credit transaction, after a default a creditor may neither accelerate maturity of the unpaid balance of the obligation nor take possession of collateral, except voluntarily surrendered collateral, because of such default until twenty days after a notice of the consumer's right to cure is given. The consumer shall have twenty days after the notice is given to cure any default by tendering the amount of all unpaid sums due at the time of the tender, without acceleration, plus any unpaid charges, or by tendering any other performance necessary to cure the default as specified in the notice of right to cure. Cure shall restore the consumer to his or her rights under the agreement as though the default had not occurred.

(2) With respect to defaults on the same obligation after a creditor has once given notice of the consumer's right to cure, the consumer shall have no further right to cure and the creditor has no obligation to proceed against the consumer or the collateral.

Source: Laws 1983, LB 111, § 3.

45-1,108 Consumer credit transaction; voluntary surrender of goods; creditor's right to enforce security interest.

Sections 45-1,105 to 45-1,107 shall not prohibit a consumer from voluntarily surrendering possession of goods which are collateral and shall not prohibit the creditor from thereafter enforcing any security interest in the goods at any time after default.

Source: Laws 1983, LB 111, § 4.

45-1,109 Consumer credit transactions; procedures; when applicable.

Sections 45-1,105 to 45-1,110 shall apply to all consumer credit transactions in this state subject to a security interest, as defined in subdivision (35) of section 1-201, Uniform Commercial Code, entered into, extended, or renewed on or after January 1, 1984.

Source: Laws 1983, LB 111, § 5; Laws 2005, LB 570, § 1.

45-1,110 Consumer credit default procedures; not applicable to certain licensees.

Sections 45-1,105 to 45-1,110 shall not apply to any licensee operating under the Nebraska Installment Loan Act.

Source: Laws 1983, LB 111, § 6; Laws 1997, LB 555, § 26; Laws 2001, LB 53, § 100.

Cross References

Nebraska Installment Loan Act, see section 45-1001.

(j) FORCED SALES

45-1,111 Forced sale; disposition of certain proceeds.

In any forced sale of real or personal property conducted to satisfy the claims of creditors, any proceeds of such sale which exceed the claims of such creditors shall be retained by the debtor.

Source: Laws 1987, LB 335, § 3.

(k) CREDIT AGREEMENTS

45-1,112 Terms, defined.

For purposes of sections 45-1,112 to 45-1,115:

(1)(a) Credit agreement means:

(i) A contract, promise, undertaking, offer, or commitment to loan money or to grant or extend credit; or

(ii) A contract, promise, undertaking, or offer to forebear repayment of money or to make any other financial accommodation in connection with a loan of money or grant or extension of credit, or any amendment of, cancellation of, waiver of, or substitution for any or all of the terms or provisions of any instrument or document executed in connection with a loan of money or grant or extension of credit, except for loans of money or grants or extensions of credit which are:

(A) Not in excess of twenty-five thousand dollars and used primarily for personal, family, or household purposes of the debtor or debtors; or

(B) Used for the purchase of and secured solely by the principal residence of the debtor or debtors.

(b) Credit agreement does not include (i) letters of credit or (ii) promissory notes, real estate mortgages, trust deeds, security agreements, financing statements, guarantee agreements, pledge agreements, or other similar documents or instruments evidencing an obligation to repay indebtedness or securing the repayment of indebtedness;

(2) Creditor means any financial institution which makes a credit agreement with a debtor;

(3) Debtor means a person or entity which obtains credit from a creditor, seeks a credit agreement with a creditor, or owes money to a creditor; and

(4) Financial institution means a state-chartered or federally chartered bank, savings bank, building and loan association, credit union, or savings and loan association or a holding company or affiliate or subsidiary of such an institution.

Source: Laws 1989, LB 606, § 1; Laws 1990, LB 1199, § 1; Laws 2003, LB 131, § 27.

The broad language in the definition of credit agreements precludes recovery for a credit agreement based on the promissory estoppel doctrine, which is wholly dependent on reliance on a promise or assurance. Synergy4 Enters. v. Pinnacle Bank, 290 Neb. 241, 859 N.W.2d 552 (2015).

45-1,113 Action or defense based on credit agreement; requirements.

(1) A debtor or a creditor may not maintain an action or assert a defense in an action based on a credit agreement unless the credit agreement is in writing, expresses consideration, sets forth the relevant terms and conditions of the credit agreement, and is signed by the creditor and by the debtor.

(2) Subsection (1) of this section shall not apply to (a) credit extended on an account as defined in section 4-104, Uniform Commercial Code, (b) loans initiated by credit card or other type of transaction card, or (c) credit agreements as defined in subdivision (1)(a)(ii) of section 45-1,112 unless the creditor, at the time of the initial loan of money or grant or extension of credit, has given to the debtor a written notice, signed or initialed by the debtor, which contains substantially the following language: A credit agreement must be in writing to be enforceable under Nebraska law. To protect you and us from any misunderstandings or disappointments, any contract, promise, undertaking, or offer to forebear repayment of money or to make any other financial accommodation in connection with this loan of money or grant or extension of credit, or any amendment of, cancellation of, waiver of, or substitution for any or all of the terms or provisions of any instrument or document executed in connection with this loan of money or grant or extension of credit, must be in writing to be effective.

(3) This section shall not be construed to limit or bar the recovery of money owed or collateral securing a loan in any way.

Source: Laws 1989, LB 606, § 2; Laws 1990, LB 1199, § 2.

The credit agreement statute of frauds is not coextensive with the general statute of frauds with all the common-law exceptions. Synergy4 Enters. v. Pinnacle Bank, 290 Neb. 241, 859 N.W.2d 552 (2015).

This section supersedes the common-law theory of promissory estoppel insofar as it applies to unwritten credit agreements or oral promises to loan money or extend credit. Synergy4 Enters. v. Pinnacle Bank, 290 Neb. 241, 859 N.W.2d 552 (2015).

45-1,114 Implied credit agreement; limitations.

A credit agreement shall not be implied under any circumstances from (1) the relationship, fiduciary or otherwise, of the creditor and the debtor, (2) the rendering of financial advice by a creditor to a debtor, or (3) consultation by a creditor with a debtor.

Source: Laws 1989, LB 606, § 3; Laws 1990, LB 1199, § 3.

45-1,115 Sections; applicability.

Sections 45-1,112 to 45-1,115 shall apply to credit agreements entered into on or after July 10, 1990.

Source: Laws 1989, LB 606, § 4; Laws 1990, LB 1199, § 4.

(l) REVERSE MORTGAGES

45-1,116 Transferred to section 45-1068.

ARTICLE 2
REVOLVING CHARGE AGREEMENTS

Section
45-201. Repealed. Laws 1965, c. 267, § 7.
45-202. Repealed. Laws 1965, c. 267, § 7.
45-203. Repealed. Laws 1965, c. 267, § 7.
45-204. Terms, defined.
45-205. Agreements; requirements; fees and delinquency charges authorized.
45-206. Monthly statement by seller; contents; payment in full; requirements.
45-207. Time-price differential; rate; maximum.
45-208. Violations; penalty.
45-209. Prohibited acts.

45-201 Repealed. Laws 1965, c. 267, § 7.

45-202 Repealed. Laws 1965, c. 267, § 7.

45-203 Repealed. Laws 1965, c. 267, § 7.

45-204 Terms, defined.

As used in sections 45-204 to 45-209, unless the context otherwise requires:

(1) Seller shall mean a person, firm, or corporation, except a bank, selling goods or furnishing services to a buyer under a revolving charge agreement, including the operator of a card system whereby a cardholder purchases goods or services from participating merchants or others;

(2) Buyer shall mean a person, firm, or corporation buying goods or services from a seller or using a card system for the purchase of goods or services from participating merchants or others under a revolving charge agreement;

(3) Time-price differential, however denominated or expressed, shall mean the amount or rate which is paid or payable for the privilege of purchasing goods or services to be paid for by the buyer in installments over a period of time; and

(4) Revolving charge agreement shall mean an agreement prescribing the terms of installment sales to be made from time to time pursuant thereto wherein the buyer's total unpaid balance is payable in installments over a period of time, and under the terms of which a time-price differential as provided in section 45-207 is to be computed in relation to the buyer's unpaid balance from time to time.

Source: Laws 1965, c. 267, § 1, p. 754; Laws 1984, LB 736, § 1.

45-205 Agreements; requirements; fees and delinquency charges authorized.

Every revolving charge agreement shall be in writing and shall be signed by the buyer. Such requirements may be met when disclosure of the revolving charge credit terms has been made to the buyer in conformity with the requirements of the federal Consumer Credit Protection Act before the first extension of credit to the buyer under the revolving charge agreement, and the buyer has signed an application for the revolving charge credit or the buyer signs a sales slip in connection with such extension of credit if the application

has been solicited by telephone with disclosure of the periodic rate of the time-price differential by the seller at the time of the telephone solicitation. A copy of any such agreement shall be delivered or mailed to the buyer by the seller prior to the date on which the first payment is due thereunder. All agreements executed on or after such date shall state the amount or rate of the time-price differential to be charged and paid pursuant thereto. If a seller proffers a revolving charge agreement as part of a transaction which delays or cancels, or promises to delay or cancel, the payment of the time-price differential on the revolving charge agreement, if the buyer pays the basic time price, cash price, or cash sale price within a certain period of time, the seller shall, in clear and conspicuous writing, either within the revolving charge agreement or in a separate document or, in lieu thereof, within a statement sent by the seller to the buyer no later than thirty-five days after the buyer's purchase of goods or services, or in the case of special order goods which are not available for immediate delivery no later than thirty-five days after the buyer's receipt of goods, inform the buyer of the exact date by which the buyer must pay the basic time price, cash price, or cash sale price in order to delay or cancel the payment of the time-price differential. The seller or any subsequent purchaser of the revolving charge agreement shall not be allowed to change such date. In addition to the sale price of the goods or services and the time-price differential provided for in sections 45-204 to 45-208, no further or other amount whatsoever shall be directly or indirectly charged, contracted for, or received, except that a seller may (1) contract for and receive fees for participation in a card system which offers services other than revolving charges and (2) impose delinquency charges on each payment in default for a period of not less than ten days not to exceed five percent of the amount due or five dollars, whichever is greater. A delinquency charge under this section may be collected only once on each payment due, however long it remains in default. A delinquency charge may be collected at the time it accrues or at any time afterward.

Source: Laws 1965, c. 267, § 2, p. 754; Laws 1984, LB 736, § 3; Laws 1995, LB 614, § 2; Laws 2000, LB 932, § 31; Laws 2004, LB 999, § 32.

45-206 Monthly statement by seller; contents; payment in full; requirements.

(1) The seller under a revolving charge agreement shall promptly supply the buyer under such agreement with a statement as of the end of each monthly period, which need not be a calendar month, or other regular period agreed upon by the seller and the buyer, in which there is any unpaid balance thereunder, which shall recite the following: (a) The unpaid balance under the revolving charge agreement at the beginning and end of the period; (b) unless otherwise furnished by the seller to the buyer by sales slip, memorandum, or otherwise, a description or identification of the goods or services purchased, the cash price, and the date of each purchase; (c) the payments made by the buyer to the seller and any other credits to the buyer during the period; (d) the amount of the time-price differential, if any; and (e) a legend to the effect that the buyer may at any time pay the total balance or any portion thereof. The items need not be stated in the sequence or order set forth in this subsection and additional items may be included to explain the computations made in determining the amount to be paid by the buyer. Compliance with the applicable disclosure requirements of the federal regulations which implement the

federal Consumer Credit Protection Act shall be deemed compliance with this section.

(2) If the amount owed under a revolving charge agreement has been paid in full and has been inactive for at least twenty-four months, the seller shall mark the revolving charge agreement as closed or paid in full. The seller shall give written notice to the buyer of the closed or paid-in-full status of the revolving charge agreement within forty-five days after the seller has so marked the revolving charge agreement.

Source: Laws 1965, c. 267, § 3, p. 754; Laws 1984, LB 736, § 4; Laws 2004, LB 999, § 33.

45-207 Time-price differential; rate; maximum.

Notwithstanding the provisions of any other law, the seller or assignee under a revolving charge agreement may charge, receive, and collect a time-price differential which shall not exceed the following rate: One and three-quarters percent per month on amounts less than five hundred dollars, and one and one-half percent per month on amounts of five hundred dollars or more. The rate shall be computed on the unpaid balance under the agreement from month to month, which need not be a calendar month, or other period as agreed, except that no time-price differential shall be assessed on an account if payment of the outstanding balance is received prior to the beginning of the next billing cycle under the agreement.

Source: Laws 1965, c. 267, § 4, p. 755; Laws 1977, LB 40, § 253; Laws 1980, LB 308, § 1; Laws 1984, LB 736, § 5.

45-208 Violations; penalty.

Any person who willfully and knowingly violates any provisions of section 45-207 shall be guilty of a Class II misdemeanor. In addition the seller shall forfeit all time-price differential paid and cancel the outstanding indebtedness.

Source: Laws 1965, c. 267, § 5, p. 755; Laws 1977, LB 40, § 253.

45-209 Prohibited acts.

No person shall purchase securities, deposit funds, or make investments under a revolving charge agreement.

Source: Laws 1984, LB 736, § 2.

ARTICLE 3

INSTALLMENT SALES

Section
45-301. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-302. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-303. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-304. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-305. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-306. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-307. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-308. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-309. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-310. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-311. Repealed. Laws 1963, c. 270, § 21, p. 817.

Section
45-312. Repealed. Laws 1963, c. 270, § 21, p. 817.
45-313. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-314. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-315. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-316. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-317. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-318. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-319. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-320. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-321. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-322. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-323. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-324. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-325. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-326. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-327. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-328. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-329. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-330. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-331. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-332. Repealed. Laws 1965, c. 268, § 22, p. 768.
45-333. Transferred to section 45-408.
45-334. Act, how cited.
45-335. Terms, defined.
45-336. Installment contract; requirements.
45-337. Insurance; policy; cancellation; premium refund; fee.
45-338. Installment contract; time-price differential; rate; maximum; origination fee.
45-339. Subsequent purchases; consolidate with previous contract; requirements.
45-340. Contracts negotiated by mail; requirements.
45-341. Delinquency charges; limitation; fee.
45-342. Prepayment; rebate; how computed.
45-343. Failure to obtain license; penalty.
45-344. Excess charges; penalty.
45-345. License; requirement; exception.
45-346. License; application; contents; issuance; bond; fee; term; director; duties.
45-346.01. Licensee; move of main office; notice to director; maintain minimum net worth; bond.
45-347. Fees; disposition.
45-348. License; renewal; licensee; duties; fee; voluntary surrender of license.
45-349. Repealed. Laws 1983, LB 447, § 104.
45-350. License; denial of renewal; suspension; revocation; appeal.
45-351. Licensee; investigation and inspection; director; appoint examiners; charges; fines; lien.
45-351.01. Holder of contract; extension or deferment authorized; fee.
45-352. Rules and regulations; adopt.
45-353. Violations; enforcement; receiver; appointment; powers; duties.
45-354. Nationwide Mortgage Licensing System and Registry; department; participation; requirements; director; duties; department; duties.
45-355. Nationwide Mortgage Licensing System and Registry; information sharing; director; powers.
45-356. Acquisition of licensee; notice; filing fee; director; duties; disapproval; grounds; notice; hearing.

45-301 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-302 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-303 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-304 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-305 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-306 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-307 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-308 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-309 Repealed. Laws 1963, c. 270, § 21, p. 817.

45-310 Repealed. Laws 1963, c. 270, § 21, p. 817.

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45-313 Repealed. Laws 1965, c. 268, § 22, p. 768.

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45-318 Repealed. Laws 1965, c. 268, § 22, p. 768.

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45-320 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-321 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-322 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-323 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-324 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-325 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-326 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-327 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-328 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-329 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-330 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-331 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-332 Repealed. Laws 1965, c. 268, § 22, p. 768.

45-333 Transferred to section 45-408.

45-334 Act, how cited.

Sections 45-334 to 45-356 shall be known and may be cited as the Nebraska Installment Sales Act.

Source: Laws 1965, c. 268, § 1, p. 756; Laws 1994, LB 979, § 11; Laws 2007, LB124, § 31; Laws 2012, LB965, § 1; Laws 2016, LB778, § 3.

Installment Sales Act of 1965 sustained as constitutional. Engelmeyer v. Murphy, 180 Neb. 295, 142 N.W.2d 342 (1966).

45-335 Terms, defined.

For purposes of the Nebraska Installment Sales Act, unless the context otherwise requires:

(1) Goods means all personal property, except money or things in action, and includes goods which, at the time of sale or subsequently, are so affixed to realty as to become part thereof whether or not severable therefrom;

(2) Services means work, labor, and services of any kind performed in conjunction with an installment sale but does not include services for which the prices charged are required by law to be established and regulated by the government of the United States or any state;

(3) Buyer means a person who buys goods or obtains services from a seller in an installment sale;

(4) Seller means a person who sells goods or furnishes services to a buyer under an installment sale;

(5) Installment sale means any transaction, whether or not involving the creation or retention of a security interest, in which a buyer acquires goods or services from a seller pursuant to an agreement which provides for a time-price differential and under which the buyer agrees to pay all or part of the time-sale price in one or more installments and within one hundred forty-five months, except that installment contracts for the purchase of mobile homes may exceed such one-hundred-forty-five-month limitation. Installment sale does not include a consumer rental purchase agreement defined in and regulated by the Consumer Rental Purchase Agreement Act;

(6) Installment contract means an agreement entered into in this state evidencing an installment sale except those otherwise provided for in separate acts;

(7) Cash price or cash sale price means the price stated in an installment contract for which the seller would have sold or furnished to the buyer and the buyer would have bought or acquired from the seller goods or services which are the subject matter of the contract if such sale had been a sale for cash instead of an installment sale. It may include the cash price of accessories or services related to the sale such as delivery, installation, alterations, modifications, and improvements and may include taxes to the extent imposed on the cash sale;

(8) Basic time price means the cash sale price of the goods or services which are the subject matter of an installment contract plus the amount included therein, if a separate identified charge is made therefor and stated in the contract, for insurance, registration, certificate of title, debt cancellation contract, debt suspension contract, electronic title and lien services, guaranteed asset protection waiver, and license fees, filing fees, an origination fee, and fees and charges prescribed by law which actually are or will be paid to public

officials for determining the existence of or for perfecting, releasing, or satisfying any security related to the credit transaction or any charge for nonfiling insurance if such charge does not exceed the amount of fees and charges prescribed by law which would have been paid to public officials for filing, perfecting, releasing, and satisfying any security related to the credit transaction and less the amount of the buyer's downpayment in money or goods or both;

(9) Time-price differential, however denominated or expressed, means the amount, as limited in the Nebraska Installment Sales Act, to be added to the basic time price;

(10) Time-sale price means the total of the basic time price of the goods or services, the amount of the buyer's downpayment in money or goods or both, and the time-price differential;

(11) Sales finance company means a person purchasing one or more installment contracts from one or more sellers or acquiring any rights of ownership, servicing, or other forms of participation in or otherwise engaging with a consumer on behalf of the purchaser of one or more installment sales contracts from one or more sellers. Sales finance company includes, but is not limited to, a financial institution or installment loan licensee, if so engaged;

(12) Department means the Department of Banking and Finance;

(13) Director means the Director of Banking and Finance;

(14) Financial institution has the same meaning as in section 8-101.03;

(15) Debt cancellation contract means a loan term or contractual arrangement modifying loan terms under which a financial institution or licensee agrees to cancel all or part of a buyer's obligation to repay an extension of credit from the financial institution or licensee upon the occurrence of a specified event. The debt cancellation contract may be separate from or a part of other loan documents. The term debt cancellation contract does not include loan payment deferral arrangements in which the triggering event is the buyer's unilateral election to defer repayment or the financial institution's or licensee's unilateral decision to allow a deferral of repayment;

(16) Debt suspension contract means a loan term or contractual arrangement modifying loan terms under which a financial institution or licensee agrees to suspend all or part of a buyer's obligation to repay an extension of credit from the financial institution or licensee upon the occurrence of a specified event. The debt suspension contract may be separate from or a part of other loan documents. The term debt suspension contract does not include loan payment deferral arrangements in which the triggering event is the buyer's unilateral election to defer repayment or the financial institution's or licensee's unilateral decision to allow a deferral of repayment;

(17) Guaranteed asset protection waiver means a waiver that is offered, sold, or provided in accordance with the Guaranteed Asset Protection Waiver Act;

(18) Licensee means any person who obtains a license under the Nebraska Installment Sales Act;

(19) Person means individual, partnership, limited liability company, association, financial institution, trust, corporation, and any other legal entity;

(20) Breach of security of the system means unauthorized acquisition of data that compromises the security, confidentiality, or integrity of the information

maintained by the Nationwide Mortgage Licensing System and Registry, its affiliates, or its subsidiaries;

(21) Nationwide Mortgage Licensing System and Registry means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators for the licensing and registration of mortgage loan originators, mortgage bankers, installment loan companies, and other state-regulated financial services entities and industries;

(22)(a) Control in the case of a corporation means (i) direct or indirect ownership of or the right to control twenty-five percent or more of the voting shares of the corporation or (ii) the ability of a person or group acting in concert to elect a majority of the directors or otherwise effect a change in policy.

(b) Control in the case of any other entity means (i) the power, directly or indirectly, to direct the management or policies of the entity, (ii) the contribution of twenty-five percent or more of the capital of the entity, or (iii) the right to receive, upon dissolution, twenty-five percent or more of the capital of the entity; and

(23) Branch office means any location, other than the main office location, at which the business of a licensee is to be conducted, including (a) any offices physically located in Nebraska, and (b) any offices that, while not physically located in this state, intend to transact business with Nebraska residents.

Source: Laws 1965, c. 266, § 1, p. 751; Laws 1965, c. 268, § 2, p. 757; Laws 1969, c. 379, § 1, p. 1340; Laws 1969, c. 380, § 1, p. 1343; Laws 1969, c. 381, § 1, p. 1345; Laws 1973, LB 455, § 1; Laws 1978, LB 373, § 1; Laws 1989, LB 94, § 1; Laws 1989, LB 681, § 16; Laws 1992, LB 269, § 1; Laws 2003, LB 217, § 34; Laws 2006, LB 876, § 25; Laws 2010, LB571, § 8; Laws 2011, LB77, § 1; Laws 2012, LB965, § 2; Laws 2016, LB778, § 4; Laws 2017, LB140, § 153; Laws 2019, LB355, § 2; Laws 2021, LB363, § 25. Effective date March 18, 2021.

Cross References

Consumer Rental Purchase Agreement Act, see section 69-2101.
Guaranteed Asset Protection Waiver Act, see section 45-1101.

Classification made by this section is very comprehensive and covers almost all installment sales. Engelmeyer v. Murphy, 180 Neb. 295, 142 N.W.2d 342 (1966).

45-336 Installment contract; requirements.

(1) Each retail installment contract shall be in writing, shall be signed by both the buyer and the seller, and shall contain the following items and a copy thereof shall be delivered to the buyer at the time the instrument is signed, except for contracts made in conformance with section 45-340: (a) The cash sale price; (b) the amount of the buyer's downpayment, and whether made in money or goods, or partly in money and partly in goods, including a brief description of any goods traded in; (c) the difference between subdivisions (a) and (b) of this subsection; (d) the amount included for insurance if a separate charge is made therefor, specifying the types of coverages; (e) the amount included for a debt cancellation contract or a debt suspension contract if the debt cancellation contract or debt suspension contract is a contract of a

financial institution or licensee, such contract is sold directly by such financial institution or licensee or by an unaffiliated, nonexclusive agent of such financial institution or licensee in accordance with 12 C.F.R. part 37, as such part existed on January 1, 2011, and the financial institution or licensee is responsible for the unaffiliated, nonexclusive agent's compliance with such part, and a separate charge is made therefor; (f) the amount included for electronic title and lien services other than fees and charges prescribed by law which actually are or will be paid to public officials for determining the existence of or for perfecting, releasing, or satisfying any security related to the credit transaction; (g) the basic time price, which is the sum of subdivisions (c), (d), (e), and (f) of this subsection; (h) the time-price differential; (i) the amount of the time-price balance, which is the sum of subdivisions (g) and (h) of this subsection, payable in installments by the buyer to the seller; (j) the number, amount, and due date or period of each installment; (k) the time-sales price; and (l) the amount included for a guaranteed asset protection waiver.

(2) The contract shall contain substantially the following notice: NOTICE TO THE BUYER. DO NOT SIGN THIS CONTRACT BEFORE YOU READ IT OR IF IT CONTAINS BLANK SPACES. YOU ARE ENTITLED TO A COPY OF THE CONTRACT YOU SIGN.

(3) The items listed in subsection (1) of this section need not be stated in the sequence or order set forth in such subsection. Additional items may be included to explain the computations made in determining the amount to be paid by the buyer. No installment contract shall be signed by the buyer or proffered by seller when it contains blank spaces to be filled in after execution, except that if delivery of the goods or services is not made at the time of the execution of the contract, the identifying numbers or marks of the goods, or similar information, and the due date of the first installment may be inserted in the contract after its execution.

(4) If a seller proffers an installment contract as part of a transaction which delays or cancels, or promises to delay or cancel, the payment of the time-price differential on the contract if the buyer pays the basic time price, cash price, or cash sale price within a certain period of time, the seller shall, in clear and conspicuous writing, either within the installment contract or in a separate document, inform the buyer of the exact date by which the buyer must pay the basic time price, cash price, or cash sale price in order to delay or cancel the payment of the time-price differential. The seller or any subsequent purchaser of the installment contract, including a sales finance company, shall not be allowed to change such date.

(5) Upon written request from the buyer, the holder of an installment contract shall give or forward to the buyer a written statement of the dates and amounts of payments and the total amount unpaid under such contract. A buyer shall be given a written receipt for any payment when made in cash.

(6) After payment of all sums for which the buyer is obligated under a contract, the holder shall deliver or mail to the buyer at his or her last-known address one or more good and sufficient instruments or copies thereof to acknowledge payment in full and shall release all security in the goods and mark canceled and return to the buyer the original agreement or copy thereof or instruments or copies thereof signed by the buyer. For purposes of this section, a copy shall meet the requirements of section 25-12,112.

Source: Laws 1965, c. 268, § 3, p. 758; Laws 1994, LB 979, § 12; Laws 1994, LB 980, § 3; Laws 1999, LB 396, § 28; Laws 2006, LB 876, § 26; Laws 2010, LB571, § 9; Laws 2011, LB77, § 2.

45-337 Insurance; policy; cancellation; premium refund; fee.

(1) The amount, if any, included for insurance, which may be purchased by the holder of the contract, shall not exceed the applicable premium rates chargeable in accordance with filings, if any, with the Department of Insurance. If dual interest insurance on the goods is purchased by the holder it shall, within thirty days after execution of the installment contract, send or cause to be sent to the buyer a policy or policies or certificate of insurance, written by an insurance company authorized to do business in this state, clearly setting forth the amount of the premium, the kind or kinds of insurance, the coverages, and all the terms and conditions of the contract or contracts of insurance.

(2) If any insurance is canceled or the premium adjusted during the term of the installment contract, any refund of the insurance premium plus the unearned time-price differential thereon received by the holder shall be credited by the holder to the last maturing installment of the contract except to the extent applied toward payment for similar insurance protecting the interests of the buyer and the holder or either of them.

(3) If any insurance is canceled due to the payment of all sums for which the buyer is liable under an installment contract, the holder of the installment contract shall, upon receipt of payment of all sums due, send notice to the buyer within fifteen business days of the name, address, and telephone number of the insurance company which issued the insurance contract or the party responsible for any refund, and notice that the buyer may be eligible for a refund. A copy of such notice shall be retained by the holder of the installment contract. This subsection does not apply if the holder of the loan contract previously credited the refund of the insurance premium to the loan contract or otherwise refunded the insurance premium to the buyer.

(4) The holder may also purchase nonfiling insurance and charge a reasonable fee. The fee shall not exceed the amount of fees and charges prescribed by law which would have been paid to public officials for filing, perfecting, releasing, and satisfying any lien or security interest in the goods or services.

Source: Laws 1965, c. 268, § 4, p. 759; Laws 1989, LB 94, § 2; Laws 2000, LB 932, § 32; Laws 2002, LB 957, § 21.

45-338 Installment contract; time-price differential; rate; maximum; origination fee.

(1)(a) Notwithstanding the provisions of any other law, the time-price differential for any goods or services sold under an installment contract shall be stated as a fixed or variable annual percentage rate and shall be at a rate agreed to in writing, not to exceed eighteen percent per annum, except that a minimum time-price differential of ten dollars may be charged on any installment contract.

(b)(i) A buyer may be required, upon the execution of the installment contract, to pay an origination fee of not to exceed ten dollars, except that if the installment contract is for an installment sale of agricultural machinery or equipment for use in commercial agriculture or if the installment contract is for an installment sale of industrial machinery or equipment the buyer may be required to pay (A) an origination fee of not to exceed one hundred dollars if the cash sale price is less than twenty-five thousand dollars or (B) an origination fee of not to exceed two hundred fifty dollars if the cash sale price is twenty-five thousand dollars or more.

(ii) The origination fee shall be refundable if the installment contract is canceled during the first thirty days. The origination fee may be collected from the buyer or included in the principal balance of the installment contract at the time the contract is made and shall not be considered interest or a time-price differential.

(c) Nothing in the Nebraska Installment Sales Act prohibits a seller or holder of an installment contract from contracting for, computing, and charging a time-price differential based upon the application of the rate charged to the unpaid principal balance for the number of days actually elapsed. The charges so computed shall be used for the purpose of calculating the time-price differential, the time-price balance, the amount of each installment, and the time-sale price.

(d) When the installment contract is payable in substantially equal and consecutive monthly installments, the time-price differential shall be computed on the basic time price of each contract, as determined under the provisions of section 45-336, from the date of the contract until the due date of the final installment, notwithstanding that the time-price balance is required to be paid in installments.

(2) When an installment contract provides for payment other than in substantially equal and consecutive monthly installments, the time-price differential may be at a rate which will provide the same return as is permitted on substantially equal monthly payment contracts under subdivision (1)(d) of this section, having due regard for the schedule of payments.

(3) Every contract payable in two or more installments shall provide for payment of such installments by stating the date and amount of each installment or the method by which any variable rate or installment shall be determined.

Source: Laws 1965, c. 268, § 5, p. 760; Laws 1969, c. 379, § 2, p. 1342; Laws 1975, LB 163, § 1; Laws 1979, LB 478, § 1; Laws 1979, LB 492, § 1; Laws 1980, LB 276, § 9; Laws 1986, LB 143, § 2; Laws 1992, LB 269, § 2; Laws 2001, LB 146, § 1; Laws 2003, LB 71, § 1.

45-339 Subsequent purchases; consolidate with previous contract; requirements.

Where a buyer makes any subsequent purchases of goods or services from a seller from whom he has previously purchased goods or services under one or more installment contracts and the amounts under such contract or contracts to the extent of cash sale price thereof have not been fully paid the subsequent purchases may be included in and consolidated with one or more of the prior contract or contracts. A memorandum of such additional purchases shall be prepared by the seller and inserted in or attached to the seller's counterpart of the contract and shall set forth:

(1) The names of the seller and the buyer and a description of the additional goods or services sold and all the information with respect to the additional purchase required by section 45-336 to be included in an installment contract;

(2) The consolidated time-price balance to be paid by the buyer; and

(3) The revised payments.

A copy of such memorandum shall be delivered to the buyer as provided in and subject to the provisions of section 45-336. When such subsequent purchases are made, the entire amount of all payments made prior to such subsequent purchases shall be deemed to have been applied on previous purchases.

Each payment thereafter made on a consolidated installment contract shall be deemed to be allocated to all of the various purchases in the same ratio or proportion as the original cash sale prices of the various purchases bear to one another. Where the amount of each deferred payment is increased in connection with such subsequent purchase, the subsequent payments, at the seller's option, may be deemed to be allocated as follows: An amount equal to the original installment payment to the previous purchase, the balance to the subsequent purchase. The amount of any initial payment or downpayment on the subsequent purchase shall be allocated in its entirety to such subsequent purchase. The provisions of this section shall not apply to cases involving equipment, parts, or to other merchandise attached or affixed to goods previously purchased, or to repairs or services in connection therewith rendered by the seller at the buyer's request.

Source: Laws 1965, c. 268, § 6, p. 761.

45-340 Contracts negotiated by mail; requirements.

Installment contracts negotiated and entered into by mail without personal solicitation by salespersons or other representatives of the seller and based upon the catalog of the seller or other printed solicitation of business, which is distributed and made available generally to the public, if such catalog or other printed solicitation clearly sets forth the cash and time-sale prices and other terms of sales to be made through such medium, may be made as provided in this section. All provisions of the Nebraska Installment Sales Act shall apply to such sales except that the seller shall not be required to deliver a copy of the contract to the buyer as provided in section 45-336 and if the contract when received by the seller contains any blank spaces the seller may insert in the appropriate blank space the amounts of money and other terms which are set forth in the seller's catalog or other printed solicitation which is then in effect. In lieu of sending the buyer a copy of the contract as provided in section 45-336, the seller shall furnish to the buyer a written statement of any items inserted in the blank spaces in the contract received from the buyer.

Source: Laws 1965, c. 268, § 7, p. 762; Laws 2007, LB124, § 32; Laws 2019, LB355, § 3.

45-341 Delinquency charges; limitation; fee.

An installment contract may provide and the holder thereof may collect, in addition to any time-price differential, a delinquency charge on each installment in default for a period of not less than fifteen days, if provided for in the contract, not in excess of five percent of each installment or twenty-five dollars, whichever is less, or, in lieu thereof, interest after maturity on each such installment not exceeding the highest permissible contract rate. If the time-price differential is computed by application of the rate charged to the unpaid principal balance for the number of days actually elapsed, such delinquency charge may not exceed five percent of each installment or twenty-five dollars, whichever is less. If any installment payment is made by a check, draft, or

similar signed order which is not honored because of insufficient funds, no account, or any other reason except an error of a third party to the contract, the holder may charge and collect a fee of not more than fifteen dollars. The delinquency charge and such fee may be collected when due or at any time thereafter.

When an installment contract is for a commercial or business purpose (1) a delinquency charge not to exceed five percent of each unpaid installment may be contracted for and received and (2) the holder of any check or draft or similar order which is not honored for any reason, except for error of a third party, may charge and collect a fee as stated in the contract. As used in this section, commercial or business purpose means primarily for a purpose other than a personal, family, or household purpose.

Source: Laws 1965, c. 268, § 8, p. 762; Laws 1979, LB 478, § 2; Laws 1989, LB 94, § 3; Laws 1995, LB 339, § 1.

45-342 Prepayment; rebate; how computed.

(1) Notwithstanding the provisions of any contract to the contrary, any buyer may prepay in full at any time before maturity the obligation of any contract.

(2) If such obligation is prepaid in full by cash, a new loan, or otherwise after the first installment due date, the borrower shall receive a rebate of an amount which shall be not less than the amount obtained by applying to the unpaid principal balances as originally scheduled or, if deferred, as deferred, for the period following prepayment, according to the actuarial method, the rate of the time-price differential previously stated to the borrower. The licensee may round the rate of the time-price differential to the nearest one-half of one percent if such procedure is not consistently used to obtain a greater yield than would otherwise be permitted. Any default and deferment charges which are due and unpaid may be deducted from any rebate. No rebate shall be required for any partial prepayment. No rebate of less than one dollar need be made. Acceleration of the maturity of the contract shall not in itself require a rebate. If judgment is obtained before the final installment date, the contract balance shall be reduced by the rebate which would be required for prepayment in full as of the date judgment is obtained.

Source: Laws 1965, c. 268, § 9, p. 762; Laws 1979, LB 478, § 3; Laws 1980, LB 279, § 8; Laws 1981, LB 214, § 6; Laws 1992, LB 269, § 3; Laws 2004, LB 999, § 34.

45-343 Failure to obtain license; penalty.

Any person who violates any provision of the Nebraska Installment Sales Act or acts as a sales finance company in this state without a license therefor as provided in the Nebraska Installment Sales Act shall be guilty of a Class II misdemeanor.

Source: Laws 1965, c. 268, § 10, p. 763; Laws 1977, LB 40, § 254; Laws 2003, LB 217, § 35.

45-344 Excess charges; penalty.

If any seller or sales finance company, in the making or collection of an installment contract, shall, directly or indirectly, contract for, take, or receive charges in excess of those authorized by the Nebraska Installment Sales Act

except as a result of an accidental and bona fide error such contract shall be void and uncollectible as to (1) all of the excessive portion of the time-price differential, (2) the first one thousand dollars of the time-price differential authorized by section 45-338, and (3) the first four thousand dollars of the principal of the contract. If any seller or sales finance company violates any provision of the act, other than the violations described above, except as a result of an accidental and bona fide error, such installment contract shall be void and uncollectible as to the first five hundred dollars of the time-price differential and the first one thousand dollars of the principal of such contract. If any of such money has been paid by the buyer, such buyer or his or her assignee may recover under the act in a civil suit brought within one year after the due date, or any extension thereof, of the last installment of the contract.

Source: Laws 1965, c. 268, § 11, p. 763; Laws 2007, LB124, § 33.

Installment contract provision for attorney fees ''to the extent permitted by law,'' which were not collected, and interest charged for extension of contract were not violations of this act. Watson v. Avco Financial Servs., 224 Neb. 778, 401 N.W.2d 485 (1987).

Although called a lease agreement, the contract involved in this case was actually for an installment sale and, therefore, subject to the provisions of this section. Humber v. Gibreal Auto Sales, Inc., 207 Neb. 286, 298 N.W.2d 363 (1980).

45-345 License; requirement; exception.

(1) No person shall act as a sales finance company in this state without obtaining a license therefor from the department as provided in the Nebraska Installment Sales Act whether or not such person maintains an office, place of doing business, or agent in this state, unless such person meets the requirements of section 45-340.

(2) No financial institution or installment loan licensee authorized to do business in this state shall be required to obtain a license under the act but shall comply with all of the other provisions of the act.

(3) A seller who does not otherwise act as a sales finance company shall not be required to obtain a license under the act but shall comply with all of the other provisions of the act in order to charge the time-price differential allowed by section 45-338.

Source: Laws 1965, c. 268, § 12, p. 763; Laws 1973, LB 39, § 4; Laws 1996, LB 1053, § 10; Laws 2003, LB 131, § 28; Laws 2003, LB 217, § 36; Laws 2012, LB965, § 3.

45-346 License; application; contents; issuance; bond; fee; term; director; duties.

(1) A license issued under the Nebraska Installment Sales Act is nontransferable and nonassignable. The same person may obtain additional licenses for each place of business operating as a sales finance company in this state upon compliance with the act as to each license, except that on or after January 1, 2020, a person is no longer required to obtain a new license for each place of business and may maintain a branch office or offices upon compliance with the act.

(2) Application for a license shall be on a form prescribed and furnished by the director and shall include, but not be limited to, (a) the applicant's name and any trade name or doing business as designation which the applicant intends to use in this state, (b) the applicant's main office address, (c) all branch office addresses at which business is to be conducted, (d) the names and titles of each director and principal officer of the applicant, (e) the names of all

shareholders, partners, or members of the applicant, (f) a description of the activities of the applicant in such detail as the department may require, (g) if the applicant is an individual, his or her social security number, and (h) audited financial statements showing a minimum net worth of one hundred thousand dollars.

(3) An applicant for a license shall file with the department a surety bond in the amount of fifty thousand dollars, furnished by a surety company authorized to do business in this state. Such bond shall be increased by an additional fifty thousand dollars for each branch location of the applicant that is licensed under the Nebraska Installment Sales Act. The bond shall be for the use of the State of Nebraska and any Nebraska resident who may have claims or causes of action against the applicant. The surety may cancel the bond only upon thirty days' written notice to the director.

(4) A license fee of one hundred fifty dollars, and, if applicable, a one-hundred-dollar fee for each branch office listed in the application, and any processing fee allowed under subsection (2) of section 45-354 shall be submitted along with each application.

(5) An initial license shall remain in full force and effect until the next succeeding December 31. Each license shall remain in force until revoked, suspended, canceled, expired, or surrendered.

(6) The director shall, after an application has been filed for a license under the act, investigate the facts, and if he or she finds that the experience, character, and general fitness of the applicant, of the members thereof if the applicant is a corporation or association, and of the officers and directors thereof if the applicant is a corporation, are such as to warrant belief that the business will be operated honestly, fairly, and efficiently within the purpose of the act, the director shall issue and deliver a license to the applicant to do business as a sales finance company in accordance with the license and the act. The director shall have the power to reject for cause any application for a license.

(7) The director shall, within his or her discretion, make an examination and inspection concerning the propriety of the issuance of a license to any applicant. The cost of such examination and inspection shall be borne by the applicant.

(8) If an applicant for a license under the act does not complete the license application and fails to respond to a notice or notices from the department to correct the deficiency or deficiencies for a period of one hundred twenty days or more after the date the department sends the initial notice to correct the deficiency or deficiencies, the department may deem the application as abandoned and may issue a notice of abandonment of the application to the applicant in lieu of proceedings to deny the application.

Source: Laws 1965, c. 268, § 13, p. 764; Laws 1997, LB 752, § 116; Laws 2004, LB 999, § 35; Laws 2005, LB 533, § 47; Laws 2007, LB124, § 34; Laws 2012, LB965, § 4; Laws 2016, LB778, § 5; Laws 2017, LB185, § 2; Laws 2019, LB355, § 4; Laws 2021, LB363, § 26.
Effective date March 18, 2021.

45-346.01 Licensee; move of main office; notice to director; maintain minimum net worth; bond.

(1) A licensee may move its main office from one place to another without obtaining a new license if the licensee gives notice thereof to the director through the Nationwide Mortgage Licensing System and Registry at least thirty days prior to such move.

(2) A licensee shall notify the director through the Nationwide Mortgage Licensing System and Registry at least thirty days prior to the occurrence of any of the following:

(a) The establishment of a new branch office. Notice of each such establishment shall be accompanied by a fee of one hundred dollars and any processing fee allowed under subsection (2) of section 45-354;

(b) The relocation or closing of an existing branch office; or

(c) A change of name, trade name, or doing business as designation.

(3) A licensee shall maintain the minimum net worth as required by section 45-346 while a license issued under the Nebraska Installment Sales Act is in effect. The minimum net worth shall be proven by an annual audit conducted by a certified public accountant. A licensee shall submit a copy of the annual audit to the director as required by section 45-348 or upon written request of the director. If a licensee fails to maintain the required minimum net worth, the department may issue a notice of cancellation of the license in lieu of revocation proceedings.

(4) The surety bond or a substitute bond as required by section 45-346 shall remain in effect while a license issued under the Nebraska Installment Sales Act is in effect. If a licensee fails to maintain a surety bond or substitute bond, the licensee shall immediately cease doing business and surrender the license to the department. If the licensee does not surrender the license, the department may issue a notice of cancellation of the license in lieu of revocation proceedings.

Source: Laws 2007, LB124, § 35; Laws 2009, LB327, § 17; Laws 2012, LB965, § 5; Laws 2019, LB355, § 5.

45-347 Fees; disposition.

All money collected under the authority of the Nebraska Installment Sales Act shall be remitted to the State Treasurer for credit to the Financial Institution Assessment Cash Fund.

Source: Laws 1965, c. 268, § 14, p. 764; Laws 1973, LB 39, § 5; Laws 1995, LB 599, § 13; Laws 2007, LB124, § 36.

45-348 License; renewal; licensee; duties; fee; voluntary surrender of license.

(1) An installment sales license may be renewed annually on or before December 31 by paying to the director a fee of one hundred fifty dollars, plus one hundred dollars for each branch office, if applicable, and any processing fee allowed under subsection (2) of section 45-354 and by submitting such information as the director may require to indicate any material change in the information contained in the original application or succeeding renewal applications, including a copy of the licensee's most recent annual audit.

(2) A licensee may voluntarily surrender a license at any time by delivering to the director written notice of the surrender. The department shall cancel the license following such surrender.

(3) If a licensee fails to renew its license and does not voluntarily surrender the license pursuant to this section, the department may issue a notice of expiration of the license to the licensee in lieu of revocation proceedings.

Source: Laws 1965, c. 268, § 15, p. 765; Laws 2005, LB 533, § 48; Laws 2009, LB327, § 18; Laws 2012, LB965, § 6; Laws 2016, LB778, § 6; Laws 2019, LB355, § 6.

45-349 Repealed. Laws 1983, LB 447, § 104.

45-350 License; denial of renewal; suspension; revocation; appeal.

