IC 27-8-8 Chapter 8. Indiana Life and Health Insurance Guaranty Association Law

IC 27-8-8-0.3 Coverage obligations affected by statutory amendments; governing law

Sec. 0.3. (a) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are not affected by changes made by P.L.193-2006.

(b) The association's coverage obligations under this chapter with respect to a member insurer that has a coverage date before March 28, 2006, are governed by this chapter as it existed on January 1, 2006.

(c) The amendments made during the 2013 regular session of the general assembly to section 2.1 of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

(d) The amendment made during the 2013 regular session of the general assembly to section 2.3(e) of this chapter does not apply to a member insurer that has a coverage date before January 1, 2012.

(e) The amendments made during the 2013 regular session of the general assembly to section 2.3(f) of this chapter do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before January 1, 2013.

(f) The amendments made during the 2018 regular session of the general assembly to this chapter:

(1) do not apply to a member insurer that has been placed under an order of rehabilitation or liquidation before July 1, 2018; and

(2) apply to a member insurer that is placed under an order of rehabilitation or liquidation after June 30, 2018.

As added by P.L.220-2011, SEC.438. Amended by P.L.276-2013, SEC.30; P.L.208-2018, SEC.11.

IC 27-8-8-1 Repealed

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.1-1989, SEC.56; P.L.192-1991, SEC.3; P.L.1-1992, SEC.154; P.L.251-1995, SEC.18. Repealed by P.L.193-2006, SEC.32.

IC 27-8-8-1.5 Repealed

As added by P.L.251-1995, SEC.19. Repealed by P.L.193-2006, SEC.32.

IC 27-8-8-2 Definitions

Sec. 2. (a) The definitions in this section apply throughout this chapter.

(b) "Account" means one (1) of the two (2) accounts created under section 3 of this chapter.

(c) "Annuity contract", except as provided in section 2.3(e) of this chapter, includes:

(1) a guaranteed investment contract;

(2) a deposit administration contract;

(3) a structured settlement annuity;

(4) an annuity issued to or in connection with a government lottery; and

(5) an immediate or a deferred annuity contract.

(d) "Assessment base year" means, for an impaired insurer or insolvent insurer, the most recent calendar year for which required premium information is available preceding the calendar year during which the impaired insurer's or insolvent insurer's coverage date occurs.

(e) "Association", except when the context otherwise requires, means the Indiana life and health insurance guaranty association created by section 3 of this chapter.

(f) "Benefit plan" means a specific plan, fund, or program that is established or maintained by an employer or an employee organization, or both, that:

(1) provides retirement income to employees; or

(2) results in a deferral of income by employees for a period extending to or beyond the termination of employment.

(g) "Board" refers to the board of directors of the association selected under IC 27-8-8-4.

(h) "Called", when used in the context of assessments, means that notice has been issued by the association to member insurers requiring the member insurers to pay, within a time frame set forth in the notice, an assessment that has been authorized by the board.

(i) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(j) "Contractual obligation" means an enforceable obligation under a covered policy for which and to the extent that coverage is provided under section 2.3 of this chapter.

(k) "Coverage date" means, with respect to a member insurer, the date on which the earlier of the following occurs:

(1) The member insurer becomes an insolvent insurer.

(2) The association determines that the association will provide coverage under section 5(a) of this chapter with respect to the member insurer.

(l) "Covered policy" means a:

(1) nongroup policy or contract;

(2) certificate under a group policy or contract; or

(3) part of a policy, contract, or certificate described in subdivisions (1) and (2);

for which coverage is provided under section 2.3 of this chapter.

(m) "Extracontractual claims" includes claims that relate to bad faith in the payment of claims, punitive or exemplary damages, or attorney's fees and costs.

(n) "Funding agreement" has the meaning set forth in IC 27-1-12.7-1.

(o) "Health benefit plan" means a hospital or medical expense policy or certificate, a

health maintenance organization subscriber contract or certificate, or another similar health contract. The term does not include the following:

(1) Accident only, credit, dental only, vision only, Medicare supplement, or disability income insurance.

(2) Coverage for:

(A) long term care;

(B) home health care;

(C) community based care; or

(D) a combination of coverage specified in clauses (A) through (C).