(1) Renewal of a license originally granted under the Nebraska Installment Sales Act may be denied or a license may be suspended or revoked by the director on the following grounds: (a) Material misstatement in the application for license; (b) willful failure to comply with any provision of the Nebraska Installment Sales Act relating to installment contracts; (c) defrauding any buyer to the buyer's damage; or (d) fraudulent misrepresentation, circumvention, or concealment by the licensee through whatever subterfuge or device of any of the material particulars or the nature thereof required to be stated or furnished to the buyer under the Nebraska Installment Sales Act.

(2) If a licensee is a partnership, limited liability company, association, or corporation, it shall be sufficient cause for the suspension or revocation of a license that any officer, director, or trustee of a licensed association or corporation or any member of a licensed partnership or limited liability company has so acted or failed to act as would be cause for suspending or revoking a license to such party as an individual.

(3) No license shall be denied, suspended, or revoked except after hearing in accordance with the Administrative Procedure Act. The director shall give the licensee at least ten days' written notice, in the form of an order to show cause, of the time and place of such hearing by either registered or certified mail addressed to the principal place of business in this state of such licensee. Such notice shall contain the grounds of complaint against the licensee. Any order suspending or revoking such license shall recite the grounds upon which the same is based. The order shall be entered upon the records of the director and shall not be effective until after thirty days' written notice thereof given after such entry forwarded by either registered or certified mail to the licensee at such principal place of business.

(4) Revocation, suspension, cancellation, expiration, or surrender of any license shall not impair or affect the obligation of any lawful installment contract acquired previously thereto by the licensee.

(5) Revocation, suspension, cancellation, expiration, or surrender of any license shall not affect civil or criminal liability for acts committed before the revocation, suspension, cancellation, expiration, or surrender or affect liability for any fines which may be levied against the licensee or any of its officers, directors, shareholders, partners, or members pursuant to the Nebraska Installment Sales Act for acts committed before the revocation, suspension, cancellation, expiration, or surrender.

(6) Any person, licensee, or applicant considering himself or herself aggrieved by an order of the director entered under the provisions of this section

may appeal the order. The appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1965, c. 268, § 17, p. 766; Laws 1967, c. 276, § 3, p. 744; Laws 1988, LB 352, § 74; Laws 1993, LB 121, § 272; Laws 2005, LB 533, § 49.

Cross References

Administrative Procedure Act, see section 84-920.

45-351 Licensee; investigation and inspection; director; appoint examiners; charges; fines; lien.

(1) The department shall be charged with the duty of inspecting the business, records, and accounts of all persons who engage in the business of a sales finance company subject to the Nebraska Installment Sales Act. The director shall have the power to appoint examiners who shall, under his or her direction, investigate the installment contracts and business and examine the books and records of licensees when the director shall so determine. Such examinations shall not be conducted more often than annually except as provided in subsection (2) of this section.

(2) The director or his or her duly authorized representative shall have the power to make such investigations as he or she shall deem necessary, and to the extent necessary for this purpose, he or she may examine such licensee or any other person and shall have the power to compel the production of all relevant books, records, accounts, and documents.

(3) The expenses of the director incurred in the examination of the books and records of licensees shall be charged to the licensees as set forth in sections 8-605 and 8-606. The director may charge the costs of an investigation of a nonlicensed person to such person, and such costs shall be paid within thirty days after receipt of billing.

(4) Upon receipt by a licensee of a notice of investigation or inquiry request for information from the department, the licensee shall respond within twenty-one calendar days. Each day a licensee fails to respond as required by this subsection shall constitute a separate violation.

(5) If the director finds, after notice and opportunity for hearing in accordance with the Administrative Procedure Act, that any person has willfully and intentionally violated any provision of the Nebraska Installment Sales Act, any rule or regulation adopted and promulgated under the act, or any order issued by the director under the act, the director may order such person to pay (a) an administrative fine of not more than one thousand dollars for each separate violation and (b) the costs of investigation. The department shall remit fines collected under this subsection to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

(6) If a person fails to pay an administrative fine and the costs of investigation ordered pursuant to subsection (5) of this section, a lien in the amount of such fine and costs may be imposed upon all assets and property of such person in this state and may be recovered in a civil action by the director. The lien shall attach to the real property of such person when notice of the lien is filed and indexed against the real property in the office of the register of deeds in the county where the real property is located. The lien shall attach to any other property of such person when notice of the lien is filed against the property in

the manner prescribed by law. Failure of the person to pay such fine and costs shall constitute a separate violation of the Nebraska Installment Sales Act.

Source: Laws 1965, c. 268, § 18, p. 767; Laws 1994, LB 979, § 13; Laws 1997, LB 137, § 22; Laws 1999, LB 396, § 29; Laws 2004, LB 999, § 36; Laws 2007, LB124, § 37; Laws 2012, LB965, § 7.

Cross References

Administrative Procedure Act, see section 84-920.

45-351.01 Holder of contract; extension or deferment authorized; fee.

The holder of a retail installment contract may, upon agreement with the buyer:

(1) Extend the scheduled due date or defer the scheduled payment of any installment payment under the retail installment contract; and

(2) Charge and collect a reasonable flat service fee for such extension or deferment in addition to the time-price differential calculated for the period of such extension or deferment at the rate originally agreed upon in the retail installment contract on the outstanding balance.

Source: Laws 1994, LB 979, § 14.

45-352 Rules and regulations; adopt.

The director shall have the power to make such general rules and regulations and specific rulings, demands, and findings as may be necessary for the proper conduct of the business licensed under the Nebraska Installment Sales Act, and the enforcement of the act, in addition thereto and not inconsistent therewith.

Source: Laws 1965, c. 268, § 19, p. 767; Laws 2007, LB124, § 38.

45-353 Violations; enforcement; receiver; appointment; powers; duties.

(1) Whenever the director has reasonable cause to believe that any person is violating or is threatening to or intends to violate any of the provisions of the Nebraska Installment Sales Act, he or she may, in addition to all actions provided for in the act and without prejudice thereto, enter an order requiring such person to desist or to refrain from such violation. An action may also be brought, on the relation of the Attorney General or the director, to enjoin such person from engaging in or continuing such violation or from doing any act or acts in furtherance thereof.

(2) In any such action an order or judgment may be entered awarding such preliminary or final injunction as may be deemed proper. In addition to all other means provided by law for the enforcement of a restraining order or injunction, the court, in which such action is brought, shall have power and jurisdiction to impound and appoint a receiver for the property and business of the defendant, including books, papers, documents, and records pertaining thereto or so much thereof as the court may deem reasonably necessary to prevent violations of the Nebraska Installment Sales Act through or by means of the use of such property and business. Such receiver, when so appointed and qualified, shall have such powers and duties as to custody, collection, administration, winding up and liquidation of such property and business as shall, from time to time, be conferred upon him or her by the court.

Source: Laws 1965, c. 268, § 20, p. 767; Laws 2007, LB124, § 39.

45-354 Nationwide Mortgage Licensing System and Registry; department; participation; requirements; director; duties; department; duties.

(1) Effective January 1, 2013, or within one hundred eighty days after the Nationwide Mortgage Licensing System and Registry is capable of accepting licenses issued under the Nebraska Installment Sales Act, whichever is later, the department shall require such licensees under the act to be licensed and registered through the Nationwide Mortgage Licensing System and Registry. In order to carry out this requirement, the department is authorized to participate in the Nationwide Mortgage Licensing System and Registry. For this purpose, the department may establish, by adopting and promulgating rules and regulations or by order, requirements as necessary. The requirements may include, but not be limited to:

(a) Background checks of applicants and licensees, including, but not limited to:

(i) Criminal history through fingerprint or other databases;

(ii) Civil or administrative records;

(iii) Credit history; or

(iv) Any other information as deemed necessary by the Nationwide Mortgage Licensing System and Registry;

(b) The payment of fees to apply for or renew a license through the Nationwide Mortgage Licensing System and Registry;

(c) Compliance with prelicensure education and testing and continuing education;

(d) The setting or resetting, as necessary, of renewal processing or reporting dates; and

(e) Amending or surrendering a license or any other such activities as the director deems necessary for participation in the Nationwide Mortgage Licensing System and Registry.

(2) In order to fulfill the purposes of the Nebraska Installment Sales Act, the department is authorized to establish relationships or contracts with the Nationwide Mortgage Licensing System and Registry or other entities designated by the Nationwide Mortgage Licensing System and Registry to collect and maintain records and process transaction fees or other fees related to licensees or other persons subject to the act. The department may allow such system to collect licensing fees on behalf of the department and allow such system to collect a processing fee for the services of the system directly from each licensee or applicant for a license.

(3) The director is required to regularly report enforcement actions and other relevant information to the Nationwide Mortgage Licensing System and Registry subject to the provisions contained in section 45-355.

(4) The director shall establish a process whereby applicants and licensees may challenge information entered into the Nationwide Mortgage Licensing System and Registry by the director.

(5) The department shall ensure that the Nationwide Mortgage Licensing System and Registry adopts a privacy, data security, and breach of security of the system notification policy. The director shall make available upon written request a copy of the contract between the department and the Nationwide

Mortgage Licensing System and Registry pertaining to the breach of security of the system provisions.

(6) The department shall upon written request provide the most recently available audited financial report of the Nationwide Mortgage Licensing System and Registry.

Source: Laws 2012, LB965, § 8.

45-355 Nationwide Mortgage Licensing System and Registry; information sharing; director; powers.

(1) In order to promote more effective regulation and reduce the regulatory burden through supervisory information sharing:

(a) Except as otherwise provided in this section, the requirements under any federal or state law regarding the privacy or confidentiality of any information or material provided to the Nationwide Mortgage Licensing System and Registry, and any privilege arising under federal or state law, including the rules of any federal or state court, with respect to such information or material, shall continue to apply to such information or material after the information or material has been disclosed to the Nationwide Mortgage Licensing System and Registry. Such information and material may be shared with all federal and state regulatory officials with mortgage industry oversight authority without the loss of privilege or the loss of confidentiality protections provided by federal or state law;

(b) Information or material that is subject to privilege or confidentiality under subdivision (a) of this subsection shall not be subject to:

(i) Disclosure under any federal or state law governing the disclosure to the public of information held by an officer or an agency of the federal government or the respective state; or

(ii) Subpoena or discovery or admission into evidence in any private civil action or administrative process unless, with respect to any privilege held by the Nationwide Mortgage Licensing System and Registry with respect to such information or material, the person to whom such information or material pertains waives, in whole or in part, in the discretion of such person, that privilege;

(c) Any state statute relating to the disclosure of confidential supervisory information or any information or material described in subdivision (a) of this subsection that is inconsistent with such subdivision shall be superseded by the requirements of this section; and

(d) This section shall not apply with respect to the information or material relating to the employment history of, and publicly adjudicated disciplinary and enforcement actions against, applicants and licensees that is included in the Nationwide Mortgage Licensing System and Registry for access by the public.

(2) For these purposes, the director is authorized to enter into agreements or sharing arrangements with other governmental agencies, the Conference of State Bank Supervisors, the American Association of Residential Mortgage Regulators, or other associations representing governmental agencies as established by adopting and promulgating rules and regulations or an order of the director.

Source: Laws 2012, LB965, § 9.

45-356 Acquisition of licensee; notice; filing fee; director; duties; disapproval; grounds; notice; hearing.

(1) No person acting personally or as an agent shall acquire control of any licensee under the Nebraska Installment Sales Act without first (a) giving thirty days' notice to the department on a form prescribed by the department of such proposed acquisition and (b) paying a filing fee of one hundred fifty dollars and any processing fee allowed under subsection (2) of section 45-354.

(2) The director, upon receipt of such notice, shall act upon the acquisition within thirty days, and unless he or she disapproves of the proposed acquisition within such period of time, the acquisition shall become effective on the thirty-first day after receipt without the director's approval, except that the director may extend the thirty-day period an additional thirty days if, in his or her judgment, any material information submitted is substantially inaccurate or the acquiring party has not furnished all the information required by the department.

(3) An acquisition may become effective prior to the expiration of the disapproval period if the director issues written notice of his or her intent not to disapprove the action.

(4)(a) The director may disapprove any proposed acquisition if:

(i) The financial condition of any acquiring person is such as might jeopardize the financial stability of the acquired licensee;

(ii) The character and general fitness of any acquiring person or of any of the proposed management personnel indicate that the acquired installment sales licensee would not be operated honestly, fairly, or efficiently within the purpose of the Nebraska Installment Sales Act; or

(iii) Any acquiring person neglects, fails, or refuses to furnish all information required by the department.

(b) The director shall notify the acquiring party in writing of disapproval of the acquisition. The notice shall provide a statement of the basis for the disapproval.

(c) Within fifteen business days after receipt of written notice of disapproval, the acquiring party may make a written request for a hearing on the proposed acquisition in accordance with the Administrative Procedure Act and rules and regulations adopted and promulgated by the department under the Administrative Procedure Act. The director shall, by order, approve or disapprove the proposed acquisition on the basis of the record made at the hearing.

Source: Laws 2016, LB778, § 7.

Cross References

Administrative Procedure Act, see section 84-920.

ARTICLE 4
VALIDITY OF PURCHASE AGREEMENTS

Section
45-401. Repealed. Laws 1973, LB 3, § 1.
45-402. Repealed. Laws 1973, LB 3, § 1.
45-403. Repealed. Laws 1973, LB 3, § 1.
45-404. Repealed. Laws 1973, LB 3, § 1.
45-405. Repealed. Laws 1973, LB 3, § 1.

Section
45-406. Repealed. Laws 1973, LB 3, § 1.
45-407. Repealed. Laws 1973, LB 3, § 1.
45-408. Repealed. Laws 1989, LB 3, § 2.

45-401 Repealed. Laws 1973, LB 3, § 1.

45-402 Repealed. Laws 1973, LB 3, § 1.

45-403 Repealed. Laws 1973, LB 3, § 1.

45-404 Repealed. Laws 1973, LB 3, § 1.

45-405 Repealed. Laws 1973, LB 3, § 1.

45-406 Repealed. Laws 1973, LB 3, § 1.

45-407 Repealed. Laws 1973, LB 3, § 1.

45-408 Repealed. Laws 1989, LB 3, § 2.

ARTICLE 5
DISCLOSURE OF RATE OF CHARGE

Section
45-501. Repealed. Laws 1969, c. 45, § 3.
45-502. Repealed. Laws 1969, c. 45, § 3.

45-501 Repealed. Laws 1969, c. 45, § 3.

45-502 Repealed. Laws 1969, c. 45, § 3.

ARTICLE 6
COLLECTION AGENCIES

Section
45-601. Act, how cited; collection agency; license required; violation; penalty; foreign agency; communication authorized.
45-602. Terms, defined.
45-603. Collection Agency Licensing Board; created; members; term; expenses; employees; Secretary of State; duties.
45-604. Board; adopt rules and regulations.
45-605. Board; duties; application for license; filing; issuance; denial; appeal.
45-605.01. Nationwide Mortgage Licensing System and Registry; licensure and registration; requirements.
45-606. License; application; fees; financial statement; form.
45-607. License; qualifications of licensee.
45-608. Licensee; bond; conditions.
45-609. License; form; display.
45-610. Licensee; employees; solicitor's certificates; form.
45-611. Licenses; certificates; expiration; renewal; application; time.
45-612. Licensee; solicitor; violation; conviction; revocation; hearing; order.
45-613. Licensee; solicitor; complaint; citation; notice; hearing.
45-614. Licensee; solicitor; citation; power to issue subpoenas; depositions.
45-615. Licensee; solicitor; citation; hearing; board; findings; powers.
45-616. License; solicitor's certificate; appeals; procedure.
45-617. Licensee; solicitor's certificate; appeal; effect.
45-618. Licensee; change place of business; notify Secretary of State; new license; issuance; solicitor; employment terminated; return certificate.

45-601 Act, how cited; collection agency; license required; violation; penalty; foreign agency; communication authorized.

Sections 45-601 to 45-622 shall be known and may be cited as the Collection Agency Act.

No person, firm, corporation, or association shall conduct or operate a collection agency or do a collection agency business as defined in the act until he, she, or it has secured a license as provided in the act. Any person, firm, corporation, or association conducting or operating such a collection agency or doing such a collection agency business without a license shall be guilty of a Class III misdemeanor for each day that such unlawful business is conducted. Any officer or agent of a firm, corporation, or association who personally participates in any violation of the act shall be guilty of a Class III misdemeanor.

Nothing contained in this section shall be construed to require a regular employee of a collection agency duly licensed as such in this state to procure a collection agency license.

Nothing in the act shall be construed to prohibit a person, firm, corporation, or association regulated as a collection agency in another state and residing in another state from communicating with a debtor in this state.

Source: Laws 1963, c. 500, § 1, p. 1592; Laws 1977, LB 39, § 299; R.S.1943, (1981), § 81-8,158; Laws 1984, LB 471, § 1; Laws 1993, LB 261, § 1; Laws 2020, LB909, § 25.

Cross References

Exemptions from Credit Services Organization Act, see section 45-803.

Failure to report and pay collections made within specified time justified revocation of license. State ex rel. Hartman v. Weiss, 181 Neb. 685, 150 N.W.2d 264 (1967).

45-602 Terms, defined.

For purposes of the Collection Agency Act:

(1) Board means the Collection Agency Licensing Board;

(2) Collection agency means and includes:

(a) All persons, firms, corporations, and associations directly or indirectly engaged in soliciting, from more than one person, firm, corporation, or association, claims of any kind owed or due or asserted to be owed or due such solicited person, firm, corporation, or association, and all persons, firms, corporations, and associations directly or indirectly engaged in asserting, enforcing, or prosecuting such claims;

(b) Any person, firm, corporation, or association which, in attempting to collect or in collecting his, her, or its own accounts or claims, uses a fictitious name or any name other than his, her, or its own name which would indicate to the debtor that a third person is collecting or attempting to collect such account or claim; and

(c) Any person, firm, corporation, or association which attempts to or does give away or sell to any person, firm, corporation, or association, other than one licensed under the act, any system or series of letters or forms for use in the collection of accounts or claims which assert or indicate, directly or indirectly, that the claim or account is being asserted or collected by any other person, firm, corporation, or association other than the creditor or owner of the claim or demand;

(3) Collection agency does not mean or include (a) regular employees of a single creditor, (b) banks, (c) trust companies, (d) savings and loan associations, (e) building and loan associations, (f) abstract companies doing an escrow business, (g) duly licensed real estate brokers and agents when the claims or accounts being handled by such broker or agent are related to or are in connection with such brokers' or agents' regular real estate business, (h) express and telegraph companies subject to public regulation and supervision, (i) attorneys at law handling claims and collections in their own names and not operating a collection agency under the management of a layperson, (j) any person, firm, corporation, or association handling claims, accounts, or collections under an order or orders of any court, or (k) a person, firm, corporation, or association which, for valuable consideration, purchases accounts, claims, or demands of another and then, in such purchaser's own name, proceeds to assert or collect such accounts, claims, or demands; and

(4) Nationwide Mortgage Licensing System and Registry means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators for the licensing and registration of mortgage loan originators, mortgage bankers, installment loan companies, and other state-regulated financial services entities and industries.

Source: Laws 1963, c. 500, § 2, p. 1593; R.S.1943, (1981), § 81-8,159; Laws 1984, LB 471, § 2; Laws 1993, LB 261, § 2; Laws 2020, LB909, § 26.

45-603 Collection Agency Licensing Board; created; members; term; expenses; employees; Secretary of State; duties.

(1) There is hereby created the Collection Agency Licensing Board which shall consist of the Secretary of State, who shall be chairperson of the board, and four members appointed by the Governor. Three of the members appointed by the Governor shall be licensees actively engaged in the collection business in this state, one of whom shall reside in each of the state's three congressional districts. The remaining member shall be appointed at large as a representative of the public. Such person shall not be a licensee actively engaged in the collection business in this state.

(2) The term of office of each appointed member shall be for four years, except that of the members of the first board appointed under this section, two shall be appointed for a term of two years. Before a member's term expires, the Governor shall appoint a successor to take office on the expiration of the member's term. A member shall continue to serve after the expiration of his or her term until a successor is appointed and qualified. A vacancy in the office of a member shall be filled by appointment for the unexpired term.

(3) The members of the board shall be reimbursed for expenses as provided in sections 81-1174 to 81-1177.

(4) The board may employ such persons as may be necessary to carry out the Collection Agency Act, fix the salaries of such employees, and make such other expenditures as are necessary to properly carry out the act, except that all remuneration, expenses, salaries, and expenditures provided for in the act shall be paid out of the Secretary of State Cash Fund.

(5) The Secretary of State shall keep a record of all the proceedings, transactions, communications, and official acts performed pursuant to the act and perform such other duties as may be necessary to carry out the intent and purpose of the act.

Source: Laws 1963, c. 500, § 8, p. 1595; R.S.1943, (1981), § 81-8,165; Laws 1984, LB 471, § 4; Laws 1989, LB 3, § 1; Laws 1993, LB 261, § 3; Laws 2020, LB381, § 37; Laws 2020, LB910, § 13.

45-604 Board; adopt rules and regulations.

The board may enact rules and regulations relating to the administration of, but not inconsistent with, the Collection Agency Act.

Source: Laws 1963, c. 500, § 8, p. 1595; R.S.1943, (1981), § 81-8,165; Laws 1984, LB 471, § 4; Laws 1993, LB 261, § 4.

45-605 Board; duties; application for license; filing; issuance; denial; appeal.

The board shall be responsible for the administration of the Collection Agency Act. All applications for licenses provided for in the act shall be made to the board. If the applicant is an individual, the application shall include the applicant's social security number. The board shall investigate the qualifications of each applicant for a license. Based on the results of the investigation, the board may either issue a license to the applicant upon the payment of the license fee and any processing fee allowed under section 45-605.01 and the furnishing of the bond provided for in section 45-608 or refuse to issue such license. The action of the board may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1963, c. 500, § 9, p. 1595; R.S.1943, (1981), § 81-8,166; Laws 1984, LB 471, § 5; Laws 1988, LB 352, § 75; Laws 1993, LB 261, § 5; Laws 1997, LB 752, § 117; Laws 2020, LB909, § 27.

Cross References

Administrative Procedure Act, see section 84-920.

45-605.01 Nationwide Mortgage Licensing System and Registry; licensure and registration; requirements.

(1) Effective October 1, 2020, or within one year after the Nationwide Mortgage Licensing System and Registry is capable of processing licenses issued under the Collection Agency Act, whichever is later, the board, upon its discretion, may require licensees under the act to be licensed and registered through the Nationwide Mortgage Licensing System and Registry. In order to carry out this requirement, the board may participate in the Nationwide Mortgage Licensing System and Registry. For this purpose, the board may establish, by adopting and promulgating rules and regulations or by order, requirements as necessary. The requirements may include, but not be limited to:

(a) Any information as deemed necessary by the Nationwide Mortgage Licensing System and Registry;

(b) The payment of fees to apply for or renew a license provided for in sections 45-606 and 45-620 and any processing fee allowed under this section through the Nationwide Mortgage Licensing System and Registry;

(c) The setting or resetting, as necessary, of renewal processing or reporting dates; and

(d) Amending or surrendering a license or any other such activities as the board deems necessary for participation in the Nationwide Mortgage Licensing System and Registry.

(2) In order to fulfill the purposes of the Nebraska Collection Agency Act, the board may establish relationships or contracts with the Nationwide Mortgage Licensing System and Registry or other entities designated by the Nationwide Mortgage Licensing System and Registry to collect and maintain records and process transaction fees or other fees related to licensees or other persons subject to the act. The board may allow such system to collect licensing fees on behalf of the board and allow such system to collect a processing fee for the services of the system directly from each licensee or applicant for a license.

(3) The board shall regularly report enforcement actions and other relevant information to the Nationwide Mortgage Licensing System and Registry.

(4) The board shall establish a process whereby applicants and licensees may challenge information entered into the Nationwide Mortgage Licensing System and Registry by the board.

(5) The board shall ensure that the Nationwide Mortgage Licensing System and Registry adopts a privacy, data security, and breach of security of the system notification policy. The board shall make available upon written request a copy of the contract between the board and the Nationwide Mortgage Licensing System and Registry pertaining to the breach of security of the system provisions.

(6) Upon written request, the board shall provide the most recently available audited financial report of the Nationwide Mortgage Licensing System and Registry.

Source: Laws 2020, LB909, § 33.

45-606 License; application; fees; financial statement; form.

(1) Any person, firm, corporation, or association desiring to engage in this state in the collection business under the Collection Agency Act shall make written and sworn application for such license to the board upon a form to be prescribed by the board, which application shall be accompanied by an investigation fee of not to exceed two hundred fifty dollars and any processing fee allowed under section 45-605.01. The amount of the investigation fee shall be fixed by the board and shall not exceed the amount actually necessary to sustain the administration and enforcement of the act. Such application shall be accompanied by a duly verified financial statement of the applicant in form prescribed by the board. The Secretary of State shall remit the fees received pursuant to this section to the State Treasurer for credit to the Secretary of State Cash Fund.

(2) The board may require applicants to utilize the Nationwide Mortgage Licensing System and Registry or an entity designated by the Nationwide

Mortgage Licensing System and Registry for the processing of applications and fees.

Source: Laws 1963, c. 500, § 10, p. 1596; Laws 1974, LB 639, § 2; R.S.1943, (1981), § 81-8,167; Laws 1984, LB 471, § 6; Laws 1989, LB 206, § 1; Laws 1993, LB 261, § 6; Laws 2020, LB909, § 28; Laws 2020, LB910, § 14.

45-607 License; qualifications of licensee.

(1) The license provided for by section 45-606 shall be granted only to applicants who are trustworthy, who have a good reputation for honesty and fair dealings, who are financially responsible, and who are, in the opinion of the board, competent to engage in the collection of accounts and claims of others. No license shall be issued to a partnership, limited liability company, corporation, or association unless the manager or executive officer thereof has been engaged in the collection business either as owner, officer, partner, member, or employee of an established reputable collection agency for a period of at least two years, except that the board may, if satisfied that the applicant or the manager or executive officer thereof has had sufficient business experience to be fully competent to engage in the collection business without such previous collection experience, approve such application.

(2) No such license shall be issued to any person, firm, limited liability company, corporation, or association who or which is not a resident of this state or does not keep and maintain a regular office in this state in which are kept complete records of collections and claims handled by such person, firm, limited liability company, corporation, or association for creditors residing in this state and against debtors residing in this state, except that a foreign corporation or limited liability company duly authorized, admitted, and licensed to do business in this state may be issued such a license if it complies with all requirements of the Collection Agency Act, nor shall any license be issued to any person, firm, limited liability company, corporation, or association who or which or the principal officers of which have, within the past five years, been convicted in any court of fraud or have been convicted of or had judgment entered against them in any court for failure to account to their client or customer for money or property collected by them for such client or customer.

Source: Laws 1963, c. 500, § 11, p. 1596; R.S.1943, (1981), § 81-8,168; Laws 1984, LB 471, § 7; Laws 1993, LB 121, § 273; Laws 1993, LB 261, § 7.

45-608 Licensee; bond; conditions.

No license shall be issued under section 45-607 until the applicant has furnished a good and sufficient corporate surety bond in the sum of fifteen thousand dollars for those agencies or foreign corporations having sixteen or more licensed solicitors, ten thousand dollars for any agency having five to fifteen licensed solicitors, and five thousand dollars for any agency having less than five solicitors, payable to and approved by the board and conditioned that the licensee shall faithfully and truly perform all agreements entered into with the licensee's clients or customers and shall, within forty-five days after the close of each calendar month, report to and pay to his, her, or its client or customer the net proceeds of all collections made during the preceding calen-

dar month and due to each client or customer, which bond shall be in such form as approved by the board and shall be filed in the office of the Secretary of State. No person shall be required to post a bond in excess of one hundred thousand dollars.

An action may be brought in any court of competent jurisdiction upon such bond by any person to whom the licensee fails to account and pay as set forth in such bond or who has been damaged by failure of the licensee to comply with all agreements entered into with such person, except that the aggregate liability of the surety to all such persons shall, in no event, exceed the sum of such bond.

Source: Laws 1963, c. 500, § 12, p. 1597; R.S.1943, (1981), § 81-8,169; Laws 1984, LB 471, § 8; Laws 1993, LB 261, § 8.

45-609 License; form; display.

The license provided for in section 45-607 shall be in such form as prescribed by the board. If the licensee maintains a branch office, the licensee shall not do a collection agency business in such branch office until the licensee has secured a branch office certificate for such branch office. A licensee, so long as his, her, or its license is in full force and effect and in good standing, shall be entitled to branch office certificates for any branch offices operated by such licensee upon payment of the fee as set forth in section 45-620 and any processing fee allowed under section 45-605.01. A licensee shall display his, her, or its license in a conspicuous place in his, her, or its principal place of business, and if the licensee conducts a branch office, the branch office certificate shall be conspicuously displayed in the branch office.

Source: Laws 1963, c. 500, § 13, p. 1598; R.S.1943, (1981), § 81-8,170; Laws 1984, LB 471, § 9; Laws 1993, LB 261, § 9; Laws 2020, LB909, § 29.

45-610 Licensee; employees; solicitor's certificates; form.

The board shall, upon written application by a licensee and the payment of the fee as set forth in section 45-620 and any processing fee allowed under section 45-605.01, issue solicitor's certificates to employees of the licensee who solicit or collect accounts, which certificates shall be in such form as determined by the board. Such certificates shall entitle the solicitor named in the certificate to solicit and handle, for the licensee named in the certificate, collection agency business, accounts, and claims. Upon the termination of the employment of the solicitor by the licensee, such certificate shall become null and void and shall be returned by such solicitor to the licensee for cancellation by the board.

Source: Laws 1963, c. 500, § 14, p. 1598; R.S.1943, (1981), § 81-8,171; Laws 1984, LB 471, § 10; Laws 1993, LB 261, § 10; Laws 2020, LB909, § 30.

45-611 Licenses; certificates; expiration; renewal; application; time.

(1) All licenses and certificates issued under the Collection Agency Act shall expire on December 31 following the date of issuance unless renewed as provided in this section prior to such date. All branch office certificates and solicitor's certificates shall continue in full force and effect only so long as the license under which they are issued is in full force and effect.

(2) Each licensee shall, if he or she desires to have his or her license renewed, make application to the board for such renewal on or before December 31 of each year and shall, with such application, furnish the bond required by section 45-608 or furnish evidence of the continuation in effect of the prior bond so furnished and pay the renewal fee provided for in section 45-620 and any processing fee allowed under section 45-605.01.

(3) If an application for renewal of a license is denied, the applicant may appeal from such refusal the same as from the refusal to issue an original license.

(4) Upon renewal of a license, the board shall issue to the licensee a new license or a certificate of renewal of the previous license in such form as the board determines. Upon the renewal of a license, the licensee may, if the licensee maintains a branch office, secure a renewal of his, her, or its branch office certificate upon payment of the renewal fee provided for in section 45-620 and any processing fee allowed under section 45-605.01. Such licensee may also secure renewals of his, her, or its solicitor's certificates upon payment of the renewal fee provided for in section 45-620 and any processing fee allowed under section 45-605.01.

Source: Laws 1963, c. 500, § 15, p. 1598; R.S.1943, (1981), § 81-8,172; Laws 1984, LB 471, § 11; Laws 1993, LB 261, § 11; Laws 2020, LB909, § 31.

45-612 Licensee; solicitor; violation; conviction; revocation; hearing; order.

Upon final conviction of any licensee or solicitor by any court in Nebraska of fraud or embezzlement or upon final judgment against such licensee or solicitor in any court in Nebraska for fraud or embezzlement or for failure to account to his, her, or its client or customer within the time provided for in section 45-608 or upon the termination of the bond furnished by the licensee under such section without another sufficient bond being substituted therefor, the board shall forthwith revoke such license or, in the case of a solicitor, such solicitor's certificate. Such license shall also be revoked by the board at any time a licensee fails to maintain a regular office in this state in which are kept complete records of all collections and claims handled and being handled by such licensee or at any time the licensee becomes a nonresident of this state or, in the case of a foreign corporation, is no longer licensed to do business in this state. Such license or solicitor's certificate shall also be revoked if after a hearing, as provided in sections 45-613 and 45-614, the board finds that such license or certificate should be revoked.

Source: Laws 1963, c. 500, § 16, p. 1599; Laws 1969, c. 778, § 5, p. 2952; R.S.1943, (1981), § 81-8,173; Laws 1984, LB 471, § 12; Laws 1993, LB 261, § 12.

Cross References

Additional cause for revocation or suspension of license as collection agency, see section 71-3205.

45-613 Licensee; solicitor; complaint; citation; notice; hearing.

The board may, upon its own motion, and shall, upon the sworn complaint of any customer or client of a licensee, cite such licensee or solicitor of such licensee to appear before it at a time and place as set forth in such citation to show cause, if any, why such license or certificate should not be suspended or

revoked. Such citation shall be in writing and shall set forth the exact charges against the licensee or solicitor, and a true copy thereof shall be served on such licensee or solicitor at least twenty days prior to the day of hearing in the same manner as summons of the district courts are served. If the citation is against a solicitor, a true copy of the citation shall also be served upon the licensee under whose license the solicitor's certificate has been issued.

Source: Laws 1963, c. 500, § 17, p. 1600; R.S.1943, (1981), § 81-8,174; Laws 1984, LB 471, § 13; Laws 1993, LB 261, § 13.

45-614 Licensee; solicitor; citation; power to issue subpoenas; depositions.

In the preparation for and the conduct of a hearing held pursuant to section 45-613, the board may issue subpoenas to require the attendance and testimony of witnesses and the production of any pertinent records, papers, books, and documents and may administer oaths, examine witnesses, and take any evidence it deems pertinent to a proper determination of the charge. The party against whom such citation is issued shall have the right to obtain from the Secretary of State subpoenas for witnesses such party may desire to have at such hearing. Depositions may be taken and used at such hearings the same as taken and used in civil actions in the district courts of this state. Witnesses so subpoenaed shall receive the same fees as witnesses in the district courts of this state.

Source: Laws 1963, c. 500, § 18, p. 1600; R.S.1943, (1981), § 81-8,175; Laws 1984, LB 471, § 14; Laws 1993, LB 261, § 14.

45-615 Licensee; solicitor; citation; hearing; board; findings; powers.

After a hearing held pursuant to sections 45-613 and 45-614, the board shall state in writing its findings in the matter. If the board finds that the cited licensee or solicitor has failed to comply with the intent and purposes of the Collection Agency Act or, in the case of a licensee, has failed to account to a customer or client as provided for in section 45-608 or is not financially responsible, the board may suspend or revoke such license or certificate. A certified copy of the findings of the board shall be served upon the cited licensee or solicitor by certified mail within five days of the issuance of such findings.

Source: Laws 1963, c. 500, § 19, p. 1600; Laws 1969, c. 778, § 6, p. 2952; R.S.1943, (1981), § 81-8,176; Laws 1984, LB 471, § 15; Laws 1993, LB 261, § 15.

Failure to report and pay collections made within specified time justified revocation of license. State ex rel. Hartman v. Weiss, 181 Neb. 685, 150 N.W.2d 264 (1967).

45-616 License; solicitor's certificate; appeals; procedure.

Any refusal to grant a license or solicitor's certificate under the Collection Agency Act or the suspension or revocation of a license or solicitor's certificate may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1963, c. 500, § 20, p. 1601; R.S.1943, (1981), § 81-8,177; Laws 1984, LB 471, § 16; Laws 1988, LB 352, § 76; Laws 1993, LB 261, § 16.

Cross References

Administrative Procedure Act, see section 84-920.

45-617 Licensee; solicitor's certificate; appeal; effect.

Pending final determination of an appeal as provided in section 45-616, the holder of a license or the holder of a solicitor's certificate shall be permitted to do business as a collection agency or as a collection agency solicitor the same as though such license or certificate was in full force and effect.

Source: Laws 1963, c. 500, § 21, p. 1602; R.S.1943, (1981), § 81-8,178; Laws 1984, LB 471, § 17.

45-618 Licensee; change place of business; notify Secretary of State; new license; issuance; solicitor; employment terminated; return certificate.

If a licensed collection agency or its branch office changes the location of its place of business, the licensee shall forthwith notify the Secretary of State of such change and the Secretary of State shall thereupon issue a new license or branch office certificate, as the case may be, setting forth the new address. If the employment, by a licensee, of a solicitor holding a certificate is terminated, such certificate shall be forthwith turned over to the licensee by such solicitor and the licensee shall forthwith turn such certificate over to the Secretary of State for cancellation.

Source: Laws 1963, c. 500, § 22, p. 1602; R.S.1943, (1981), § 81-8,179; Laws 1984, LB 471, § 18.

45-619 Licensee; board; require financial statement; confidential.

The board may, at any time, require a licensee to submit a verified financial statement for examination so that it may determine whether the licensee is financially responsible to carry on a collection agency business within the intents and purposes of the Collection Agency Act. Any financial statement submitted by a licensee shall be confidential and not a public record unless introduced in evidence at a hearing conducted by the board.

Source: Laws 1963, c. 500, § 23, p. 1602; R.S.1943, (1981), § 81-8,180; Laws 1984, LB 471, § 19; Laws 1993, LB 261, § 17.

45-620 License; certificates; fees.

No license, renewal of license, branch office certificate, or solicitor's certificate, as provided for in the Collection Agency Act, shall be issued by the board until any processing fee allowed under section 45-605.01 has been paid and the following fees have been paid to the Secretary of State: For a license, not to exceed two hundred dollars; for renewal of a license, not to exceed one hundred dollars; for a branch office certificate, not to exceed fifty dollars; for renewal of a branch office certificate, not to exceed thirty-five dollars; for a solicitor's certificate and for renewal of a solicitor's certificate, not to exceed ten dollars. The amount of the fees to be paid to the Secretary of State shall be fixed by the board and shall not exceed the amounts actually necessary to sustain the administration and enforcement of the act. The Secretary of State

shall remit the fees received pursuant to this section to the State Treasurer for credit to the Secretary of State Cash Fund.

Source: Laws 1963, c. 500, § 24, p. 1603; Laws 1974, LB 639, § 3; R.S.1943, (1981), § 81-8,181; Laws 1984, LB 471, § 20; Laws 1989, LB 206, § 2; Laws 1993, LB 261, § 18; Laws 2020, LB909, § 32; Laws 2020, LB910, § 15.

45-621 Repealed. Laws 2020, LB910, § 49.

45-622 Licensee; solicitor; prohibited from practice of law.

Nothing in the Collection Agency Act shall be construed to authorize or permit the holder of a license or the holder of a solicitor's certificate, as provided for in the act, to engage in the practice of law.

Source: Laws 1963, c. 500, § 26, p. 1603; R.S.1943, (1981), § 81-8,183; Laws 1984, LB 471, § 22; Laws 1993, LB 261, § 20.

45-623 Collection of public debts; contracts authorized; requirements.

(1) Any state agency, county, city, village, or other political subdivision may contract to retain a collection agency licensed pursuant to the Collection Agency Act, within or without this state, for the purpose of collecting public debts owed by any person to such state agency, county, city, village, or other political subdivision.

(2) No debt owed pursuant to subsection (1) of this section may be assigned to a collection agency unless (a) there has been an attempt to advise the debtor by first-class mail, postage prepaid, at the last-known address of the debtor (i) of the existence of the debt and (ii) that the debt may be assigned to a collection agency for collection if the debt is not paid and (b) at least thirty days have elapsed from the time the notice was sent, except that in the case of an order for support being enforced by a county attorney, authorized attorney, or prosecuting attorney pursuant to Chapter 42 or 43, this notice requirement shall not apply and Title IV-D of the federal Social Security Act, as amended, shall be complied with.

(3) A collection agency which is assigned a debt under this section shall have only those remedies and powers which would be available to it as an assignee of a private creditor. This subsection shall not be construed to in any way limit the remedies and powers available to an authorized attorney as defined in section 43-512.

(4) For purposes of this section, debt shall include all delinquent fees or payments except delinquent property taxes on real estate. In the case of debt arising as a result of an order or judgment of a court in a criminal or traffic matter, a collection fee may be added to the debt. The collection fee shall be twenty-five dollars or four and one-half percent of the debt, whichever is greater. The collection fee shall be paid by the person who owes the debt directly to the person or agency providing the collection service.

Source: Laws 1993, LB 161, § 1; Laws 2020, LB909, § 34.

Cross References

Collection Agency Act, see section 45-601.

ARTICLE 7
RESIDENTIAL MORTGAGE LICENSING

45-701 Act, how cited.

Sections 45-701 to 45-754 shall be known and may be cited as the Residential Mortgage Licensing Act.

Source: Laws 1989, LB 272, § 4; Laws 1995, LB 163, § 1; Laws 2006, LB 876, § 27; Laws 2007, LB124, § 40; Laws 2009, LB328, § 3; Laws 2010, LB892, § 3; Laws 2012, LB965, § 10; Laws 2013, LB290, § 1.

45-702 Terms, defined.

For purposes of the Residential Mortgage Licensing Act:

(1) Borrower means the mortgagor or mortgagors under a real estate mortgage or the trustor or trustors under a trust deed;

(2) Branch office means any location at which the business of a mortgage banker or mortgage loan originator is to be conducted, including (a) any offices physically located in Nebraska, (b) any offices that, while not physically located in this state, intend to transact business with Nebraska residents, and (c) any third-party or home-based locations that mortgage loan originators, agents, and representatives intend to use to transact business with Nebraska residents;

(3) Breach of security of the system means unauthorized acquisition of data that compromises the security, confidentiality, or integrity of the information maintained by the Nationwide Mortgage Licensing System and Registry, its affiliates, or its subsidiaries;

(4) Clerical or support duties means tasks which occur subsequent to the receipt of a residential mortgage loan application including (a) the receipt,

collection, distribution, and analysis of information common for the processing or underwriting of a residential mortgage loan or (b) communication with a consumer to obtain the information necessary for the processing or underwriting of a residential mortgage loan, to the extent that such communication does not include offering or negotiating loan rates or terms or counseling consumers about residential mortgage loan rates or terms;

(5) Control means the power, directly or indirectly, to direct the management or policies of a mortgage banking business, whether through ownership of securities, by contract, or otherwise. Any person who (a) is a director, a general partner, or an executive officer, including the president, chief executive officer, chief financial officer, chief operating officer, chief legal officer, chief compliance officer, and any individual with similar status and function, (b) directly or indirectly has the right to vote ten percent or more of a class of voting security or has the power to sell or direct the sale of ten percent or more of a class of voting securities, (c) in the case of a limited liability company, is a managing member, or (d) in the case of a partnership, has the right to receive, upon dissolution, or has contributed, ten percent or more of the capital, is presumed to control that mortgage banking business;

(6) Department means the Department of Banking and Finance;

(7) Depository institution means any person (a) organized or chartered under the laws of this state, any other state, or the United States relating to banks, savings institutions, trust companies, savings and loan associations, credit unions, or industrial banks or similar depository institutions which the Board of Directors of the Federal Deposit Insurance Corporation finds to be operating substantially in the same manner as an industrial bank and (b) engaged in the business of receiving deposits other than funds held in a fiduciary capacity, including, but not limited to, funds held as trustee, executor, administrator, guardian, or agent;

(8) Director means the Director of Banking and Finance;

(9) Dwelling means a residential structure located or intended to be located in this state that contains one to four units, whether or not that structure is attached to real property, including an individual condominium unit, cooperative unit, mobile home, or trailer, if it is used as a residence;

(10) Federal banking agencies means the Board of Governors of the Federal Reserve System, the Office of the Comptroller of the Currency, the Consumer Financial Protection Bureau, the National Credit Union Administration, and the Federal Deposit Insurance Corporation;

(11) Immediate family member means a spouse, child, sibling, parent, grandparent, or grandchild, including stepparents, stepchildren, stepsiblings, and adoptive relationships;

(12) Installment loan company means any person licensed pursuant to the Nebraska Installment Loan Act;

(13) Licensee means any person licensed under the Residential Mortgage Licensing Act as either a mortgage banker or mortgage loan originator;

(14) Loan processor or underwriter means an individual who (a) performs clerical or support duties as an employee at the direction of and subject to the supervision and instruction of a person licensed, or exempt from licensing, under the Residential Mortgage Licensing Act or Nebraska Installment Loan Act and (b) does not represent to the public, through advertising or other means

of communicating or providing information including the use of business cards, stationery, brochures, signs, rate lists, or other promotional items, that such individual can or will perform any of the activities of a mortgage loan originator;

(15) Mortgage banker or mortgage banking business means any person (a) other than (i) a person exempt under section 45-703, (ii) an individual who is a loan processor or underwriter, or (iii) an individual who is licensed in this state as a mortgage loan originator and (b) who, for compensation or gain or in the expectation of compensation or gain, directly or indirectly makes, originates, services, negotiates, acquires, sells, arranges for, or offers to make, originate, service, negotiate, acquire, sell, or arrange for a residential mortgage loan;

(16)(a) Mortgage loan originator means an individual who for compensation or gain or in the expectation of compensation or gain (i) takes a residential mortgage loan application or (ii) offers or negotiates terms of a residential mortgage loan.

(b) Mortgage loan originator does not include (i) an individual engaged solely as a loan processor or underwriter except as otherwise provided in section 45-727, (ii) a person or entity that only performs real estate brokerage activities and is licensed or registered in accordance with Nebraska law, unless the person or entity is compensated by a lender, a mortgage broker, or other mortgage loan originator or by any agent of such lender, mortgage broker, or other mortgage loan originator, and (iii) a person solely involved in extensions of credit relating to time-share programs as defined in section 76-1702;

(17) Nationwide Mortgage Licensing System and Registry means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators for the licensing and registration of mortgage loan originators, mortgage bankers, installment loan companies, and other state-regulated financial services entities and industries;

(18) Nontraditional mortgage product means any residential mortgage loan product other than a thirty-year fixed rate residential mortgage loan;

(19) Offer means every attempt to provide, offer to provide, or solicitation to provide a residential mortgage loan or any form of mortgage banking business. Offer includes, but is not limited to, all general and public advertising, whether made in print, through electronic media, or by the Internet;

(20) Person means an association, joint venture, joint-stock company, partnership, limited partnership, limited liability company, business corporation, nonprofit corporation, individual, or any group of individuals however organized;

(21) Purchase-money mortgage means a mortgage issued to the borrower by the seller of the property as part of the purchase transaction;

(22) Real estate brokerage activity means any activity that involves offering or providing real estate brokerage services to the public, including (a) acting as a real estate salesperson or real estate broker for a buyer, seller, lessor, or lessee of real property, (b) bringing together parties interested in the sale, purchase, lease, rental, or exchange of real property, (c) negotiating, on behalf of any party, any portion of a contract relating to the sale, purchase, lease, rental, or exchange of real property, other than in connection with providing financing with respect to any such transaction, (d) engaging in any activity for which a

person engaged in the activity is required to be registered or licensed as a real estate salesperson or real estate broker under any applicable law, and (e) offering to engage in any activity or act in any capacity described in subdivision (a), (b), (c), or (d) of this subdivision;

(23) Registered bank holding company means any bank holding company registered with the department pursuant to the Nebraska Bank Holding Company Act of 1995;

(24) Registered mortgage loan originator means any individual who (a) meets the definition of mortgage loan originator and is an employee of (i) a depository institution, (ii) a subsidiary that is (A) wholly owned and controlled by a depository institution and (B) regulated by a federal banking agency, or (iii) an institution regulated by the Farm Credit Administration and (b) is registered with, and maintains a unique identifier through, the Nationwide Mortgage Licensing System and Registry;

(25) Registrant means a person registered pursuant to section 45-704;

(26) Residential mortgage loan means any loan or extension of credit, including a refinancing of a contract of sale or an assumption or refinancing of a prior loan or extension of credit, which is primarily for personal, family, or household use and is secured by a mortgage, trust deed, or other equivalent consensual security interest on a dwelling or residential real estate upon which is constructed or intended to be constructed a dwelling;

(27) Residential real estate means any real property located in this state upon which is constructed or intended to be constructed a dwelling;

(28) Reverse-mortgage loan means a loan made by a licensee which (a) is secured by residential real estate, (b) is nonrecourse to the borrower except in the event of fraud by the borrower or waste to the residential real estate given as security for the loan, (c) provides cash advances to the borrower based upon the equity in the borrower's owner-occupied principal residence, (d) requires no payment of principal or interest until the entire loan becomes due and payable, and (e) otherwise complies with the terms of section 45-702.01;

(29) Service means accepting payments or maintenance of escrow accounts in the regular course of business in connection with a residential mortgage loan;

(30) State means any state of the United States, the District of Columbia, any territory of the United States, Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, the Virgin Islands, or the Northern Mariana Islands; and

(31) Unique identifier means a number or other identifier assigned by protocols established by the Nationwide Mortgage Licensing System and Registry.

Source: Laws 1989, LB 272, § 5; Laws 1993, LB 121, § 274; Laws 1993, LB 217, § 1; Laws 1995, LB 163, § 2; Laws 1995, LB 384, § 17; Laws 1999, LB 396, § 30; Laws 2003, LB 131, § 29; Laws 2003, LB 218, § 1; Laws 2006, LB 876, § 28; Laws 2007, LB124, § 41; Laws 2008, LB851, § 19; Laws 2009, LB328, § 4; Laws 2010, LB892, § 4; Laws 2012, LB965, § 11; Laws 2019, LB258, § 15.

Cross References

Nebraska Bank Holding Company Act of 1995, see section 8-908.
Nebraska Installment Loan Act, see section 45-1001.

45-702.01 Reverse-mortgage loans; rules applicable; fees authorized; failure by licensee to make loan advances and cure default; forfeiture.

(1) Reverse-mortgage loans shall be governed by the following rules without regard to the requirements set out elsewhere for other types of mortgage transactions: (a) Payment in whole or in part is permitted without penalty at any time during the period of the loan; (b) an advance and interest on the advance have priority over a lien filed after the closing of a reverse-mortgage loan; (c) an interest rate may be fixed or adjustable and may also provide for interest that is contingent on appreciation in the value of the residential real estate; and (d) the advance shall not be reduced in amount or number based on an adjustment in the interest rate when a reverse-mortgage loan provides for periodic advances to a borrower.

(2) Reverse-mortgage loans may be made or acquired without regard to the following provisions for other types of mortgage transactions: (a) Limitations on the purpose and use of future advances or any other mortgage proceeds; (b) limitations on future advances to a term of years or limitations on the term of credit line advances; (c) limitations on the term during which future advances take priority over intervening advances; (d) requirements that a maximum mortgage amount be stated in the mortgage; (e) limitations on loan-to-value ratios; (f) prohibitions on balloon payments; (g) prohibitions on compounded interest and interest on interest; and (h) requirements that a percentage of the loan proceeds must be advanced prior to loan assignment.

(3) A licensee may, in connection with a reverse-mortgage loan, charge to the borrower (a) a nonrefundable loan origination fee which does not exceed two percent of the appraised value of the owner-occupied principal residence at the time the loan is made, (b) a reasonable fee paid to third parties originating loans on behalf of the licensee, and (c) such other fees as are necessary and required, including fees for inspections, insurance, appraisals, and surveys.

(4) Licensees failing to make loan advances as required in the loan documents and failing to cure the default as required in the loan documents shall forfeit to the borrower an amount equal to the greater of two hundred dollars or one percent of the amount of the loan advance the licensee failed to make.

Source: Laws 2010, LB892, § 5.

45-703 Act; exemptions.

(1) Except as provided in section 45-704, the following shall be exempt from the Residential Mortgage Licensing Act:

(a) Any depository institution or wholly owned subsidiary thereof;

(b) Any registered bank holding company;

(c) Any insurance company that is subject to regulation by the Department of Insurance and is either (i) organized or chartered under the laws of Nebraska or (ii) organized or chartered under the laws of any other state if such insurance company has a place of business in Nebraska;

(d) Any person licensed to practice law in this state in connection with activities that are (i) considered the practice of law by the Supreme Court, (ii) carried out within an attorney-client relationship, and (iii) accomplished by the attorney in compliance with all applicable laws, rules, ethics, and standards;

(e) Any person licensed in this state as a real estate broker or real estate salesperson pursuant to section 81-885.02 who is engaging in real estate

brokerage activities unless such person is compensated by a lender, a mortgage broker, or other mortgage loan originator or by any agent of such lender, mortgage broker, or other mortgage loan originator;

(f) Any registered mortgage loan originator when acting for an entity described in subdivision (24)(a)(i), (ii), or (iii) of section 45-702;

(g) Any sales finance company licensed pursuant to the Nebraska Installment Sales Act if such sales finance company does not engage in mortgage banking business in any capacity other than as a purchaser or servicer of an installment contract, as defined in section 45-335, which is secured by a mobile home or trailer;

(h) Any trust company chartered pursuant to the Nebraska Trust Company Act;

(i) Any wholly owned subsidiary of an organization listed in subdivisions (b) and (c) of this subsection if the listed organization maintains a place of business in Nebraska;

(j) Any individual who offers or negotiates terms of a residential mortgage loan with or on behalf of an immediate family member of the individual;

(k) Any individual who does not repetitively and habitually engage in the business of a mortgage banker, a mortgage loan originator, or a loan processor or underwriter, either inside or outside of this state, who (i) makes a residential mortgage loan with his or her own funds for his or her own investment, (ii) makes a purchase-money mortgage, or (iii) finances the sale of a dwelling or residential real estate owned by such individual without the intent to resell the residential mortgage loan;

(l) Any employee or independent agent of a mortgage banker licensed or registered pursuant to the Residential Mortgage Licensing Act or exempt from the act if such employee or independent agent does not conduct the activities of a mortgage loan originator or loan processor or underwriter;

(m) The United States of America; the State of Nebraska; any other state, district, territory, commonwealth, or possession of the United States of America; any city, county, or other political subdivision; and any agency or division of any of the foregoing;

(n) The Nebraska Investment Finance Authority;

(o) Any individual who is an employee of an entity described in subdivision (m) or (n) of this subsection and who acts as a mortgage loan originator or loan processor or underwriter only pursuant to his or her official duties as an employee of such entity;

(p) A bona fide nonprofit organization which has received a certificate of exemption pursuant to section 45-703.01; and

(q) Any employee of a bona fide nonprofit organization which has received a certificate of exemption pursuant to section 45-703.01 if such employee acts as a mortgage loan originator or mortgage loan processor or underwriter (i) only with respect to his or her work duties for the nonprofit organization and (ii) only with respect to residential mortgage loans with terms that are favorable to the borrower.

(2) It shall not be necessary to negate any of the exemptions provided in this section in any complaint, information, indictment, or other writ or proceedings brought under the Residential Mortgage Licensing Act, and the burden of

establishing the right to any exemption shall be upon the person claiming the benefit of such exemption.

Source: Laws 1989, LB 272, § 6; Laws 1999, LB 396, § 31; Laws 2002, LB 957, § 22; Laws 2005, LB 533, § 50; Laws 2008, LB851, § 20; Laws 2009, LB328, § 5; Laws 2012, LB965, § 12.

Cross References

Nebraska Installment Sales Act, see section 45-334.
Nebraska Trust Company Act, see section 8-201.01.

45-703.01 Nonprofit organization; certificate of exemption; qualification; application; denial; notice; appeal; department; powers; revocation of certificate; grounds.

(1) A nonprofit organization may apply to the director for a certificate of exemption on a form as prescribed by the department. The director shall grant such certificate if the director finds that the nonprofit organization is a bona fide nonprofit organization. In order for a nonprofit organization to qualify as a bona fide nonprofit organization, the director shall find that it meets the following:

(a) Has the status of a tax exempt organization under section 501(c) of the Internal Revenue Code of 1986;

(b) Promotes affordable housing or provides homeownership education or similar services;

(c) Conducts its activities in a manner that serves public or charitable purposes rather than commercial purposes;

(d) Receives funding and revenue and charges fees in a manner that does not incentivize it or its employees to act other than in the best interests of its clients;

(e) Compensates its employees in a manner that does not incentivize employees to act other than in the best interests of its clients; and

(f) Provides or identifies for the borrower residential mortgage loans with terms favorable to the borrower and comparable to mortgage loans and housing assistance provided under government assistance programs.

(2) For residential mortgage loans to have terms that are favorable to the borrower, the director shall determine that terms are consistent with loan origination in a public or charitable context rather than in a commercial context.

(3) If the director determines that the application for a certificate of exemption should be denied, the director shall notify the applicant in writing of the denial and of the reasons for the denial. A decision of the director denying an application for a certificate of exemption pursuant to the Residential Mortgage Licensing Act may be appealed. The appeal shall be in accordance with the Administrative Procedure Act and rules and regulations adopted and promulgated by the department.

(4) The department has the authority to examine the books and activities of an organization it determines is a bona fide nonprofit organization. The director may, following a hearing under the Administrative Procedure Act, revoke the certificate of exemption granted to a bona fide nonprofit organization if he or she determines that such nonprofit organization fails to meet the requirements of subsection (1) of this section.

(5) In making its determinations and examinations under subsections (1), (2), and (4) of this section, the department may rely on its receipt and review of:

(a) Reports filed with federal, state, or local housing agencies and authorities; or

(b) Reports and attestations required by the department.

Source: Laws 2012, LB965, § 13.

Cross References

Administrative Procedure Act, see section 84-920.

45-704 Registration required; registration statement; fee; procedure; bond; registrant; duties; renewal.

(1) Notwithstanding any other provision of the Residential Mortgage Licensing Act, no person exempt from licensing under section 45-703 who employs or enters into an independent agent agreement with an individual who is required to obtain a mortgage loan originator license in this state pursuant to section 45-727 shall act as a mortgage banker until such person has registered with the department.

(2) Any person required to register pursuant to subsection (1) of this section shall submit to the department a registration statement on a form prescribed by the department. The form shall contain such information as the department may prescribe as necessary or appropriate, including, but not limited to, (a) all addresses at which business is to be conducted, (b) the names and titles of each director and principal officer of the business, and (c) a description of the activities of the applicant in such detail as the department may require.

(3) The registration statement required in subsection (2) of this section shall be accompanied by a registration fee of two hundred dollars.

(4) The department shall acknowledge the registration by issuing to the registrant a receipt or other form of acknowledgment.

(5) A registrant shall maintain a surety bond as required by section 45-724, submit mortgage reports of condition as required by section 45-726, and comply with the requirements of section 45-735 pertaining to the employment of mortgage loan originators.

(6) A registration under this section shall not be assignable.

(7) After original registration, all registrations shall remain in full force and effect until the next succeeding December 31. Thereafter, a registration under this section may be renewed on an annual basis for a renewal fee of one hundred dollars.

(8)(a) If a registrant fails to maintain a surety bond as required by section 45-724, the department may issue a notice of cancellation of the registration.

(b) If a registrant fails to renew his, her, or its registration as required by this section and does not voluntarily surrender the registration by delivering to the director written notice of the surrender, the department may issue a notice of expiration of the registration.

Source: Laws 1989, LB 272, § 7; Laws 1999, LB 396, § 32; Laws 2003, LB 218, § 2; Laws 2005, LB 533, § 51; Laws 2008, LB851, § 21; Laws 2009, LB328, § 6; Laws 2010, LB892, § 6.

45-705 License or registration required; application; fees; background investigation; registered agent.

(1) No person shall act as a mortgage banker or use the title mortgage banker in this state unless he, she, or it is licensed as a mortgage banker, is registered with the department as provided in section 45-704, is licensed under the Nebraska Installment Loan Act, or is otherwise exempt from the act pursuant to section 45-703.

(2) Applicants for a license as a mortgage banker shall submit to the department an application on a form prescribed by the department. The application shall include, but not be limited to, (a) the applicant's corporate name and no more than one trade name or doing business as designation which the applicant intends to use in this state, if applicable, (b) the applicant's main office address, (c) all branch office addresses at which business is to be conducted, (d) the names and titles of each director and principal officer of the applicant, (e) the names of all shareholders, partners, or members of the applicant, (f) a description of the activities of the applicant in such detail as the department may require, (g) if the applicant is an individual, his or her social security number, and (h) fingerprints of any principal officer, director, partner, member, or sole proprietor for submission to the Federal Bureau of Investigation and any other governmental agency or entity authorized to receive such information for a state, national, and international criminal history record information check.

(3) The application for a license as a mortgage banker shall include or be accompanied by, in a manner as prescribed by the director, (a) the name and street address in this state of a registered agent appointed by the licensee for receipt of service of process and (b) the written consent of the registered agent to the appointment. A post office box number may be provided in addition to the street address.

(4) The application for a license as a mortgage banker shall be accompanied by an application fee of four hundred dollars and, if applicable, a seventy-five-dollar fee for each branch office listed in the application and any processing fee allowed under subsection (2) of section 45-748.

(5) The application for a license as a mortgage banker shall include or be accompanied by, in a manner as prescribed by the director, a background investigation of each applicant by means of fingerprints and a check of his or her criminal history record information maintained by the Federal Bureau of Investigation through the Nationwide Mortgage Licensing System and Registry. If the applicant is a partnership, association, corporation, or other form of business organization, the director shall require a criminal history record information check on each member, director, or principal officer of each applicant or any individual acting in the capacity of the manager of an office location. Fingerprints of any principal officer, director, partner, member, or sole proprietor shall be submitted to the Federal Bureau of Investigation and any other governmental agency or entity authorized to receive such information for a state, national, and international criminal history record information check. The applicant shall be responsible for the direct costs associated with criminal history record information checks performed. The information obtained thereby may be used by the director to determine the applicant's eligibility for licensing under this section. Except as authorized pursuant to

subsection (2) of section 45-748, receipt of criminal history record information by a private person or entity is prohibited.

(6) In order to reduce the points of contact which the Federal Bureau of Investigation may have to maintain for purposes of subsection (5) of this section, the director may use the Nationwide Mortgage Licensing System and Registry as a channeling agent for requesting information from and distributing information to the United States Department of Justice or any other governmental agency.

(7) A license as a mortgage banker granted under the Residential Mortgage Licensing Act shall not be assignable.

(8) An application is deemed filed when accepted as substantially complete by the director.

Source: Laws 1989, LB 272, § 8; Laws 1995, LB 163, § 3; Laws 1997, LB 752, § 118; Laws 2003, LB 218, § 3; Laws 2005, LB 533, § 52; Laws 2007, LB124, § 42; Laws 2008, LB380, § 1; Laws 2009, LB328, § 7; Laws 2010, LB892, § 7; Laws 2019, LB355, § 7.

Cross References

Nebraska Installment Loan Act, see section 45-1001.

45-706 License; issuance; denial; abandonment; appeal; renewal; fees; inactive status; renewal; reactivation of license; notice of cancellation.

(1) Upon the filing of an application for a license as a mortgage banker, if the director finds that the character and general fitness of the applicant, the members thereof if the applicant is a partnership, limited liability company, association, or other organization, and the officers, directors, and principal employees if the applicant is a corporation are such that the business will be operated honestly, soundly, and efficiently in the public interest consistent with the purposes of the Residential Mortgage Licensing Act, the director shall issue a license as a mortgage banker to the applicant. The director shall approve or deny an application for a license within ninety days after (a) acceptance of the application, (b) delivery of the bond required under section 45-724, and (c) payment of the required fee.

(2) If the director determines that the mortgage banker license application should be denied, the director shall notify the applicant in writing of the denial and of the reasons for the denial. The director shall not deny an application for a mortgage banker license because of the failure to submit information required under the act or rules and regulations adopted and promulgated under the act without first giving the applicant an opportunity to correct the deficiency by supplying the missing information. A decision of the director denying a mortgage banker license application pursuant to the act may be appealed. The appeal shall be in accordance with the Administrative Procedure Act and rules and regulations adopted and promulgated by the department under the act. The director may deny an application for a mortgage banker license application if (a) he or she determines that the applicant does not meet the conditions of subsection (1) of this section or (b) an officer, director, shareholder owning five percent or more of the voting shares of the applicant, partner, or member was convicted of, pleaded guilty to, or was found guilty after a plea of nolo contendere to (i) a misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking

business, depository institution business, or installment loan company business or (ii) any felony under state or federal law.

(3) If an applicant for a mortgage banker license does not complete the license application and fails to respond to a notice or notices from the department to correct the deficiency or deficiencies for a period of one hundred twenty days or more after the date the department sends the initial notice to correct the deficiency, the department may deem the application as abandoned and may issue a notice of abandonment of the application to the applicant in lieu of proceedings to deny the application.

(4)(a) All initial licenses shall remain in full force and effect until the next succeeding December 31. Mortgage banker licenses may be renewed annually by submitting to the director a request for renewal and any supplemental material as required by the director. The mortgage banker licensee shall certify that the information contained in the license application, as subsequently amended, that is on file with the department and the information contained in any supplemental material previously provided to the department remains true and correct.

(b) For the annual renewal of a license to conduct a mortgage banking business under the Residential Mortgage Licensing Act, the fee shall be two hundred dollars plus seventy-five dollars for each branch office, if applicable, and any processing fee allowed under subsection (2) of section 45-748.

(5)(a) The department may place a mortgage banker licensee that is a sole proprietorship on inactive status for a period of up to twelve months upon receipt of a request from the licensee for inactive status. The request shall include notice that the licensee has temporarily suspended business, is not acting as a mortgage banker in this state, and has no pending customer complaints. The department shall notify the licensee within ten business days as to whether the request has been granted and, if granted, of the date of expiration of the inactive status.

(b) If a mortgage banker license becomes inactive under this section, the license shall remain inactive until the license expires, is canceled, is surrendered, is suspended, is revoked, or is reactivated pursuant to subdivision (d) of this subsection.

(c) An inactive mortgage banker licensee may renew such inactive license if the licensee remains otherwise eligible for renewal pursuant to subdivision (4)(a) of this section, except for being covered by a surety bond pursuant to section 45-724. Such renewal shall not reactivate the license.

(d) The department has the authority to reactivate an inactive mortgage banker license following the department's receipt of a request from the inactive licensee that the licensee intends to resume business as a mortgage banker in this state if the inactive mortgage banker licensee meets the conditions for licensing at the time reactivation is requested, including, but not limited to, coverage by a surety bond pursuant to section 45-724.

(e) The department shall issue a notice of cancellation of an inactive mortgage banker license following the expiration of the period of inactive status set by the department pursuant to subdivision (a) of this subsection if the inactive mortgage banker licensee fails to request reactivation of the license prior to the date of expiration.

(6) The director may require a mortgage banker licensee to maintain a minimum net worth, proven by an audit conducted by a certified public accountant, if the director determines that the financial condition of the licensee warrants such a requirement or that the requirement is in the public interest.

Source: Laws 1989, LB 272, § 9; Laws 1993, LB 121, § 275; Laws 1995, LB 163, § 4; Laws 2003, LB 218, § 4; Laws 2005, LB 533, § 53; Laws 2006, LB 876, § 29; Laws 2007, LB124, § 43; Laws 2008, LB380, § 2; Laws 2009, LB328, § 8; Laws 2012, LB965, § 14; Laws 2015, LB352, § 1.

Cross References

Administrative Procedure Act, see section 84-920.

45-707 Transferred to section 45-742.

45-708 Transferred to section 45-747.

45-709 Transferred to section 45-724.

45-710 Transferred to section 45-741.

45-711 Transferred to section 45-737.

45-712 Transferred to section 45-738.

45-713 Transferred to section 45-739.

45-714 Transferred to section 45-740.

45-715 Transferred to section 45-750.

45-716 Transferred to section 45-751.

45-717 Transferred to section 45-744.

45-717.01 Transferred to section 45-743.

45-717.02 Transferred to section 45-746.

45-718 Transferred to section 45-745.

45-719 Transferred to section 45-752.

45-720 Transferred to section 45-753.

45-721 Transferred to section 45-754.

45-722 Transferred to section 45-725.

45-723 Transferred to section 45-748.

45-724 Surety bond; requirements.

(1) Except as provided in subsection (2) of this section, an applicant for a mortgage banker license or registration shall file with the department a surety bond in the amount of one hundred thousand dollars, furnished by a surety company authorized to do business in the State of Nebraska. The surety bond also shall cover all mortgage loan originators who are employees or indepen-

dent agents of the applicant. The bond shall be for the use of the State of Nebraska and any Nebraska resident who may have claims or causes of action against the applicant or against an individual who is a mortgage loan originator employed by, or in an independent agent relationship with, the applicant. Submission of a rider to an existing bond indicating that the required coverage is outstanding and evidencing the beneficiaries required in this subsection shall satisfy the requirements of this section. The bond or a substitute bond shall remain in effect during all periods of licensing or registration.

(2) Upon filing of the mortgage report of condition required by section 45-726, a mortgage banker licensee or registrant shall maintain or increase its surety bond to reflect the total dollar amount of the closed residential mortgage loans originated in this state in the preceding calendar year in accordance with the following table. A licensee or registrant may decrease its surety bond in accordance with the following table if the surety bond required is less than the amount of the surety bond on file with the department.

Dollar Amount of Closed Residential Mortgage Loans	Surety Bond Required
$0.00 to $5,000,000.00	$100,000.00
$5,000,000.01 to $10,000,000.00	$125,000.00
$10,000,000.01 to $25,000,000.00	$150,000.00
Over $25,000,000.00	$200,000.00

(3) Should the department determine that a mortgage banker licensee or registrant does not maintain a surety bond in the amount required by subsection (2) of this section, the department shall give written notification to the mortgage banker licensee or registrant requiring him, her, or it to increase the surety bond within thirty days to the amount required by subsection (2) of this section.

(4) At any time the director may require the filing of a new or supplemental bond in the form as provided in subsection (1) of this section if he or she determines that the bond filed under subsection (1) or (2) of this section is exhausted or is inadequate for any reason, including the financial condition of the licensee, the registrant, or the applicant for a license or registration. The new or supplemental bond shall not exceed one million dollars.

Source: Laws 1989, LB 272, § 12; Laws 1993, LB 217, § 2; Laws 2003, LB 218, § 6; Laws 2006, LB 876, § 31; R.S.Supp.,2008, § 45-709; Laws 2009, LB328, § 9; Laws 2010, LB892, § 8.

45-725 Acquisition of control of mortgage banking business; procedure; fee; disapproval; hearing.

(1) No person acting personally or as an agent shall acquire control of any mortgage banking business required to be licensed under the Residential Mortgage Licensing Act without first giving thirty days' notice to the department on a form prescribed by the department of such proposed acquisition and paying a filing fee of two hundred dollars.

(2) The director, upon receipt of such notice, shall act upon it within thirty days and, unless he or she disapproves the proposed acquisition within that period of time, the acquisition shall become effective on the thirty-first day after receipt without the director's approval, except that the director may extend the thirty-day period an additional thirty days if, in his or her judgment, any

material information submitted is substantially inaccurate or the acquiring party has not furnished all the information required by the department.

(3) An acquisition may be made prior to the expiration of the disapproval period if the director issues written notice of his or her intent not to disapprove the action.

(4)(a) The director may disapprove any proposed acquisition if:

(i) The financial condition of any acquiring person is such as might jeopardize the financial stability of the acquired mortgage banking business;

(ii) The character and general fitness of any acquiring person or of any of the proposed management personnel indicate that the acquired mortgage banking business would not be operated honestly, soundly, or efficiently in the public interest; or

(iii) Any acquiring person neglects, fails, or refuses to furnish all information required by the department.

(b) The director shall notify the acquiring party in writing of disapproval of the acquisition. The notice shall provide a statement of the basis for the disapproval.

(c) Within fifteen business days after receipt of written notice of disapproval, the acquiring party may request a hearing on the proposed acquisition in accordance with the Administrative Procedure Act and rules and regulations adopted and promulgated by the department under the act. At the conclusion of such hearing, the director shall, by order, approve or disapprove the proposed acquisition on the basis of the record made at the hearing.

Source: Laws 2007, LB124, § 49; Laws 2008, LB851, § 22; R.S.Supp.,2008, § 45-722; Laws 2009, LB328, § 10; Laws 2010, LB892, § 9.

Cross References

Administrative Procedure Act, see section 84-920.

45-726 Reports.

Each licensed mortgage banker, registrant, and installment loan company shall submit to the Nationwide Mortgage Licensing System and Registry mortgage reports of condition, which shall be in such form and shall contain such information as the department may require.

Source: Laws 2009, LB328, § 11; Laws 2010, LB892, § 10.

45-727 Mortgage loan originator; license required; loan processor or underwriter; license required; temporary authority to act as mortgage loan originator; conditions.

(1) An individual, unless specifically exempted from the Residential Mortgage Licensing Act under section 45-703 or, on or after November 24, 2019, unless having temporary authority under subsections (4) or (5) of this section, shall not engage in, or offer to engage in, the business of a mortgage loan originator with respect to any residential real estate or dwelling located or intended to be located in this state without first obtaining and maintaining annually a license under the act. Each licensed mortgage loan originator shall obtain and maintain a valid unique identifier issued by the Nationwide Mortgage Licensing System and Registry.

(2) An independent agent shall not engage in the activities as a loan processor or underwriter unless such independent agent loan processor or underwriter obtains and maintains a license under subsection (1) of this section. Each independent agent loan processor or underwriter licensed as a mortgage loan originator shall obtain and maintain a valid unique identifier issued by the Nationwide Mortgage Licensing System and Registry.

(3) For the purposes of implementing an orderly and efficient licensing process, the director may adopt and promulgate licensing rules or regulations and interim procedures for licensing and acceptance of applications. For previously registered or licensed individuals, the director may establish expedited review and licensing procedures.

(4) Beginning November 24, 2019, upon becoming employed by a mortgage banker licensed in this state, an individual who is a registered mortgage loan originator shall be deemed to have temporary authority to act as a mortgage loan originator in this state for one hundred twenty days after submitting a mortgage loan originator application unless:

(a) The individual withdraws his or her mortgage loan originator application;

(b) The director denies the mortgage loan originator application;

(c) The director grants the individual a mortgage loan originator license;

(d) The application remains incomplete more than one hundred twenty days after the application was submitted;

(e) The individual has had an application for a mortgage loan originator license denied, revoked, or suspended at any time in any governmental jurisdiction;

(f) The individual has been subject to, or served with, a cease and desist order in any governmental jurisdiction;

(g) The individual has been convicted of a misdemeanor or felony that precludes licensure under the act; or

(h) The individual was not a registered mortgage loan originator for at least one year prior to application under the act.

(5) Beginning November 24, 2019, an individual who is a licensed mortgage loan originator in another state employed by a mortgage banker licensed in this state shall be deemed to have temporary authority to act as a mortgage loan originator in this state for one hundred twenty days after submitting a mortgage loan originator application unless:

(a) The individual withdraws his or her mortgage loan originator application;

(b) The director denies the mortgage loan originator application;

(c) The director grants the individual a mortgage loan originator license;

(d) The application remains incomplete more than one hundred twenty days after the application was submitted;

(e) The individual has had an application for a mortgage loan originator license denied, revoked, or suspended at any time in any governmental jurisdiction;

(f) The individual has been subject to, or served with, a cease and desist order in any governmental jurisdiction;

(g) The individual has been convicted of a misdemeanor or felony that precludes licensure under the act; or

(h) The individual has not been a licensed mortgage loan originator in another state for at least thirty days prior to application under the act.

(6) Beginning November 24, 2019, any person employing an individual who is deemed to have temporary authority to act as a mortgage loan originator in this state, and any individual who is deemed to have temporary authority to act as a mortgage loan originator in this state, shall be subject to the requirements of the act to the same extent as if that individual was a licensed mortgage loan originator under the act.

Source: Laws 2009, LB328, § 12; Laws 2013, LB290, § 2; Laws 2019, LB355, § 8.

45-728 License; application; form; fee; use of nationwide registry.

(1) An applicant for a license shall apply on a form prescribed by the director.

(2) The application for a license as a mortgage loan originator shall be accompanied by an application fee of one hundred fifty dollars, plus the cost of the criminal history background check required by subsection (3) of this section and any processing fee allowed under subsection (2) of section 45-748.

(3) In connection with an application for licensing as a mortgage loan originator, the applicant shall, at a minimum, furnish to the Nationwide Mortgage Licensing System and Registry information concerning the applicant's identity, including the following:

(a) Fingerprints for submission to the Federal Bureau of Investigation and any other governmental agency or entity authorized to receive such information for a state, national, and international criminal history background check; and

(b) Personal history and experience in a format prescribed by the Nationwide Mortgage Licensing System and Registry, including the submission of authorization for the Nationwide Mortgage Licensing System and Registry and the director to obtain the following:

(i) An independent credit report obtained from a consumer reporting agency described in 15 U.S.C. 1681a(p), as such section existed on January 1, 2010; and

(ii) Information related to any administrative, civil, or criminal findings by any governmental jurisdiction.

(4) For the purposes of this section and in order to reduce the points of contact which the Federal Bureau of Investigation may have to maintain for purposes of subdivisions (3)(a) and (3)(b)(ii) of this section, the director may use the Nationwide Mortgage Licensing System and Registry as a channeling agent for requesting information from and distributing information to the United States Department of Justice or any other governmental agency.

(5) For the purposes of this section and in order to reduce the points of contact which the director may have to maintain for purposes of subdivisions (3)(b)(i) and (3)(b)(ii) of this section, the director may use the Nationwide Mortgage Licensing System and Registry as a channeling agent for requesting and distributing information to and from any source so directed by the director.

Source: Laws 2009, LB328, § 13; Laws 2010, LB892, § 11.

45-729 Issuance of mortgage loan originator license; director; findings required; denial; notice; appeal; application deemed abandoned; when; effect.

(1) The director shall not issue a mortgage loan originator license unless the director makes at a minimum the following findings:

(a) The applicant has never had a mortgage loan originator license revoked in any governmental jurisdiction, except that a subsequent formal vacation of such revocation shall not be deemed a revocation;

(b) The applicant has not been convicted of, or pleaded guilty or nolo contendere or its equivalent to, in a domestic, foreign, or military court:

(i) A misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the business of a mortgage banker, depository institution, or installment loan company unless such individual has received a pardon for such conviction or such conviction has been expunged, except that the director may consider the underlying crime, facts, and circumstances of a pardoned or expunged conviction in determining the applicant's eligibility for a license pursuant to subdivision (c) of this subsection; or

(ii) Any felony under state or federal law unless such individual has received a pardon for such conviction or such conviction has been expunged, except that the director may consider the underlying crime, facts, and circumstances of a pardoned or expunged conviction in determining the applicant's eligibility for a license pursuant to subdivision (c) of this subsection;

(c) The applicant has demonstrated financial responsibility, character, and general fitness such as to command the confidence of the community and to warrant a determination that the mortgage loan originator will operate honestly, fairly, and efficiently within the purposes of the Residential Mortgage Licensing Act. For purposes of this subsection, an individual has shown that he or she is not financially responsible when he or she has shown a disregard in the management of his or her own financial condition. The director may consider the following factors in making a determination as to financial responsibility:

(i) The applicant's current outstanding judgments except judgments solely as a result of medical expenses;

(ii) The applicant's current outstanding tax liens or other government liens and filings;

(iii) The applicant's foreclosures within the past three years; and

(iv) A pattern of seriously delinquent accounts within the past three years by the applicant;

(d) The applicant has completed the prelicensing education requirements described in section 45-730;

(e) The applicant has passed a written test that meets the test requirement described in section 45-731; and

(f) The applicant is covered by a surety bond as required pursuant to section 45-724 or a supplemental surety bond as required pursuant to section 45-1007.

(2)(a) If the director determines that a mortgage loan originator license application should be denied, the director shall notify the applicant in writing of the denial and of the reasons for the denial.

(b) The director shall not deny an application for a mortgage loan originator license because of the failure to submit information required under the act or rules and regulations adopted and promulgated under the act without first

giving the applicant an opportunity to correct the deficiency by supplying the missing information.

(c) If an applicant for a mortgage loan originator license does not complete his or her license application and fails to respond to a notice or notices from the department to correct the deficiency or deficiencies for a period of one hundred twenty days or more after the date the department sends the initial notice after initial filing of the application, the department may deem the application as abandoned and may issue a notice of abandonment of the application to the applicant in lieu of proceedings to deny the application.

(d) A decision of the director denying a mortgage loan originator license application pursuant to the Residential Mortgage Licensing Act may be appealed. The appeal shall be in accordance with the Administrative Procedure Act and rules and regulations adopted and promulgated by the department.

(3) A mortgage loan originator license shall not be assignable.

Source: Laws 2009, LB328, § 14; Laws 2012, LB965, § 15; Laws 2013, LB290, § 3.

Cross References

Administrative Procedure Act, see section 84-920.

45-730 Prelicensing education requirements; course review and approval; relicensure requirements.

(1) In order to meet the prelicensing education requirements referred to in subdivision (1)(d) of section 45-729, an individual shall complete at least twenty hours of education approved in accordance with subsection (2) of this section, which shall include at least the following:

(a) Three hours of instruction in federal law and regulations regarding mortgage origination;

(b) Three hours of instruction in ethics, which shall include instruction on fraud, consumer protection, and fair lending issues; and

(c) Two hours of instruction related to lending standards for the nontraditional mortgage product marketplace.

(2) For purposes of subsection (1) of this section, prelicensing education courses shall be reviewed and approved by the Nationwide Mortgage Licensing System and Registry based upon reasonable standards. Review and approval of a prelicensing education course shall include review and approval of the course provider.

(3) Nothing in this section shall preclude any prelicensing education course, as approved by the Nationwide Mortgage Licensing System and Registry, that is provided by the employer of the applicant or an entity which is affiliated with the applicant by an agency contract or any subsidiary or affiliate of such employer or entity.

(4) Prelicensing education may be offered either in a classroom, online, or by any other means approved by the Nationwide Mortgage Licensing System and Registry.

(5) The prelicensing education requirements approved by the Nationwide Mortgage Licensing System and Registry in subsection (1) of this section for any state shall be accepted as credit towards completion of prelicensing education requirements in this state.

(6) An individual who previously held a mortgage loan originator license applying to be licensed again shall prove that he or she has either (a) completed all of the continuing education requirements for the year in which the license was last held or (b) made up any deficiency in continuing education as provided by subsection (8) of section 45-733.

Source: Laws 2009, LB328, § 15; Laws 2010, LB892, § 12.

45-731 Written test requirement; subject areas.

(1) In order to meet the written test requirement referred to in subdivision (1)(e) of section 45-729, an individual shall pass, in accordance with the standards established under this section, a qualified written test developed by the Nationwide Mortgage Licensing System and Registry and administered by a test provider approved by the Nationwide Mortgage Licensing System and Registry based upon reasonable standards.

(2) A written test shall not be treated as a qualified written test for purposes of subsection (1) of this section unless the test adequately measures the applicant's knowledge and comprehension in appropriate subject areas, including the following:

(a) Ethics;

(b) Federal laws and regulations pertaining to mortgage origination;

(c) State laws and regulations pertaining to mortgage origination; and

(d) Federal and state laws and regulations, including instruction on fraud, consumer protection, the nontraditional mortgage marketplace, and fair lending issues.

(3) Nothing in this section shall prohibit a test provider approved by the Nationwide Mortgage Licensing System and Registry from providing a test at the location of the employer of the applicant, the location of any subsidiary or affiliate of the employer of the applicant, or the location of any entity with which the applicant holds an exclusive arrangement to conduct the business of a mortgage loan originator.

(4)(a) An individual shall not be considered to have passed a qualified written test unless the individual achieves a test score of not less than seventy-five percent correct answers to questions.

(b) An individual may take a test three consecutive times with each consecutive taking occurring at least thirty days after the preceding test.

(c) After failing three consecutive tests, an individual shall wait at least six months before taking the test again.

(d) A licensed mortgage loan originator who fails to maintain a valid license for a period of five years or longer shall retake the test, not taking into account any time during which such individual is a registered mortgage loan originator.

Source: Laws 2009, LB328, § 16; Laws 2012, LB965, § 16.

45-732 License; term; renewal; minimum standards for renewal; fee; denial; appeal.

(1) All initial mortgage loan originator licenses shall remain in full force and effect until the next succeeding December 31. Mortgage loan originator licenses may be renewed annually by submitting to the director a request for renewal and any supplemental material as required by the director. The mortgage loan

originator licensee shall certify that the information contained in the license application, as subsequently amended, that is on file with the department, and the information contained in any supplemental material previously provided to the department, remains true and correct.

(2) The minimum standards for license renewal for mortgage loan originators shall include the following:

(a) The mortgage loan originator continues to meet the minimum standards for license issuance under subdivisions (1)(a) through (f) of section 45-729;

(b) The mortgage loan originator has satisfied the annual continuing education requirements described in section 45-733; and

(c) The mortgage loan originator has paid all required fees for renewal of the license.

(3) For the annual renewal of a mortgage loan originator license, the fee shall be one hundred twenty-five dollars, plus the cost of the criminal history background check required by the director and any processing fee allowed under subsection (2) of section 45-748.

(4) Except as provided in subsection (4) of section 45-734 and subsection (4) of section 45-742, should the director conclude that a mortgage loan originator does not meet the minimum standards for license renewal, the director shall deny the renewal application. A decision of the director denying a renewal of a mortgage loan originator license pursuant to the Residential Mortgage Licensing Act may be appealed. The appeal shall be in accordance with the Administrative Procedure Act and the rules and regulations adopted and promulgated by the department under the act.

Source: Laws 2009, LB328, § 17.

Cross References

Administrative Procedure Act, see section 84-920.

45-733 Licensed mortgage loan originator; continuing education; continuing education courses; review and approval; credit as instructor; relicensure requirements.

(1) A licensed mortgage loan originator shall complete annually at least eight hours of education approved in accordance with subsection (2) of this section, which shall include at least:

(a) Three hours of instruction in federal laws and regulations regarding mortgage origination;

(b) Two hours of instruction in ethics, which shall include instruction on fraud, consumer protection, and fair lending issues; and

(c) Two hours of instruction related to lending standards for the nontraditional mortgage product marketplace.

(2) For purposes of subsection (1) of this section, continuing education courses shall be reviewed and approved by the Nationwide Mortgage Licensing System and Registry based upon reasonable standards. Review and approval of a continuing education course shall include review and approval of the course provider.

(3) Nothing in this section shall preclude any education course, as approved by the Nationwide Mortgage Licensing System and Registry, that is provided by the employer of the mortgage loan originator, an entity which is affiliated with

the mortgage loan originator by an agency contract, or any subsidiary or affiliate of such employer or entity.

(4) Continuing education may be offered either in a classroom, online, or by any other means approved by the Nationwide Mortgage Licensing System and Registry.

(5) A licensed mortgage loan originator:

(a) Shall only receive credit for a continuing education course in the year in which the course is taken except as provided in subsection (8) of this section; and

(b) Shall not take the same approved course in the same or consecutive years to meet the annual requirements for continuing education.

(6) A licensed mortgage loan originator who is an instructor of an approved continuing education course may receive credit for the licensed mortgage loan originator's own annual continuing education requirement at the rate of two hours credit for every one hour taught.

(7) An individual having successfully completed the education requirements approved by the Nationwide Mortgage Licensing System and Registry in subdivisions (1)(a), (b), and (c) of this section for any state shall be accepted as credit towards completion of continuing education requirements in this state.

(8) A licensed mortgage loan originator who subsequently becomes unlicensed shall complete the continuing education requirements for the last year in which the license was held prior to issuance of a new license or renewal license. Such individual may make up any deficiency in continuing education as established by rule, regulation, or order of the director if such individual meets the requirements of subdivision (2)(a) of section 45-732 and has paid the new application fee as provided by subsection (2) of section 45-728 or the reinstatement fee as provided by subdivision (4)(b) of section 45-742.

Source: Laws 2009, LB328, § 18; Laws 2010, LB892, § 13.

45-734 Mortgage loan originator license; inactive status; duration; renewal; reactivation.

(1) A mortgage loan originator whose license is placed on inactive status under this section shall not act as a mortgage loan originator in this state until such time as the license is reactivated.

(2) The department shall place a mortgage loan originator license on inactive status upon the occurrence of one of the following:

(a) Upon receipt of a notice from either the licensed mortgage banker, registrant, installment loan company, or mortgage loan originator that the mortgage loan originator's relationship as an employee or independent agent of a licensed mortgage banker or installment loan company has been terminated;

(b) Upon the cancellation of the employing licensed mortgage banker's license pursuant to section 45-742 or upon the cancellation of the employing installment loan company's license pursuant to subdivision (3)(b) of section 45-1033 for failure to maintain the required surety bond;

(c) Upon the voluntary surrender of the employing licensed mortgage banker's license pursuant to section 45-742 or upon the voluntary surrender of the employing installment loan company's license pursuant to section 45-1032;

(d) Upon the expiration of the employing licensed mortgage banker's license pursuant to section 45-742 or upon the expiration of the employing installment loan company's license pursuant to subdivision (3)(a) of section 45-1033 if such mortgage loan originator has renewed his or her license pursuant to section 45-732;

(e) Upon the revocation or suspension of the employing licensed mortgage banker's license pursuant to section 45-742 or upon the revocation or suspension of the employing installment loan company's license pursuant to subsection (1) of section 45-1033; or

(f) Upon the cancellation, surrender, or expiration of the employing registrant's registration with the department.