(3) Coverage for onsite medical clinics.

(4) 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, contracts, or certificates.

(p) "Health care provider" means a health care provider that renders health care services covered under a health insurance policy or contract for which coverage is provided under section 2.3 of this chapter.

(q) "Impaired insurer" means a member insurer that is:

(1) not an insolvent insurer; and

(2) placed under an order of rehabilitation or conservation by a court with jurisdiction.

(r) "Insolvent insurer" means a member insurer that is placed under an order of liquidation with a finding of insolvency by a court with jurisdiction.

(s) "Member insurer" means any person that holds a certificate of authority to transact in Indiana any kind of insurance or health maintenance organization business for which coverage is provided under section 2.3 of this chapter. The term includes an insurer whose certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily withdrawn but does not include the following:

(1) A for-profit or nonprofit hospital or medical service organization.

(2) A fraternal benefit society under IC 27-11.

(3) The Indiana Comprehensive Health Insurance Association or any other mandatory state pooling plan or arrangement.

(4) An assessment company or another person that operates on an assessment plan (as defined in IC 27-1-2-3(y)).

(5) An interinsurance or reciprocal exchange authorized by IC 27-6-6.

(6) A farm mutual insurance company under IC 27-5.1.

(7) A person operating as a Lloyds under IC 27-7-1.

(8) The political subdivision risk management fund established by IC 27-1-29-10 and the political subdivision catastrophic liability fund established by IC 27-1-29.1-7.

(9) The small employer health reinsurance board established by IC 27-8-15.5-5.

(10) A person similar to any person described in subdivisions (1) through (9).

(t) "Moody's Corporate Bond Yield Average" means:

(1) the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc.; or

(2) if the monthly average described in subdivision (1) is no longer published, an alternative publication of interest rates or yields determined appropriate by the association.

(u) "Multiple employer welfare arrangement" has the meaning set forth in IC 27-1-34-1.

(v) "Owner" means the person:

(1) identified as the legal owner of a policy or contract according to the terms of the policy or contract; or

(2) otherwise vested with legal title to a 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 insurer.

The term does not include a person with a mere beneficial interest in a policy or contract.

(w) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a governmental entity, a voluntary organization, a trust, a trustee, or another business entity or organization.

(x) "Plan sponsor" refers to only one (1) of the following with respect to a benefit plan:

(1) The employer, in the case of a benefit plan established or maintained by a single employer.

(2) The holding company or controlling affiliate, in the case of a benefit plan established or maintained by affiliated companies comprising a consolidated corporation.

(3) The employee organization, in the case of a benefit plan established or maintained by an employee organization.

(4) In a case of a benefit plan established or maintained:

(A) by two (2) or more employers;

(B) by two (2) or more employee organizations; or

(C) jointly by one (1) or more employers and one (1) or more employee organizations;

and that is not of a type described in subdivision (2), the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan.

(y) "Premiums" means amounts, deposits, and considerations received on covered policies, less returned premiums, returned deposits, returned considerations, dividends, and experience credits. The term does not include the following:

(1) Amounts, deposits, and considerations received for policies or contracts or parts of policies or contracts for which coverage is not provided under section 2.3(d) of this chapter, as qualified by section 2.3(e) of this chapter, except that an assessable premium must not be reduced on account of the limitations set forth in section 2.3(e)(3), 2.3(e)(15), or 2.3(f)(2) of this chapter.

(2) Premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued or not connected with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(z) "Principal place of business" refers to the single state in which individuals who establish policy for the direction, control, and coordination of the operations of an entity as a whole primarily exercise the direction, control, and coordination, as determined by the association in the association's reasonable judgment by considering the following factors:

(1) The state in which the primary executive and administrative headquarters of the entity is located.

(2) The state in which the principal office of the chief executive officer of the entity is located.

(3) The state in which the board of directors or similar governing person of the entity conducts the majority of the board of directors' or governing person's meetings.

(4) The state in which the executive or management committee of the board of directors or similar governing person of the entity conducts the majority of the committee's meetings.

(5) The state from which the management of the overall operations of the entity is directed.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are employed in a single state, that state is considered to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in subsection (x)(4), if more than fifty percent (50%) of the participants in the plan sponsor's benefit plan are not employed in a single state, is considered to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties that establish or maintain the benefit plan and, in the absence of a specific or clear designation of a principal place of

business, is considered to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question on the coverage date.

(aa) "Receivership court" refers to the court in an insolvent insurer's or impaired insurer's state that has jurisdiction over the conservation, rehabilitation, or liquidation of the insolvent insurer or impaired insurer.

(bb) "Resident" means the following:

(1) An individual who resides in Indiana on the applicable coverage date.

(2) A person that is not an individual and has the person's principal place of business in Indiana on the applicable coverage date.

(cc) "State" includes a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(dd) "Structured settlement annuity" means an annuity purchased 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.

(ee) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(ff) "Unallocated annuity contract" means an annuity contract or group annuity certificate:

(1) the owner of which is not a natural person; and

(2) that does not identify at least one (1) specific natural person as an annuitant;

except to the extent of any annuity benefits guaranteed to a natural person by an insurer under the contract or certificate. For purposes of this chapter, an unallocated annuity contract shall not be considered a group policy or group contract.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.8-1993, SEC.431; P.L.251-1995, SEC.20; P.L.129-2003, SEC.13; P.L.193-2006, SEC.9; P.L.276-2013, SEC.31; P.L.208-2018, SEC.12.

IC 27-8-8-2.1 Policy, contract, rider descriptions; plan sponsor; residency

Sec. 2.1. (a) For purposes of this chapter:

(1) a policy or contract issued on a blanket basis is a group policy or group contract;

(2) each individual insured under a policy or contract issued on a blanket basis is a certificate holder under the policy or contract; and

(3) a policy or contract issued on a franchise plan to members of a qualified group is a nongroup policy or nongroup contract.

(b) For purposes of this chapter, a benefit plan may have only one (1) plan sponsor.

(c) For purposes of this chapter, an individual who, on the applicable coverage date:

(1) is a citizen of the United States; and

(2) resides in a:

(A) foreign country; or

(B) United States possession, territory, or protectorate;

that does not have an association similar to the association created by this chapter;

is considered to be a resident of the state of domicile of the insurer that issued the policies or contracts.

(d) For purposes of this chapter, benefits provided under a long term care insurance rider to:

(1) a life insurance policy; or

(2) an annuity contract;

are considered to be the same kind of benefits as the benefits under the life insurance policy or annuity contract to which the rider benefits relate.

As added by P.L.193-2006, SEC.10. Amended by P.L.276-2013, SEC.32; P.L.208-2018, SEC.13.

IC 27-8-8-2.3 Coverage provided; exclusions; limitations

Sec. 2.3. (a) Except as otherwise excluded or limited by this chapter, this chapter provides coverage for policies and contracts specified in subsection (d) as follows:

(1) To a person, other than a certificate holder or enrollee under a group policy or a group contract, that, regardless of where the person resides, is the health care provider, beneficiary, nonowner assignee, or payee of a person covered under subdivision (2).

(2) To a person that is a certificate holder under a group policy or group contract, and to a person that is the owner of a nongroup policy or nongroup contract that is not an unallocated annuity contract or a structured settlement annuity, and that:

(A) is a resident; or

(B) is not a resident if all the following conditions are satisfied:

(i) The member insurer that issued the policy or contract is domiciled in Indiana.

(ii) The state in which the person resides has an association similar to the association.

(iii) The nonresident is not eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(3) For an unallocated annuity contract, subdivisions (1) and (2) do not apply, and this chapter provides coverage to the following:

(A) A person that is the owner of the unallocated annuity contract, if the contract was issued to or in connection with a benefit plan whose plan sponsor is a resident or, if the plan sponsor is not a resident, if all the following conditions are satisfied:

(i) The member insurer that issued the unallocated annuity contract is domiciled in Indiana.

(ii) The state in which the plan sponsor resides has an association similar to the association.

(iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(B) A person that is the owner of an unallocated annuity contract issued to or in connection with a government lottery, if the owner is a resident or, if the owner is not a resident, if all the following conditions are satisfied:

(i) The member insurer that issued the unallocated annuity contract is domiciled in Indiana.