(3) If a mortgage loan originator license becomes inactive under this section, the license shall remain inactive until the license expires, the licenseholder surrenders the license, the license is revoked or suspended pursuant to section 45-742, or the license is reactivated.

(4) Except as provided in subsection (5) of this section, a mortgage loan originator who holds an inactive mortgage loan originator license may renew such inactive license if he or she remains otherwise eligible for renewal pursuant to section 45-732 except for being covered by a surety bond pursuant to subdivision (1)(f) of section 45-729. Such renewal shall not reactivate the license.

(5) A mortgage loan originator who holds an inactive mortgage loan originator license that has been renewed one time may not renew such inactive license for a second annual licensing period unless (a) the inactive license was reactivated after such inactive license was renewed or (b) the mortgage loan originator demonstrates good cause to the director to allow renewal of the inactive license for an additional annual licensing period.

(6) The department has the authority to reactivate a mortgage loan originator license upon receipt of a notice pursuant to section 45-735 that the mortgage loan originator licensee has been hired as a mortgage loan originator by a licensed mortgage banker, registrant, or installment loan company and if such mortgage loan originator meets the conditions for licensing at the time the reactivation notice is received, including, but not limited to, coverage by a surety bond pursuant to subdivision (1)(f) of section 45-729.

Source: Laws 2009, LB328, § 19; Laws 2012, LB965, § 17; Laws 2019, LB355, § 9.

45-735 Mortgage loan originator; employee or independent agent; restriction on activities; written agency contract; notification to department; fee; notice of termination.

(1) A mortgage loan originator shall be an employee or independent agent of a single licensed mortgage banker, registrant, or installment loan company that shall directly supervise, control, and maintain responsibility for the acts and omissions of the mortgage loan originator.

(2) A mortgage loan originator shall not engage in mortgage loan origination activities at any location that is not a main office location of a licensed mortgage banker, registrant, or installment loan company or a branch office of a licensed mortgage banker or registrant. The licensed mortgage banker, registrant, or installment loan company shall designate the location or locations

at which each mortgage loan originator is originating residential mortgage loans.

(3) Any licensed mortgage banker, registrant, or installment loan company who engages an independent agent as a mortgage loan originator shall maintain a written agency contract with such mortgage loan originator. Such written agency contract shall provide that the mortgage loan originator is originating loans exclusively for the licensed mortgage banker, registrant, or installment loan company.

(4) A licensed mortgage banker, registrant, or installment loan company that has hired a licensed mortgage loan originator as an employee or entered into an independent agent agreement with such licensed mortgage loan originator shall provide notification to the department as soon as reasonably possible after entering into such relationship, along with a fee of fifty dollars. The employing entity shall not allow the mortgage loan originator to conduct such activity in this state prior to such notification to the department and confirmation that the department has received notice of the termination of the mortgage loan originator's prior employment.

(5) A licensed mortgage banker, registrant, or installment loan company shall notify the department no later than ten days after the termination, whether voluntary or involuntary, of a mortgage loan originator unless the mortgage loan originator has previously notified the department of the termination.

Source: Laws 2009, LB328, § 20.

45-736 Unique identifier; use.

The unique identifier of any licensee originating a residential mortgage loan shall be clearly shown on all residential mortgage loan application forms, solicitations, or advertisements, including business cards or websites, and any other documents as established by rule, regulation, or order of the director.

Source: Laws 2009, LB328, § 21; Laws 2012, LB965, § 18.

45-737 Mortgage banker; licensee; duties.

A licensee licensed as a mortgage banker shall:

(1) Disburse required funds paid by the borrower and held in escrow for the payment of insurance payments no later than the date upon which the premium is due under the insurance policy;

(2) Disburse funds paid by the borrower and held in escrow for the payment of real estate taxes prior to the time such real estate taxes become delinquent;

(3) Pay any penalty incurred by the borrower because of the failure of the licensee to make the payments required in subdivisions (1) and (2) of this section unless the licensee establishes that the failure to timely make the payments was due solely to the fact that the borrower was sent a written notice of the amount due more than fifteen calendar days before the due date to the borrower's last-known address and failed to timely remit the amount due to the licensee;

(4) At least annually perform a complete escrow analysis. If there is a change in the amount of the periodic payments, the licensee shall mail written notice of such change to the borrower at least twenty calendar days before the effective date of the change in payment. The following information shall be provided to the borrower, without charge, in one or more reports, at least annually:

(a) The name and address of the licensee;

(b) The name and address of the borrower;

(c) A summary of the escrow account activity during the year which includes all of the following:

(i) The balance of the escrow account at the beginning of the year;

(ii) The aggregate amount of deposits to the escrow account during the year; and

(iii) The aggregate amount of withdrawals from the escrow account for each of the following categories:

(A) Payments applied to loan principal;

(B) Payments applied to interest;

(C) Payments applied to real estate taxes;

(D) Payments for real property insurance premiums; and

(E) All other withdrawals; and

(d) A summary of loan principal for the year as follows:

(i) The amount of principal outstanding at the beginning of the year;

(ii) The aggregate amount of payments applied to principal during the year; and

(iii) The amount of principal outstanding at the end of the year;

(5) Establish and maintain a toll-free telephone number or accept collect telephone calls to respond to inquiries from borrowers, if the licensee services residential mortgage loans. If a licensee ceases to service residential mortgage loans, it shall continue to maintain a toll-free telephone number or accept collect telephone calls to respond to inquiries from borrowers for a period of twelve months after the date the licensee ceased to service residential mortgage loans. A telephonic messaging service which does not permit the borrower an option of personal contact with an employee, agent, or contractor of the licensee shall not satisfy the conditions of this section. Each day such licensee fails to comply with this subdivision shall constitute a separate violation of the Residential Mortgage Licensing Act;

(6) Answer in writing, within seven business days after receipt, any written request for payoff information received from a borrower or a borrower's designated representative. This service shall be provided without charge to the borrower, except that when such information is provided upon request within sixty days after the fulfillment of a previous request, a processing fee of up to ten dollars may be charged;

(7) Record or cause to be recorded a release of mortgage pursuant to the provisions of section 76-2803 or, in the case of a trust deed, record or cause to be recorded a reconveyance pursuant to the provisions of section 76-2803;

(8) Maintain a copy of all documents and records relating to each residential mortgage loan and application for a residential mortgage loan, including, but not limited to, loan applications, federal Truth in Lending Act statements, good faith estimates, appraisals, notes, rights of rescission, and mortgages or trust deeds for a period of five years after the date the residential mortgage loan is funded or the loan application is denied or withdrawn;

(9) Notify the director in writing or through the Nationwide Mortgage Licensing System and Registry within three business days after the occurrence of any of the following:

(a) The filing of a voluntary petition in bankruptcy by the licensee or notice of a filing of an involuntary petition in bankruptcy against the licensee;

(b) The licensee has lost the ability to fund a loan or loans after it had made a loan commitment or commitments and approved a loan application or applications;

(c) Any other state or jurisdiction institutes license denial, cease and desist, suspension, or revocation procedures against the licensee;

(d) The attorney general of any state, the Consumer Financial Protection Bureau, or the Federal Trade Commission initiates an action to enforce consumer protection laws against the licensee or any of the licensee's officers, directors, shareholders, partners, members, employees, or agents;

(e) The Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, Federal Housing Administration, or Government National Mortgage Association suspends or terminates the licensee's status as an approved seller or seller and servicer;

(f) The filing of a criminal indictment or information against the licensee or any of its officers, directors, shareholders, partners, members, employees, or agents; or

(g) The licensee or any of the licensee's officers, directors, shareholders, partners, members, employees, or agents was convicted of, pleaded guilty to, or was found guilty after a plea of nolo contendere to (i) a misdemeanor under state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, depository institution business, or installment loan company business or (ii) any felony under state or federal law; and

(10) Notify the director in writing or through the Nationwide Mortgage Licensing System and Registry within thirty days after the occurrence of a material development other than as described in subdivision (9) of this section, including, but not limited to, any of the following:

(a) Business reorganization;

(b) A change of name, trade name, doing business as designation, or main office address;

(c) The establishment of a branch office. Notice of such establishment shall be on a form prescribed by the department and accompanied by a fee of seventy-five dollars for each branch office;

(d) The relocation or closing of a branch office; or

(e) The entry of an order against the licensee or any of the licensee's officers, directors, shareholders, partners, members, employees, or agents, including orders to which the licensee or other parties consented, by any other state or federal regulator.

Source: Laws 1989, LB 272, § 14; Laws 1994, LB 1275, § 4; Laws 1995, LB 163, § 6; Laws 1995, LB 396, § 1; Laws 1996, LB 1053, § 11; Laws 2003, LB 218, § 8; Laws 2005, LB 533, § 55; Laws 2007,

LB124, § 46; R.S.Supp.,2008, § 45-711; Laws 2009, LB328, § 22; Laws 2010, LB892, § 14; Laws 2013, LB290, § 4; Laws 2015, LB352, § 2; Laws 2018, LB750, § 1; Laws 2019, LB355, § 10.

45-737.01 Mortgage loan originator; licensee; duties.

(1) A licensee licensed as a mortgage loan originator shall notify the director in writing or through the Nationwide Mortgage Licensing System and Registry within three business days after the occurrence of any of the following:

(a) The filing of a voluntary petition in bankruptcy by such licensee or notice of a filing of an involuntary petition in bankruptcy against such licensee;

(b) The filing of a criminal indictment or information against such licensee regarding (i) a misdemeanor under state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, depository institution business, or installment loan company business or (ii) any felony under state or federal law;

(c) Such licensee was convicted of, pleaded guilty to, or was found guilty after a plea of nolo contendere to (i) a misdemeanor under state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, depository institution business, or installment loan company business or (ii) any felony under state or federal law;

(d) Any other state or jurisdiction institutes license denial, cease and desist, suspension, or revocation procedures against such licensee;

(e) The attorney general of any state, the Consumer Financial Protection Bureau, or the Federal Trade Commission initiates an action to enforce consumer protection laws against such licensee; or

(f) The Federal National Mortgage Association, Federal Home Loan Mortgage Corporation, Federal Housing Administration, or Government National Mortgage Association suspends or terminates such licensee's status as an approved loan originator.

(2) A licensee licensed as a mortgage loan originator shall update through the Nationwide Mortgage Licensing System and Registry his or her employment history on file with the department no later than ten business days after the submission of the required notice of the creation or termination of an employment relationship pursuant to section 45-735.

(3) A licensee licensed as a mortgage loan originator shall notify the director in writing or through the Nationwide Mortgage Licensing System and Registry within thirty days after the occurrence of a material development other than as described in subsections (1) and (2) of this section, including, but not limited to, any of the following:

(a) A change in such licensee's name;

(b) A change in such licensee's residential address;

(c) A change in such licensee's employment address;

(d) The filing of a tax or other governmental lien against such licensee;

(e) The entry of a monetary judgment against such licensee; or

(f) The entry of an order against such licensee, including orders to which such licensee consented, by any other state or federal regulator.

Source: Laws 2013, LB290, § 5.

45-738 Licensee; failure to deliver abstract of title.

If a licensee in connection with a residential mortgage loan has possession of an abstract of title and fails to deliver the abstract to the borrower within twenty business days of the borrower's request made by certified mail, return receipt requested, in connection with a proposed sale of the real property, the borrower may authorize the preparation of a new abstract of title to the real property and the person failing to deliver the original abstract shall pay the borrower the reasonable costs of the preparation of the new abstract of title. If a borrower brings an action against the person failing to deliver an abstract of title to recover the payment made, the borrower shall also be entitled to recover reasonable attorney's fees and court costs incurred in the action.

Source: Laws 1989, LB 272, § 15; R.S.1943, (2004), § 45-712; Laws 2009, LB328, § 23.

45-739 Transfer of servicing rights; duties.

Not less than fifteen days prior to the effective date of the transfer of servicing rights involving any residential mortgage loan, the licensee transferring the servicing rights shall send a written notice of transfer to each borrower which shall include:

(1) The effective date of the transfer;

(2) The name, address, and telephone number of the transferee and the name of a referral person or department of the transferee;

(3) Instructions concerning payments made before the effective date of the transfer; and

(4) Instructions concerning payments made after the effective date of the transfer.

The provisions of this section shall not apply when the licensee transferring the servicing rights has provided the borrower with a written notice of transfer at the time of closing on the residential mortgage loan.

Source: Laws 1989, LB 272, § 16; Laws 1996, LB 1053, § 12; R.S.1943, (2004), § 45-713; Laws 2009, LB328, § 24.

45-740 Prohibited acts; violation; penalty; civil liability.

(1) A licensee, an officer, an employee, or an agent of the licensee shall not:

(a) Assess a late charge if all payments due are received before the date upon which late charges are authorized in the underlying mortgage or trust deed or other loan documents;

(b) Delay closing of a residential mortgage loan for the purpose of increasing interest, costs, fees, or charges payable by the borrower;

(c) Misrepresent or conceal material facts or make false promises intended to influence, persuade, or induce an applicant for a residential mortgage loan or a borrower to take a residential mortgage loan or cause or contribute to such a misrepresentation by any person acting on a licensee's or any other lender's behalf;

(d) Misrepresent to, or conceal from, an applicant for a residential mortgage loan or a borrower material facts, terms, or conditions of a residential mortgage loan to which the licensee is a party;

(e) Fail to make disclosures as required by the Residential Mortgage Licensing Act and any other applicable state or federal law including regulations thereunder;

(f) Engage in any transaction, practice, or business conduct that is not in good faith or that operates a fraud upon any person in connection with the making of any residential mortgage loan;

(g) Receive compensation for acting as a mortgage banker or mortgage loan originator if the licensee has otherwise acted as a real estate broker or agent in connection with the sale of the real estate which secures the residential mortgage loan unless the licensee has provided written disclosure to the person from whom compensation is collected that the licensee is receiving compensation both for acting as a mortgage banker or mortgage loan originator and for acting as a real estate broker or agent;

(h) Advertise, display, distribute, broadcast, televise, or cause or permit to be advertised, displayed, distributed, broadcasted, or televised, in any manner, including by the Internet, any false, misleading, or deceptive statement or representation with regard to rates, terms, or conditions for a residential mortgage loan or any false, misleading, or deceptive statement regarding the qualifications of the licensee or of any officer, employee, or agent thereof;

(i) Record a lien on real property if money is not available for the immediate disbursal to the borrower unless, before that recording, the licensee (i) informs the borrower in writing of the reason for the delay and of a definite date by which disbursement shall be made and (ii) obtains the borrower's written permission for the delay unless the delay is required by any other state or federal law;

(j) Fail to account for or deliver to any person personal property obtained in connection with the mortgage banking business, including, but not limited to, money, funds, deposits, checks, drafts, mortgages, trust deeds, or other documents or things of value which the licensee was not entitled to retain;

(k) Fail to disburse, without just cause, any funds in accordance with any agreement connected with the mortgage banking business;

(l) Collect fees and charges on funds other than new funds if the licensee makes a residential mortgage loan to refinance an existing residential mortgage loan to a current borrower of the licensee within twelve months after the previous residential mortgage loan made by the licensee;

(m) Assess any fees against the borrower other than those which are reasonable and necessary, including actual charges incurred in connection with the making, closing, disbursing, servicing, extending, transferring, or renewing of a loan, including, but not limited to, (i) prepayment charges, (ii) delinquency charges, (iii) premiums for hazard, private mortgage, disability, life, or title insurance, (iv) fees for escrow services, appraisal services, abstracting services, title services, surveys, inspections, credit reports, notary services, and recording of documents, (v) origination fees, (vi) interest on interest after default, and (vii) costs and charges incurred for determining qualification for the loan proceeds and disbursement of the loan proceeds;

(n) Allow the borrower to finance, directly or indirectly, (i) any credit life, credit accident, credit health, credit personal property, or credit loss-of-income insurance or debt suspension coverage or debt cancellation coverage, whether or not such coverage is insurance under applicable law, that provides for

cancellation of all or part of a borrower's liability in the event of loss of life, health, personal property, or income or in the case of accident written in connection with a residential mortgage loan or (ii) any life, accident, health, or loss-of-income insurance without regard to the identity of the ultimate beneficiary of such insurance. For purposes of this section, any premiums or charges calculated and paid on a periodic basis that are not added to the principal of the loan shall not be considered financed directly or indirectly by the creditor;

(o) Falsify any documentation relating to a residential mortgage loan or a residential mortgage loan application;

(p) Recommend or encourage default on an existing loan or other debt prior to and in connection with the closing or planned closing of a residential mortgage loan that refinances all or any portion of such existing loan or debt;

(q) Borrow money from, personally loan money to, or guarantee any loan made to any customer or applicant for a residential mortgage loan;

(r) Obtain a signature on a document required to be notarized in connection with a residential mortgage loan or a residential mortgage loan application unless the qualified notary public performing the notarization is physically present at the time the signature is obtained; or

(s) Make any payment, threat, or promise, directly or indirectly, to any person for the purposes of influencing the independent judgment of the person in connection with a residential mortgage loan or make any payment, threat, or promise, directly or indirectly, to any appraiser of a property for the purposes of influencing the independent judgment of the appraiser with respect to the value of the property.

(2) Any person who violates any provision of subsection (1) of this section is guilty of a Class III misdemeanor.

(3) Any person who violates any provision of subsection (1) of this section is liable to the applicant for a residential mortgage loan or to the borrower for the fees, costs, and charges incurred in connection with obtaining or attempting to obtain the residential mortgage loan, damages resulting from such violation, interest on the damage from the date of the violation, and court costs, including reasonable attorney's fees.

Source: Laws 1989, LB 272, § 17; Laws 2003, LB 218, § 9; Laws 2006, LB 876, § 32; Laws 2007, LB124, § 47; R.S.Supp.,2008, § 45-714; Laws 2009, LB328, § 25.

45-741 Director; examine documents and records; investigate violations or complaints; director; powers; costs; confidentiality.

(1) The director may examine documents and records maintained by a licensee, registrant, individual, or person subject to the Residential Mortgage Licensing Act. The director may investigate complaints about a licensee, registrant, individual, or person subject to the act. The director may investigate reports of alleged violations of the act, any federal law governing residential mortgage loans, or any rule, regulation, or order of the director under the act. For purposes of investigating violations or complaints arising under the act or for the purposes of examination, the director may review, investigate, or examine any licensee, registrant, individual, or person subject to the act as often as necessary in order to carry out the purposes of the act.

(2) For purposes of any investigation, examination, or proceeding, including, but not limited to, initial licensing, license renewal, license suspension, license conditioning, or license revocation, the director shall have the authority to access, receive, and use any books, accounts, records, files, documents, information, or evidence, including, but not limited to:

(a) Criminal, civil, and administrative history information;

(b) Personal history and experience information, including independent credit reports obtained from a consumer reporting agency described in 15 U.S.C. 1681a(p), as such section existed on January 1, 2010; and

(c) Any other documents, information, or evidence the director deems relevant to the inquiry or investigation regardless of the location, possession, control, or custody of such documents, information, or evidence.

(3) Each licensee, registrant, individual, or person subject to the Residential Mortgage Licensing Act shall make available to the director upon request the books, accounts, records, files, or documents relating to the operations of such licensee, registrant, individual, or person subject to the act. The director shall have access to such books, accounts, records, files, and documents and may interview the officers, principals, mortgage loan originators, employees, independent contractors, agents, and customers of the licensee, registrant, individual, or person subject to the act, concerning the business of the licensee, registrant, individual, or person subject to the act.

(4) Each licensee, registrant, individual, or person subject to the act shall make or compile reports or prepare other information as instructed by the director in order to carry out the purposes of this section, including, but not limited to:

(a) Accounting compilations;

(b) Information lists and data concerning loan transactions on a form prescribed by the director; or

(c) Such other information deemed necessary to carry out the purposes of this section.

(5) The director may send a notice of investigation or inquiry request for information to a licensee or registrant. Upon receipt by a licensee or registrant of the director's notice of investigation or inquiry request for information, the licensee or registrant shall respond within twenty-one calendar days. Each day beyond that time a licensee or registrant fails to respond as required by this subsection shall constitute a separate violation of the act. This subsection shall not be construed to require the director to send a notice of investigation to a licensee, a registrant, or any person.

(6) For the purpose of any investigation, examination, or proceeding under the act, the director or any officer designated by him or her may administer oaths and affirmations, subpoena witnesses and compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records which the director deems relevant or material to the inquiry. If any person refuses to comply with a subpoena issued under this section or to testify with respect to any matter relevant to the proceeding, the district court of Lancaster County may, on application of the director, issue an order requiring the person to comply with the subpoena and to testify. Failure to obey an order of the court to comply with the subpoena may be punished by the court as civil contempt.

(7) In conducting an examination or investigation under this section, the director may rely on reports made by the licensee or registrant which have been prepared within the preceding twelve months for the following federal agencies or federally related entities:

(a) The United States Department of Housing and Urban Development;

(b) The Federal Housing Administration;

(c) The Federal National Mortgage Association;

(d) The Government National Mortgage Association;

(e) The Federal Home Loan Mortgage Corporation;

(f) The United States Department of Veterans Affairs; or

(g) The Consumer Financial Protection Bureau.

(8) In order to carry out the purposes of this section, the director may:

(a) Enter into agreements or relationships with other government officials or regulatory associations in order to improve efficiencies and reduce the regulatory burden by sharing resources, standardized or uniform methods or procedures, and documents, records, information, or evidence obtained under this section;

(b) Use, hire, contract, or employ publicly or privately available analytical systems, methods, or software to examine or investigate the licensee, registrant, individual, or person subject to the act;

(c) Accept and rely on examination or investigation reports made by other government officials, within or without this state; or

(d) Accept audit reports made by an independent certified public accountant for the licensee, registrant, individual, or person subject to the act in the course of that part of the examination covering the same general subject matter as the audit and incorporate the audit report in the report of the examination, report of investigation, or other writing of the director.

(9) If the director receives a complaint or other information concerning noncompliance with the act by an exempt person, the director shall inform the agency having supervisory authority over the exempt person of the complaint.

(10) No licensee, registrant, individual, or person subject to investigation or examination under this section shall knowingly withhold, abstract, remove, mutilate, destroy, or secrete any books, records, computer records, or other information.

(11) The total charge for an examination or investigation shall be paid by the licensee or registrant as set forth in sections 8-605 and 8-606.

(12) Examination reports shall not be deemed public records and may be withheld from the public pursuant to section 84-712.05.

(13) Complaint files shall be deemed public records.

(14) The authority of this section shall remain in effect, whether such a licensee, registrant, individual, or person subject to the Residential Mortgage Licensing Act acts or claims to act under any licensing or registration law of this state or claims to act without such authority.

Source: Laws 1989, LB 272, § 13; Laws 1993, LB 217, § 3; Laws 1995, LB 163, § 5; Laws 2003, LB 218, § 7; Laws 2007, LB124, § 45; R.S.Supp.,2008, § 45-710; Laws 2009, LB328, § 26; Laws 2010, LB892, § 15; Laws 2013, LB290, § 6.

45-742 License; suspension or revocation; administrative fine; procedure; surrender; cancellation; expiration; effect; reinstatement.

(1) The director may, following a hearing under the Administrative Procedure Act and the rules and regulations adopted and promulgated under the act, suspend or revoke any license issued under the Residential Mortgage Licensing Act. The director may also impose an administrative fine for each separate violation of the act if the director finds:

(a) The licensee has materially violated or demonstrated a continuing pattern of violating the act, rules and regulations adopted and promulgated under the act, any order, including a cease and desist order, issued under the act, or any other state or federal law applicable to the conduct of its business;

(b) A fact or condition exists which, if it had existed at the time of the original application for the license, would have warranted the director to deny the application;

(c) The licensee has violated a voluntary consent or compliance agreement which had been entered into with the director;

(d) The licensee has made or caused to be made, in any document filed with the director or in any proceeding under the act, any statement which was, at the time and in light of the circumstances under which it was made, false or misleading in any material respect or suppressed or withheld from the director any information which, if submitted by the licensee, would have resulted in denial of the license application;

(e) The licensee has refused to permit an examination by the director of the licensee's books and affairs pursuant to subsection (1) or (2) of section 45-741 or has refused or failed to comply with subsection (5) of section 45-741 after written notice of the violation by the director. Each day the licensee continues in violation of this subdivision after such written notice constitutes a separate violation;

(f) The licensee has failed to maintain records as required by subdivision (8) of section 45-737 or as otherwise required following written notice of the violation by the director. Each day the licensee continues in violation of this subdivision after such written notice constitutes a separate violation;

(g) The licensee knowingly has employed any individual or knowingly has maintained a contractual relationship with any individual acting as an agent, if such individual has been convicted of, pleaded guilty to, or was found guilty after a plea of nolo contendere to (i) a misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, depository institution business, or installment loan company business or (ii) any felony under state or federal law;

(h) The licensee knowingly has employed any individual or knowingly has maintained a contractual relationship with any individual acting as an agent, if such individual (i) has had a mortgage loan originator license revoked in any state, unless such revocation was subsequently vacated, (ii) has a mortgage loan originator license which has been suspended by the director, or (iii) while previously associated in any other capacity with another licensee, was the subject of a complaint under the act and the complaint was not resolved at the time the individual became employed by, or began acting as an agent for, the licensee and the licensee with reasonable diligence could have discovered the existence of such complaint;

(i) The licensee knowingly has employed any individual or knowingly has maintained a contractual relationship with any individual acting as an agent if such individual is conducting activities requiring a mortgage loan originator license in this state without first obtaining such license;

(j) The licensee has violated the written restrictions or conditions under which the license was issued;

(k) The licensee, or if the licensee is a business entity, one of the officers, directors, shareholders, partners, and members, was convicted of, pleaded guilty to, or was found guilty after a plea of nolo contendere to (i) a misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, depository institution business, or installment loan company business or (ii) any felony under state or federal law;

(l) The licensee has had a similar license revoked in any other jurisdiction; or

(m) The licensee has failed to reasonably supervise any officer, employee, or agent to assure his or her compliance with the act or with any state or federal law applicable to the mortgage banking business.

(2) Except as provided in this section and section 45-742.01, a license shall not be revoked or suspended except after notice and a hearing in accordance with the Administrative Procedure Act and the rules and regulations adopted and promulgated by the department.

(3) A licensee may voluntarily surrender a license by delivering to the director written notice of the surrender, but a surrender shall not affect civil or criminal liability for acts committed before the surrender or liability for any fines which may be levied against the licensee or any of its officers, directors, shareholders, partners, or members pursuant to section 45-743 for acts committed before the surrender. The director's approval of such license surrender shall not be required unless the director has commenced an examination or investigation pursuant to section 45-741 or has commenced a proceeding to revoke or suspend the licensee's license or impose an administrative fine pursuant to this section.

(4)(a) If a licensee fails to (i) renew its license as required by sections 45-706 and 45-732 and does not voluntarily surrender the license pursuant to this section or (ii) pay the required fee for renewal of the license, the department may issue a notice of expiration of the license to the licensee in lieu of revocation proceedings.

(b) The director may adopt by rule, regulation, or order procedures for the reinstatement of licenses for which a notice of expiration was issued in accordance with subdivision (a) of this subsection. Such procedures shall be consistent with standards established by the Nationwide Mortgage Licensing System and Registry. The fee for reinstatement shall be the same fee as the fee for the initial license application.

(c) If a licensee fails to maintain a surety bond as required by section 45-724, the department may issue a notice of cancellation of the license in lieu of revocation proceedings.

(5) Revocation, suspension, surrender, cancellation, or expiration of a license shall not impair or affect the obligation of a preexisting lawful contract between the licensee and any person, including a borrower.

(6) Revocation, suspension, cancellation, or expiration of a license shall not affect civil or criminal liability for acts committed before the revocation, suspension, cancellation, or expiration or liability for any fines which may be levied against the licensee or any of its officers, directors, shareholders, partners, or members pursuant to section 45-743 for acts committed before the revocation, suspension, cancellation, or expiration.

Source: Laws 1989, LB 272, § 10; Laws 1997, LB 137, § 23; Laws 1999, LB 396, § 33; Laws 2003, LB 218, § 5; Laws 2005, LB 533, § 54; Laws 2006, LB 876, § 30; R.S.Supp.,2008, § 45-707; Laws 2009, LB328, § 27; Laws 2010, LB892, § 16; Laws 2011, LB75, § 4; Laws 2012, LB965, § 19.

Cross References

Administrative Procedure Act, see section 84-920.

45-742.01 Mortgage banker or mortgage loan originator license; emergency orders authorized; grounds; notice; emergency hearing; judicial review; director; additional proceedings.

(1) The director may enter an emergency order suspending, limiting, or restricting the license of any mortgage banker or mortgage loan originator without notice or hearing if it appears upon grounds satisfactory to the director that:

(a) The licensee has failed to file the report of condition as required by section 45-726;

(b) The licensee has failed to increase its surety bond to the amount required by subsection (2) of section 45-724;

(c) The licensee has failed to provide any report required by the director as a condition of issuing such person a mortgage banker or mortgage loan originator license;

(d) The licensee is in such financial condition that it cannot continue in business safely with its customers;

(e) The licensee has been indicted, charged with, or found guilty of any act involving fraud, deception, theft, or breach of trust;

(f) The licensee has had its license suspended or revoked in any state based upon any act involving fraud, deception, theft, or breach of trust; or

(g) The licensee has refused to permit an examination by the director of the licensee's books and affairs pursuant to subsection (1) or (2) of section 45-741 or has refused or failed to comply with subsection (5) of section 45-741.

(2) An emergency order issued under this section becomes effective when signed by the director. Upon entry of an emergency order, the director shall promptly notify the affected person that such order has been entered, the reasons for such order, and the right to request an emergency hearing.

(3) A party aggrieved by an emergency order issued by the director under this section may request an emergency hearing. The request for hearing shall be filed with the director within ten business days after the date of the emergency order.

(4) Upon receipt of a written request for emergency hearing, the director shall conduct an emergency hearing within ten business days after the date of

receipt of the request for hearing unless the parties agree to a later date or a hearing officer sets a later date for good cause shown.

(5) A person aggrieved by an emergency order of the director may obtain judicial review of the order in the manner prescribed in the Administrative Procedure Act and the rules and regulations adopted and promulgated by the department.

(6) The director may obtain an order from the district court of Lancaster County for the enforcement of the emergency order.

(7) The director may vacate or modify an emergency order if he or she finds that the conditions which caused its entry have changed or that it is otherwise in the public interest to do so.

(8) If an emergency hearing has not been requested pursuant to subsection (3) of this section and the emergency order remains in effect sixty days after issuance, the director shall initiate proceedings pursuant to section 45-742 unless the license was surrendered or expired during the sixty-day time period after issuance of the emergency order.

(9) An emergency order issued under this section shall remain in effect until it is vacated, modified, or superseded by an order of the director, superseded by a voluntary consent or compliance agreement between the director and the licensee, or until it is terminated by a court order.

Source: Laws 2012, LB965, § 20.

Cross References

Administrative Procedure Act, see section 84-920.

45-743 Violations; administrative fine; costs; lien.

(1) The director may, following a hearing under the Administrative Procedure Act and the rules and regulations adopted and promulgated under the act, impose an administrative fine against any officer, director, shareholder, partner, or member of a licensee, if the director finds the licensee or any such person participated in or had knowledge of any act prohibited by sections 45-737, 45-740, and 45-742 or otherwise violated the Residential Mortgage Licensing Act. Such administrative fine shall be in addition to or separate from any fine imposed against a licensee pursuant to section 45-742.

(2) If the director finds, after notice and hearing in accordance with the Administrative Procedure Act and the rules and regulations adopted and promulgated under the act, that any person has knowingly committed any act prohibited by section 45-742 or otherwise violated the Residential Mortgage Licensing Act, the director may order such person to pay (a) an administrative fine of not more than five thousand dollars for each separate violation and (b) the costs of investigation.

(3) If a person fails to pay an administrative fine and the costs of investigation ordered pursuant to this section, a lien in the amount of such fine and costs may be imposed upon all assets and property of such person in this state and may be recovered in a civil action by the director. The lien shall attach to the real property of such person when notice of the lien is filed and indexed against the real property in the office of the register of deeds in the county where the real property is located. The lien shall attach to any other property of such person when notice of the lien is filed against the property in the manner

prescribed by law. Failure of the person to pay such fine and costs shall constitute a separate violation of the act.

Source: Laws 1995, LB 163, § 9; Laws 2003, LB 218, § 12; Laws 2006, LB 876, § 34; R.S.Supp.,2008, § 45-717.01; Laws 2009, LB328, § 28.

Cross References

Administrative Procedure Act, see section 84-920.

45-744 Cease and desist orders; department; powers; judicial review; violation; penalty.

(1) The department may order any person to cease and desist whenever the department determines that the person has violated any provision of the Residential Mortgage Licensing Act. Upon entry of a cease and desist order, the director shall promptly notify the affected person that such order has been entered, of the reasons for such order, and that upon receipt, within fifteen business days after the date of the order, of written request from the affected person a hearing will be scheduled within thirty business days after the date of receipt of the written request unless the parties consent to a later date or the hearing officer sets a later date for good cause. If a hearing is not requested and none is ordered by the director, the order shall remain in effect until it is modified or vacated.

(2) The director may vacate or modify a cease and desist order if he or she finds that the conditions which caused its entry have changed or that it is otherwise in the public interest to do so.

(3) A person aggrieved by a cease and desist order of the director may obtain judicial review of the order in the manner prescribed in the Administrative Procedure Act and the rules and regulations adopted and promulgated under the act. The director may obtain an order from the district court of Lancaster County for the enforcement of the cease and desist order.

(4) A person who violates a cease and desist order of the director may, after notice and hearing and upon further order of the director, be subject to a penalty of not more than five thousand dollars for each act in violation of the cease and desist order.

Source: Laws 1989, LB 272, § 20; Laws 1995, LB 163, § 8; Laws 2000, LB 932, § 33; Laws 2001, LB 53, § 102; Laws 2006, LB 876, § 33; R.S.Supp.,2008, § 45-717; Laws 2009, LB328, § 29.

Cross References

Administrative Procedure Act, see section 84-920.

45-745 Appeals.

In addition to any other remedy a licensee may have, any licensee or any person considering himself or herself aggrieved by any action of the department under the Residential Mortgage Licensing Act may appeal the action, and the appeal shall be in accordance with the Administrative Procedure Act and the rules and regulations adopted and promulgated under the act.

Source: Laws 1989, LB 272, § 21; R.S.1943, (2004), § 45-718; Laws 2009, LB328, § 30.

Cross References

Administrative Procedure Act, see section 84-920.

45-746 Enforcement of act; director; powers; construction of act; failure to comply with act; effect.

(1) The director may request the Attorney General to enforce the Residential Mortgage Licensing Act. A civil enforcement action by the Attorney General may be filed in the district court of Lancaster County. A civil enforcement action by the Attorney General may seek temporary and permanent injunctive relief, restitution for a borrower aggrieved by a violation of the act, and costs for the investigation and prosecution of the enforcement action.

(2) Except when expressly authorized, there shall be no private cause of action for any violation of the act.

(3) Nothing in the act shall limit any statutory or common-law right of any person to bring any action in any court for any act involved in the mortgage banking business or the right of the state to punish any person for any violation of law.

(4) Failure to comply with the act shall not affect the validity or enforceability of any residential mortgage loan. A person acquiring a residential mortgage loan or an interest in a residential mortgage loan is not required to ascertain the extent of compliance with the act.

Source: Laws 2006, LB 876, § 35; R.S.Supp.,2008, § 45-717.02; Laws 2009, LB328, § 31.

45-747 Prohibited acts; penalty.

(1) Any person required to be licensed or registered under the Residential Mortgage Licensing Act who, without first obtaining a license or registration under the act or while such license is on inactive status or expired or has been suspended, revoked, or canceled by the director, engages in the business of or occupation of, advertises or holds himself or herself out as, claims to be, or temporarily acts as a mortgage banker or mortgage loan originator in this state is guilty of a Class II misdemeanor.

(2) Any individual who has been convicted of, pleaded guilty to, or been found guilty after a plea of nolo contendere to (a) a misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, depository institution business, or installment loan company business or (b) any felony under state or federal law, and is employed by or maintains a contractual relationship as an agent of, any person required to be licensed or registered under the act, is guilty of a Class I misdemeanor.

Source: Laws 1989, LB 272, § 11; Laws 1999, LB 396, § 34; Laws 2007, LB124, § 44; R.S.Supp.,2008, § 45-708; Laws 2009, LB328, § 32.

45-748 License and registration under Nationwide Mortgage Licensing System and Registry; department; powers and duties; director; duties.

(1) The department shall require mortgage bankers, registrants, and mortgage loan originators to be licensed and registered through the Nationwide Mortgage Licensing System and Registry. In order to carry out this requirement, the department is authorized to participate in the Nationwide Mortgage

Licensing System and Registry. For this purpose, the department may establish, by adopting and promulgating rules and regulations or by order, requirements, as necessary. The requirements may include, but not be limited to:

(a) Background checks of mortgage bankers, registrants, and mortgage loan originators, including, but not limited to:

(i) Criminal history through fingerprint or other databases;

(ii) Civil or administrative records;

(iii) Credit history; or

(iv) Any other information as deemed necessary by the Nationwide Mortgage Licensing System and Registry;

(b) The payment of fees to apply for or renew a license through the Nationwide Mortgage Licensing System and Registry;

(c) Compliance with the prelicensure education and testing and continuing education requirements as provided in the Residential Mortgage Licensing Act;

(d) The setting or resetting, as necessary, of renewal processing or reporting dates; and

(e) Amending or surrendering a license or any other such activities as the director deems necessary for participation in the Nationwide Mortgage Licensing System and Registry.

(2) In order to fulfill the purposes of the act, the department is authorized to establish relationships or contracts with the Nationwide Mortgage Licensing System and Registry or other entities designated by the Nationwide Mortgage Licensing System and Registry to collect and maintain records and process transaction fees or other fees related to licensees or other persons subject to the act. The department may allow such system to collect licensing fees on behalf of the department and allow such system to collect a processing fee for the services of the system directly from each licensee or applicant for a license.

(3) The director is required to regularly report violations of the act, as well as enforcement actions and other relevant information, to the Nationwide Mortgage Licensing System and Registry subject to the provisions contained in section 45-749.

(4) The director shall establish a process whereby mortgage bankers, registrants, and mortgage loan originators may challenge information entered into the Nationwide Mortgage Licensing System and Registry by the director.

(5) The department shall ensure that the Nationwide Mortgage Licensing System and Registry adopts a privacy, data security, and security breach notification policy. The director shall make available upon written request a copy of the contract between the department and the Nationwide Mortgage Licensing System and Registry pertaining to the breach of security of the system provisions.

(6) The department shall upon written request provide the most recently available audited financial report of the Nationwide Mortgage Licensing System and Registry.

Source: Laws 2007, LB124, § 50; R.S.Supp.,2008, § 45-723; Laws 2009, LB328, § 33; Laws 2010, LB892, § 17.

45-749 Information sharing; privilege and confidentiality; limitations; applicability of section; director; powers.

(1) In order to promote more effective regulation and reduce the regulatory burden through supervisory information sharing:

(a) Except as otherwise provided in this section, the requirements under any federal or state law regarding the privacy or confidentiality of any information or material provided to the Nationwide Mortgage Licensing System and Registry, and any privilege arising under federal or state law, including the rules of any federal or state court, with respect to such information or material, shall continue to apply to such information or material after the information or material has been disclosed to the Nationwide Mortgage Licensing System and Registry. Such information and material may be shared with all federal and state regulatory officials with mortgage industry oversight authority without the loss of privilege or the loss of confidentiality protections provided by federal or state law;

(b) Information or material that is subject to a privilege or confidentiality under subdivision (1)(a) of this section shall not be subject to:

(i) Disclosure under any federal or state law governing the disclosure to the public of information held by an officer or an agency of the federal government or the respective state; or

(ii) Subpoena or discovery, or admission into evidence, in any private civil action or administrative process, unless with respect to any privilege held by the Nationwide Mortgage Licensing System and Registry with respect to such information or material, the person to whom such information or material pertains waives, in whole or in part, in the discretion of such person, that privilege;

(c) Any state statute relating to the disclosure of confidential supervisory information or any information or material described in subdivision (1)(a) of this section that is inconsistent with such subdivision shall be superseded by the requirements of this section; and

(d) This section shall not apply with respect to the information or material relating to the employment history of, and publicly adjudicated disciplinary and enforcement actions against, applicants and licensees that is included in the Nationwide Mortgage Licensing System and Registry for access by the public.

(2) For these purposes, the director is authorized to enter into agreements or sharing arrangements with other governmental agencies, the Conference of State Bank Supervisors, the American Association of Residential Mortgage Regulators, or other associations representing governmental agencies as established by adopting and promulgating rules and regulations or by order of the director.

Source: Laws 2009, LB328, § 34; Laws 2010, LB892, § 18.

45-750 Department; duties; rules and regulations.

(1) The department shall be responsible for the administration and enforcement of the Residential Mortgage Licensing Act.

(2) The department may adopt and promulgate such rules and regulations as it may deem necessary in the administration of the act and not inconsistent with the act. The department shall make a good faith effort to provide a copy of

the notice of hearing as required by section 84-907 in a timely manner to all licensees. Such notice may be sent electronically to licensees.

Source: Laws 1989, LB 272, § 18; Laws 2003, LB 218, § 10; Laws 2007, LB124, § 48; R.S.Supp.,2008, § 45-715; Laws 2009, LB328, § 35.

45-751 Money collected; disposition.

(1) All fees, charges, and costs collected by the department pursuant to the Residential Mortgage Licensing Act shall be remitted to the State Treasurer for credit to the Financial Institution Assessment Cash Fund.

(2) The department shall remit fines collected under the Residential Mortgage Licensing Act to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Source: Laws 1989, LB 272, § 19; Laws 1994, LB 1066, § 32; Laws 1995, LB 163, § 7; Laws 1995, LB 599, § 14; Laws 2003, LB 218, § 11; Laws 2007, LB124, § 51; R.S.Supp.,2008, § 45-716; Laws 2009, LB328, § 36.

45-752 Act; liberal construction.

The Residential Mortgage Licensing Act shall be construed liberally so as to effectuate its purposes.

Source: Laws 1989, LB 272, § 22; R.S.1943, (2004), § 45-719; Laws 2009, LB328, § 37.

45-753 Personal jurisdiction; when.

Application for a license as a mortgage banker, for registration as a mortgage banker, or for a license as a mortgage loan originator pursuant to the Residential Mortgage Licensing Act shall constitute sufficient contact with this state for the exercise of personal jurisdiction in any action arising under the act.

Source: Laws 1989, LB 272, § 23; R.S.1943, (2004), § 45-720; Laws 2009, LB328, § 38.

45-754 Loans subject to act.

Any residential mortgage loan made with respect to real property located in this state shall be subject to the Residential Mortgage Licensing Act and all other applicable laws of this state, notwithstanding the place of execution, either nominal or real, of such residential mortgage loan.

Source: Laws 1989, LB 272, § 24; R.S.1943, (2004), § 45-721; Laws 2009, LB328, § 39.

ARTICLE 8

CREDIT SERVICES ORGANIZATIONS

Section
45-801. Act, how cited.
45-802. Terms, defined.
45-803. Exemptions.
45-804. Prohibited acts.
45-805. Surety bond or surety account; requirements; action on surety; depository; Secretary of State; powers and duties.
45-806. Registration statement; contents; requirements; fee.

Section
45-807. Written statement to buyer; contents; credit services organization; duties.
45-808. Contract; requirements; cancellation; procedure; notice; breach; effect.
45-809. Waiver of rights; void.
45-810. Damages.
45-811. Violation; injunction.
45-812. Violation; deceptive trade practice.
45-813. Statute of limitations.
45-814. Violation; penalty.
45-815. Remedies.

45-801 Act, how cited.

Sections 45-801 to 45-815 shall be known and may be cited as the Credit Services Organization Act.

Source: Laws 1991, LB 292, § 1.

45-802 Terms, defined.

For purposes of the Credit Services Organization Act:

(1) Buyer shall mean an individual who is solicited to purchase or who purchases the services of a credit services organization;

(2) Consumer reporting agency shall have the meaning assigned by the Fair Credit Reporting Act, 15 U.S.C. 1681a(f);

(3) Credit services organization shall mean a person who, with respect to the extension of credit by others and in return for the payment of money or other valuable consideration, provides or represents that the person can or will provide any of the following services:

(a) Improving a buyer's credit record, history, or rating;

(b) Obtaining an extension of credit for a buyer; or

(c) Providing advice or assistance to a buyer with regard to subdivision (a) or (b) of this subdivision;

(4) Extension of credit shall mean the right to defer payment of debt or to incur debt and defer its payment offered or granted primarily for personal, family, or household purposes; and

(5) Person shall include individual, corporation, company, association, partnership, limited liability company, and other business entity.