(ii) The state in which the owner resides has an association similar to the association.

(iii) The other association referred to in item (ii) does not provide coverage of the unallocated annuity contract solely because the member insurer was not licensed in the state of residence at the time specified in the guaranty association law of the state of residence.

(4) For a structured settlement annuity, subdivisions (1) and (2) do not apply, and this chapter provides coverage to a person that is a payee under the structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(A) is a resident, regardless of where the contract owner resides; or

(B) is not a resident if all the following conditions are satisfied:

(i) The member insurer that issued the structured settlement annuity is domiciled in Indiana.

(ii) The state in which the payee resides has an association similar to the association.

(iii) Neither the payee nor the beneficiary of the payee (if the payee is deceased) is eligible for coverage by the other association referred to in item (ii) solely because the member insurer was not licensed in the state of residence at the time

specified in the guaranty association law of the state of residence.

(b) This chapter does not provide coverage to a person that is:

(1) a payee or beneficiary of a contract owner that is a resident, if the payee or beneficiary is afforded any coverage by the association of another state; or

(2) otherwise covered under subsection (a)(3), if any coverage is provided to the person by the association of another state.

(c) To avoid duplicate coverage, if a person that would otherwise receive coverage under this chapter is provided coverage under the laws of another state, the person is not eligible for coverage under this chapter. In determining the application of this subsection when a person may be covered by the association of more than one (1) state as an owner, a payee, a beneficiary, or an assignee, this chapter must be construed in conjunction with the laws of the other state to result in coverage by only one (1) association.

(d) Except as otherwise excluded or limited by this chapter, this chapter provides coverage to the persons specified in subsection (a) for:

(1) direct nongroup life insurance and health insurance policies or contracts, including health maintenance organization subscriber contracts and certificates;

(2) direct nongroup annuity contracts;

(3) supplemental contracts to direct nongroup policies and contracts described in subdivisions (1) and (2);

(4) certificates under direct group life insurance and health insurance policies and contracts;

(5) certificates under direct group annuity contracts; and

(6) unallocated annuity contracts;

issued by member insurers.

(e) This chapter does not provide coverage for or with respect to the following:

(1) A part of a certificate, policy, or contract:

(A) not guaranteed by the member insurer; or

(B) under which the risk is borne by the payee, certificate holder, or the policy or contract owner.

(2) A reinsurance policy or contract, unless and to the extent that assumption certificates have been issued under the reinsurance policy or contract.

(3) A part of a certificate, policy, or contract to the extent that the certificate's, policy's, or contract's interest rate, crediting rate, or similar factor employed in calculating returns or changes in values, whether expressly stated in the certificate, policy, or contract or determined by use of an index or other external referent stated in the certificate, policy, or contract, either:

(A) when averaged over a period of four (4) years immediately before the applicable coverage date, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for the same four (4) year period or for a lesser period if the certificate, policy, or contract was issued less than four (4) years before the applicable coverage date; or

(B) in effect under the certificate, policy, or contract on and after the applicable coverage date, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available on the applicable coverage date.

However, this subdivision does not apply to a part of a certificate, policy, or contract (including a rider) that provides long term care or another health insurance benefit.

(4) The obligations of a plan or program of an employer, an association, or another person to provide life, health, or annuity benefits to the employer's, association's, or other person's employees, members, or others, including obligations arising under and benefits payable by the employer, association, or other person under a multiple employer welfare arrangement.

(5) A minimum premium group insurance plan.

(6) A stop-loss or excess loss insurance policy or contract providing for the indemnification of or payment to a policy owner, a contract owner, a plan, or another person obligated to pay life, health, or annuity benefits or to provide services in connection with a benefit plan or another plan, fund, or program for the provision of employee welfare or pension benefits.

(7) An administrative services only contract.

(8) A part of a certificate, policy, or contract to the extent that the certificate, policy, or contract provides for:

(A) dividends or experience rating credits;

(B) voting rights; or

(C) payment of fees or allowances to a person, including the certificate holder or policy or contract owner, in connection with service with respect to or administration of the certificate, policy, or contract.

(9) A certificate, policy, or contract issued in Indiana by a member insurer when the member insurer did not have a certificate of authority to issue the certificate, policy, or contract in Indiana.