Source: Laws 1991, LB 292, § 2; Laws 1993, LB 121, § 276.

45-803 Exemptions.

(1) The following shall be exempt from the Credit Services Organization Act:

(a) A person authorized to make loans or extensions of credit under the laws of this state or the United States who is subject to regulation and supervision by this state or the United States or a lender approved by the United States Secretary of Housing and Urban Development for participation in a mortgage insurance program under the National Housing Act, 12 U.S.C. 1701 et seq.;

(b) A bank or savings and loan association whose deposit or accounts are eligible for insurance by the Federal Deposit Insurance Corporation or a subsidiary of such a bank or savings and loan association;

(c) A credit union doing business in this state;

(d) A nonprofit organization exempt from taxation under section 501(c)(3) of the Internal Revenue Code;

(e) A person licensed as a real estate broker or salesperson under the Nebraska Real Estate License Act acting within the course and scope of that license;

(f) A person licensed to practice law in this state acting within the course and scope of the person's practice as an attorney;

(g) A broker-dealer registered with the Securities and Exchange Commission or the Commodity Futures Trading Commission acting within the course and scope of that regulation;

(h) A consumer reporting agency;

(i) A person whose primary business is making loans secured by liens on real property;

(j) A person, firm, corporation, or association licensed as a collection agency in this state or a person holding a solicitor's certificate in this state acting within the course and scope of that license or certificate; and

(k) A person licensed to engage in the business of debt management pursuant to sections 69-1201 to 69-1217.

(2) The burden of proving an exemption under this section shall be on the person claiming the exemption.

Source: Laws 1991, LB 292, § 3; Laws 1995, LB 574, § 50.

Cross References

For provisions on licensing of collection agencies and solicitors, see Chapter 45, article 6.
Nebraska Real Estate License Act, see section 81-885.

45-804 Prohibited acts.

A credit services organization, a salesperson, an agent, or a representative of a credit services organization, or an independent contractor who sells or attempts to sell the services of a credit services organization shall not:

(1) Charge a buyer or receive from a buyer money or other valuable consideration before completing performance of all services, other than those described in subdivision (2) of this section, which the credit services organization has agreed to perform for the buyer unless the credit services organization has obtained a surety bond or established and maintained a surety account as provided in section 45-805;

(2) Charge a buyer or receive from a buyer money or other valuable consideration for obtaining or attempting to obtain an extension of credit that the credit services organization has agreed to obtain for the buyer before the extension of credit is obtained;

(3) Charge a buyer or receive from a buyer money or other valuable consideration solely for referral of the buyer to a retail seller who will or may extend credit to the buyer if the credit that is or will be extended to the buyer is substantially the same as that available to the general public;

(4) Make or use a false or misleading representation in the offer or sale of the services of a credit services organization, including (a) guaranteeing to erase bad credit or words to that effect unless the representation clearly discloses that this can be done only if the credit history is inaccurate or obsolete and (b) guaranteeing an extension of credit regardless of the person's previous credit

problem or credit history unless the representation clearly discloses the eligibility requirements for obtaining an extension of credit;

(5) Engage, directly or indirectly, in a fraudulent or deceptive act, practice, or course of business in connection with the offer or sale of the services of a credit services organization;

(6) Make or advise a buyer to make a statement with respect to a buyer's credit worthiness, credit standing, or credit capacity that is false or misleading or that should be known by the exercise of reasonable care to be false or misleading to a consumer reporting agency or to a person who has extended credit to a buyer or to whom a buyer is applying for an extension of credit;

(7) Advertise or cause to be advertised, in any manner whatsoever, the services of a credit services organization without filing a registration statement with the Secretary of State under section 45-806 unless otherwise provided by the Credit Services Organization Act; or

(8) Notwithstanding any other provision of law, charge any brokerage fees or any other fees or charges whatsoever in connection with a loan governed by the Nebraska Installment Loan Act.

Source: Laws 1991, LB 292, § 4; Laws 2018, LB194, § 1.

Cross References

Nebraska Installment Loan Act, see section 45-1001.

45-805 Surety bond or surety account; requirements; action on surety; depository; Secretary of State; powers and duties.

(1) A credit services organization conducting business in this state shall obtain a surety bond or establish a surety account which complies with this section. The bond or account shall be in the amount of one hundred thousand dollars.

(2) If a surety bond is obtained, the bond shall be issued by a surety company authorized to do business in this state and a copy of the bond shall be filed with the Secretary of State. If a surety account is established, the account shall be established and maintained at a federally insured bank or savings and loan association located in this state and notification of the depository, the trustee, and the account number shall be filed with the Secretary of State.

(3) The bond or account shall be in favor of the state for the benefit of any person who is damaged by any violation of the Credit Services Organization Act. The bond or account shall also be in favor of any person damaged by such a violation.

(4) Any person claiming against the bond or account for a violation of the act may maintain an action at law against the credit services organization and against the surety or trustee. The surety or trustee shall be liable only for damages awarded under section 45-810. The aggregate liability of the surety or trustee to all persons damaged by a credit services organization's violation of the act shall not exceed the amount of the bond or account.

(5) A depository holding money in a surety account under the act shall not convey money in the account to the credit services organization that established the account or a representative of the credit services organization unless the credit services organization or representative presents a statement issued by the Secretary of State indicating that subsection (6) of this section has been satisfied in relation to the account. The Secretary of State may conduct

investigations and require submission of information as necessary to enforce this subsection.

(6) The bond or account shall be maintained until two years after the date that the credit services organization ceases operation in this state.

Source: Laws 1991, LB 292, § 5.

45-806 Registration statement; contents; requirements; fee.

(1) A credit services organization shall file a registration statement with the Secretary of State before conducting business in this state. The registration statement shall contain:

(a) The name and address of the credit services organization; and

(b) The name and address of any person who directly or indirectly owns or controls ten percent or more of the outstanding shares of stock in the credit services organization.

(2) The registration statement shall also contain either:

(a) A full and complete disclosure of any litigation or unresolved complaint filed with a governmental authority of this state relating to the operation of the credit services organization; or

(b) A notarized statement that there has been no litigation or unresolved complaint filed with a governmental authority of this state relating to the operation of the credit services organization.

(3) The credit services organization shall update the registration statement within ninety days after the date on which a change in the information required in the statement occurs.

(4) Each credit services organization registering under this section shall maintain a copy of the registration statement in the files of the credit services organization. The credit services organization shall allow a buyer to inspect the registration statement on request.

(5) The Secretary of State may charge each credit services organization that files a registration statement with the Secretary of State a reasonable fee not to exceed one hundred dollars to cover the cost of filing. The Secretary of State shall remit the fees received pursuant to this section to the State Treasurer for credit to the Secretary of State Cash Fund. The Secretary of State shall not require a credit services organization to provide information other than that provided in the registration statement.

Source: Laws 1991, LB 292, § 6; Laws 2020, LB910, § 16.

45-807 Written statement to buyer; contents; credit services organization; duties.

(1) Before executing a contract or agreement with or receiving money or other valuable consideration from a buyer, a credit services organization shall provide the buyer with a written statement containing:

(a) A complete and detailed description of the services to be performed by the credit services organization for the buyer and the total cost of the services;

(b) A statement explaining the buyer's right to proceed against the surety bond or surety account required by section 45-805;

(c) The name and address of the surety company that issued the bond or the name and address of the depository and the trustee and the account number of the surety account;

(d) A complete and accurate statement of the buyer's right to review any file on the buyer maintained by a consumer reporting agency as provided by the Fair Credit Reporting Act, 15 U.S.C. 1681 et seq.;

(e) A statement that the buyer's file is available for review at no charge on request made to the consumer reporting agency within thirty days after the date of receipt of notice that credit has been denied and that the buyer's file is available for a minimal charge at any other time;

(f) A complete and accurate statement of the buyer's right to dispute directly with the consumer reporting agency the completeness or accuracy of any item contained in a file on the buyer maintained by the consumer reporting agency;

(g) A statement that accurate information cannot be permanently removed from the files of a consumer reporting agency;

(h) A complete and accurate statement of when consumer information becomes obsolete and of when consumer reporting agencies are prevented from issuing reports containing obsolete information; and

(i) A complete and accurate statement of the availability of nonprofit credit counseling services.

(2) The credit services organization shall maintain on file, for a period of two years after the date the statement is provided, an exact copy of the statement, signed by the buyer, acknowledging receipt of the statement.

Source: Laws 1991, LB 292, § 7.

45-808 Contract; requirements; cancellation; procedure; notice; breach; effect.

(1) Each contract between the buyer and a credit services organization for the purchase of the services of the credit services organization shall be in writing, dated, and signed by the buyer and shall include:

(a) A statement in type that is boldface, capitalized, underlined, or otherwise set out from surrounding written materials so as to be conspicuous, in immediate proximity to the space reserved for the signature of the buyer, as follows: ''You, the buyer, may cancel this contract at any time before midnight of the third day after the date the contract is signed. See the attached notice of cancellation form for an explanation of this right.'';

(b) The terms and conditions of payment, including the total of all payments to be made by the buyer, whether to the credit services organization or to another person;

(c) A full and detailed description of the services to be performed by the credit services organization for the buyer, including all guarantees and all promises of full or partial refunds, and the estimated length of time, not to exceed one hundred eighty days, for performing the services; and

(d) The address of the credit services organization's principal place of business and the name and address of its agent in the state authorized to receive service of process.

(2) The credit services organization shall return any payment made by a buyer under the contract if the buyer cancels the contract within three days

after it is signed. The payment shall be returned within ten days after the date the organization receives the cancellation notice from the buyer.

(3) The contract shall have attached two easily detachable copies of a notice of cancellation. The notice shall be in boldface in the following form:

Notice of Cancellation

You may cancel this contract, without any penalty or obligation, within three days after the date the contract is signed.

If you cancel, any payment made by you under this contract will be returned within ten days after the date of receipt by the seller of your cancellation notice.

To cancel this contract, mail or deliver a signed, dated copy of this cancellation notice or other written notice to: (name of seller) at (address of seller) (place of business) not later than midnight (date) I hereby cancel this transaction.

(date)

(purchaser's signature)

(4) The credit services organization shall give to the buyer a copy of the completed contract and all other documents the credit services organization requires the buyer to sign at the time they are signed.

(5) The breach by a credit services organization of a contract under the Credit Services Organization Act or of any obligation arising from a contract under the act shall be a violation of the act.

Source: Laws 1991, LB 292, § 8.

45-809 Waiver of rights; void.

A credit services organization shall not attempt to cause a buyer to waive a right under the Credit Services Organization Act. A purported waiver by a buyer of any part of the act shall be void.

Source: Laws 1991, LB 292, § 9.

45-810 Damages.

A buyer injured by a violation of the Credit Services Organization Act may bring an action for recovery of damages. The damages awarded shall not be less than the amount paid by the buyer to the credit services organization plus reasonable attorney's fees and court costs.

Source: Laws 1991, LB 292, § 10.

45-811 Violation; injunction.

The Attorney General or a buyer may bring an action in district court to enjoin a violation of the Credit Services Organization Act.

Source: Laws 1991, LB 292, § 11.

45-812 Violation; deceptive trade practice.

A violation of the Credit Services Organization Act shall be a deceptive trade practice under the Uniform Deceptive Trade Practices Act.

Source: Laws 1991, LB 292, § 12.

Cross References

Uniform Deceptive Trade Practices Act, see section 87-306.

45-813 Statute of limitations.

An action may not be brought under section 45-810 or 45-812 after four years after the date of the execution of the contract for services to which the action relates.

Source: Laws 1991, LB 292, § 13.

45-814 Violation; penalty.

A person who violates the Credit Services Organization Act shall be guilty of a Class II misdemeanor.

Source: Laws 1991, LB 292, § 14.

45-815 Remedies.

The remedies provided by the Credit Services Organization Act shall be in addition to other remedies provided by law.

Source: Laws 1991, LB 292, § 15.

ARTICLE 9

DELAYED DEPOSIT SERVICES LICENSING ACT

Section

45-901 Act, how cited.

Sections 45-901 to 45-931 shall be known and may be cited as the Delayed Deposit Services Licensing Act.

Source: Laws 1994, LB 967, § 1; Laws 2006, LB 876, § 36; Laws 2012, LB269, § 1; Laws 2018, LB194, § 2; Laws 2020, LB909, § 35.

45-902 Terms, defined.

For purposes of the Delayed Deposit Services Licensing Act:

(1) Annual percentage rate means an annual percentage rate as determined under section 107 of the federal Truth in Lending Act, 15 U.S.C. 1606, as such section existed on January 1, 2020, and includes all fees, interest, and charges contained in a delayed deposit service contract, except for charges permitted for the presentation of instruments that are not negotiable under subdivision (1)(a)(v) of section 45-917 or returned unpaid under section 45-918.01;

(2) Check means any check, draft, or other instrument for the payment of money. Check also means an authorization to debit an account electronically;

(3) Default means a maker's failure to repay a delayed deposit transaction in compliance with the terms contained in a delayed deposit service agreement;

(4) Delayed deposit services business means any person who for a fee (a) accepts a check dated subsequent to the date it was written or (b) accepts a check dated on the date it was written and holds the check for a period of days prior to deposit or presentment pursuant to an agreement with or any representation made to the maker of the check, whether express or implied;

(5) Department means the Department of Banking and Finance;

(6) Director means the Director of Banking and Finance or his or her designee;

(7) Financial institution has the same meaning as in section 8-101.03;

(8) Licensee means any person licensed under the Delayed Deposit Services Licensing Act;

(9) Maker means an individual who receives the proceeds of a delayed deposit transaction;

(10) Nationwide Mortgage Licensing System and Registry means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators for the licensing and registration of mortgage loan originators, mortgage bankers, installment loan companies, and other state-regulated financial services entities and industries; and

(11) Person means an individual, proprietorship, association, joint venture, joint-stock company, partnership, limited partnership, limited liability company, business corporation, nonprofit corporation, or any group of individuals however organized.

Source: Laws 1994, LB 967, § 2; Laws 2001, LB 53, § 103; Laws 2003, LB 217, § 37; Laws 2017, LB140, § 154; Laws 2018, LB194, § 3; Laws 2020, LB909, § 36.

45-903 Act; not applicable to financial institutions.

The Delayed Deposit Services Licensing Act shall not apply to a financial institution organized under the laws of this state or the laws of the United States.

Source: Laws 1994, LB 967, § 3.

45-904 License required; void transaction; effect.

No person shall operate a delayed deposit services business or make or offer a delayed deposit transaction in this state unless the person is licensed by the director as provided in the Delayed Deposit Services Licensing Act. Any delayed deposit transaction that is made by a person who is required to be licensed pursuant to the act but who is not licensed is void, and the person making such delayed deposit transaction has no right to collect, receive, or retain any principal, interest, fees, or any other charges in connection with such delayed deposit transaction.

Source: Laws 1994, LB 967, § 4; Laws 2018, LB194, § 4.

45-905 Application for license; form; contents; criminal history record information check.

(1) An applicant for a license shall submit an application, under oath, to the director on forms prescribed by the director. The forms shall contain such information as the director may prescribe, including, but not limited to:

(a) The applicant's financial condition;

(b) The qualifications and business history of the applicant and of its officers, directors, shareholders, partners, or members;

(c) Whether the applicant or any of its officers, directors, shareholders, partners, or members have ever been convicted of any (i) misdemeanor involving any aspect of a delayed deposit services business or any business of a similar nature or (ii) felony;

(d) Whether the applicant or any of its officers, directors, shareholders, partners, or members have ever been permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of a delayed deposit services business or any business of a similar nature;

(e) A description of the applicant's proposed method of doing business; and

(f) If the applicant is an individual, the applicant's social security number.

(2) The director shall cause a criminal history record information check to be conducted of the applicant, its officers, directors, shareholders, partners, or members and, on or after January 1, 2021, as provided in subsection (1) of

section 45-905.01. The direct cost of the criminal history record information check shall be paid by the applicant.

Source: Laws 1994, LB 967, § 5; Laws 1997, LB 752, § 119; Laws 2020, LB909, § 37.

45-905.01 Nationwide Mortgage Licensing System and Registry; licensees; requirements; director; powers and duties.

(1) On and after January 1, 2021, licensees under the Delayed Deposit Services Licensing Act are required to be licensed and registered through the Nationwide Mortgage Licensing System and Registry. In order to carry out this requirement, the department is authorized to participate in the Nationwide Mortgage Licensing System and Registry. For this purpose, the director may establish requirements as necessary by adopting and promulgating rules and regulations or by order. The requirements may include, but are not limited to:

(a) Background checks of applicants and licensees, including, but not limited to:

(i) Fingerprints of any principal officer, director, partner, member, or sole proprietor submitted to the Federal Bureau of Investigation and any other governmental agency or entity authorized to receive such information for a state, national, and international criminal history record information check;

(ii) Checks of civil or administrative records;

(iii) Checks of an applicant's or a licensee's credit history; or

(iv) Any other information as deemed necessary by the director;

(b) The payment of fees to apply for or renew a license through the Nationwide Mortgage Licensing System and Registry;

(c) The setting or resetting, as necessary, of renewal processing or reporting dates; and

(d) Amending or surrendering a license or any other such activities as the director deems necessary for participation in the Nationwide Mortgage Licensing System and Registry.

(2) In order to fulfill the purposes of the Delayed Deposit Services Licensing Act, the department may contract with the Nationwide Mortgage Licensing System and Registry or other entities designated by the Nationwide Mortgage Licensing System and Registry to collect and maintain records and process transaction fees or other fees related to applicants, licensees, or other persons subject to the act. The department may allow such system to collect licensing fees on behalf of the department and may allow such system to collect a processing fee for the services of the system directly from each applicant or licensee.

(3) The director shall regularly report enforcement actions and other relevant information to the Nationwide Mortgage Licensing System and Registry.

(4) The director shall establish a process whereby applicants and licensees may challenge information entered by the director into the Nationwide Mortgage Licensing System and Registry.

(5) The department shall ensure that the Nationwide Mortgage Licensing System and Registry adopts a privacy, data security, and breach of security of the system notification policy. The director shall make available upon written

request a copy of such policy and the contract between the department and the system.

(6) Upon written request the department shall provide the most recently available audited financial report of the Nationwide Mortgage Licensing System and Registry.

(7) The director may use the Nationwide Mortgage Licensing System and Registry as a channeling agent for requesting information from and distributing information to the United States Department of Justice or any other governmental agency in order to reduce the points of contact which the Federal Bureau of Investigation may have to maintain for purposes of subsection (5) of this section.

Source: Laws 2020, LB909, § 39.

45-906 Application; fees; bond.

The application required by section 45-905 shall be accompanied by:

(1) A nonrefundable application fee of five hundred dollars and any processing fee allowed under subsection (2) of section 45-905.01; and

(2) A surety bond in the base amount of fifty thousand dollars which, on or after January 1, 2021, shall be increased by fifty thousand dollars for each branch office established or to be established in Nebraska. The surety bond shall be executed by the licensee and a surety company authorized to do business in Nebraska and approved by the director conditioned for the faithful performance by the licensee of the duties and obligations pertaining to the delayed deposit services business so licensed and the prompt payment of any judgment recovered against the licensee. The bond or a substitute bond shall remain in effect during all periods of licensing or the licensee shall immediately cease doing business and its license shall be surrendered to or canceled by the department. A surety may cancel a bond only upon thirty days' written notice to the director.

(3) The director may at any time require the filing of a new or supplemental bond in the form as provided in subdivision (2) of this section if he or she determines that the bond filed under this section is exhausted or is inadequate for any reason, including, but not limited to, the financial condition of the licensee or the applicant for a license, or violations of the Delayed Deposit Services Licensing Act, any rule, regulation, or order thereunder, or any state or federal law applicable to the licensee or applicant for a license. The new or supplemental bond shall not exceed one hundred thousand dollars over the amount of the bond required by subdivision (2) of this section.

Source: Laws 1994, LB 967, § 6; Laws 2001, LB 53, § 104; Laws 2006, LB 876, § 37; Laws 2020, LB909, § 38.

45-907 Application; notice of filing; publication; hearing; investigation; costs.

(1) When an application for a delayed deposit services business license has been accepted by the director as substantially complete, notice of the filing of the application shall be published by the director for three successive weeks in a legal newspaper published in or of general circulation in the county where the applicant proposes to operate the delayed deposit services business. A public hearing shall be held on each application except as provided in subsection (2) of this section. The date for hearing shall not be less than thirty days

after the last publication. Written protest against the issuance of the license may be filed with the department by any person not less than five days before the date set for hearing. The director, in his or her discretion, may grant a continuance. The costs of the hearing shall be paid by the applicant. The director may investigate the propriety of the issuance of a license to the applicant. The costs of such investigation shall be paid by the applicant.

(2) The director may waive the hearing requirements of subsection (1) of this section if (a) the applicant has held and operated under a license to engage in the delayed deposit services business in Nebraska pursuant to the Delayed Deposit Services Licensing Act for at least three calendar years immediately prior to the filing of the application, (b) no written protest against the issuance of the license has been filed with the department within fifteen days after publication of a notice of the filing of the application one time in a newspaper of general circulation in the county where the applicant proposes to operate the delayed deposit services business, and (c) in the judgment of the director, the experience, character, and general fitness of the applicant warrant the belief that the applicant will comply with the act.

(3) The expense of any publication made pursuant to this section shall be paid by the applicant.

Source: Laws 1994, LB 967, § 7; Laws 2006, LB 876, § 38; Laws 2008, LB851, § 23; Laws 2018, LB194, § 5.

45-908 License; issuance; conditions.

The director shall issue a license to an applicant, if, after public hearing and any investigation of the applicant, the director determines that:

(1) The experience, character, and general fitness of the applicant and its officers, directors, shareholders, partners, or members are such as to warrant the belief that the applicant will conduct the delayed deposit services business honestly, fairly, and efficiently;

(2) The applicant and its officers, directors, shareholders, partners, or members have not been convicted of a felony in this state or any other jurisdiction which would indicate moral turpitude on the part of the applicant;

(3) The applicant is financially responsible and will conduct the delayed deposit services business pursuant to the Delayed Deposit Services Licensing Act; and

(4) The applicant has assets of at least twenty-five thousand dollars available for operating the delayed deposit services business.

Source: Laws 1994, LB 967, § 8.

45-909 Application for license; timely action of director required; appeal.

The director shall approve or deny an application for a license by written order not more than ninety days after the filing of a substantially complete application. Failure of the director to act on a substantially complete application within ninety days shall constitute approval of the application. An order of the director issued pursuant to this section may be appealed, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1994, LB 967, § 9.

Cross References

Administrative Procedure Act, see section 84-920.

45-910 License; posting; renewal; fees.

(1) A license issued pursuant to the Delayed Deposit Services Licensing Act shall be conspicuously posted at the licensee's place of business.

(2)(a) Except as provided in subdivision (2)(b) of this section, all licenses shall remain in effect until the next succeeding May 1, unless earlier canceled, suspended, or revoked by the director pursuant to section 45-922 or surrendered by the licensee pursuant to section 45-911.

(b) All licenses issued on or after November 14, 2020, and before January 1, 2021, shall remain in effect until December 31, 2021, unless earlier canceled, suspended, or revoked by the director pursuant to section 45-922 or surrendered by the licensee pursuant to section 45-911. All licenses issued on or after January 1, 2021, shall remain in effect until the next succeeding December 31, unless earlier canceled, suspended, or revoked by the director pursuant to section 45-922 or surrendered by the licensee pursuant to section 45-911.

(3) Licenses may be renewed annually by filing with the director (a) a renewal fee consisting of five hundred dollars and any processing fee allowed under subsection (2) of section 45-905.01 for the main office location and five hundred dollars and any processing fee allowed under subsection (2) of section 45-905.01 for each branch office location and (b) an application for renewal in writing through the Nationwide Mortgage Licensing System and Registry containing such information as the director may require to indicate any material change in the information contained in the original application or succeeding renewal applications.

Source: Laws 1994, LB 967, § 10; Laws 2001, LB 53, § 105; Laws 2005, LB 533, § 56; Laws 2012, LB269, § 2; Laws 2020, LB909, § 40.

45-911 Surrender of license; effect.

A licensee may surrender a delayed deposit services business license by delivering to the director written notice that the license is surrendered and any processing fee allowed under subsection (2) of section 45-905.01. The department may issue a notice of cancellation of the license following such surrender in lieu of revocation proceedings. The surrender shall not affect the licensee's civil or criminal liability for acts committed prior to such surrender, affect the liability for any fines which may be levied against the licensee or any of its officers, directors, shareholders, partners, or members for acts committed before the surrender, affect the liability of the surety on the bond, or entitle such licensee to a return of any part of the annual license fee or fees. The director may establish procedures for the disposition of the books, accounts, and records of the licensee and may require such action as he or she deems necessary for the protection of the makers of checks which are outstanding at the time of surrender of the license.

Source: Laws 1994, LB 967, § 11; Laws 2006, LB 876, § 39; Laws 2018, LB194, § 6; Laws 2020, LB909, § 41.

45-912 Licensee; duty to inform director; when.

A licensee shall be required to notify the director in writing through the Nationwide Mortgage Licensing System and Registry within thirty days after the occurrence of any material development, including, but not limited to:

(1) Bankruptcy or corporate reorganization;

(2) Business reorganization;

(3) Institution of license revocation procedures by any other state or jurisdiction;

(4) The filing of a criminal indictment or complaint against the licensee or any of its officers, directors, shareholders, partners, members, employees, or agents;

(5) A felony conviction against the licensee or any of the licensee's officers, directors, shareholders, partners, members, employees, or agents; or

(6) The termination of employment or association with the licensee of any of the licensee's officers, directors, shareholders, partners, members, employees, or agents for violations or suspected violations of the Delayed Deposit Services Licensing Act, any rule, regulation, or order thereunder, or any state or federal law applicable to the licensee.

Source: Laws 1994, LB 967, § 12; Laws 2006, LB 876, § 40; Laws 2020, LB909, § 42.

45-913 License; not transferable or assignable.

A license issued pursuant to the Delayed Deposit Services Licensing Act shall not be transferable or assignable.

Source: Laws 1994, LB 967, § 13.

45-914 Change in control of licensee; approval required.

The prior written approval of the director shall be required whenever a change in control of a licensee is proposed. Control in the case of a corporation shall mean (1) direct or indirect ownership or the right to control ten percent or more of the voting shares of the corporation or (2) the ability of a person or group acting in concert to elect a majority of the directors or otherwise effect a change in policy. Control in the case of any other entity shall mean any change in the principals of the organization, whether active or passive. The director may require such information as he or she deems necessary to determine whether a new application is required. Costs incurred by the director in investigating a change of control request shall be paid by the person or persons requesting such approval.

Source: Laws 1994, LB 967, § 14.

45-915 Licensee; principal place of business; change of location; branch offices; approval required; fees.

(1) Except as provided in subsection (2) of this section, a licensee, on or before December 31, 2020, may offer a delayed deposit services business only at an office designated as its principal place of business in the application. A licensee may change the location of its designated principal place of business with the prior written approval of the director. The director may establish forms and procedures for determining whether the change of location should be approved.

(2) On or before December 31, 2020, a licensee may operate branch offices only in the same county in which the licensee's designated principal place of business is located. The licensee may establish a branch office or change the location of a branch office with the prior written approval of the director. The director may establish forms and procedures for determining whether an original branch or branches or a change of location of a branch should be approved.

(3) On or after January 1, 2021, a licensee shall designate an office in Nebraska as its principal place of business. A licensee may change the location of its designated principal place of business with the prior written approval of the director. The director may establish forms and procedures for determining whether the change of location should be approved.

(4) On or after January 1, 2021, a licensee may operate branch offices in Nebraska. The licensee may establish a branch office or change the location of a branch office with the prior written approval of the director. The director may establish forms and procedures for determining whether an original branch or branches or a change of location of a branch should be approved.

(5) A licensee may offer a delayed deposit services business only at an office designated as its principal place of business and any branch office established pursuant to this section.

(6) A fee of one hundred fifty dollars and any processing fee allowed under subsection (2) of section 45-905.01 shall be submitted with each request made pursuant to this section.

Source: Laws 1994, LB 967, § 15; Laws 2006, LB 876, § 41; Laws 2020, LB909, § 43.

45-915.01 Licensee; books and records.

(1) Each licensee shall keep or make available the books and records relating to transactions made under the Delayed Deposit Services Licensing Act as are necessary to enable the department to determine whether the licensee is complying with the act. The books and records shall be maintained in a manner consistent with accepted accounting practices.

(2) A licensee shall, at a minimum, include in its books and records copies of all application materials relating to makers, disclosure agreements, checks, payment receipts, and proofs of compliance required by section 45-919.

(3) A licensee shall preserve or keep its books and records relating to every delayed deposit transaction for three years from the date of the inception of the transaction, or two years from the date a final entry is made thereon, including any applicable collection effort, whichever is later.

(4) The licensee shall maintain its books, accounts, and records, whether in physical or electronic form, at its designated principal place of business, except that books, accounts, and records which are older than two years may be maintained at any other place within this state as long as such records are available for inspection by the department.

Source: Laws 2006, LB 876, § 47; Laws 2018, LB194, § 7.

45-916 Operating with other business; conditions.

A licensee may operate a delayed deposit services business at a location where any other business is operated or in association or conjunction with any other business if:

(1) The books, accounts, and records of the delayed deposit services business are kept and maintained separate and apart from the books, accounts, and records of the other business;

(2) The other business is not of a type which would tend to conceal evasion of the Delayed Deposit Services Licensing Act. If the director determines upon investigation that the other business is of a type which would conceal evasion of the act, the director shall order such licensee to cease the operation of the other business at such location; and

(3) At least thirty days prior to conducting such other business, the licensee provides written notice to the director of (a) its intent to conduct such other business at its location or locations and (b) the nature of such other business and the director does not disapprove of such other business within thirty days after receiving the written notice.

Source: Laws 1994, LB 967, § 16; Laws 2006, LB 876, § 42.

45-917 Licensee; written notice; contents; fees, charges, and penalties; posting required.

(1)(a) Every licensee shall, at the time any delayed deposit transaction is made, give to the maker of the check, or if there are two or more makers, to one of them, a notice written in plain English disclosing:

(i) The name of the maker, transaction date, and transaction amount;

(ii) The payment due date and total payment due;

(iii) The total of fees on the transaction, expressed as both a dollar amount and an annual percentage rate;

(iv) The date on which the check will be deposited or presented for negotiation; and

(v) Any penalty not to exceed fifteen dollars which the licensee will charge if the check is not negotiable on the date agreed upon. If the licensee required the maker to give two checks for one delayed deposit transaction, the licensee shall charge only one penalty in the event both checks are not negotiable on the date agreed upon.

(b) The notice required by this subsection shall include the following language, all capitalized and in at least ten-point font:

1. THIS TYPE OF SERVICE SHOULD BE USED ONLY TO MEET SHORT-TERM CASH NEEDS.

2. THE LAW DOES NOT ALLOW THIS TYPE OF TRANSACTION TO BE MORE THAN FIVE HUNDRED DOLLARS ($500) IN TOTAL, INCLUDING FEES AND CHARGES, FROM ONE LENDER.

3. YOU HAVE THE RIGHT TO RESCIND THIS TRANSACTION IF YOU DO SO BY THE NEXT BUSINESS DAY BEFORE 5 P.M.

4. YOU HAVE THE RIGHT TO RESCIND YOUR AUTHORIZATION FOR ELECTRONIC PAYMENT.

(2) In addition to the notice required by subsection (1) of this section, every licensee shall conspicuously display a schedule of all fees, charges, and penal-

ties for all services provided by the licensee. Such notice shall be posted at every office of the licensee.

Source: Laws 1994, LB 967, § 17; Laws 2006, LB 876, § 43; Laws 2018, LB194, § 8.

45-918 Annual percentage rate; violation; effect; fee; limitation.

(1) A licensee shall not impose an annual percentage rate greater than thirty-six percent in connection with a delayed deposit transaction. Any delayed deposit transaction made in violation of this section is void, and the licensee making such delayed deposit transaction has no right to collect, receive, or retain any principal, interest, fees, or any other charges in connection with such delayed deposit transaction.

(2) The fees set forth in this section shall not be charged to individuals on active duty military or their spouses or dependents in an amount that exceeds what is allowed under 10 U.S.C. 987, as such section existed on January 1, 2018.

Source: Laws 1994, LB 967, § 18; Laws 2018, LB194, § 9; Initiative Law 2020, No. 428, § 1.

45-918.01 Returned check; collection; returned check charge; court costs; attorney's fees.

If a check held by a licensee as a result of a delayed deposit transaction is returned unpaid to the licensee from a payor financial institution due to insufficient funds, a closed account, a stop-payment order, or any other reason, not including a bank error, the licensee shall have the right to exercise all civil means authorized by law to collect the face value of the check. In addition, the licensee may contract for and collect one returned check charge for each delayed deposit transaction, not to exceed fifteen dollars, plus court costs and reasonable attorney's fees as awarded by a court and incurred as a result of the default. However, such attorney's fees shall not exceed the amount of the check. The licensee shall not collect any other fees as a result of default. A returned check charge shall not be allowed if, due to forgery or theft, the transaction proceeds check is dishonored by the financial institution.

Source: Laws 2018, LB194, § 10.

45-918.02 Prepayment; how treated.

A licensee shall accept prepayment from a maker prior to the due date without charging the maker a penalty of any kind.

Source: Laws 2018, LB194, § 11.

45-918.03 Rescission; redemption.

(1) A maker shall have the right to rescind a delayed deposit transaction before 5 p.m. the next business day following the delayed deposit transaction.

(2) Prior to the licensee negotiating or presenting the check, the maker shall have the right to redeem any check held by a licensee as a result of a delayed deposit transaction if the maker pays the full amount to the licensee.

Source: Laws 2018, LB194, § 12.

45-918.04 Licensee; payment options; electronic payment with authorization.

(1) A licensee may pay the proceeds from a delayed deposit transaction or rebate to the maker in the form of check, money order, cash, stored value card, Internet transfer, or authorized automated clearinghouse transaction. Neither the licensee nor any affiliate of the licensee shall charge the maker an additional finance charge or fee for cashing the licensee's check or for negotiating forms of transaction proceeds or rebates other than cash.

(2) A licensee may utilize electronic payment through transfer or withdrawal of funds from the maker's account only, but only with the written authorization of the maker.

Source: Laws 2018, LB194, § 13.

45-919 Acts prohibited.

(1) No licensee shall:

(a) At any one time hold from any one maker more than two checks;

(b) At any one time hold from any one maker a check or checks in an aggregate face amount of more than five hundred dollars;

(c) Hold or agree to hold a check for more than thirty-four days. A check which is in the process of collection for the reason that it was not negotiable on the day agreed upon shall not be deemed as being held in excess of the thirty-four-day period;

(d) Require the maker to receive payment by a method which causes the maker to pay additional or further fees and charges to the licensee, an affiliate of the licensee, or any other person;

(e) Accept a check as repayment, refinancing, or any other consolidation of a check or checks held by the same licensee;

(f) Except as provided in section 45-919.01, renew, roll over, defer, or in any way extend a delayed deposit transaction by allowing the maker to pay less than the total amount of the check and any authorized fees or charges. This subdivision shall not prevent a licensee that agreed to hold a check for less than thirty-four days from agreeing to hold the check for an additional period of time no greater than the thirty-four days it would have originally been able to hold the check if (i) the extension is at the request of the maker, (ii) no additional fees are charged for the extension, and (iii) the delayed deposit transaction is completed as required by subdivision (1)(c) of this section. The licensee shall retain written or electronic proof of compliance with this subdivision. If a licensee fails, or is unable, to provide such proof to the department upon request, there shall be a rebuttable presumption that a violation of this subdivision has occurred and the department may pursue any remedies or actions available to it under the Delayed Deposit Services Licensing Act;

(g) Enter into another delayed deposit transaction with the same maker on the same business day as the completion of a delayed deposit transaction unless prior to entering into the transaction the maker and the licensee verify on a form prescribed by the department that completion of the prior delayed deposit transaction has occurred. The licensee shall retain written proof of compliance with this subdivision. If a licensee fails, or is unable, to provide such proof to the department upon request, there shall be a rebuttable presumption that a violation of this subdivision has occurred and the department may pursue any remedies or actions available to it under the act;

(h) Charge, collect, or receive any finance charges, fees, interest, or similar charges for loan brokerage, insurance, or any other ancillary products;

(i) Negotiate or present a paper check for payment unless the check is endorsed with the actual business name of the licensee;

(j) Engage, in connection with a delayed deposit transaction, in unfair or deceptive practices or advertising under the Uniform Deceptive Trade Practices Act to engage in any act that limits or restricts the application of the Delayed Deposit Services Licensing Act, including, but not limited to, making transactions disguised as personal property, personal sales, or leaseback transactions, or disguise transaction proceeds as cash rebated for the pretextual installment sale of goods and services;

(k) Evade the requirements of section 45-918, including, but not limited to, making, offering, assisting, arranging, or guaranteeing a delayed deposit transaction with a greater rate of interest, consideration, fees, or charges than is permitted therein through any method including mail, telephone, Internet or any electronic means regardless of whether the licensee has a physical location in the state; or

(l) Attempt to deposit or negotiate a check after two consecutive failed collection attempts unless the licensee has obtained a new, written payment authorization from the maker.

(2) No licensee, affiliate of a licensee, or any other person, including a person operating as a credit services organization, shall charge, collect, or receive any finance charges, fees, interest, or similar charges that would cause a maker to pay an amount in excess of or in addition to those permitted under the Delayed Deposit Services Licensing Act in connection with a delayed deposit transaction, including, but not limited to, charges for loan brokerage, insurance, or any other ancillary products.

(3) For purposes of this section, (a) completion of a delayed deposit transaction means the licensee has presented a maker's check for payment to a financial institution as defined in section 8-101.03 or the maker redeemed the check by paying the full amount of the check in cash to the licensee and (b) licensee shall include (i) a person related to the licensee by common ownership or control, (ii) a person in whom such licensee has any financial interest of ten percent or more, or (iii) any employee or agent of the licensee.

Source: Laws 1994, LB 967, § 19; Laws 2000, LB 932, § 34; Laws 2006, LB 876, § 44; Laws 2017, LB140, § 155; Laws 2018, LB194, § 14; Initiative Law 2020, No. 428, § 2.

Cross References

Uniform Deceptive Trade Practices Act, see section 87-306.

45-919.01 Extended payment plan; request; terms; default.

(1) A maker who cannot pay back a delayed deposit transaction when it is due may elect once in any twelve-month period to repay the delayed deposit transaction to the licensee by means of an extended payment plan.

(2) To request an extended payment plan, the maker, before the due date of the outstanding delayed deposit transaction, must request the plan and sign an amendment to the delayed deposit agreement that reflects the new payment schedule and terms.

(3) The extended payment plan's terms must allow the maker, at no additional cost, to repay the outstanding delayed deposit transaction, including any fee due, in at least four equal payments that coincide with the maker's periodic pay dates.

(4) The maker may prepay an extended payment plan in full at any time without penalty. The licensee shall not charge the maker any interest or additional fees during the term of the extended payment plan.

(5) If the maker fails to pay any extended payment plan installment when due, the maker shall be in default of the payment plan and the licensee immediately may accelerate payment on the remaining balance. Upon default, the licensee may take action to collect all amounts due.

Source: Laws 2018, LB194, § 15.

45-920 Director; examination of licensee; powers; costs.

(1) The director shall examine the books, accounts, and records of each licensee no more often than annually, except as provided in section 45-921. The costs of the director incurred in an examination shall be paid by the licensee as set forth in sections 8-605 and 8-606.

(2) The director may accept any examination, report, or information regarding a licensee from the Consumer Financial Protection Bureau or a foreign state agency. The director may provide any examination, report, or information regarding a licensee to the Consumer Financial Protection Bureau or a foreign state agency. As used in this section, unless the context otherwise requires, foreign state agency means any duly constituted regulatory or supervisory agency which has authority over delayed deposit services businesses, payday lenders, or similar entities, and which is created under the laws of any other state or any territory of the United States, including Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, or the Virgin Islands, or which is operating under the code of law for the District of Columbia.

Source: Laws 1994, LB 967, § 20; Laws 2007, LB124, § 52; Laws 2013, LB279, § 3.

45-921 Alleged violations; director; powers and duties.

(1) The director may examine or investigate complaints about or reports of alleged violations of the Delayed Deposit Services Licensing Act or any rule, regulation, or order of the director thereunder. The director may order the actual cost of such examination or investigation to be paid by the person who is the subject of the examination or investigation, whether the alleged violator is licensed or not.

(2) The director may publish information concerning any violation of the act or any rule, regulation, or order of the director under the act.

(3) For purposes of any investigation, examination, or proceeding under the act, the director may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence, and require the production of any books, papers, correspondence, memoranda, agreements, or other documents or records which the director deems relevant or material to the examination, investigation, or proceeding.

(4) In the case of contumacy by or refusal to obey a subpoena issued to any person, the district court of Lancaster County, upon application by the director, may issue an order requiring such person to appear before the director and to produce documentary evidence if so ordered to give evidence on the matter under investigation or in question. Failure to obey the order of the court may be punished by the court as contempt.

(5) Upon receipt by a licensee of a notice of investigation or inquiry request for information from the department, the licensee shall respond within twenty-one calendar days. Each day a licensee fails to respond as required by this subsection shall constitute a separate violation.

(6) If the director finds, after notice and opportunity for hearing in accordance with the Administrative Procedure Act, that any person has violated subsection (5) of this section, the director may order such person to pay (a) an administrative fine of not more than two thousand dollars for each separate violation and (b) the costs of investigation. The department shall remit fines collected under this subsection to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

(7) If a person fails to pay an administrative fine and the costs of investigation ordered pursuant to subsection (6) of this section, a lien in the amount of such fine and costs may be imposed upon all assets and property of such person in this state and may be recovered in a civil action by the director. The lien shall attach to the real property of such person when notice of the lien is filed and indexed against the real property in the office of the register of deeds in the county where the real property is located. The lien shall attach to any other property of such person when notice of the lien is filed against the property in the manner prescribed by law. Failure of the person to pay such fine and costs shall constitute a separate violation of the Delayed Deposit Services Licensing Act.

Source: Laws 1994, LB 967, § 21; Laws 1997, LB 137, § 24; Laws 2004, LB 999, § 37; Laws 2018, LB194, § 16.

Cross References

Administrative Procedure Act, see section 84-920.

45-922 Licensee; disciplinary actions; failure to renew.

(1) The director may, following a hearing in accordance with the Administrative Procedure Act, suspend or revoke any license issued pursuant to the Delayed Deposit Services Licensing Act if he or she finds:

(a) A licensee or any of its officers, directors, partners, or members has knowingly violated the act or any rule, regulation, or order of the director thereunder;

(b) A fact or condition existing which, if it had existed at the time of the original application for such license, would have warranted the director to refuse to issue such license;

(c) A licensee has abandoned its place of business for a period of thirty days or more;

(d) A licensee or any of its officers, directors, partners, or members has knowingly subscribed to, made, or caused to be made any false statement or false entry in the books and records of any licensee, has knowingly subscribed to or exhibited false papers with the intent to deceive the department, has failed

to make a true and correct entry in the books and records of such licensee of its business and transactions in the manner and form prescribed by the department, or has mutilated, altered, destroyed, secreted, or removed any of the books or records of such licensee without the written approval of the department or as provided in section 45-925; or

(e) A licensee has knowingly violated a voluntary consent or compliance agreement which had been entered into with the director.

(2) Except as provided in this section, a license shall not be revoked or suspended except after notice and a hearing in accordance with the Administrative Procedure Act.

(3)(a) If a licensee fails to renew its license as required by section 45-910 and does not voluntarily surrender the license pursuant to section 45-911, the department may issue a notice of expiration of the license to the licensee in lieu of revocation proceedings.

(b) If a licensee fails to maintain a surety bond as required by section 45-906, the department may issue a notice of cancellation of the license in lieu of revocation proceedings.

(4) Revocation, suspension, cancellation, or expiration of a license shall not impair or affect the obligation of a preexisting lawful contract between the licensee and any person, including a maker of a check.

(5) Revocation, suspension, cancellation, or expiration of a license shall not affect civil or criminal liability for acts committed before the revocation, suspension, cancellation, or expiration or liability for fines levied against the licensee or any of its officers, directors, shareholders, partners, or members, pursuant to section 45-925, for acts committed before the revocation, suspension, cancellation, or expiration.

Source: Laws 1994, LB 967, § 22; Laws 2001, LB 53, § 106; Laws 2006, LB 876, § 45; Laws 2008, LB851, § 24; Laws 2009, LB327, § 19; Laws 2018, LB194, § 17.

Cross References

Administrative Procedure Act, see section 84-920.

45-923 Cease and desist order; procedure; appeal.

If the director believes that any person has engaged in or is about to engage in any act or practice constituting a violation of the Delayed Deposit Services Licensing Act or any rule, regulation, or order of the director, the director may issue a cease and desist order and prohibit the making of additional delayed deposit transactions as part of such order.

Upon entry of a cease and desist order the director shall promptly notify in writing all persons to whom the order is directed that it has been entered and of the reasons for the order. Any person to whom the order is directed may in writing request a hearing within fifteen business days after the date of the issuance of the order. Upon receipt of such written request, the matter shall be set for hearing within thirty business days after receipt by the director, unless the parties consent to a later date or the hearing officer sets a later date for good cause. If a hearing is not requested within fifteen business days and none is ordered by the director, the order of the director shall automatically become final and shall remain in effect until modified or vacated by the director. If a hearing is requested or ordered, the director, after notice and hearing, shall

issue his or her written findings of fact and conclusions of law and may affirm, vacate, or modify the order.

The director may vacate or modify an order if he or she finds that the conditions which caused its entry have changed or that it is otherwise in the public interest to do so. Any person aggrieved by a final order of the director may appeal the order, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1994, LB 967, § 23; Laws 2001, LB 53, § 107; Laws 2018, LB194, § 18.

Cross References

Administrative Procedure Act, see section 84-920.

45-924 Injunction, restraining order, or writ of mandamus.

If the director believes that any person has engaged in or is about to engage in any act or practice constituting a violation of the Delayed Deposit Services Licensing Act or a violation of any rule, regulation, or order of the director thereunder, the director may initiate an action in the district court of Lancaster County to enjoin such acts or practices and to enforce compliance with the act or any order under the act. Upon a proper showing a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted or a receiver or conservator may be appointed for the defendant's assets. The director shall not be required to post a bond.

Source: Laws 1994, LB 967, § 24.

45-925 Violations; orders authorized; administrative fine; lien; failure to pay; separate violation.

(1) If the director finds, after notice and hearing in accordance with the Administrative Procedure Act, that any person has violated the Delayed Deposit Services Licensing Act or any rule, regulation, or order of the director thereunder, the director may order such person to pay (a) an administrative fine of not more than five thousand dollars for each separate violation and (b) the costs of investigation.

(2) If any person is found to have violated subdivision (1)(e), (1)(f), or (1)(g) of section 45-919, the director may also order such person to (a) return to the maker or makers all fees collected plus all or part of the amount of the check or checks which the licensee accepted in violation of such subdivision or subdivisions and (b) for a period up to one year not engage in any delayed deposit transaction with any maker for at least three days after the completion of a delayed deposit transaction with the same maker. If a person fails to pay an administrative fine and the costs of investigation ordered pursuant to subsection (1) of this section, a lien in the amount of such fine and costs may be imposed upon all assets and property of such person in this state and may be recovered in a civil action by the director. Failure of the person to pay such fine and costs shall constitute a separate violation of the act.

Source: Laws 1994, LB 967, § 25; Laws 2006, LB 876, § 46.

Cross References

Administrative Procedure Act, see section 84-920.

45-926 Operating without a license; penalty.

Any person required to be licensed under the Delayed Deposit Services Licensing Act who operates a delayed deposit services business in this state without first obtaining a license under the act or while such license is suspended or revoked by the director shall be guilty of a Class IV felony.

Source: Laws 1994, LB 967, § 26.

45-927 Fees, charges, costs, and fines; distribution.

(1) The director shall collect fees, charges, costs, and fines under the Delayed Deposit Services Licensing Act and remit them to the State Treasurer. Except as provided in subsection (2) of this section, the State Treasurer shall credit the fees, charges, and costs to the Financial Institution Assessment Cash Fund and distribute the fines in accordance with Article VII, section 5, of the Constitution of Nebraska.

(2) For fees collected pursuant to section 45-910, the State Treasurer shall (a) credit one hundred fifty dollars of each renewal fee for a main office to the Financial Institution Assessment Cash Fund and three hundred fifty dollars of each renewal fee for a main office to the Financial Literacy Cash Fund and (b) credit one hundred dollars of each renewal fee for a branch office to the Financial Institution Assessment Cash Fund and four hundred dollars of each renewal fee for a branch office to the Financial Literacy Cash Fund.

Source: Laws 1994, LB 967, § 27; Laws 1995, LB 599, § 15; Laws 2007, LB124, § 53; Laws 2012, LB269, § 3.

45-928 Personal jurisdiction over licensee.

Obtaining a license pursuant to the Delayed Deposit Services Licensing Act shall constitute sufficient contact with the state for the exercise of personal jurisdiction over the licensee in any action arising out of the licensee's activities in this state.

Source: Laws 1994, LB 967, § 28.

45-929 Director; rules and regulations; additional powers.

The director may adopt and promulgate rules and regulations and issue orders, rulings, findings, and demands as may be necessary to carry out the purposes of the Delayed Deposit Services Licensing Act.

Source: Laws 1994, LB 967, § 29.

45-930 Financial Literacy Cash Fund; created; use; investment.

The Financial Literacy Cash Fund is created. Amounts credited to the fund shall include that portion of each renewal fee as provided in section 45-927 and such other revenue as is incidental to administration of the fund. The fund shall be administered by the University of Nebraska and shall be used to provide assistance to nonprofit entities that offer financial literacy programs to students in grades kindergarten through twelve. Any money in the fund available for investment shall be invested by the state investment officer pursuant to the Nebraska Capital Expansion Act and the Nebraska State Funds Investment Act.

Source: Laws 2012, LB269, § 4.

Cross References

Nebraska Capital Expansion Act, see section 72-1269.
Nebraska State Funds Investment Act, see section 72-1260.

45-931 Licensees; annual report; contents; department; duties; report.

(1) Licensees shall, on an annual basis, provide the following information to the director, in a uniform manner prescribed by the department: Total number of makers; total number of transactions; average transaction size; total contracted transaction charges; total transaction actual charges; number of defaulted transactions; number of charged-off transactions; dollar value of transactions charged off; number of nonnegotiable check fees and dollar value for the same; average contracted annual percentage rate; and any other nonprivate information which may be requested in the discretion of the director.

(2) The department shall compile the total number of licensees operating in this state by location and the information required in subsection (1) of this section regarding the transaction activities of licensees and makers under the Delayed Deposit Services Licensing Act and shall report electronically to the Clerk of the Legislature on or before December 1, 2018, and annually thereafter.

Source: Laws 2018, LB194, § 19.

ARTICLE 10

NEBRASKA INSTALLMENT LOAN ACT

Section

45-1001 Act, how cited.

Sections 45-1001 to 45-1070 shall be known and may be cited as the Nebraska Installment Loan Act.

Source: Laws 2001, LB 53, § 29; Laws 2005, LB 533, § 57; Laws 2009, LB328, § 40; Laws 2018, LB194, § 20.

45-1002 Terms, defined; act; applicability.

(1) For purposes of the Nebraska Installment Loan Act:

(a) Applicant means a person applying for a license under the act;

(b) Breach of security of the system means unauthorized acquisition of data that compromises the security, confidentiality, or integrity of the information maintained by the Nationwide Mortgage Licensing System and Registry, its affiliates, or its subsidiaries;

(c) Department means the Department of Banking and Finance;

(d) Debt cancellation contract means a loan term or contractual arrangement modifying loan terms under which a financial institution or licensee agrees to cancel all or part of a borrower's obligation to repay an extension of credit from the financial institution or licensee upon the occurrence of a specified event. The debt cancellation contract may be separate from or a part of other loan documents. The term debt cancellation contract does not include loan payment deferral arrangements in which the triggering event is the borrower's unilateral election to defer repayment or the financial institution's or licensee's unilateral decision to allow a deferral of repayment;

(e) Debt suspension contract means a loan term or contractual arrangement modifying loan terms under which a financial institution or licensee agrees to suspend all or part of a borrower's obligation to repay an extension of credit from the financial institution or licensee upon the occurrence of a specified event. The debt suspension contract may be separate from or a part of other loan documents. The term debt suspension contract does not include loan payment deferral arrangements in which the triggering event is the borrower's unilateral election to defer repayment or the financial institution's or licensee's unilateral decision to allow a deferral of repayment;

(f) Director means the Director of Banking and Finance;

(g) Financial institution has the same meaning as in section 8-101.03;

(h) Guaranteed asset protection waiver means a waiver that is offered, sold, or provided in accordance with the Guaranteed Asset Protection Waiver Act;

(i) Licensee means any person who obtains a license under the Nebraska Installment Loan Act;

(j)(i) Mortgage loan originator means an individual who for compensation or gain (A) takes a residential mortgage loan application or (B) offers or negotiates terms of a residential mortgage loan.

(ii) Mortgage loan originator does not include (A) any individual who is not otherwise described in subdivision (i)(A) of this subdivision and who performs purely administrative or clerical tasks on behalf of a person who is described in subdivision (i) of this subdivision, (B) a person or entity that only performs real estate brokerage activities and is licensed or registered in accordance with applicable state law, unless the person or entity is compensated by a lender, a mortgage broker, or other mortgage loan originator or by any agent of such lender, mortgage broker, or other mortgage loan originator, or (C) a person or

entity solely involved in extensions of credit relating to time-share programs as defined in section 76-1702;

(k) Nationwide Mortgage Licensing System and Registry means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators for the licensing and registration of mortgage loan originators, mortgage bankers, installment loan companies, and other state-regulated financial services entities and industries;

(l) Person means individual, partnership, limited liability company, association, financial institution, trust, corporation, and any other legal entity; and

(m) Real property means an owner-occupied single-family, two-family, three-family, or four-family dwelling which is located in this state, which is occupied, used, or intended to be occupied or used for residential purposes, and which is, or is intended to be, permanently affixed to the land.

(2) Except as provided in subsection (3) of section 45-1017 and subsection (4) of section 45-1019, no revenue arising under the Nebraska Installment Loan Act shall inure to any school fund of the State of Nebraska or any of its governmental subdivisions.

(3) Loan, when used in the Nebraska Installment Loan Act, does not include any loan made by a person who is not a licensee on which the interest does not exceed the maximum rate permitted by section 45-101.03.

(4) Nothing in the Nebraska Installment Loan Act applies to any loan made by a person who is not a licensee if the interest on the loan does not exceed the maximum rate permitted by section 45-101.03.

Source: Laws 1941, c. 90, § 1, p. 345; C.S.Supp.,1941, § 45-131; Laws 1943, c. 107, § 1, p. 369; R.S.1943, § 45-114; Laws 1961, c. 225, § 1, p. 668; Laws 1963, Spec. Sess., c. 7, § 7, p. 92; Laws 1979, LB 87, § 1; Laws 1982, LB 941, § 1; Laws 1993, LB 121, § 264; Laws 1997, LB 137, § 20; Laws 1997, LB 555, § 3; R.S.1943, (1998), § 45-114; Laws 2001, LB 53, § 30; Laws 2003, LB 131, § 30; Laws 2003, LB 217, § 38; Laws 2006, LB 876, § 48; Laws 2009, LB328, § 41; Laws 2010, LB571, § 10; Laws 2010, LB892, § 19; Laws 2011, LB77, § 3; Laws 2012, LB965, § 21; Laws 2017, LB140, § 156.

Cross References

Guaranteed Asset Protection Waiver Act, see section 45-1101.

1. Transactions
2. Constitutionality
3. Recovery denied
4. Miscellaneous

1. Transactions

The Installment Loan Act comprehensibly regulates and limits all loans made by a licensee to small borrowers. Gruenemeier v. Commonwealth Co., 178 Neb. 66, 131 N.W.2d 713 (1964).

A loan of money by a nonlicensee, which does not exact interest in excess of nine percent per annum, is not within the inhibitory provisions of the Installment Loan Act. Moffitt-Harrison Builders, Inc. v. Sandman, 177 Neb. 425, 129 N.W.2d 524 (1964).

A loan of money by a nonlicensee which does not exact interest and charges in excess of nine percent per annum is not usurious. Pattavina v. Pignotti, 177 Neb. 217, 128 N.W.2d 817 (1964).

If a purported time sale is in fact a loan and the loan is made in violation of the Installment Loan Act, the penalties of the act apply to it. Lloyd v. Gutgsell, 175 Neb. 775, 124 N.W.2d 198 (1963).

Inhibitory provisions of Installment Loan Act apply alike to licensees and nonlicensees. Robertson v. Burnett, 172 Neb. 385, 109 N.W.2d 716 (1961).

Permissive provisions of Installment Loan Act apply to licensees, but inhibitory provisions apply alike to licensees and nonlicensees. Curtis v. Securities Acceptance Corp., 166 Neb. 815, 91 N.W.2d 19 (1958).

Design of the law was to license and control the business of making installment loans. A-1 Finance Co., Inc. v. Nelson, 165 Neb. 296, 85 N.W.2d 687 (1957).

Notwithstanding limitations on interest rates imposed on state banks by Nebraska law, national bank in Nebraska can charge, with respect to credit card transactions, rates allowed by Nebraska law for ''small loan companies''. Fisher v. First Nat. Bank of Omaha, 548 F.2d 255 (8th Cir. 1977).

2. Constitutionality

Amendments made to Installment Loan Act in 1963 Special Session by Legislative Bill 11 were unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

Installment Loan Act sustained as constitutional. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

3. Recovery denied

An installment sales contract which exacts interest in excess of nine percent per annum and where the seller is a nonlicensee violates the Small Loan Act. Elder v. Doerr, 175 Neb. 483, 122 N.W.2d 528 (1963).

Recovery on note payable in installments was properly denied where excessive interest was charged. Powell v. Edwards, 162 Neb. 11, 75 N.W.2d 122 (1956).

Violation of Installment Loan Act by lender makes loan void and uncollectible. Grand Island Finance Co. v. Eacker, 155 Neb. 546, 52 N.W.2d 805 (1952).

4. Miscellaneous

The Installment Loan Act applies primarily to those licensed under the act but its inhibitory provisions apply also to nonlicensees. Seldin v. Northland Mortgage Co., 189 Neb. 175, 202 N.W.2d 174 (1972).

It is a question of fact as to whether a transaction is a bona fide time sale or an installment loan. Berg v. Midwest Laundry Equipment Corp., 175 Neb. 423, 122 N.W.2d 250 (1963).

None of defendants were licensed to engage in business under Installment Loan Act. Hills v. Burnett, 172 Neb. 370, 109 N.W.2d 739 (1961).

In the absence of a bill of exceptions, dismissal of action to recover under Installment Loan Act was proper. Brierly v. Federated Finance Co., 168 Neb. 725, 97 N.W.2d 253 (1959).

Suit against national bank to have installment note and conditional sale contract adjudged void was controlled as to venue by federal statute. Michigan Nat. Bank v. Robertson, 372 U.S. 591 (1963).

In suit to declare lender's interest charge usurious where borrower paid maximum legal loan rate plus one hundred dollars, court found the latter charge only ''incidental'' to the extension of credit where borrower received other monetary consideration in addition to a loan. Campbell v. Liberty Financial Planning, Inc., 422 F.Supp. 1386 (D. Neb. 1976).

45-1003 Installment loans; financial institution ineligible.

No financial institution is eligible for a license or to make loans under the Nebraska Installment Loan Act.

Source: Laws 1965, c. 31, § 3, p. 214; R.S.1943, (1987), § 8-817; Laws 1988, LB 795, § 6; R.S.1943, (1998), § 45-115; Laws 2001, LB 53, § 31; Laws 2003, LB 131, § 31; Laws 2003, LB 217, § 39.

Notwithstanding interest rate limits under Nebraska statutes, national bank in Nebraska can legally charge, on credit card transactions, same rates allowed by section 45-114 et seq. Fisher v. First Nat. Bank of Omaha, 548 F.2d 255 (8th Cir. 1977).

45-1004 Installment loans; license required, when; authority of licensee; affiliate of licensee; how treated.

(1)(a) Any person may, after procuring a license from the department, engage or continue in the business of making loans of money and charge, contract for, and receive the maximum for interest and other charges in accordance with the authorization and requirements of the Nebraska Installment Loan Act.

(b) A license shall also be required for any person that holds or acquires any rights of ownership, servicing, or other forms of participation in a loan under the Nebraska Installment Loan Act or that engages with, or conducts loan activity with, an installment loan borrower in connection with a loan under the act.

(2)(a) A license is not required for an affiliate of a licensee if the activities of the affiliate in this state are limited solely to the securitization of loans made by the licensee and the servicing rights to the loans are retained by the licensee or assigned or otherwise transferred to a financial institution, licensee, or permittee.

(b) For purposes of this subsection:

(i) Affiliate means an entity that controls, is controlled by, or is under common control with another entity;

(ii) Control means to own directly or indirectly or to control in any manner twenty-five percent of the voting shares of an entity or to control in any manner the election of the majority of directors of any entity; and

(iii) Securitization means the placing of individual installment loans made by licensees into a commingled or pooled security that is subsequently sold or otherwise transferred to another entity.

(c) Nothing in this subsection shall be construed to exempt a licensee or affiliate from the Securities Act of Nebraska.

Source: Laws 1941, c. 90, § 4, p. 346; C.S.Supp.,1941, § 45-132; Laws 1943, c. 108, § 3, p. 376; R.S.1943, § 45-116; Laws 1997, LB 555, § 4; Laws 2000, LB 932, § 29; R.S.Supp.,2000, § 45-116; Laws 2001, LB 53, § 32; Laws 2021, LB363, § 27.
Effective date March 18, 2021.

Cross References

Securities Act of Nebraska, see section 8-1123.

Licensee may charge rates authorized by Installment Loan Act. Pattavina v. Pignotti, 177 Neb. 217, 128 N.W.2d 817 (1964).

45-1005 Installment loans; license; application; fee.

Any person who desires to obtain an original license to engage in the business of lending money under the terms and conditions of the Nebraska Installment Loan Act or an original license to hold or acquire any rights of ownership, servicing, or other forms of participation in a loan under the act or to engage with, or conduct loan activity with, an installment loan borrower in connection with a loan under the act, shall apply to the department for the license under oath, on a form prescribed by the department, and pay an original license fee of five hundred dollars. If the applicant is an individual, the application shall include the applicant's social security number.

Source: Laws 1941, c. 90, § 5, p. 346; C.S.Supp.,1941, § 45-133; R.S. 1943, § 45-117; Laws 1973, LB 39, § 1; Laws 1979, LB 87, § 2; Laws 1997, LB 555, § 5; Laws 1997, LB 752, § 115; R.S.1943, (1998), § 45-117; Laws 2001, LB 53, § 33; Laws 2005, LB 533, § 58; Laws 2010, LB892, § 20; Laws 2021, LB363, § 28.
Effective date March 18, 2021.

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

45-1006 Installment loans; application hearing; protest; procedure.

(1) When an application for an original installment loan license has been accepted by the director as substantially complete, notice of the filing of the application shall be published by the department three successive weeks in a legal newspaper published in or of general circulation in the county where the applicant proposes to operate the business of lending money. A public hearing shall be held on each application except as provided in subsection (2) of this section. The date for hearing shall not be less than thirty days after the last publication. Written protest against the issuance of the license may be filed with the department by any person not less than five days before the date set for hearing. The director, in his or her discretion, may grant a continuance. The costs of the hearing shall be paid by the applicant. The director may deny any

application for license after hearing. The director shall, in his or her discretion, make examination and inspection concerning the propriety of the issuance of a license to any applicant. The cost of such examination and inspection shall be paid by the applicant.

(2) The director may waive the hearing requirements of subsection (1) of this section if (a) the applicant has held, and operated under, a license to engage in the business of lending money in Nebraska pursuant to the Nebraska Installment Loan Act for at least one calendar year immediately prior to the filing of the application, (b) no written protest against the issuance of the license has been filed with the department within fifteen days after publication of a notice of the filing of the application one time in a newspaper of general circulation in the county where the applicant proposes to operate the business of lending money, and (c) in the judgment of the director, the experience, character, and general fitness of the applicant warrant the belief that the applicant will comply with the Nebraska Installment Loan Act.

(3) The expense of any publication made pursuant to this section shall be paid by the applicant.

Source: Laws 1941, c. 90, § 11, p. 349; C.S.Supp.,1941, § 45-139; R.S. 1943, § 45-118; Laws 1997, LB 555, § 6; Laws 1999, LB 396, § 25; R.S.Supp.,2000, § 45-118; Laws 2001, LB 53, § 34; Laws 2005, LB 533, § 59; Laws 2008, LB851, § 25.

45-1007 Installment loans; license; bond.

(1) Except as otherwise provided in this section, a license shall not be issued until the applicant gives to the department a bond in the penal sum of fifty thousand dollars to be executed by the applicant and a surety company authorized to do business in the State of Nebraska, conditioned for the faithful performance by the applicant, as a licensee, of the duties and obligations pertaining to the business of lending money and the prompt payment of any judgment recovered against the applicant, as a licensee, under the Nebraska Installment Loan Act.

(2)(a) Except as provided in subsection (3) of this section, a licensee who employs or enters into an independent agent agreement with an individual required to obtain a mortgage loan originator license pursuant to the Residential Mortgage Licensing Act shall maintain the surety bond required by subsection (1) of this section and a supplemental surety bond. The supplemental surety bond posted by such licensee shall cover all mortgage loan originators who are employees or independent agents of such licensee. The supplemental surety bond shall be for the use of the State of Nebraska and any Nebraska resident who may have claims or causes of action against such licensee arising from a transaction involving a residential mortgage loan, as defined in section 45-702, or against an individual who is a mortgage loan originator employed by, or in an independent agent relationship with, the licensee. The initial amount of the supplemental surety bond shall be one hundred thousand dollars.

(b) Upon filing of the mortgage report of condition required by section 45-1018, a licensee shall maintain or increase its supplemental surety bond to reflect the total dollar amount of the closed residential mortgage loans originated in this state in the preceding year in accordance with the following table. A licensee may decrease its supplemental surety bond in accordance with the

following table if the supplemental surety bond required is less than the amount of the supplemental surety bond on file with the department.

Dollar Amount of Closed Residential Mortgage Loans	Surety Bond Required
$0.00 to $5,000,000.00	$100,000.00
$5,000,000.01 to $10,000,000.00	$125,000.00
$10,000,000.01 to $25,000,000.00	$150,000.00
Over $25,000,000.00	$200,000.00

(3)(a) A person who has been issued multiple licenses pursuant to section 45-1010 and who employs or enters into an independent agent agreement with an individual required to obtain a mortgage loan originator license pursuant to the Residential Mortgage Licensing Act shall maintain a surety bond for each license that he, she, or it holds as required in subsection (1) of this section and shall also post one supplemental surety bond which shall cover all licenses held by such person. The supplemental surety bond posted by such person shall cover all mortgage loan originators who are employees or independent agents of such person. The supplemental surety bond shall be for the use of the State of Nebraska and any Nebraska resident who may have claims or causes of action against such person arising from a transaction involving a residential mortgage loan or against an individual who is a mortgage loan originator employed by, or in an independent agent relationship with, the person. The amount of such supplemental surety bond shall be as follows:

(i) The initial supplemental surety bond shall be in the amount of one hundred thousand dollars; and

(ii) Upon filing of the mortgage report of condition required by section 45-1018, the person's supplemental surety bond shall be maintained in accordance with subdivision (2)(b) of this section. For purposes of calculating the amount of the bond that is required, the total dollar amount of the closed loans shall include all residential mortgage loans in this state closed by the person.

(b) A person who holds both one or more installment loan licenses pursuant to the Nebraska Installment Loan Act and a mortgage banker license pursuant to the Residential Mortgage Licensing Act shall not be required to post and maintain a supplemental surety bond if such person meets the following conditions:

(i) The person maintains a surety bond as provided in subsection (1) of this section for each installment loan license he, she, or it holds;

(ii) The person maintains a mortgage banker surety bond as provided in section 45-724; and

(iii) The mortgage banker surety bond covers all transactions involving residential mortgage loans, including such transactions done pursuant to the person's installment loan license or licenses.

(4) Should the department determine that a licensee does not maintain a supplemental surety bond in the amount required by subsection (2) or (3) of this section, the department shall give written notification to the licensee requiring him, her, or it to increase the surety bond within thirty days to the amount required by subsection (2) or (3) of this section.

(5) The bond or a substitute bond required by subsection (1) of this section shall remain in effect or the licensee shall immediately cease making loans and the license shall be canceled by the director.

Source: Laws 1941, c. 90, § 31, p. 357; C.S.Supp.,1941, § 45-157; R.S. 1943, § 45-119; Laws 1997, LB 555, § 7; R.S.1943, (1998), § 45-119; Laws 2001, LB 53, § 35; Laws 2003, LB 218, § 13; Laws 2006, LB 876, § 49; Laws 2009, LB328, § 42.

Cross References

Residential Mortgage Licensing Act, see section 45-701.

45-1008 License; issuance; requirements; term.

Upon the filing of an application under the Nebraska Installment Loan Act, the payment of the license fee, and the approval of the required bond, the director shall investigate the facts regarding the applicant. If the director finds that (1) the experience, character, and general fitness of the applicant, of the applicant's partners or members if the applicant is a partnership, limited liability company, or association, and of the applicant's officers and directors if the applicant is a corporation, are such as to warrant belief that the applicant will operate the business honestly, fairly, and efficiently within the purposes of the act, and (2) allowing the applicant to engage in business will promote the convenience and advantage of the community in which the business of the applicant is to be conducted, the department shall issue and deliver an original license to the applicant to make loans at the location specified in the application, in accordance with the act. The license shall remain in full force and effect until the following December 31 and from year to year thereafter, if and when renewed under the act, until it is surrendered by the licensee or canceled, suspended, or revoked under the act.

Source: Laws 1941, c. 90, § 12, p. 349; C.S.Supp.,1941, § 45-140; R.S. 1943, § 45-120; Laws 1993, LB 121, § 265; Laws 1997, LB 555, § 8; R.S.1943, (1998), § 45-120; Laws 2001, LB 53, § 36; Laws 2009, LB328, § 43; Laws 2013, LB279, § 4.

Department of Banking may restrict number of licensees. Motors Acceptance Corp. v. McLain, 154 Neb. 354, 47 N.W.2d 919 (1951).

45-1009 License; application; grant or denial; time allowed; abandoned application; department; powers.

(1) The department shall approve or deny every application for license under section 45-1008 within ninety days after the filing of an application, if the application is substantially complete and is accompanied by the required fees and the approved bond.

(2) If an applicant for a license under section 45-1008 does not complete the license application and fails to respond to a notice or notices from the department to correct the deficiency or deficiencies for a period of one hundred twenty days or more after the date the department sends the initial notice to correct the deficiency or deficiencies, the department may deem the application as abandoned and may issue a notice of abandonment of the application to the applicant in lieu of proceedings to deny the application.

Source: Laws 1941, c. 90, § 12, p. 350; C.S.Supp.,1941, § 45-140; R.S. 1943, § 45-121; Laws 1999, LB 396, § 26; R.S.Supp.,2000, § 45-121; Laws 2001, LB 53, § 37; Laws 2017, LB185, § 3.

45-1010 Installment loans; licenses; limitations as to business and persons.

Not more than one place of business shall be maintained under the same license, but more than one license may be issued to the same licensee upon compliance with all provisions of the Nebraska Installment Loan Act governing the issuance of an original license, for each such new license.

Source: Laws 1941, c. 90, § 5, p. 346; C.S.Supp.,1941, § 45-133; R.S. 1943, § 45-122; R.S.1943, (1998), § 45-122; Laws 2001, LB 53, § 38.

45-1011 Installment loans; place of business; separate office required; exceptions; enforcement.

No licensee shall conduct the business of making loans under the Nebraska Installment Loan Act within any office, room, or place of business in which any other business is solicited or engaged in, or in association or conjunction with any other business, if the director finds that the other business is of such nature that the conducting of such other business tends to conceal evasion of the act or of the rules and regulations adopted and promulgated under the act. In such case, the director shall order such licensee in writing to cease and desist from such conduct.

Source: Laws 1941, c. 90, § 22, p. 354; C.S.Supp.,1941, § 45-150; R.S. 1943, § 45-123; Laws 1953, c. 155, § 1, p. 489; Laws 1997, LB 555, § 9; R.S.1943, (1998), § 45-123; Laws 2001, LB 53, § 39.

Where unauthorized business was conducted, loan was void and uncollectible. Grand Island Finance Co. v. Eacker, 155 Neb. 546, 52 N.W.2d 805 (1952).

45-1012 Licensee; service of process.

Obtaining a license constitutes sufficient contact with this state for the exercise of personal jurisdiction over the licensee in any action arising out of the licensee's activity in this state.

Source: Laws 1941, c. 90, § 7, p. 347; C.S.Supp.,1941, § 45-135; R.S. 1943, § 45-124; Laws 1983, LB 447, § 68; R.S.1943, (1998), § 45-124; Laws 2001, LB 53, § 40.

Service of process upon Director of Banking was proper in action to have installment loan declared void. McNish v. General Credit Corp., 164 Neb. 526, 83 N.W.2d 1 (1957).

45-1013 Installment loans; license; renewal; fees; relocation of place of business; procedure; hearing; fee.

(1) For the annual renewal of an original license under the Nebraska Installment Loan Act, the licensee shall file with the department a fee of two hundred fifty dollars and a renewal application containing such information as the director may require to indicate any material change in the information contained in the original application or succeeding renewal applications.

(2) For the relocation of its place of business, a licensee shall file with the department a fee of one hundred fifty dollars and an application containing such information as the director may require to determine whether the relocation should be approved. Upon receipt of the fee and application, the director shall publish a notice of the filing of the application in a newspaper of general circulation in the county where the licensee proposes to relocate. If the director

receives any substantive objection to the proposed relocation within fifteen days after publication of such notice, he or she shall hold a hearing on the application in accordance with the Administrative Procedure Act and the rules and regulations adopted and promulgated under the act. The expense of any publication required by this section shall be paid by the applicant licensee.

Source: Laws 1941, c. 90, § 6, p. 347; C.S.Supp.,1941, § 45-134; R.S. 1943, § 45-126; Laws 1973, LB 39, § 2; Laws 1995, LB 599, § 9; Laws 1997, LB 555, § 10; R.S.1943, (1998), § 45-126; Laws 2001, LB 53, § 41; Laws 2005, LB 533, § 60; Laws 2007, LB124, § 54; Laws 2009, LB328, § 44; Laws 2013, LB279, § 5.

Cross References

Administrative Procedure Act, see section 84-920.

45-1014 Installment loans; fees; disposition.

All original license fees and annual renewal fees shall be collected by the department and remitted to the State Treasurer for credit to the Financial Institution Assessment Cash Fund. All investigation and examination fees, charges, and costs collected by or paid to the department shall likewise be remitted to the State Treasurer for credit to the Financial Institution Assessment Cash Fund and shall be available for the uses and purposes of the fund.

Source: Laws 1941, c. 90, § 26, p. 355; C.S.Supp.,1941, § 45-154; R.S. 1943, § 45-127; Laws 1969, c. 584, § 46, p. 2373; Laws 1973, LB 39, § 3; Laws 1994, LB 967, § 31; Laws 1995, LB 7, § 41; Laws 1995, LB 599, § 10; R.S.1943, (1998), § 45-127; Laws 2001, LB 53, § 42; Laws 2007, LB124, § 55.

45-1015 Installment loans; doing business without license; penalty.

Any person who, by any device, subterfuge, or pretense whatsoever, engages in or continues any of the kinds of business or enterprise permitted to licensees by the Nebraska Installment Loan Act without having obtained the license required by the act, with intent to evade the provisions of the act, is guilty of a Class I misdemeanor.

Source: Laws 1941, c. 90, § 14, p. 350; C.S.Supp.,1941, § 45-142; R.S. 1943, § 45-128; Laws 1977, LB 40, § 248; Laws 1993, LB 121, § 266; Laws 1997, LB 555, § 11; R.S.1943, (1998), § 45-128; Laws 2001, LB 53, § 43.

Conviction under this section is not a condition precedent to imposition of civil penalty. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 803, 97 N.W.2d 583 (1959).

Statute is penal in character and voids entire contract in case of violation. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 298, 96 N.W.2d 55 (1959).

Penalties of act applied to nonlicensees. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

If exactions of interest are usurious, whole obligation is void and uncollectible. State ex rel. Beck v. Associates Discount Corp., 161 Neb. 410, 73 N.W.2d 673 (1955).

45-1016 Installment loans; rules and regulations; power of Department of Banking and Finance.

The director may adopt and promulgate rules and regulations and issue orders, rulings, demands, and findings to carry out the purposes of the Nebraska Installment Loan Act.

Source: Laws 1941, c. 90, § 23, p. 354; C.S.Supp.,1941, § 45-151; R.S. 1943, § 45-129; Laws 1997, LB 555, § 12; R.S.1943, (1998), § 45-129; Laws 2001, LB 53, § 44.

45-1017 Licensees; business, records, and accounts; inspection; expenses; fines; lien.

(1) The department shall inspect the business, records, and accounts of all persons that lend money subject to the Nebraska Installment Loan Act. The department may examine or investigate complaints about or reports of alleged violations by a licensee made to the department. The department may inspect and investigate the business, records, and accounts of all persons in the public business of lending money contrary to the act and who do not have a license under the act. The director may appoint examiners who shall, under his or her direction, investigate the loans and business and conduct examinations of licensees as often as determined by the director. The expenses incurred by the department in examining licensees and in administering the act shall be charged to the licensee as set forth in sections 8-605 and 8-606.

(2) Upon receipt by a licensee of a notice of investigation or inquiry request for information from the department, the licensee shall respond within twenty-one calendar days. Each day a licensee fails to respond as required by this subsection constitutes a separate violation.

(3) If the director finds, after notice and opportunity for hearing in accordance with the Administrative Procedure Act, that any person has willfully and intentionally violated any provision of the Nebraska Installment Loan Act, any rule or regulation adopted and promulgated under the act, or any order issued under the act, the director may order such person to pay (a) an administrative fine of not more than one thousand dollars for each separate violation and (b) the costs of investigation. The department shall remit fines collected under this subsection to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

(4) If a person fails to pay an administrative fine and the costs of investigation ordered pursuant to subsection (3) of this section, a lien in the amount of such fine and costs may be imposed upon all assets and property of such person in this state and may be recovered in a civil action by the director. The lien shall attach to the real property of such person when notice of the lien is filed and indexed against the real property in the office of the register of deeds in the county where the real property is located. The lien shall attach to any other property of such person when notice of the lien is filed against the property in the manner prescribed by law. Failure of the person to pay such fine and costs constitutes a separate violation of the act.

Source: Laws 1941, c. 90, § 25, p. 355; C.S.Supp.,1941, § 45-153; R.S. 1943, § 45-130; Laws 1997, LB 137, § 21; Laws 1997, LB 555, § 13; Laws 1999, LB 396, § 27; R.S.Supp.,2000, § 45-130; Laws 2001, LB 53, § 45; Laws 2004, LB 999, § 38; Laws 2007, LB124, § 56; Laws 2020, LB909, § 44.

Cross References

Administrative Procedure Act, see section 84-920.

45-1018 Licensees; reports.

(1) A licensee shall on or before March 1 of each year file with the department a report of the licensee's earnings and operations for the preceding calendar year, and its assets at the end of the year, and giving such other relevant information as the department may reasonably require. The report

shall be made under oath and shall be in the form and manner prescribed by the department.

(2) A licensee shall submit a mortgage report of condition as required by section 45-726, on or before a date or dates established by rule, regulation, or order of the director.

Source: Laws 1941, c. 90, § 25, p. 355; C.S.Supp.,1941, § 45-153; R.S. 1943, § 45-131; R.S.1943, (1998), § 45-131; Laws 2001, LB 53, § 46; Laws 2003, LB 217, § 40; Laws 2004, LB 999, § 39; Laws 2009, LB328, § 45; Laws 2010, LB892, § 21; Laws 2013, LB279, § 6.

45-1019 Cease and desist order; hearing; judicial review; enforcement; violation; penalty.

(1) The department may order any person to cease and desist whenever the department determines that the person has violated any provision of the Nebraska Installment Loan Act. Upon entry of a cease and desist order, the director shall promptly notify the affected person that such order has been entered, of the reasons for such order, and that upon receipt, within fifteen business days after the date of the order, of written request from the affected person a hearing will be scheduled within thirty business days after the date of receipt of the written request unless the parties consent to a later date or the hearing officer sets a later date for good cause. If a hearing is not requested and none is ordered by the director, the order shall remain in effect until it is modified or vacated.

(2) The director may vacate or modify a cease and desist order if he or she finds that the conditions which caused its entry have changed or that it is otherwise in the public interest to do so.

(3) A person aggrieved by a cease and desist order of the director may obtain judicial review of the order in the manner prescribed in the Administrative Procedure Act and the rules and regulations adopted and promulgated by the department under the act. The director may obtain an order from the district court of Lancaster County for the enforcement of the cease and desist order.

(4) A person who violates a cease and desist order of the director may, after notice and hearing and upon further order of the director, be subject to a penalty of not more than five thousand dollars for each act in violation of the cease and desist order. The department shall remit fines collected under this section to the State Treasurer for distribution in accordance with Article VII, section 5, of the Constitution of Nebraska.

Source: Laws 1941, c. 90, § 10, p. 349; C.S.Supp.,1941, § 45-138; R.S. 1943, § 45-132; Laws 1997, LB 555, § 14; R.S.1943, (1998), § 45-132; Laws 2001, LB 53, § 47; Laws 2009, LB328, § 46.

Cross References

Administrative Procedure Act, see section 84-920.

45-1020 Misleading advertising prohibited; enforcement.

No licensee or other person subject to the Nebraska Installment Loan Act shall advertise, print, display, publish, distribute, or broadcast or cause or permit to be advertised, printed, displayed, published, distributed, or broadcast in any manner whatsoever any false, misleading, or deceptive statement or

representation with regard to the rates, terms, or conditions for the lending of money, credit, goods, or things in action. The director may order any licensee to cease and desist from any conduct which he or she finds to be a violation of this section. The director may require that rates of charge, if stated by a licensee, be stated fully and clearly in such manner as the director deems necessary to prevent misunderstanding by prospective borrowers.

Source: Laws 1941, c. 90, § 21, p. 353; C.S.Supp.,1941, § 45-149; R.S. 1943, § 45-133; Laws 1993, LB 121, § 267; Laws 1997, LB 555, § 15; R.S.1943, (1998), § 45-133; Laws 2001, LB 53, § 48.

45-1021 Installment loans; interest, defined.

The payment in money, credit, goods, or things in action, as consideration for any sale or assignment of, or order for, the payment of wages, salary, commission, or other compensation for services, whether earned or to be earned, shall, for purposes of regulation under the Nebraska Installment Loan Act, be deemed a loan secured by such assignment, and the amount by which the assigned compensation exceeds the amount of the consideration actually paid, shall, for the purposes of regulation under the act, be deemed interest or charges upon the loan from the date of payment to the date the compensation is payable. Such transaction shall be governed by and be subject to the act.

Source: Laws 1941, c. 90, § 13, p. 350; C.S.Supp.,1941, § 45-141; R.S. 1943, § 45-134; Laws 1997, LB 555, § 16; R.S.1943, (1998), § 45-134; Laws 2001, LB 53, § 49.

Furnishing of insurance by wholly owned subsidiary was a device and subterfuge to collect additional compensation for money loaned. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

45-1022 Installment loans; payment in advance; application of payments.

Every licensee shall permit payment to be made in advance in any amount equal to one or more full installments on any loan contract at any time during regular business hours, but the licensee may apply such payment first to all accrued charges in full up to the date of such payment.

Source: Laws 1941, c. 90, § 19, p. 353; C.S.Supp.,1941, § 45-147; R.S. 1943, § 45-135; Laws 1963, c. 273, § 1, p. 820; R.S.1943, (1998), § 45-135; Laws 2001, LB 53, § 50.

45-1023 Installment loans; false statement to secure; penalty.

Any person who makes a false statement to secure a loan is guilty of a Class III misdemeanor. The punishment shall not be exacted, however, when such a loan is made after the licensee is aware of the falsity of the statement.

Source: Laws 1941, c. 90, § 28, p. 356; C.S.Supp.,1941, § 45-156; R.S. 1943, § 45-136; Laws 1977, LB 40, § 249; R.S.1943, (1998), § 45-136; Laws 2001, LB 53, § 51.

45-1024 Installment loans; interest rate authorized; charges permitted; computation; application of payments; violations; restrictions.

(1) Except as provided in section 45-1025 and subsection (6) of this section, every licensee may make loans and may contract for and receive on such loans charges at a rate not exceeding twenty-four percent per annum on that part of the unpaid principal balance on any loan not in excess of one thousand dollars,

and twenty-one percent per annum on any remainder of such unpaid principal balance. Except for loans secured by mobile homes, a licensee may not make loans for a period in excess of one hundred forty-five months if the amount of the loan is greater than three thousand dollars but less than twenty-five thousand dollars. Charges on loans made under the Nebraska Installment Loan Act shall not be paid, deducted, or received in advance. The contracting for, charging of, or receiving of charges as provided for in subsection (2) of this section shall not be deemed to be the payment, deduction, or receipt of such charges in advance.

(2) When the loan contract requires repayment in substantially equal and consecutive monthly installments of principal and charges combined, the licensee may, at the time the loan is made, precompute the charges at the agreed rate on scheduled unpaid principal balances according to the terms of the contract and add such charges to the principal of the loan. Every payment may be applied to the combined total of principal and precomputed charges until the contract is fully paid. All payments made on account of any loan except for default and deferment charges shall be deemed to be applied to the unpaid installments in the order in which they are due. The portion of the precomputed charges applicable to any particular month of the contract, as originally scheduled or following a deferment, shall be that proportion of such precomputed charges, excluding any adjustment made for a first installment period of more than one month and any adjustment made for deferment, which the balance of the contract scheduled to be outstanding during such month bears to the sum of all monthly balances originally scheduled to be outstanding by the contract. This section shall not limit or restrict the manner of calculating charges, whether by way of add-on, single annual rate, or otherwise, if the rate of charges does not exceed that permitted by this section. Charges may be contracted for and earned at a single annual rate, except that the total charges from such rate shall not be greater than the total charges from the several rates otherwise applicable to the different portions of the unpaid balance according to subsection (1) of this section. All loan contracts made pursuant to this subsection are subject to the following adjustments:

(a) Notwithstanding the requirement for substantially equal and consecutive monthly installments, the first installment period may not exceed one month by more than twenty-one days and may not fall short of one month by more than eleven days. The charges for each day exceeding one month shall be one-thirtieth of the charges which would be applicable to a first installment period of one month. The charge for extra days in the first installment period may be added to the first installment and such charges for such extra days shall be excluded in computing any rebate;

(b) If prepayment in full by cash, a new loan, or otherwise occurs before the first installment due date, the charges shall be recomputed at the rate of charges contracted for in accordance with subsection (1) or (2) of this section upon the actual unpaid principal balances of the loan for the actual time outstanding by applying the payment, or payments, first to charges at the agreed rate and the remainder to the principal. The amount of charges so computed shall be retained in lieu of all precomputed charges;

(c) If a contract is prepaid in full by cash, a new loan, or otherwise after the first installment due date, the borrower shall receive a rebate of an amount which is not less than the amount obtained by applying to the unpaid principal balances as originally scheduled or, if deferred, as deferred, for the period

following prepayment, according to the actuarial method, the rate of charge contracted for in accordance with subsection (1) or (2) of this section. The licensee may round the rate of charge to the nearest one-half of one percent if such procedure is not consistently used to obtain a greater yield than would otherwise be permitted. Any default and deferment charges which are due and unpaid may be deducted from any rebate. No rebate shall be required for any partial prepayment. No rebate of less than one dollar need be made. Acceleration of the maturity of the contract shall not in itself require a rebate. If judgment is obtained before the final installment date, the contract balance shall be reduced by the rebate which would be required for prepayment in full as of the date judgment is obtained;

(d) If any installment on a precomputed or interest bearing loan is unpaid in full for ten or more consecutive days, Sundays and holidays included, after it is due, the licensee may charge and collect a default charge not exceeding an amount equal to five percent of such installment. If any installment payment is made by a check, draft, or similar signed order which is not honored because of insufficient funds, no account, or any other reason except an error of a third party to the loan contract, the licensee may charge and collect a fifteen-dollar bad check charge. Such default or bad check charges may be collected when due or at any time thereafter;

(e) If, as of an installment due date, the payment date of all wholly unpaid installments is deferred one or more full months and the maturity of the contract is extended for a corresponding period, the licensee may charge and collect a deferment charge not exceeding the charge applicable to the first of the installments deferred, multiplied by the number of months in the deferment period. The deferment period is that period during which no payment is made or required by reason of such deferment. The deferment charge may be collected at the time of deferment or at any time thereafter. The portion of the precomputed charges applicable to each deferred balance and installment period following the deferment period shall remain the same as that applicable to such balance and periods under the original loan contract. No installment on which a default charge has been collected, or on account of which any partial payment has been made, shall be deferred or included in the computation of the deferment charge unless such default charge or partial payment is refunded to the borrower or credited to the deferment charge. Any payment received at the time of deferment may be applied first to the deferment charge and the remainder, if any, applied to the unpaid balance of the contract, except that if such payment is sufficient to pay, in addition to the appropriate deferment charge, any installment which is in default and the applicable default charge, it shall be first so applied and any such installment shall not be deferred or subject to the deferment charge. If a loan is prepaid in full during the deferment period, the borrower shall receive, in addition to the required rebate, a rebate of that portion of the deferment charge applicable to any unexpired full month or months of such deferment period; and

(f) If two or more full installments are in default for one full month or more at any installment date and if the contract so provides, the licensee may reduce the contract balance by the rebate which would be required for prepayment in full as of such installment date and the amount remaining unpaid shall be deemed to be the unpaid principal balance and thereafter in lieu of charging, collecting, receiving, and applying charges as provided in this subsection,

charges may be charged, collected, received, and applied at the agreed rate as otherwise provided by this section until the loan is fully paid.