(10) An unallocated annuity contract issued to or in connection with a benefit plan protected by the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet been required to make payments with respect to the benefit plan.

(11) An unallocated annuity contract or part of an unallocated annuity contract that is not issued to or in connection with a benefit plan or a government lottery.

(12) A certificate, policy, or contract or part of a certificate, policy, or contract with respect to which the Class B assessments contemplated by section 6 of this chapter may not be made or collected under federal or state law.

(13) An obligation or claim that does not arise under the express written terms of the policy or contract issued by the member insurer to the contract owner or policy owner, including any of the following obligations and claims:

(A) Obligations and claims based on marketing materials.

(B) Obligations and claims based on side letters, riders, or other documents issued by the member insurer without meeting applicable policy or contract form filing or approval requirements.

(C) Obligations and claims based on actual or alleged misrepresentations.

(D) Obligations and claims that are extracontractual claims.

(E) Obligations and claims for penalties or consequential, incidental, punitive, or exemplary damages.

(14) An obligation 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:

(A) benefit plan; or

(B) benefit plan's trustee;

that is not an affiliate of the member insurer.

(15) A part of a certificate, policy, or contract to the extent the:

(A) certificate, policy, or contract provides for the certificate's, policy's, or contract's interest rate, crediting rate, or similar factor employed in calculating returns or changes in values, to be determined by use of an index or other external referent stated in the certificate, policy, or contract; and

(B) returns or changes in value have not been credited to the certificate, policy, or contract, or as to which the certificate holder's or policy or contract owner's rights are subject to forfeiture, as of the applicable coverage date.

If a certificate's, policy's, or contract's returns or changes in values are credited to the certificate, policy, or contract less frequently than annually, for purposes of determining the returns and values that have been credited and are not subject to forfeiture under

this subdivision, the returns and changes in value determined by using the procedures defined in the certificate, policy, or contract must be considered credited as if the contractual date of crediting returns or changes in values were the applicable coverage date, and those credited returns or changes in value are not subject to forfeiture under this subdivision, but will be subject to any other applicable limitations under this chapter.

(16) A funding agreement.

(17) An annuity not subject to regulation as described in IC 27-1-12.4.

(18) A certificate, policy, or contract that provides a hospital, medical, prescription drug, or other health care benefit under:

(A) Part C of Title XVIII of the federal Social Security Act (42 U.S.C. 1395w-21 through 1395w-28);

(B) Part D of Title XVIII of the federal Social Security Act (42 U.S.C. 1395w-101 through 1395w-153);

(C) Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.); or

(D) regulations adopted under a law specified in clause (A), (B), or (C).

(f) The benefits that the association is obligated to cover do not exceed the lesser of the following:

(1) The contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an impaired insurer or insolvent insurer.

(2) The applicable limitations as follows:

(A) With respect to certificates, policies, and contracts not subject to clause (B), (C), (E), or (F), with respect to one (1) life, regardless of the number of policies or contracts, the following limitations:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values.

(ii) One hundred thousand dollars ($100,000) in health insurance benefits (other than those relating to disability income insurance, health benefit plans, and long term care insurance), including net cash surrender and net cash withdrawal values.

(iii) Three hundred thousand dollars ($300,000) in disability income insurance.

(iv) Three hundred thousand dollars ($300,000) in long term care insurance benefits (as defined in IC 27-8-12-5).

(v) Five hundred thousand dollars ($500,000) in health benefit plan benefits.

(vi) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(B) With respect to unallocated annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participant.

(C) With respect to structured settlement annuities, two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per payee.

(D) In addition to the foregoing limitations, the association is not obligated to cover more than:

(i) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) person under clauses (A), (B), and (C), except with respect to benefits for health benefit plans under clause (A)(v), an aggregate of five hundred thousand dollars ($500,000) with respect to any one (1) person; or

(ii) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, a firm, a corporation, or another person, and whether the persons insured are officers, managers, employees, or other

persons, five million dollars ($5,000,000) in benefits, including net cash surrender and net cash withdrawal values, regardless of the number of policies and contracts held by the owner.