(3) The charges, as referred to in subsection (1) of this section, shall not be compounded. The charging, collecting, and receiving of charges as provided in subsection (2) of this section shall not be deemed compounding. If part or all of the consideration for a loan contract is the unpaid principal balance of a prior loan, then the principal amount payable under such loan contract may include any unpaid charges on the prior loan which have accrued within sixty days before the making of such loan contract and may include the balance remaining after giving the rebate required by subsection (2) of this section. Except as provided in subsection (2) of this section, charges shall (a) be computed and paid only as a percentage per month of the unpaid principal balance or portions thereof and (b) be computed on the basis of the number of days actually elapsed. For purposes of computing charges, whether at the maximum rate or less, a month shall be that period of time from any date in a month to the corresponding date in the next month but if there is no such corresponding date then to the last day of the next month, and a day shall be considered one-thirtieth of a month when computation is made for a fraction of a month.

(4) Except as provided in subsections (5) and (6) of this section, in addition to that provided for under the Nebraska Installment Loan Act, no further or other amount whatsoever shall be directly or indirectly charged, contracted for, or received. If any amount, in excess of the charges permitted, is charged, contracted for, or received, the loan contract shall not on that account be void, but the licensee shall have no right to collect or receive any interest or other charges whatsoever. If such interest or other charges have been collected or contracted for, the licensee shall refund to the borrower all interest and other charges collected and shall not collect any interest or other charges contracted for and thereafter due on the loan involved, as liquidated damages, and the licensee or its assignee, if found liable, shall pay the costs of any action relating thereto, including reasonable attorney's fees. No licensee shall be found liable under this subsection if the licensee shows by a preponderance of the evidence that the violation was not intentional and resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adopted to avoid any such error.

(5) A borrower may be required to pay all reasonable expenses incurred in connection with the making, closing, disbursing, extending, readjusting, or renewing of loans. Such expenses may include abstracting, recording, releasing, and registration fees; premiums paid for nonfiling insurance; premiums paid on insurance policies covering tangible personal property securing the loan; amounts charged for a debt cancellation contract or a debt suspension contract, as agreed upon by the parties, if the debt cancellation contract or debt suspension contract is a contract of a financial institution or licensee and such contract is sold directly by such financial institution or licensee or by an unaffiliated, nonexclusive agent of such financial institution or licensee in accordance with 12 C.F.R. part 37, as such part existed on January 1, 2011, and the financial institution or licensee is responsible for the unaffiliated, nonexclusive agent's compliance with such part; title examinations; credit reports; survey; taxes or charges imposed upon or in connection with the making and recording or releasing of any mortgage; amounts charged for a guaranteed asset protection waiver; and fees and expenses charged for electronic title and lien services. Except as provided in subsection (6) of this

section, a borrower may also be required to pay a nonrefundable loan origination fee not to exceed the lesser of five hundred dollars or an amount equal to seven percent of that part of the original principal balance of any loan not in excess of two thousand dollars and five percent on that part of the original principal balance in excess of two thousand dollars, if the licensee has not made another loan to the borrower within the previous twelve months. If the licensee has made another loan to the borrower within the previous twelve months, a nonrefundable loan origination fee may only be charged on new funds advanced on each successive loan. Such reasonable initial charges may be collected from the borrower or included in the principal balance of the loan at the time the loan is made and shall not be considered interest or a charge for the use of the money loaned.

(6)(a) Loans secured solely by real property that are not made pursuant to subdivision (11) of section 45-101.04 on real property shall not be subject to the limitations on the rate of interest provided in subsection (1) of this section or the limitations on the nonrefundable loan origination fee under subsection (5) of this section if (i) the principal amount of the loan is seven thousand five hundred dollars or more and (ii) the sum of the principal amount of the loan and the balances of all other liens against the property do not exceed one hundred percent of the appraised value of the property. Acceptable methods of determining appraised value shall be made by the department pursuant to rule, regulation, or order.

(b) An origination fee on such loan shall be computed only on the principal amount of the loan reduced by any portion of the principal that consists of the amount required to pay off another loan made under this subsection by the same licensee.

(c) A prepayment penalty on such loan shall be permitted only if (i) the maximum amount of the penalty to be assessed is stated in writing at the time the loan is made, (ii) the loan is prepaid in full within two years from the date of the loan, and (iii) the loan is prepaid with money other than the proceeds of another loan made by the same licensee. Such prepayment penalty shall not exceed six months interest on eighty percent of the original principal balance computed at the agreed rate of interest on the loan.

(d) A licensee making a loan pursuant to this subsection may obtain an interest in any fixtures attached to such real property and any insurance proceeds payable in connection with such real property or the loan.

(e) For purposes of this subsection, principal amount of the loan means the total sum owed by the borrower including, but not limited to, insurance premiums, loan origination fees, or any other amount that is financed, except that for purposes of subdivision (6)(b) of this section, loan origination fees shall not be included in calculating the principal amount of the loan.

Source: Laws 1941, c. 90, § 15, p. 350; C.S.Supp.,1941, § 45-143; Laws 1943, c. 107, § 3, p. 370; R.S.1943, § 45-137; Laws 1957, c. 193, § 1, p. 684; Laws 1963, c. 273, § 2, p. 821; Laws 1963, Spec. Sess., c. 7, § 9, p. 93; Laws 1963, Spec. Sess., c. 9, § 1, p. 103; Laws 1979, LB 87, § 3; Laws 1980, LB 276, § 8; Laws 1982, LB 702, § 1; Laws 1984, LB 681, § 1; Laws 1994, LB 979, § 8; Laws 1995, LB 614, § 1; Laws 1997, LB 555, § 17; Laws 1999, LB 170, § 1; Laws 2000, LB 932, § 30; R.S.Supp.,2000, § 45-137; Laws 2001, LB 53, § 52; Laws 2003, LB 218, § 14; Laws 2004, LB 999,

§ 40; Laws 2005, LB 533, § 61; Laws 2006, LB 876, § 50; Laws 2009, LB328, § 47; Laws 2010, LB571, § 11; Laws 2011, LB77, § 4.

1. Constitutionality
2. Retroactive amendment
3. Violations
4. Miscellaneous

1. Constitutionality

Legislative Bill 17 of the 1963 Special Session of the Legislature was sustained as constitutional. Kometscher v. Wade, 177 Neb. 299, 128 N.W.2d 781 (1964).

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

2. Retroactive amendment

Retroactive amendment of this section did not apply to transactions already reduced to judgment. Berg v. Midwest Laundry Equipment Corp., 178 Neb. 770, 135 N.W.2d 457 (1965).

Retroactive reduction in penalty for violation of this section sustained as constitutional. Davis v. General Motors Acceptance Corp., 176 Neb. 865, 127 N.W.2d 907 (1964).

3. Violations

Legislature at 1963 Special Session changed penalty for violation of this section. Highway Equipment & Supply Co. v. Jones, 182 Neb. 234, 153 N.W.2d 859 (1967).

Where maximum rate of interest was exceeded, installment loan violated this section. Robertson v. Burnett, 172 Neb. 385, 109 N.W.2d 716 (1961).

Where excessive charges are made on renewal of loan, there is a violation of this act. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 803, 97 N.W.2d 583 (1959).

In an action based upon an illegal contract by a licensee under the small loan law, such licensee loses all right to collect any sum whatever on the indebtedness under the contract. Nitzel & Co. v. Nelson, 144 Neb. 662, 14 N.W.2d 197 (1944).

The method used here in calculating unearned interest to be rebated did not produce an actuarially accurate rebate but rather produced hidden charges in violation of the Consumer Protection Act, but there was no violation of the Nebraska Small Loan Act, as the Nebraska statutes do authorize calculation of prepayment rebates by this method. Ballew v. Associates Fin. Ser. Co. of Neb. Inc., 450 F.Supp. 253 (D. Neb. 1976).

4. Miscellaneous

Permissive provisions of Installment Loan Act apply to licensees. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

Amount charged for making loan was not in excess of that permitted by this section. Underwriters Acceptance Corp. v. Dunkin, 152 Neb. 550, 41 N.W.2d 855 (1950).

Notwithstanding limitations on interest rates imposed on state banks by Nebraska law, national bank in Nebraska can charge, with respect to credit card transactions, rates allowed by Nebraska law for ''small loan companies''. Fisher v. First Nat. Bank of Omaha, 548 F.2d 255 (8th Cir. 1977).

This section authorizes the calculation of prepayment rebates by the method used in this case, and an otherwise lawful transaction under this section is not rendered usurious because of the use of this method in calculating a prepayment rebate. Ballew v. Associates Fin. Ser. Co. of Neb. Inc., 450 F.Supp. 253 (D. Neb. 1976).

In suit to declare lender's interest charge usurious where borrower paid maximum legal loan rate plus one hundred dollars, court found the latter charge only ''incidental'' to the extension of credit where borrower received other monetary consideration in addition to a loan. Campbell v. Liberty Financial Planning, Inc., 422 F.Supp. 1386 (D. Neb. 1976).

Defendant's disclosure of method used in computing late charge in language of this section was meaningful. Scott v. Liberty Finance Co., 380 F.Supp. 475 (D. Neb. 1974).

45-1025 Installment loans; additional charges authorized; loan period; violation; effect.

(1) Licensees may charge, contract for, or receive any amount or rate of interest permitted by section 45-101.03, 45-101.04, or 45-1024 upon any loan or upon any part or all of any aggregate indebtedness of the same person. Except as provided in subsection (2) of this section, the charging, contracting for, or receiving of a rate of interest permitted by section 45-101.04 does not exempt the licensee from compliance with the Nebraska Installment Loan Act.

(2)(a) Loans made by a licensee pursuant to subdivision (4) of section 45-101.04 are not subject to the Nebraska Installment Loan Act if such loans are not made on real property.

(b) Loans made by a licensee pursuant to subdivision (11) of section 45-101.04 on real property are not subject to the Nebraska Installment Loan Act. A licensee making such loans shall comply with and be subject to the Residential Mortgage Licensing Act with respect to such loans, except that the licensee shall not be required to obtain a mortgage banker license under the Residential Mortgage Licensing Act.

(c) Any mortgage loan originator who works as an employee or independent agent of a licensee shall be required to obtain a mortgage loan originator license and shall be subject to the Residential Mortgage Licensing Act.

(3) Except as provided in subdivision (2)(a) of section 45-1024, no licensee shall enter into any loan contract under the Nebraska Installment Loan Act under which the borrower agrees to make any payment of principal more than thirty-six calendar months from the date of making such contract when the principal balance is not more than three thousand dollars. Every loan contract precomputed pursuant to subsection (2) of section 45-1024 shall provide for repayment of principal and charges in installments which shall be payable at approximately equal periodic intervals of time and so arranged that no installment is substantially greater in amount than any preceding installment. When necessary in order to facilitate payment in accordance with the borrower's principal source of income or when the loan contract is not precomputed pursuant to subsection (2) of section 45-1024, the payment schedule may reduce or omit installment payments. Any loan contract made in violation of this section, either knowingly or without the exercise of due care to prevent the violation, shall not on that account be void, but the licensee has no right to collect or receive any interest or charges on such loan. If any interest or other charges have been collected or contracted for, the licensee shall refund to the borrower all interest and other charges collected and shall not collect thereafter any interest or other charges contracted for and thereafter due on the loan involved, as liquidated damages, and the licensee or its assignee, if found liable, shall pay the costs of any action relating thereto, including reasonable attorney's fees. No licensee shall be found liable under this subsection if the licensee shows by a preponderance of the evidence that the violation was not intentional and resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adopted to avoid any such error.

Source: Laws 1941, c. 90, § 16, p. 351; C.S.Supp.,1941, § 45-144; Laws 1943, c. 107, § 4, p. 371; R.S.1943, § 45-138; Laws 1953, c. 155, § 2, p. 490; Laws 1957, c. 193, § 2, p. 685; Laws 1963, Spec. Sess., c. 7, § 10, p. 94; Laws 1963, Spec. Sess., c. 9, § 2, p. 108; Laws 1971, LB 18, § 1; Laws 1979, LB 87, § 4; Laws 1982, LB 702, § 2; Laws 1984, LB 681, § 2; Laws 1994, LB 979, § 9; Laws 1997, LB 555, § 18; R.S.1943, (1998), § 45-138; Laws 2001, LB 53, § 53; Laws 2003, LB 218, § 15; Laws 2004, LB 999, § 41; Laws 2009, LB328, § 48.

Cross References

Residential Mortgage Licensing Act, see section 45-701.

1. Usury as a defense
2. Prohibited acts
3. 1963 amendments
4. Miscellaneous

1. Usury as a defense

The defense of usury based upon the usury statute is not assignable to a stranger who is not a surety for or in privity with the original borrower. General Electric Credit Corp. v. Best Refr'd Express, 222 Neb. 499, 385 N.W.2d 81 (1986).

The defense of usury is personal to the borrower, his sureties, and those in privity with him. Commonwealth Trailer Sales, Inc. v. Bradt, 166 Neb. 1, 87 N.W.2d 705 (1958).

Burden is on defendant to prove usury where instruments taken separately did not have on their face the appearance of usury. Nitzel & Co. v. Nelson, 144 Neb. 662, 14 N.W.2d 197 (1944).

2. Prohibited acts

Usurious loan disguised as conditional or time sale is subject to forfeiture of interest. Midstates Acceptance v. Voss, 189 Neb. 411, 202 N.W.2d 822 (1972).

Where the indebtedness exceeds three thousand dollars, charge in excess of nine percent per annum is prohibited. Berg v. Midwest Laundry Equipment Corp., 175 Neb. 423, 122 N.W.2d 250 (1963).

Violation of various prohibitions of Small Loan Act rendered entire contract void. Wood v. Commonwealth Trailer Sales, Inc., 172 Neb. 494, 110 N.W.2d 87 (1961).

Loan repayable in sixty months violated this section. Robertson v. Burnett, 172 Neb. 385, 109 N.W.2d 716 (1961).

Payment for an extension of time, in addition to interest charge at maximum rate, was usurious. Curtis v. Securities Acceptance Corp., 166 Neb. 815, 91 N.W.2d 19 (1958).

Requirement of large final payment is prohibited. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

3. 1963 amendments

Legislature at 1963 Special Session changed penalty for violation of this section. Highway Equipment & Supply Co. v. Jones, 182 Neb. 234, 153 N.W.2d 859 (1967).

By terms of 1963 amendment, penalty for violation of section was changed to forfeiture of interest and charges. Dailey v. A. C. Nelsen Co., 178 Neb. 881, 136 N.W.2d 186 (1965).

Legislative Bill 17 of the 1963 Special Session of the Legislature was sustained as constitutional. Kometscher v. Wade, 177 Neb. 299, 128 N.W.2d 781 (1964).

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

Contract which was held to be usurious and void under former provisions of this section was not void ab initio and did not bar assignee for value from obtaining adjudication of its rights. Industrial Credit Co. v. Berg, 388 F.2d 835 (8th Cir. 1968).

4. Miscellaneous

The provision of recovery of interest or other charges collected in violation of this section applies only to installment loans. Seldin v. Northland Mortgage Co., 189 Neb. 175, 202 N.W.2d 174 (1972).

Penalties under this section did not apply to downpayment on property which was no part of loan. Berg v. Midwest Laundry Equipment Corp., 178 Neb. 770, 135 N.W.2d 457 (1965).

The equal payment provision of the Installment Loan Act carries the equal payment provision over into all loans under the act. Gruenemeier v. Commonwealth Co., 178 Neb. 66, 131 N.W.2d 713 (1964).

This section is not violated if interest is not charged in excess of nine percent per annum. Moffitt-Harrison Builders, Inc. v. Sandman, 177 Neb. 425, 129 N.W.2d 524 (1964).

Retroactive reduction in penalty for violation of this section sustained as constitutional. Davis v. General Motors Acceptance Corp., 176 Neb. 865, 127 N.W.2d 907 (1964).

Where a loan contract has not been entered into, there can be no usury. Metschke v. Marxsen, 176 Neb. 240, 125 N.W.2d 684 (1964).

Recovery of principal and interest paid for violation of Installment Loan Act is a proper exercise of the police power and is not a penalty. Abel v. Conover, 170 Neb. 926, 104 N.W.2d 684 (1960).

Special statute prescribing specific penalty controls over general statute. Thompson v. Commercial Credit Equipment Corp., 169 Neb. 377, 99 N.W.2d 761 (1959).

Terms of Installment Loan Act are broad enough to apply when consideration of loan is unpaid balance of a preexisting debt. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 803, 97 N.W.2d 583 (1959).

Usurious character of transaction is determined as of the time of its inception. Nelson v. General Credit Corp., 166 Neb. 770, 90 N.W.2d 799 (1958).

Buyer must be informed of difference between time sale price and cash sale price to avoid charge of usury. McNish v. Grand Island Finance Co., 164 Neb. 543, 83 N.W.2d 13 (1957); McNish v. General Credit Corp., 164 Neb. 526, 83 N.W.2d 1 (1957).

Installment loan made by licensee in excess of authorized rate is void, and neither principal nor interest may be recovered. Powell v. Edwards, 162 Neb. 11, 75 N.W.2d 122 (1956).

45-1026 Installment loans; insurance upon security; licensee may require; restrictions; refunds; when.

(1) The following types of insurance or one or more of the following types of insurance may be written in connection with loans made by licensees under the Nebraska Installment Loan Act:

(a) Fire, theft, windstorm, or comprehensive, including fire, theft, and windstorm, fifty dollars or more deductible collision, and bodily injury liability and property damage liability upon motor vehicles;

(b) Fire and extended-coverage insurance upon real property;

(c) Fire and extended-coverage insurance upon tangible personal property, limited to the principal amount of the loan;

(d) Involuntary unemployment or job protection insurance. In the event of a renewal of a loan contract, this type of insurance shall be canceled and a refund of the unearned premium credited or made before new insurance of this type may be rewritten. Such insurance shall not be required as a condition precedent to the making of such loan; and

(e) Life, health, and accident insurance or any of them, except that the amount of such insurance shall not exceed the total amount to be repaid under the loan contract and the term shall not extend beyond the final maturity date of the loan contract. In the event of a renewal of a loan contract, this type of insurance shall be canceled and a refund of the unearned premium credited or made before new insurance of this type may be written in connection with such loan. Such insurance shall not be required as a condition precedent to the making of such loan.

(2) In addition to the types of insurance written under subsection (1) of this section by licensees under the act, any other type of insurance or motor club service as defined in section 44-3707 may be provided for the benefit of a licensee's borrower or the borrower's immediate family whether or not in connection with a loan, except that such insurance or motor club service shall not be required as a condition precedent to the making of any loan. Nothing in this subsection alters or eliminates any insurance licensing requirements or certificate of authority requirements under the Motor Club Services Act.

(3) Notwithstanding sections 45-1024 and 45-1025, any gain or advantage, in the form of commission or otherwise, to the licensee or to any employee, affiliate, or associate of the licensee from such insurance or motor club service or the sale thereof shall not be deemed to be an additional or further charge in connection with the loan contract. The insurance premium or motor club service contract fee may be collected from the borrower or financed through the loan contract at the time the loan is made.

(4)(a) Insurance permitted under this section shall be obtained through a duly licensed insurance agent, agency, or broker. Premiums shall not exceed those fixed by law or current applicable manual rates. Insurance written, as authorized by this section, may contain a mortgage clause or other appropriate provision to protect the insurable interest of the licensee.

(b) Motor club services permitted under this section shall be obtained through a motor club which holds a certificate of authority under the Motor Club Services Act.

(5) In the event of a renewal of a loan contract, any insurance or motor club service sold pursuant to this section shall be canceled and (a) a refund of the unearned premium or motor club service contract fee credited or made before new insurance or motor club service of the same type as that being canceled may be rewritten or (b) the holder of the loan contract shall send notice to the buyer within fifteen business days after cancellation of the name, address, and telephone number of the insurance company or motor club which issued the insurance contract or motor club service contract or the party responsible for any refund and notice that the buyer may be eligible for a refund. A copy of such notice shall be retained by the holder of the loan contract.

(6) If any insurance or motor club service sold pursuant to this section is canceled or the premium or motor club service contract fee adjusted during the term of the loan contract, any refund of the insurance premium or motor club service contract fee plus the unearned interest thereon received by the holder shall be credited by the holder to the loan contract or otherwise refunded, except to the extent applied toward payment for similar insurance or motor club service protecting the interests of the buyer and the holder or either of them.

(7) If any insurance or motor club service sold pursuant to this section is canceled due to the payment of all sums for which the buyer is liable under a loan contract, the holder of the loan contract shall, upon receipt of payment of all sums due, send notice to the buyer within fifteen business days after payment of the sums due of the name, address, and telephone number of the insurance company or motor club which issued the insurance contract or motor club service contract or the party responsible for any refund and notice that the buyer may be eligible for a refund. A copy of such notice shall be retained by the holder of the loan contract. This subsection does not apply if the

holder of the loan contract previously credited the refund of the insurance premium or motor club service contract fee to the loan contract or otherwise refunded the insurance premium or motor club service contract fee to the buyer.

Source: Laws 1941, c. 90, § 17, p. 351; C.S.Supp.,1941, § 45-145; R.S. 1943, § 45-139; Laws 1953, c. 155, § 3, p. 491; Laws 1987, LB 306, § 2; Laws 1990, LB 1094, § 1; Laws 1997, LB 555, § 19; R.S.1943, (1998), § 45-139; Laws 2001, LB 53, § 54; Laws 2002, LB 957, § 23; Laws 2006, LB 876, § 51.

Cross References

Motor Club Services Act, see section 44-3701.

Charges made under this section are permitted to be included in an installment loan. Berg v. Midwest Laundry Equipment Corp., 178 Neb. 770, 135 N.W.2d 457 (1965).

Charges for life, health, and accident insurance as a condition for making loan were violation of act. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

Insurance premium is a proper item to be included in loan. Underwriters Acceptance Corp. v. Dunkin, 152 Neb. 550, 41 N.W.2d 855 (1950).

45-1027 Installment loans; insurance procured through licensee; statement.

The licensee shall, at the time the loan is made, give to the borrower, or if more than one, to one of them, a statement concerning any insurance procured by or through the licensee, which includes the amount of any premium which the borrower has paid or is obligated to pay, the amount, the expiration date of the policy, and a concise description of the risks insured. If a borrower procures insurance by or through a licensee, the licensee shall deliver to the borrower within fifteen days after the making of the loan an executed copy of the insurance policy or certificate of insurance.

Source: Laws 1941, c. 90, § 17, p. 352; C.S.Supp.,1941, § 45-145; R.S. 1943, § 45-140; R.S.1943, (1998), § 45-140; Laws 2001, LB 53, § 55.

Failure to deliver statement of insurance, where charge for insurance was made, was a violation of act. Curtis v. Securities Acceptance Corp., 166 Neb. 815, 91 N.W.2d 19 (1958).

Statement concerning insurance procured must be furnished to borrower. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

45-1028 Installment loans; assignments of wages or security agreement in blank; prohibited.

No licensee shall receive any security agreement or assignment of salary or wages signed in blank. All blank spaces shall be filled in with ink or typewritten or printed with the proper names and amounts showing the name of the person by whom the individual making the conveyance or assignment is employed. No assignment or order for wages is valid if it contains an amount in excess of the sum borrowed together with the interest and charges as provided in the Nebraska Installment Loan Act.

Source: Laws 1941, c. 90, § 18, p. 352; C.S.Supp.,1941, § 45-146; Laws 1943, c. 107, § 5, p. 373; R.S.1943, § 45-142; Laws 1972, LB 1060, § 2; Laws 1993, LB 121, § 268; R.S.1943, (1998), § 45-142; Laws 2001, LB 53, § 56.

Taking chattel mortgage in blank, with spaces to be later filled in, constituted violation of act. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 298, 96 N.W.2d 55 (1959).

Taking chattel mortgage signed in blank was violative of act. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

45-1029 Installment loans; power of attorney and instruments with blanks prohibited.

No licensee shall take a power of attorney, or any instrument signed by an attorney in fact and not personally, or any instrument signed in which blanks are left to be filled after execution.

Source: Laws 1941, c. 90, § 18, p. 352; C.S.Supp.,1941, § 45-146; Laws 1943, c. 107, § 5, p. 373; R.S.1943, § 45-143; R.S.1943, (1998), § 45-143; Laws 2001, LB 53, § 57.

This section, being special statute relating to a specific subject, is controlling rather than Negotiable Instruments Act as to filling in blanks. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 298, 96 N.W.2d 55 (1959).

Taking purchaser's statement in blank was a violation of act. Curtis v. Securities Acceptance Corp., 166 Neb. 815, 91 N.W.2d 19 (1958).

All blank spaces in power of attorney must be filled in before execution. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

45-1030 Installment loans; assignment of wages; consent of spouse necessary.

No assignment of or order for wages to secure a loan or advancement is valid when made by a married man or woman unless the written consent of the wife or husband to the making of such loan is attached thereto.

Source: Laws 1941, c. 90, § 18, p. 353; C.S.Supp.,1941, § 45-146; Laws 1943, c. 107, § 5, p. 373; R.S.1943, § 45-144; R.S.1943, (1998), § 45-144; Laws 2001, LB 53, § 58.

Cross References

For other provisions for execution of assignments of wages, see section 36-213.

45-1031 Installment loans; statement to borrower; contents.

Every licensee shall, at the time any loan is made, give to the borrower, or if there are two or more borrowers, to one of them, a statement in the English language disclosing in clear and distinct terms the information required to be disclosed under the federal Consumer Credit Protection Act.

Source: Laws 1941, c. 90, § 18, p. 353; C.S.Supp.,1941, § 45-146; Laws 1943, c. 107, § 5, p. 373; R.S.1943, § 45-145; Laws 1963, c. 273, § 3, p. 825; Laws 1963, Spec. Sess., c. 7, § 11, p. 96; Laws 1984, LB 681, § 3; Laws 1993, LB 121, § 269; Laws 1997, LB 555, § 20; R.S.1943, (1998), § 45-145; Laws 2001, LB 53, § 59.

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

Failure to give borrower a statement of loan was a violation of act. Curtis v. Securities Acceptance Corp., 166 Neb. 815, 91 N.W.2d 19 (1958).

Borrower must be given a statement showing terms of loan. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

Requirement under this section is only imposed on licensee. Powell v. Edwards, 162 Neb. 11, 75 N.W.2d 122 (1956).

45-1032 Surrender of license; effect.

A licensee may voluntarily surrender a license by delivering to the director written notice of the surrender. Surrender of a license (1) shall not affect civil or criminal liability for acts committed before the surrender or liability for any fines which may be levied against the licensee or any of its officers, directors, shareholders, partners, or members pursuant to section 45-1033 for acts committed before the surrender and (2) shall not impair or affect the obligation of a preexisting lawful contract between the licensee and any person, including a borrower. The department shall issue a notice of cancellation of the license following such surrender.

Source: Laws 2001, LB 53, § 60; Laws 2005, LB 533, § 62.

45-1033 License; administrative fine; disciplinary actions; failure to renew.

(1) The director may, following a hearing under the Administrative Procedure Act and the rules and regulations adopted and promulgated by the department under the act, suspend or revoke any license issued pursuant to the Nebraska Installment Loan Act. The director may also impose an administrative fine on the licensee for each separate violation of the act. The director may take one or more of these actions if the director finds:

(a) The licensee has materially violated or demonstrated a continuing pattern of violating the Nebraska Installment Loan Act or rules and regulations adopted and promulgated under the act, any order issued under the act, or any other state or federal law applicable to the conduct of its business;

(b) A fact or condition exists which, if it had existed at the time of the original application for the license, would have warranted the director to deny the application;

(c) The licensee has violated a voluntary consent or compliance agreement which had been entered into with the director;

(d) The licensee has knowingly provided or caused to be provided to the director any false or fraudulent representation of a material fact or any false or fraudulent financial statement or suppressed or withheld from the director any information which, if submitted by the licensee, would have resulted in denial of the license application;

(e) The licensee has refused to permit an examination by the director of the licensee pursuant to subsection (1) of section 45-1017 or refused or failed to comply with subsection (2) of section 45-1017 or failed to make any report required under section 45-1018. Each day the licensee continues in violation of this subdivision constitutes a separate violation;

(f) The licensee has failed to maintain records as required by the director following written notice. Each day the licensee continues in violation of this subdivision constitutes a separate violation;

(g) The licensee knowingly has employed any individual or knowingly has maintained a contractual relationship with any individual acting as an agent, if such individual has been convicted of, pleaded guilty to, or was found guilty after a plea of nolo contendere to (i) a misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, financial institution business, or installment loan business or (ii) any felony under state or federal law;

(h) The licensee has violated the written restrictions or conditions under which the license was issued;

(i) The licensee, or if the licensee is a business entity, one of the officers, directors, members, partners, or controlling shareholders, was found guilty after a plea of nolo contendere to (i) a misdemeanor under any state or federal law which involves dishonesty or fraud or which involves any aspect of the mortgage banking business, financial institution business, or installment loan business or (ii) any felony under state or federal law; or

(j) The licensee knowingly has employed any individual or knowingly has maintained a contractual relationship with any individual acting as an agent, if such individual is conducting activities requiring a mortgage loan originator license in this state without first obtaining such license.

(2) Except as provided in this section, a license shall not be revoked or suspended except after notice and a hearing in accordance with the Administrative Procedure Act and the rules and regulations adopted and promulgated by the department under the act.

(3)(a) If a licensee fails to renew its license as required by subsection (1) of section 45-1013 and does not voluntarily surrender the license pursuant to section 45-1032, the department may issue a notice of expiration of the license to the licensee in lieu of revocation proceedings.

(b) If a licensee fails to maintain a surety bond as required by section 45-1007, the department may issue a notice of cancellation of the license in lieu of revocation proceedings.

(4) Revocation, suspension, cancellation, or expiration of a license shall not impair or affect the obligation of a preexisting lawful contract between the licensee and any person, including a borrower.

(5) Revocation, suspension, cancellation, or expiration of a license shall not affect civil or criminal liability for acts committed before the revocation, suspension, cancellation, or expiration or liability for any fines which may be imposed against the licensee or any of its officers, directors, shareholders, partners, or members pursuant to this section or section 45-1069 for acts committed before the surrender.

Source: Laws 2001, LB 53, § 61; Laws 2003, LB 218, § 16; Laws 2005, LB 533, § 63; Laws 2007, LB124, § 57; Laws 2009, LB328, § 49; Laws 2020, LB909, § 45.

Cross References

Administrative Procedure Act, see section 84-920.

45-1033.01 License and registration under Nationwide Mortgage Licensing System and Registry; department; powers and duties; director; duties.

(1) The department shall require licensees to be licensed and registered through the Nationwide Mortgage Licensing System and Registry. In order to carry out this requirement, the department is authorized to participate in the Nationwide Mortgage Licensing System and Registry. For this purpose, the department may establish, by adopting and promulgating rules and regulations or by order, requirements as necessary. The requirements may include, but not be limited to:

(a) Background checks of applicants and licensees, including, but not limited to:

(i) Criminal history through fingerprint or other databases;

(ii) Civil or administrative records;

(iii) Credit history; or

(iv) Any other information as deemed necessary by the Nationwide Mortgage Licensing System and Registry;

(b) The payment of fees to apply for or renew a license through the Nationwide Mortgage Licensing System and Registry;

(c) Compliance with prelicensure education and testing and continuing education;

(d) The setting or resetting, as necessary, of renewal processing or reporting dates; and

(e) Amending or surrendering a license or any other such activities as the director deems necessary for participation in the Nationwide Mortgage Licensing System and Registry.

(2) In order to fulfill the purposes of the Nebraska Installment Loan Act, the department is authorized to establish relationships or contracts with the Nationwide Mortgage Licensing System and Registry or other entities designated by the Nationwide Mortgage Licensing System and Registry to collect and maintain records and process transaction fees or other fees related to licensees or other persons subject to the act. The department may allow such system to collect licensing fees on behalf of the department and allow such system to collect a processing fee for the services of the system directly from each licensee or applicant for a license.

(3) The director is required to regularly report violations of the act pertaining to residential mortgage loans, as defined in section 45-702, as well as enforcement actions and other relevant information, to the Nationwide Mortgage Licensing System and Registry subject to the provisions contained in section 45-1033.02.

(4) The director shall establish a process whereby applicants and licensees may challenge information entered into the Nationwide Mortgage Licensing System and Registry by the director.

(5) The department shall ensure that the Nationwide Mortgage Licensing System and Registry adopts a privacy, data security, and security breach notification policy. The director shall make available upon written request a copy of the contract between the department and the Nationwide Mortgage Licensing System and Registry pertaining to the breach of security of the system provisions.

(6) The department shall upon written request provide the most recently available audited financial report of the Nationwide Mortgage Licensing System and Registry.

Source: Laws 2009, LB328, § 50; Laws 2010, LB892, § 22.

45-1033.02 Information sharing; privilege and confidentiality; limitations; applicability of section; director; powers.

(1) In order to promote more effective regulation and reduce the regulatory burden through supervisory information sharing:

(a) Except as otherwise provided in this section, the requirements under any federal or state law regarding the privacy or confidentiality of any information or material provided to the Nationwide Mortgage Licensing System and Registry, and any privilege arising under federal or state law, including the rules of any federal or state court, with respect to such information or material, shall continue to apply to such information or material after the information or material has been disclosed to the Nationwide Mortgage Licensing System and Registry. Such information and material may be shared with all federal and state regulatory officials with mortgage industry oversight authority without the loss of privilege or the loss of confidentiality protections provided by federal or state law;

(b) Information or material that is subject to a privilege or confidentiality under subdivision (1)(a) of this section shall not be subject to:

(i) Disclosure under any federal or state law governing the disclosure to the public of information held by an officer or an agency of the federal government or the respective state; or

(ii) Subpoena or discovery, or admission into evidence, in any private civil action or administrative process, unless with respect to any privilege held by the Nationwide Mortgage Licensing System and Registry with respect to such information or material, the person to whom such information or material pertains waives, in whole or in part, in the discretion of such person, that privilege;

(c) Any state statute relating to the disclosure of confidential supervisory information or any information or material described in subdivision (1)(a) of this section that is inconsistent with such subdivision shall be superseded by the requirements of this section; and

(d) This section shall not apply with respect to the information or material relating to the employment history of, and publicly adjudicated disciplinary and enforcement actions against, applicants and licensees that is included in the Nationwide Mortgage Licensing System and Registry for access by the public.

(2) For these purposes, the director is authorized to enter into agreements or sharing arrangements with other governmental agencies, the Conference of State Bank Supervisors, the American Association of Residential Mortgage Regulators, or other associations representing governmental agencies as established by adopting and promulgating rules and regulations or an order of the director.

Source: Laws 2009, LB328, § 51; Laws 2010, LB892, § 23.

45-1034 License; revocation; new license; court order required.

Whenever, for any cause, a license is revoked, the department shall not issue another license to the licensee unless the department is otherwise ordered by a court of competent jurisdiction to do so.

Source: Laws 1941, c. 90, § 8, p. 348; C.S.Supp.,1941, § 45-136; R.S. 1943, § 45-148; R.S.1943, (1998), § 45-148; Laws 2001, LB 53, § 62.

45-1035 License; revocation; record of proceedings.

At the request of the licensee or any other aggrieved person, the department shall prepare a written record which includes a transcript of the evidence, the findings with respect to the evidence, the order, and the reasons supporting the suspension, revocation, or denial of a license, and shall, after being paid for the cost of the written record, deliver to the licensee or other aggrieved person a copy of the written record in person or by certified or registered mail.

Source: Laws 1941, c. 90, § 8, p. 348; C.S.Supp.,1941, § 45-136; R.S. 1943, § 45-149; Laws 1972, LB 1060, § 3; R.S.1943, (1998), § 45-149; Laws 2001, LB 53, § 63.

45-1036 Appeal; procedure.

In addition to any other remedy he, she, or it may have, any licensee or any other person considering himself, herself, or itself aggrieved by any action of the department under the Nebraska Installment Loan Act may appeal the

action, and the appeal shall be in accordance with the Administrative Procedure Act.

Source: Laws 1941, c. 90, § 9, p. 348; C.S.Supp.,1941, § 45-137; R.S. 1943, § 45-150; Laws 1969, c. 378, § 1, p. 1339; Laws 1988, LB 352, § 73; Laws 1997, LB 555, § 23; R.S.1943, (1998), § 45-150; Laws 2001, LB 53, § 64.

Cross References

Administrative Procedure Act, see section 84-920.

45-1037 Violations; penalty.

Any person violating sections 45-1025 to 45-1031 is guilty of a Class II misdemeanor.

Source: Laws 1941, c. 90, § 27, p. 356; C.S.Supp.,1941, § 45-155; Laws 1943, c. 107, § 6, p. 373; R.S.1943, § 45-153; Laws 1977, LB 40, § 250; Laws 1993, LB 121, § 270; R.S.1943, (1998), § 45-153; Laws 2001, LB 53, § 65.

Public policy as to effect of violation of Installment Loan Act has been fixed by Legislature. McNish v. General Credit Corp., 164 Neb. 526, 83 N.W.2d 1 (1957).

Penalty applies to both licensees and nonlicensees. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

Violation, whether by licensee or nonlicensee, is a misdemeanor. Powell v. Edwards, 162 Neb. 11, 75 N.W.2d 122 (1956).

45-1038 Licensees; loan provisions; violations; effect.

If, in the making of, or collection on, any loan contract, any act is done which constitutes a Class II misdemeanor under section 45-1037, that loan shall not be void, but the licensee shall have no right to collect or receive any interest or charges whatsoever. If any interest or other charges have been collected, the licensee shall forfeit and refund to the borrower all interest and other charges collected on the loan involved.

Source: Laws 1941, c. 90, § 27, p. 356; C.S.Supp.,1941, § 45-155; Laws 1943, c. 107, § 6, p. 373; R.S.1943, § 45-154; Laws 1963, Spec. Sess., c. 9, § 3, p. 110; Laws 1963, Spec. Sess., c. 7, § 12, p. 96; Laws 1977, LB 40, § 251; R.S.1943, (1998), § 45-154; Laws 2001, LB 53, § 66.

1. Constitutional
2. Miscellaneous

1. Constitutional

Legislative Bill 17 of the 1963 Special Session of the Legislature was sustained as constitutional. Kometscher v. Wade, 177 Neb. 299, 128 N.W.2d 781 (1964).

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

Retroactive change in penalty for violation of Installment Loan Act sustained as constitutional. Davis v. General Motors Acceptance Corp., 176 Neb. 865, 127 N.W.2d 907 (1964).

The 1957 act purporting to repeal this section was unconstitutional. Thompson v. Commercial Credit Equipment Corp., 169 Neb. 377, 99 N.W.2d 761 (1959).

2. Miscellaneous

Legislature at 1963 Special Session changed penalty for violation of this section. Highway Equipment & Supply Co. v. Jones, 182 Neb. 234, 153 N.W.2d 859 (1967).

By terms of 1963 amendment, violation of section did not render contract void. Dailey v. A. C. Nelsen Co., 178 Neb. 881, 136 N.W.2d 186 (1965).

Retroactive amendment of this section did not apply to transactions already reduced to judgment. Berg v. Midwest Laundry Equipment Corp., 178 Neb. 770, 135 N.W.2d 457 (1965).

Installment loan made in this state was governed by laws of Nebraska. Robertson v. Burnett, 172 Neb. 385, 109 N.W.2d 716 (1961).

45-1039 Licensees; violations; effect.

Violation of the Nebraska Installment Loan Act, except as provided by section 45-1058 in connection with any indebtedness, however acquired, shall not

render such indebtedness void and uncollectible. If however, any interest or other charges have been collected or contracted for on such indebtedness, the licensee shall refund to the borrower all interest and other charges which have been collected, and shall not collect thereafter any interest or other charges contracted for and thereafter due on the loan involved, as liquidated damages, and the licensee or its assignee, if found liable, shall pay the costs of any action relating thereto, including reasonable attorney's fees. No licensee shall be found liable under this section if the licensee shows by a preponderance of the evidence that the violation was not intentional and resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adopted to avoid any such error.

Source: Laws 1941, c. 90, § 14, p. 350; C.S.Supp.,1941, § 45-142; R.S. 1943, § 45-155; Laws 1963, Spec. Sess., c. 9, § 4, p. 110; Laws 1963, Spec. Sess., c. 7, § 13, p. 96; Laws 1979, LB 87, § 4; Laws 1997, LB 555, § 24; R.S.1943, (1998), § 45-155; Laws 2001, LB 53, § 67.

1. Retroactive legislation
2. 1963 amendments
3. Penalty
4. Usury
5. Miscellaneous

1. Retroactive legislation

Retroactive amendment of this section did not apply to transactions already reduced to judgment. Berg v. Midwest Laundry Equipment Corp., 178 Neb. 770, 135 N.W.2d 457 (1965).

Retroactive change in penalty for violation of Installment Loan Act sustained as constitutional. Davis v. General Motors Acceptance Corp., 176 Neb. 865, 127 N.W.2d 907 (1964).

Change in penalty was not retroactive as to prior contracts. Curtis v. Securities Acceptance Corp., 166 Neb. 815, 91 N.W.2d 19 (1958).

2. 1963 amendments

Legislature at 1963 Special Session changed penalty for violation of this section. Highway Equipment & Supply Co. v. Jones, 182 Neb. 234, 153 N.W.2d 859 (1967); Dailey v. A. C. Nelsen Co., 178 Neb. 881, 136 N.W.2d 186 (1965).

Legislative Bill 17 of the 1963 Special Session of the Legislature was sustained as constitutional. Kometscher v. Wade, 177 Neb. 299, 128 N.W.2d 781 (1964).

Amendment to this section in 1963 Special Session by Legislative Bill 11 was unconstitutional as special legislation. State Securities Co. v. Ley, 177 Neb. 251, 128 N.W.2d 766 (1964).

3. Penalty

Civil penalty can be imposed for violation of this act. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 803, 97 N.W.2d 583 (1959).

Penalty applies to any person making installment loan in violation of act, whether licensed or not. McNish v. General Credit Corp., 164 Neb. 526, 83 N.W.2d 1 (1957).

Penalty applies where other business is conducted without consent of department. Grand Island Finance Co. v. Eacker, 155 Neb. 546, 52 N.W.2d 805 (1952).

4. Usury

Upon violation of provisions of Installment Loan Act, contract was void and indebtedness due thereunder was uncollectible. General Motors Acceptance Corp. v. Mackrill, 175 Neb. 631, 122 N.W.2d 742 (1963).

Any violations of Installment Loan Act renders indebtedness void and uncollectible. Robertson v. Burnett, 172 Neb. 385, 109 N.W.2d 716 (1961).

Charging usurious interest by nonlicensee rendered entire indebtedness void and uncollectible. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

If exactions of interest are usurious, whole obligation is void and uncollectible. State ex rel. Beck v. Associates Discount Corp., 161 Neb. 410, 73 N.W.2d 673 (1955).

5. Miscellaneous

Where installment loan contract was dependent upon doing of an agreed upon condition which was never performed, there was no violation of this section. Metschke v. Marxsen, 176 Neb. 240, 125 N.W.2d 684 (1964).

The 1957 amendment to this section was unconstitutional. Thompson v. Commercial Credit Equipment Corp., 169 Neb. 377, 99 N.W.2d 761 (1959).

45-1040 Repayment of loan; licensee; duties.

Upon repayment of the loan in full, the licensee shall mark plainly every obligation or copy of the obligation and security or copy of the security signed by any obligor with the word Paid or Canceled and shall release any mortgage, trust deed, or lien, restore any pledge, and cancel and return any note or copy of the note and any assignment or copy of the assignment given to the licensee.

For purposes of this section, a copy shall meet the requirements of section 25-12,112.

Source: Laws 1943, c. 107, § 7, p. 374; R.S.1943, § 45-156; Laws 1994, LB 979, § 10; Laws 1994, LB 980, § 2; R.S.1943, (1998), § 45-156; Laws 2001, LB 53, § 68.

45-1041 Installment loans; enforcement.

Whenever the director has reasonable cause to believe that any person is violating or is threatening to or intends to violate section 45-1024 or 45-1025, the director may, in addition to all actions provided for in the Nebraska Installment Loan Act, and without prejudice thereto, enter an order requiring such person to cease and desist or to refrain from such violation. An action may also be brought, on the relation of the Attorney General and the director, to enjoin such person from engaging in or continuing such violation or from doing any act or acts in furtherance of such violation. In any such action an order or judgment may be entered awarding such preliminary or final injunction as may be deemed proper. In addition to all other means provided by law for the enforcement of a restraining order or injunction, the court, in which such action is brought, has power and jurisdiction to impound and appoint a receiver for the property and business of the defendant, including books, papers, documents, and records pertaining thereto or so much thereof as the court may deem reasonably necessary to prevent violations of the act through or by means of the use of such property and business. Such receiver, when so appointed and qualified, has such powers and duties as to custody, collection, administration, winding up, and liquidation of such property and business as shall, from time to time, be conferred upon the receiver by the court.

Source: Laws 1943, c. 107, § 8, p. 374; R.S.1943, § 45-157; R.S.1943, (1998), § 45-157; Laws 2001, LB 53, § 69.

Imposition of civil penalty is recognized. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 803, 97 N.W.2d 583 (1959).

Receiver appointed under this section was entitled to allowance of fair and reasonable fees. State ex rel. Beck v. Associates Discount Corp., 168 Neb. 298, 96 N.W.2d 55 (1959).

Equity will provide the same measure of relief for individual borrowers. McNish v. General Credit Corp., 164 Neb. 526, 83 N.W.2d 1 (1957).

Remedies of injunction and receivership are expressly authorized. State ex rel. Beck v. Associates Discount Corp., 162 Neb. 683, 77 N.W.2d 215 (1956).

45-1042 Loans made outside of state; enforcement in this state.

No loan, made outside this state, in the amount or of the value of three thousand dollars or less, for which a greater rate of interest, consideration, or charges than is permitted by section 45-1025 has been charged, contracted for, or received, shall be enforced in this state. Every person participating in such loan in this state is subject to the Nebraska Installment Loan Act, except that the act shall not apply to loans legally made in any state under and in accordance with a regulatory small loan law similar in principle to such act.

Source: Laws 1943, c. 107, § 9, p. 375; R.S.1943, § 45-158; Laws 1957, c. 193, § 3, p. 687; R.S.1943, (1998), § 45-158; Laws 2001, LB 53, § 70.

Interest rates under a contract which was valid in the forum where executed will not be construed usurious in this state. Grady v. Denbeck, 198 Neb. 31, 251 N.W.2d 864 (1977).

Loans lawfully made and to be performed outside of state are valid in this state. Kinney Loan & Finance Co. v. Sumner, 159 Neb. 57, 65 N.W.2d 240 (1954).

45-1043 Borrower's obligation; licensee; contacts limitation.

Except as otherwise provided by the Nebraska Installment Loan Act or other law, a licensee shall not contact any individual who is not living, residing, or present in the household of the borrower regarding the borrower's obligation to pay a debt, other than the borrower's spouse, the borrower's attorney, another creditor, or a credit reporting agency.

Source: Laws 1979, LB 87, § 6; R.S.1943, (1998), § 45-173; Laws 2001, LB 53, § 71.

45-1044 Borrower's obligation; contact; limitation; waiver.

The borrower may waive the benefits of section 45-1043 at any time by giving consent if such consent is given at a time subsequent to the date the debt arises.

Source: Laws 1979, LB 87, § 7; R.S.1943, (1998), § 45-174; Laws 2001, LB 53, § 72.

45-1045 Licensee; contacts permitted without borrower's consent.

The licensee may contact any person without the borrower's consent:

(1) To ascertain information relating to a borrower's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the borrower's eligibility for credit or insurance if such contacts are not designed to collect a delinquent debt; or

(2) To locate the borrower when the licensee has reason to believe the borrower has changed his or her employment or has moved from his or her last-known address.

Source: Laws 1979, LB 87, § 8; R.S.1943, (1998), § 45-175; Laws 2001, LB 53, § 73.

45-1046 Borrower; default; notice to licensee; effect.

If the borrower has defaulted on his or her promise to pay and if he or she has given specific notice in writing, by registered or certified mail, instructing the licensee to cease further contacts with the borrower in regard to the indebtedness, the licensee shall, after such notice, except as provided in sections 45-1047 and 45-1048, limit contacts to one notice per month by mail. No notice shall be designed to threaten action not otherwise permitted by law.

Source: Laws 1979, LB 87, § 9; R.S.1943, (1998), § 45-176; Laws 2001, LB 53, § 74.

45-1047 Licensee; actions; permitted; prohibited.

(1) Sections 45-1043 to 45-1046 shall not prohibit the licensee from:

(a) Contacting any person in order to discover property belonging to the borrower that may be seized to satisfy a debt that has been reduced to judgment;

(b) Making amicable demand and filing suit on the debt; or

(c) Contacting persons related to the borrower if permission is specifically given in writing at the time the debt arises or at any time after such debt arises.

(2) In connection with the collection of any loan, a licensee may not:

(a) Use or threaten to use violence;

(b) Use obscene or profane language;

(c) Cause a telephone to ring or engage a person in telephone conversation at times known to be inconvenient to the borrower;

(d) Falsely represent the character, amount, or legal status of any debt;

(e) Falsely represent that an individual is an attorney when he or she is not;

(f) Falsely represent that nonpayment of any debt will result in the arrest or imprisonment of the borrower or any member of the borrower's household;

(g) Threaten to take any action that the licensee knows cannot legally be taken at the time the threat is made;

(h) Falsely represent that the borrower committed any crime when he or she did not;

(i) Communicate or threaten to communicate to any person credit information which is known to be false;

(j) Use or distribute any written communication which falsely represents that it is a document authorized, issued, or approved by any court, official, or agency of the United States or any state;

(k) Charge or collect any fees, charges, or expenses, incidental to the collection of any loan, unless such amount is expressly authorized by the loan agreement or permitted by law;

(l) Accept from any person a check or other payment instrument postdated by more than five days unless such person is notified in writing of the licensee's intent to deposit such check or instrument not more than ten nor less than three business days prior to such deposit;

(m) Solicit any postdated check or other postdated payment instrument for the purpose of threatening or instituting criminal prosecution;

(n) Deposit or threaten to deposit any postdated check prior to the date on such check;

(o) Cause charges to be made to any person for communications by concealment of the true purpose of the communication, including, but not limited to, collect telephone calls and telegram fees;

(p) Communicate with a borrower regarding a debt by postcard; or

(q) Communicate with a borrower at the borrower's place of employment if the licensee has received actual notice that the borrower's employer prohibits the borrower from receiving such communication.

Source: Laws 1979, LB 87, § 10; R.S.1943, (1998), § 45-177; Laws 2001, LB 53, § 75.

45-1048 Borrower; right to action; licensee; judgment; effect.

Nothing in sections 45-1043 and 45-1046 shall limit a borrower's right to bring an action for damages. When the licensee has filed suit and obtained judgment, the licensee shall be permitted to resume contacts with the borrower against whom judgment has been obtained.

Source: Laws 1979, LB 87, § 11; R.S.1943, (1998), § 45-178; Laws 2001, LB 53, § 76.

45-1049 Borrower; default; agreement; extent of enforceability.

An agreement of the parties to a loan, with respect to default on the part of the borrower, is enforceable only to the extent that:

(1) The borrower fails to make a payment on the loan or other charges required by the agreement; or

(2) The prospect of payment, performance, or realization of collateral is significantly impaired. The burden of establishing the prospect of significant impairment is on the licensee.

Source: Laws 1979, LB 87, § 12; R.S.1943, (1998), § 45-179; Laws 2001, LB 53, § 77.

45-1050 Borrower; loan; default; licensee; notice; contents.

(1) With respect to a loan, after a borrower has been in default for ten days for failure to make a required payment, a licensee may give the borrower the notice described in this section. A licensee gives notice to the borrower under this section when the licensee delivers the notice to the borrower or delivers or mails the notice to the last-known address of the borrower's residence.

(2) The notice shall be in writing and shall conspicuously state: The name, address, and telephone number of the licensee to which payment is to be made, a brief identification of the loan, the borrower's right to cure the default, the amount of payment and date by which payment must be made to cure the default, and that any credit insurance issued in connection with the loan contract may be canceled unless the borrower cures the default. The department shall prescribe the form of such notice.

Source: Laws 1979, LB 87, § 13; R.S.1943, (1998), § 45-180; Laws 2001, LB 53, § 78.

45-1051 Borrower; loan; default; right to cure; procedure.

(1) With respect to a loan, after a default consisting only of the borrower's failure to make a required payment, a licensee may neither accelerate maturity of the unpaid balance of the obligation nor take possession of collateral, except voluntarily surrendered collateral, because of such default until twenty days after a notice of the borrower's right to cure is given. The borrower shall have twenty days after the notice is given to cure any default consisting of a failure to make the required payment by tendering the amount of all unpaid sums due at the time of the tender, without acceleration, plus any unpaid charges. Cure restores the borrower to his or her rights under the agreement as though the default had not occurred.

(2) With respect to defaults on the same obligation after a licensee has once given a notice of borrower's right to cure, the borrower shall have no further right to cure and the licensee has no obligation to proceed against the borrower or the collateral.

Source: Laws 1979, LB 87, § 14; R.S.1943, (1998), § 45-181; Laws 2001, LB 53, § 79.

45-1052 Borrower; loan; default; licensee; possession of collateral; restrictions.

Upon default by a borrower with respect to a loan, unless the borrower voluntarily surrenders possession of the collateral to the licensee, the licensee may take possession of the collateral without judicial process only if possession

can be taken without entry into a dwelling or a locked, unoccupied motor vehicle, and without the use of force or other breach of the peace.

Source: Laws 1979, LB 87, § 15; R.S.1943, (1998), § 45-182; Laws 2001, LB 53, § 80.

45-1053 Loan; third-party obligation; when.

(1) No individual, other than the spouse of the borrower, is obligated as a cosigner, comaker, guarantor, endorser, surety, or similar party with respect to a loan, unless before or contemporaneously with signing any separate agreement of loan or any writing setting forth the terms of the borrower's agreement, the individual receives a separate written notice that contains a completed identification of the loan he or she may have to pay and reasonably informs him or her of his or her obligation with respect to it.

(2) Such notice shall be in the form prescribed by the department.

(3) An individual entitled to notice under this section shall also be given a copy of any writing setting forth the terms of the borrower's agreement and of any separate agreement of obligation signed by the individual entitled to the notice.

Source: Laws 1979, LB 87, § 16; R.S.1943, (1998), § 45-183; Laws 2001, LB 53, § 81.

This section, as part of the Consumer Credit Act, does not apply to loans made in the traditional manner by nonlicensees at conventional rates. Albers v. Overland Nat. Bank, 212 Neb. 578, 324 N.W.2d 396 (1982).

45-1054 Borrower; deficiency; liability; how treated.

(1) A borrower is not liable for a deficiency unless the licensee has disposed of the collateral in good faith and in a commercially reasonable manner.

(2) If the licensee takes possession or voluntarily accepts surrender of goods in which the licensee has a security interest to secure a loan and at the time thereof the unpaid balance due on the loan is three thousand dollars or less, the borrower is not personally liable to the licensee for the unpaid balance of the debt arising from the loan and the licensee's duty to dispose of the collateral is governed by the provisions on disposition of collateral, article 9, Uniform Commercial Code.

(3) The borrower may be liable in damages to the licensee if the borrower has wrongfully damaged the collateral if, after default, failure to cure, and demand, the borrower has wrongfully failed to make the collateral available to the licensee.

(4) If the licensee elects to bring an action against the borrower for a debt arising from a loan, when under this section the licensee would not be entitled to a deficiency judgment if the licensee took possession of the collateral, and obtains judgment (a) the licensee may not take possession of the collateral, and (b) the collateral is not subject to levy or sale on execution or similar proceedings pursuant to the judgment.

Source: Laws 1979, LB 87, § 17; Laws 1999, LB 550, § 9; R.S.Supp.,2000, § 45-184; Laws 2001, LB 53, § 82.

45-1055 Writing evidencing borrower's obligation; form; copies; fee; licensee; duties.

(1) The licensee shall give to the borrower a copy of any writing evidencing a loan if the writing requires or provides for the signature of the borrower. The writing evidencing the borrower's obligation to pay under a loan shall contain a clear and conspicuous notice in form and content substantially as follows:

NOTICE TO CONSUMER: 1. Do not sign this paper before you read it. 2. You are entitled to a copy of this paper. 3. You may prepay the unpaid balance at any time without penalty and may be entitled to receive a refund of unearned charges in accordance with law.

(2) Upon written request of a borrower, the licensee shall provide a written statement of the dates and amounts of payments made and the amounts of any default and deferment charges assessed preceding the month in which the request is received and the total amount unpaid as the end of the period covered by the statement and a copy of the loan agreement, security agreement, and a facsimile of any insurance certificate issued as part of the transaction, if applicable. The licensee may charge a reasonable fee for such copies, not to exceed fifty cents per page.

(3) The licensee shall answer in writing, within ten business days after receipt, any written request for payoff information from the borrower or the borrower's representative. This service shall be provided without charge to the borrower, except that when such information is provided upon request within sixty days after the fulfillment of a previous request, a processing fee of up to ten dollars may be charged.

Source: Laws 1979, LB 87, § 18; R.S.1943, (1998), § 45-185; Laws 2001, LB 53, § 83; Laws 2005, LB 533, § 65.

45-1056 Licensee; discrimination prohibited.

A licensee shall not refuse to enter into a loan or impose finance charges or other terms or conditions of credit more onerous than those regularly extended by that licensee to borrowers of similar economic backgrounds because of the age, color, creed, national origin, political affiliation, race, religion, sex, marital status, or disability of the borrower or because the borrower receives public assistance, social security benefits, pension benefits, or the like.

Source: Laws 1979, LB 87, § 19; R.S.1943, (1998), § 45-186; Laws 2001, LB 53, § 84.

45-1057 Licensee; loan; former debt; how treated.

No licensee shall, directly or indirectly, require a borrower as a condition of granting a loan to such borrower to reaffirm or otherwise obligate himself or herself to pay a former debt to the licensee which has been discharged in bankruptcy proceedings.

Source: Laws 1979, LB 87, § 20; R.S.1943, (1998), § 45-187; Laws 2001, LB 53, § 85.

45-1058 Violation; loan transaction; licensee; liability.

Any violation of sections 45-1043 to 45-1058 in connection with any loan transaction, however acquired, shall not render the indebtedness, any interest, or other charges void or uncollectible. In an action, other than a class action, the borrower may recover from the licensee violating such sections an award of liquidated damages in an amount determined by the court, but not less than

five hundred dollars nor more than one thousand dollars. In any legal action brought pursuant to this section in which the licensee is found liable, the court shall award costs and reasonable attorneys' fees to the borrower. A licensee is not liable under this section if the licensee notifies the borrower of an error before the licensee receives from the borrower written notice of the error or before the borrower has brought an action under this section and the licensee corrects the error within thirty days after notifying the borrower. A licensee may not be held liable in any action brought under this section if the licensee shows by a preponderance of evidence that the violation was not intentional and resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error.

Source: Laws 1979, LB 87, § 21; R.S.1943, (1998), § 45-188; Laws 2001, LB 53, § 86.

45-1059 Preauthorized loans; definitions; where found.

For purposes of sections 45-1059 to 45-1067, unless the context otherwise requires, the definitions found in sections 45-1060 and 45-1061 shall also be used.

Source: Laws 1981, LB 271, § 1; R.S.1943, (1998), § 45-194; Laws 2001, LB 53, § 91.

45-1060 Billing cycle, defined.

Billing cycle means the time interval between periodic billing dates. A billing cycle shall be considered monthly if the closing date of the cycle is the same date each month or does not vary by more than four days from such date.

Source: Laws 1981, LB 271, § 2; R.S.1943, (1998), § 45-195; Laws 2001, LB 53, § 92.

45-1061 Preauthorized loan, defined.

Preauthorized loan means a loan made by a licensee pursuant to an agreement between the licensee and the borrower whereby:

(1) The licensee may permit the borrower to obtain advances of money from the licensee from time to time or the licensee may advance money on behalf of the borrower from time to time as directed by the borrower;

(2) The amount of each advance and permitted charge and cost is debited to the borrower's account and payments and other credits are credited to the same account;

(3) The charges are computed on the unpaid principal balance or balances of the account from time to time;

(4) The borrower has the privilege of paying the account in full at any time or, if the account is not in default, in monthly installments or fixed or determinable amounts as provided in the agreement; and

(5) The loan agreement expressly states that it covers preauthorized loans. Preauthorized loan does not mean a transaction, resulting in either a credit or a debit to the borrower's account, which is initiated by the use or application of a plastic, metal, or other type of credit or transaction card.

Source: Laws 1981, LB 271, § 3; R.S.1943, (1998), § 45-196; Laws 2001, LB 53, § 93.

45-1062 Preauthorized loans; charges authorized; computation.

A licensee may make preauthorized loans and may contract for and receive charges on such loans as set forth in subsection (1) of section 45-1024 as follows:

(1) A licensee shall not compound charges by adding any unpaid charges authorized by section 45-1024 or sections 45-1059 to 45-1067 to the unpaid principal balance of the borrower's account, except that the unpaid principal balance may include the additional charges authorized by section 45-1064;

(2) Charges authorized by section 45-1024 or sections 45-1059 to 45-1067 shall be deemed not to exceed the maximum charges permitted by such sections if such charges are computed in each billing cycle by any of the following methods:

(a) By converting each graduated monthly rate to a daily rate and multiplying such daily rate by the applicable portion of the daily unpaid principal balance of the account, in which case each daily rate is determined by multiplying the authorized monthly rate by twelve and dividing by three hundred sixty-five;

(b) By multiplying each graduated monthly rate by the applicable portion of the average daily unpaid principal balance of the account in the billing cycle, in which case the average daily unpaid principal balance is the sum of the amount unpaid each day during the cycle divided by the number of days in the cycle; or

(c) By converting each graduated monthly rate to a daily rate and multiplying such daily rate by the applicable portion of the average daily unpaid principal balance of the account in the billing cycle, in which case each daily rate is determined by multiplying the authorized monthly rate by twelve and dividing by three hundred sixty-five, and the average daily unpaid principal balance is the sum of the amount unpaid each day during the cycle divided by the number of days in the cycle; and

(3) For each method of computation set forth in subdivision (2) of this section, the billing cycle shall be monthly and the unpaid principal balance on any day shall be determined by adding to any balance unpaid as of the beginning of that day all advances and other permissible amounts charged to the borrower and deducting all payments and other credits made or received that day.

Source: Laws 1981, LB 271, § 5; R.S.1943, (1998), § 45-198; Laws 2001, LB 53, § 94.

45-1063 Preauthorized loan; repayment; requirements.

The borrower under a preauthorized loan may at any time pay all or any part of the unpaid balance in his or her account, or, if the account is not in default, the borrower may pay the unpaid principal balance in monthly installments. Minimum monthly payment requirements shall be determined by the licensee and set forth in the preauthorized loan agreement, except that the minimum monthly payment shall not be less than one and one-half percent of the average daily unpaid principal balance of an account having an average daily balance of more than three thousand dollars nor less than two percent of the average daily unpaid principal balance of an account having an average daily balance of three thousand dollars or less.

Source: Laws 1981, LB 271, § 6; R.S.1943, (1998), § 45-199; Laws 2001, LB 53, § 95.

45-1064 Preauthorized loans; additional fees, costs, and expenses authorized; restrictions.

In addition to the charges permitted under section 45-1062, a licensee may contract for and receive the fees, costs, and expenses permitted by the Nebraska Installment Loan Act on other loans, subject to all the conditions and restrictions set forth in the act with the following variations:

(1) If credit life or disability insurance is provided and if the insured dies or becomes disabled when there is an outstanding preauthorized loan indebtedness, the insurance shall be sufficient to pay the total balance of the loan due on the date of the borrower's death or the amount due as of the end of the previous billing cycle, whichever is less, in the case of credit life insurance, or all minimum payments which become due on the loan during the covered period of disability in the case of credit disability insurance. The additional charge for credit life insurance or credit disability insurance shall be calculated in each billing cycle by applying the current monthly premium rate for such insurance, as such rate may be determined by the Director of Insurance, to the unpaid balances in the borrower's account, using either of the methods specified in section 45-1062 for the calculation of loan charges;

(2) No credit life or disability insurance written in connection with a preauthorized loan shall be canceled by the licensee because of delinquency of the borrower in the making of the required minimum payments on the loan unless one or more of such payments is past due for a period of ninety days or more, and the licensee shall advance to the insurer the amounts required to keep the insurance in force during such period, which amounts may be debited to the borrower's account;

(3) The department may, by rule and regulation, require a statement of insurance that will be appropriate for preauthorized loans in lieu of that required by section 45-1027; and

(4) The amount, terms, and conditions of any insurance against loss or damage to property must be reasonable in relation to the character and value of the property insured and the maximum anticipated amount of credit to be extended.

Source: Laws 1981, LB 271, § 7; R.S.1943, (1998), § 45-1,100; Laws 2001, LB 53, § 96.

45-1065 Preauthorized loans; security interest authorized.

A licensee may retain any security interest, including a mortgage on real property, until the preauthorized account is terminated.

Source: Laws 1981, LB 271, § 8; R.S.1943, (1998), § 45-1,101; Laws 2001, LB 53, § 97; Laws 2004, LB 999, § 42.

45-1066 Preauthorized loans; sections not applicable.

Subsection (3) of section 45-1025 and sections 45-1031 and 45-1040 shall not apply to preauthorized loans.

Source: Laws 1981, LB 271, § 9; R.S.1943, (1998), § 45-1,102; Laws 2001, LB 53, § 98; Laws 2003, LB 218, § 17.

45-1067 Preauthorized loans; department; powers.

The department may approve record-keeping systems for licensees and may prescribe policies and procedures necessary to the administration of sections 45-1059 to 45-1067.

Source: Laws 1981, LB 271, § 10; R.S.1943, (1998), § 45-1,103; Laws 2001, LB 53, § 99.

45-1068 Reverse-mortgage loan; rules governing; how made or acquired; charges authorized; forfeiture by lender.

(1) For purposes of this section, reverse-mortgage loan means a loan made by a licensee which (a) is secured by residential real estate, (b) is nonrecourse to the borrower except in the event of fraud by the borrower or waste to the residential real estate given as security for the loan, (c) provides cash advances to the borrower based upon the equity in the borrower's owner-occupied principal residence, (d) requires no payment of principal or interest until the entire loan becomes due and payable, and (e) otherwise complies with the terms of this section.

(2) Reverse-mortgage loans shall be governed by the following rules without regard to the requirements set out elsewhere for other types of mortgage transactions: (a) Payment in whole or in part is permitted without penalty at any time during the period of the loan; (b) an advance and interest on the advance have priority over a lien filed after the closing of a reverse-mortgage loan; (c) an interest rate may be fixed or adjustable and may also provide for interest that is contingent on appreciation in the value of the residential real estate; and (d) the advance shall not be reduced in amount or number based on an adjustment in the interest rate when a reverse-mortgage loan provides for periodic advances to a borrower.

(3) Reverse-mortgage loans may be made or acquired without regard to the following provisions for other types of mortgage transactions: (a) Limitations on the purpose and use of future advances or any other mortgage proceeds; (b) limitations on future advances to a term of years or limitations on the term of credit line advances; (c) limitations on the term during which future advances take priority over intervening advances; (d) requirements that a maximum mortgage amount be stated in the mortgage; (e) limitations on loan-to-value ratios; (f) prohibitions on balloon payments; (g) prohibitions on compounded interest and interest on interest; and (h) requirements that a percentage of the loan proceeds must be advanced prior to loan assignment.

(4) A licensee may, in connection with a reverse-mortgage loan, charge to the borrower (a) a nonrefundable loan origination fee which does not exceed two percent of the appraised value of the owner-occupied principal residence at the time the loan is made, (b) a reasonable fee paid to third parties originating loans on behalf of the licensee, and (c) such other fees as are necessary and required, including fees for inspections, insurance, appraisals, and surveys.

(5) Licensees failing to make loan advances as required in the loan documents and failing to cure the default as required in the loan documents shall forfeit an amount equal to the greater of two hundred dollars or one percent of the amount of the loan advance the licensee failed to make.

Source: Laws 1995, LB 397, § 2; Laws 1997, LB 555, § 27; R.S.1943, (1998), § 45-1,116; Laws 2001, LB 53, § 101; Laws 2010, LB892, § 24.

45-1069 Administrative fine; procedure; lien.

(1) The director may, following a hearing under the Administrative Procedure Act, impose an administrative fine against any officer, director, shareholder, partner, or member of a licensee, if the director finds the licensee or any such person participated in or had knowledge of any act prohibited by the Nebraska Installment Loan Act or otherwise violated the act. Such administrative fine shall be in addition to or separate from any fine imposed against a licensee pursuant to section 45-1033.

(2) If the director finds, after notice and hearing in accordance with the Administrative Procedure Act, that any person has knowingly committed any act prohibited by section 45-1033 or otherwise violated the Nebraska Installment Loan Act or any rule and regulation or order adopted thereunder, the director may order such person to pay (a) an administrative fine of not more than one thousand dollars for each separate violation and (b) the costs of investigation.

(3) If a person fails to pay an administrative fine and the costs of investigation ordered pursuant to this section, a lien in the amount of such fine and costs may be imposed upon all assets and property of such person in this state and may be recovered in a civil action by the director. The lien shall attach to the real property of such person when notice of the lien is filed and indexed against the real property in the office of the register of deeds in the county where the real property is located. The lien shall attach to any other property of such person when notice of the lien is filed against the property in the manner prescribed by law. Failure of the person to pay such fine and costs shall constitute a separate violation of the act.

Source: Laws 2005, LB 533, § 64.

Cross References

Administrative Procedure Act, see section 84-920.

45-1070 Minimum term.

Notwithstanding any other provision of law, the minimum term of a loan contract for any loan governed by the Nebraska Installment Loan Act shall be six months from the loan transaction date.

Source: Laws 2018, LB194, § 21.

ARTICLE 11

GUARANTEED ASSET PROTECTION WAIVER ACT

Section

45-1101 Act, how cited.

Sections 45-1101 to 45-1107 shall be known and may be cited as the Guaranteed Asset Protection Waiver Act.

Source: Laws 2010, LB571, § 1.

45-1102 Purpose of act; exclusions from act; exemption from insurance requirements.

(1) The purpose of the Guaranteed Asset Protection Waiver Act is to provide a framework within which guaranteed asset protection waivers are offered, sold, and provided in this state.

(2) The act does not apply to:

(a) An insurance policy offered by an insurer under the insurance laws of this state;

(b) A debt cancellation or debt suspension contract being offered in compliance with 12 C.F.R. part 37 or 12 C.F.R. part 721 or other federal law as such part or law existed on July 15, 2010; or

(c) Guaranteed asset protection waivers offered, sold, or provided to borrowers by a financial institution.

(3) Guaranteed asset protection waivers governed under the Guaranteed Asset Protection Waiver Act are not insurance and are exempt from the insurance laws of this state. Persons marketing, selling, or offering to sell guaranteed asset protection waivers to borrowers that comply with the act are exempt from this state's insurance licensing requirements.

Source: Laws 2010, LB571, § 2.

45-1103 Terms, defined.

For purposes of the Guaranteed Asset Protection Waiver Act:

(1) Borrower means a debtor, retail buyer, or lessee under a finance agreement;

(2) Creditor means:

(a) The lender in a loan or credit transaction involving a motor vehicle;

(b) The lessor in a lease transaction involving a motor vehicle;

(c) Any retail seller of motor vehicles that provides credit to retail buyers of such motor vehicles if such entities comply with the provisions of the act; or

(d) The assignees of any of the foregoing to whom the credit obligation is payable;

(3) Creditor's designee means a person other than the creditor that performs administrative or operational functions pursuant to a guaranteed asset protection waiver program;

(4) Finance agreement means a loan, credit transaction, lease, or retail installment sales contract for the purchase or lease of a motor vehicle;

(5) Financial institution has the same meaning as in section 8-101.03;

(6) Free-look period means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the contract without penalty, fees, or costs to the borrower. This period of time must not be shorter than thirty days;

(7) Guaranteed asset protection waiver means a contractual agreement wherein a creditor or the creditor's designee agrees, for a separate charge, to cancel or waive all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss as determined by the insurer issuing the motor vehicle insurance policy subject to the terms of the waiver or unrecovered theft as determined by the insurer issuing the motor vehicle insurance policy subject to the terms of the waiver of the motor vehicle, which agreement must be part of, or a separate addendum to, the finance agreement. If a borrower does not have motor vehicle insurance, the creditor or the creditor's designee will accept a report prepared pursuant to insurance industry standards by a qualified inspector declaring the motor vehicle a total loss or a law enforcement report declaring the motor vehicle an unrecovered theft. Nothing in the act shall be construed to require the waiver to pay more than the amount that would have been paid if the borrower had motor vehicle insurance at the time of loss;

(8) Motor vehicle means self-propelled or towed vehicles designed for personal or commercial use, including, but not limited to, automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, snowmobiles, campers, boats, personal watercraft, and motorcycle, boat, camper, and personal watercraft trailers; and

(9) Person includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

Source: Laws 2010, LB571, § 3; Laws 2017, LB140, § 157.

45-1104 Guaranteed asset protection waivers; not insurance; exempt from insurance laws; sale options; separate statement of cost; part of finance agreement; sale and marketing restrictions.

(1) Guaranteed asset protection waivers offered, sold, or provided to borrowers under the terms of the Guaranteed Asset Protection Waiver Act are not insurance and are exempt from the insurance laws of this state. Persons marketing, selling, or offering to sell guaranteed asset protection waivers to borrowers that comply with the act are exempt from this state's insurance licensing requirements.

(2) Guaranteed asset protection waivers may, at the option of the creditor, be sold for a single payment or may be offered with a monthly or periodic payment option.

(3) Notwithstanding any other provision of law, any cost to the borrower for a guaranteed asset protection waiver entered into in compliance with the federal Truth in Lending Act, 15 U.S.C. 1601 et seq., and its implementing regulations, as such act and regulations existed on July 15, 2010, shall be separately stated and is not to be considered a finance charge or interest.

(4) The guaranteed asset protection waiver remains a part of the finance agreement upon the assignment, sale, or transfer of such finance agreement by the creditor.

(5) Neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease may be conditioned upon the purchase of a guaranteed asset protection waiver.

(6) Persons marketing, selling, or offering to sell guaranteed asset protection waivers to a borrower shall not market such guaranteed asset protection

waivers to any borrower or potential borrowers as being insured under a contractual liability or other insurance policy issued by an insurer.

Source: Laws 2010, LB571, § 4.

45-1105 Guaranteed asset protection waiver; disclosures required.

Guaranteed asset protection waivers shall disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

(1) The name and address of the initial creditor or the creditor's designee and the borrower at the time of sale;

(2) The purchase price and the terms of the guaranteed asset protection waiver, including the requirements for protection, conditions, or exclusions associated with the guaranteed asset protection waiver;

(3) That the borrower may cancel the guaranteed asset protection waiver within the free-look period as specified in the waiver, and will be entitled to a full refund of the purchase price, so long as no benefits have been provided. In the event benefits have been provided during the free-look period, the borrower may receive a full refund less any benefits provided under the waiver;

(4) The procedure the borrower shall follow, if any, to obtain guaranteed asset protection waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits;

(5) Whether or not the guaranteed asset protection waiver is cancelable after the free-look period and the conditions under which it may be canceled or terminated including the procedures for requesting any refund due;

(6) That in order to receive any refund due in the event of a borrower's cancellation of the guaranteed asset protection waiver agreement or early termination of the finance agreement after the free-look period of the guaranteed asset protection waiver, the borrower, in accordance with terms of the waiver, shall provide a written request to cancel to the creditor or the creditor's designee within ninety days after the occurrence of the event terminating the finance agreement;

(7) The methodology for calculating any refund of the unearned purchase price of the guaranteed asset protection waiver due, in the event of cancellation of the guaranteed asset protection waiver or early termination of the finance agreement;

(8) That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease shall be conditioned upon the purchase of the guaranteed asset protection waiver;

(9) That a guaranteed asset protection waiver is not insurance and is not regulated by the Department of Insurance and that the guaranteed asset protection waiver remains a part of the finance agreement upon the assignment, sale, or transfer of such finance agreement by the creditor or the creditor's designee; and

(10) The events or losses to which the guaranteed asset protection waiver does not apply.

Source: Laws 2010, LB571, § 5.

45-1106 Guaranteed asset protection waiver agreement; authorized terms; cancellation or early termination of finance agreement; refund; calculation; disposition.

(1) Guaranteed asset protection waiver agreements may be cancelable or noncancelable after the free-look period. A creditor or the creditor's designee may offer a borrower a waiver that does not provide for a refund if the creditor or the creditor's designee also offers the borrower a bona fide option to purchase a comparable waiver that provides for a refund. Guaranteed asset protection waivers shall provide that if a borrower cancels a waiver within the free-look period, the borrower will be entitled to a full refund of the purchase price, so long as no benefits have been provided. In the event benefits have been provided, the borrower may receive a full or partial refund pursuant to the terms of the waiver.

(2) In the event of a borrower's cancellation of the guaranteed asset protection waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free-look period, the borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. The creditor or the creditor's designee shall calculate the amount of the refund using a method at least as favorable to the borrower as the actuarial method. In order to receive a refund, the borrower, in accordance with any applicable terms of the waiver, must provide a written request to the creditor or the creditor's designee within ninety days after the event terminating the waiver or finance agreement.

(3) If the cancellation of a guaranteed asset protection waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or the creditor's designee and applied as set forth in subsection (4) of this section.

(4) Any cancellation refund under this section may be applied by the creditor or the creditor's designee as a reduction of the amount owed under the finance agreement unless the borrower can show that the finance agreement has been paid in full.

Source: Laws 2010, LB571, § 6.

45-1107 Modification of guaranteed asset protection waiver; limitations.

The creditor or the creditor's designee shall not offer a guaranteed asset protection waiver when the guaranteed asset protection waiver contains terms that allow the creditor or the creditor's designee to modify, unilaterally, the guaranteed asset protection waiver, unless (1) the modification is favorable to the borrower and is made without any additional charge to the borrower or (2) the borrower is notified of the proposed modification and has the option to cancel the guaranteed asset protection waiver without penalty.

Source: Laws 2010, LB571, § 7.

ARTICLE 12

NEBRASKA CONSTRUCTION PROMPT PAY ACT

Section
45-1201. Act, how cited.
45-1202. Terms, defined.

Section

45-1201 Act, how cited.

Sections 45-1201 to 45-1211 shall be known and may be cited as the Nebraska Construction Prompt Pay Act.

Source: Laws 2010, LB552, § 1; Laws 2014, LB961, § 4.

45-1202 Terms, defined.

For purposes of the Nebraska Construction Prompt Pay Act:

(1) Contractor includes individuals, firms, partnerships, limited liability companies, corporations, or other associations of persons engaged in the business of the construction, alteration, repairing, dismantling, or demolition of buildings, roads, bridges, viaducts, sewers, water and gas mains, streets, disposal plants, water filters, tanks and towers, airports, dams, levees and canals, water wells, pipelines, transmission and power lines, and every other type of structure, project, development, or improvement coming within the definition of real property and personal property, including such construction, repairing, or alteration of such property to be held either for sale or rental. Contractor also includes any subcontractor engaged in the business of such activities and any person who is providing or arranging for labor for such activities, either as an employee or as an independent contractor, for any contractor or person. Contractor does not include an individual or an entity performing work on a contract for the State of Nebraska or performing work on a federal-aid or state-aid project of a political subdivision in which the state makes payments to the contractor on behalf of the political subdivision;

(2) Owner means a person (a) who has an interest in any real property improved, (b) for whom an improvement is made, or (c) who contracted for an improvement to be made. Owner includes a person, an entity, or any political subdivision of this state. Owner does not include the State of Nebraska;

(3) Owner's representative means an architect, an engineer, or a construction manager in charge of a project for the owner or such other contract representative or officer as designated in the contract document as the party representing the owner's interest regarding administration and oversight of the project;

(4) Real property means real estate that is improved, including private and public land, and leaseholds, tenements, and improvements placed on the real property;

(5) Receipt means actual receipt of cash or funds by the contractor or subcontractor;

(6) Subcontractor means a person or an entity that has contracted to furnish labor or materials to, or performed labor or supplied materials for, a contractor

or another subcontractor in connection with a contract to improve real property. Subcontractor includes materialmen and suppliers. Subcontractor does not include an individual or an entity performing work as a subcontractor on a contract for the State of Nebraska or performing work on a federal-aid or state-aid project of a political subdivision in which the state makes payments to the contractor on behalf of the political subdivision; and

(7) Substantially complete means the stage of a construction project when the project, or a designated portion thereof, is sufficiently complete in accordance with the contract so that the owner can occupy or utilize the project for its intended use.

Source: Laws 2010, LB552, § 2; Laws 2014, LB961, § 5.

45-1203 Contractor; payment; payment request; subcontractor; payment; retainage; payment.

(1) When a contractor has performed work in accordance with the provisions of a contract with an owner, the owner shall pay the contractor within thirty days after receipt by the owner or the owner's representative of a payment request made pursuant to the contract.

(2) When a subcontractor has performed work in accordance with the provisions of a subcontract and all conditions precedent to payment contained in the subcontract have been satisfied, the contractor shall pay the subcontractor and the subcontractor shall pay his, her, or its subcontractor, within ten days after receipt by the contractor or subcontractor of each periodic or final payment, the full amount received for the subcontractor's work and materials based on work completed or service provided under the subcontract for which the subcontractor has properly requested payment, if the subcontractor provides or has provided satisfactory and reasonable assurances of continued performance and financial responsibility to complete the work.

(3) The owner or the owner's representative shall release and pay all retainage for work completed in accordance with the provisions of the contract within forty-five days after the project, or a designated portion thereof, is substantially complete. When a subcontractor has performed work in accordance with the provisions of a subcontract and all conditions precedent to payment contained in the subcontract have been satisfied, the contractor shall pay all retainage due such subcontractor within ten days after receipt of the retainage.

Source: Laws 2010, LB552, § 3; Laws 2014, LB961, § 6.

45-1204 Withholdings; authorized.

When work has been performed pursuant to a contract, an owner, a contractor, or a subcontractor may only withhold payment:

(1) For retainage, in an amount not to exceed the amount specified in the applicable contract, which shall not exceed a rate of ten percent. If the scope of work for the contractor or subcontractor from which retainage is withheld is fifty percent complete and if the contractor or subcontractor has performed work in accordance with the provisions in the applicable contract, no more than five percent of any additional progress payment may be withheld as retainage if the contractor or subcontractor provides or has provided satisfacto-

ry and reasonable assurances of continued performance and financial responsibility to complete the work;

(2) Of a reasonable amount, to the extent that such withholding is allowed in the contract, for any of the following reasons:

(a) Reasonable evidence showing that the contractual completion date will not be met due to unsatisfactory job progress;

(b) Third-party claims filed or reasonable evidence that such a claim will be filed with respect to work under the contract; or

(c) Failure of the contractor to make timely payments for labor, equipment, subcontractors, or materials; or

(3) After substantial completion, in an amount not to exceed one hundred twenty-five percent of the estimated cost to complete the work remaining on the contract.

Source: Laws 2010, LB552, § 4; Laws 2014, LB961, § 7.

45-1205 Delay in payment; additional interest payment.

Except as provided in section 45-1204, if a periodic or final payment to (1) a contractor is delayed by more than thirty days after receipt of a properly submitted periodic or final payment request by the owner or owner's representative or (2) a subcontractor is delayed by more than ten days after receipt of a periodic or final payment by the contractor or subcontractor, then the remitting owner, contractor, or subcontractor shall pay the contractor or subcontractor interest due until such amount is paid, beginning on the day following the payment due date at the rate of one percent per month or a pro rata fraction thereof on the unpaid balance. Interest is due under this section only after the person charged the interest has been notified of the provisions of this section by the contractor or subcontractor. Acceptance of progress payments or a final payment shall release all claims for interest on such payments.

Source: Laws 2010, LB552, § 5; Laws 2014, LB961, § 9.

45-1206 Other remedies available.

The Nebraska Construction Prompt Pay Act shall not modify the remedies available to any person under the terms of a contract in existence prior to October 1, 2010, or by any other statute.

Source: Laws 2010, LB552, § 6.

45-1207 Residential real property; applicability of act.

The Nebraska Construction Prompt Pay Act does not apply to improvements to real property intended for residential purposes when the residence consists of no more than four residential units.

Source: Laws 2010, LB552, § 7.

45-1208 Applicability to contracts entered into on or after October 1, 2010.

The Nebraska Construction Prompt Pay Act applies to contracts or subcontracts entered into on or after October 1, 2010.

Source: Laws 2010, LB552, § 8.

45-1209 Contract provisions; void.

The following provisions in any contract or subcontract for construction work performed within the State of Nebraska shall be against public policy and shall be void and unenforceable:

(1) A provision that purports to waive, release, or extinguish rights to file a claim against a payment or performance bond, except that a contract or subcontract may require a contractor or subcontractor to provide a waiver or release of such rights as a condition for payment, but only to the extent of the amount of the payment received;

(2) A provision that purports to make any state law other than that of Nebraska applicable to or governing any contract for construction within the state; or

(3) A provision that purports to require that the venue for a court or arbitration hearing be held at any location outside of the state.

Source: Laws 2010, LB552, § 9.

45-1210 Construction performed for political subdivision; liquidated or unliquidated claim; procedure; civil action authorized.

(1) Any liquidated or unliquidated claim against any political subdivision of this state arising from construction performed for such political subdivision shall: (a) Be presented in writing to the individual or officer as set forth in subsection (2) of this section; (b) state the name of the claimant and the amount of the claim; and (c) identify the item or service for which payment is claimed or the time, place, nature, and circumstance giving rise to the claim. All claims shall be filed within one hundred eighty days after the date of substantial completion of the construction project.

(2) A construction contract entered into by any political subdivision of this state may provide the name and location of the office in which a claim under this section may be filed. In the absence of such provision, a written claim shall be filed as follows:

(a) Claims against a city of the metropolitan, primary, first, or second class shall be filed with the appropriate city clerk;

(b) Claims against a village shall be filed with the village clerk;

(c) Claims against a county shall be filed with the county clerk; and

(d) Claims against any other political subdivision shall be filed with the person who executed the contract on behalf of the political subdivision or that person's successor in office.

(3) The applicable political subdivision shall issue a decision on the claim within ninety days after receipt thereof. If no decision has been issued after such period, the claim shall be deemed to be denied in whole and the claimant may commence an action in accordance with subsection (4) of this section.

(4) If a claim is denied in whole or in part, a claimant may bring a civil action on the claim. An action under this subsection may only be brought within two years after the denial of the claim or the date upon which the claim is deemed to be denied. Any such action shall be in the nature of an original action and not an appeal and shall be commenced in the district court of the county in which the construction project at issue was located. Either party may appeal from the decision of the district court.

(5) Notwithstanding any other provision of law in Chapters 13, 14, 15, 16, 17, and 23, claims against a political subdivision of this state arising from construction performed for such political subdivision shall be governed by this section.

Source: Laws 2010, LB552, § 10.

45-1211 Violation of act; action for recovery; attorney's fees and costs.

Any individual, partnership, firm, limited liability company, corporation, or company may bring an action to recover any damages caused to such person or entity by a violation of the Nebraska Construction Prompt Pay Act. In addition to an award of damages, the court may award a plaintiff reasonable attorney's fees and costs as the court determines is appropriate.

Source: Laws 2014, LB961, § 8.