(E) With respect to unallocated annuity contracts issued to or in connection with a government lottery, five million dollars ($5,000,000) in benefits per contract owner, regardless of the number of contracts held by the contract owner.

(F) With respect to unallocated annuity contracts:

(i) issued to or in connection with a benefit plan; and

(ii) not subject to clause (B);

five million dollars ($5,000,000) in benefits per plan sponsor, regardless of the number of unallocated annuity contracts entitled to coverage under this chapter.

(g) The limitations set forth in subsection (f) are limitations on the benefits for which the association is obligated before taking into account the:

(1) association's subrogation and assignment rights; or

(2) extent to which the benefits could be provided out of the assets of the impaired insurer or insolvent insurer attributable to covered policies.

The costs of discharging the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association under the association's subrogation and assignment rights.

(h) In discharging the association's obligations to provide coverage under this chapter, the association is not required to:

(1) guarantee, assume, reissue, reinsure, or perform;

(2) cause to be guaranteed, assumed, reissued, reinsured, or performed; or

(3) otherwise assure the discharge of;

the obligations of the insolvent insurer or impaired insurer under a covered policy that do not materially affect the economic values or economic benefits of the covered policy.

As added by P.L.193-2006, SEC.11. Amended by P.L.276-2013, SEC.33; P.L.208-2018, SEC.14.

IC 27-8-8-3 Creation of association; membership; accounts; supervision

Sec. 3. (a) There is created a nonprofit legal entity referred to as the Indiana Life and Health Insurance Guaranty Association. A member insurer shall be and remain a member of the association as a condition of the member insurer's authority to transact insurance in Indiana. The association shall perform its functions under the plan of operation established and approved under section 7 of this chapter. The association shall exercise its powers through a board of directors established under section 4 of this chapter. For purposes of administration and assessment the association shall maintain the following two (2) accounts:

(1) The health account.

(2) The life insurance and annuity account, which includes the following subaccounts:

(A) The life insurance subaccount.

(B) The annuity subaccount, which includes annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, but otherwise excludes unallocated annuities.

(C) The unallocated annuity subaccount, which excludes annuity contracts issued to or in connection with a governmental benefit plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code.

(b) The association is under the immediate supervision of the commissioner and subject to the applicable provisions of the insurance laws of Indiana.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.130-1994, SEC.43; P.L.116-1994, SEC.61; P.L.193-2006, SEC.12; P.L.208-2018, SEC.15.

IC 27-8-8-4 Board of directors

Sec. 4. (a) The board of directors of the association shall consist of not less than seven (7) nor more than eleven (11) member insurers serving terms established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner.

(b) Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(c) To select the initial board and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. At the organizational meeting, each member insurer is entitled to one (1) vote in person or by proxy. If the board is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members of the board.

(d) In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(e) Members of the board may be reimbursed from the assets of the association for expenses incurred by the members as members of the board. The association shall not otherwise compensate members of the board for the members' services on the board.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.13; P.L.208-2018, SEC.16.

IC 27-8-8-5 Impaired insurers; insolvent insurers; liens; association powers and duties

Sec. 5. (a) If a member insurer is an impaired insurer, the association may, in the association's sole 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 commissioner:

(1) guarantee, assume, reissue, reinsure, or perform, or cause to be guaranteed, assumed, reissued, reinsured, or performed, the contractual obligations of any of the covered policies of the impaired insurer or otherwise assure the discharge of the contractual obligations of the covered policies of the impaired insurer; and

(2) provide money, pledges, loans, notes, guarantees, or use other means as determined by the association in the association's sole discretion to be necessary or appropriate to effectuate subdivision (1).

(b) An obligation undertaken by the association under subsection (a) with respect to a covered policy of an impaired insurer ceases on the date the covered policy is replaced by the policy owner, insured, or association.

(c) If a member insurer is an insolvent insurer, the association shall, in the association's sole discretion, do one (1) of the following for each covered policy:

(1) Guarantee, assume, reissue, reinsure, or perform, or cause to be guaranteed, assumed, reissued, reinsured, or performed, the contractual obligations of the covered policy or otherwise assure the discharge of the contractual obligations of the covered policy.

(2) Terminate existing benefits and coverage and provide benefits and coverages in accordance with the following provisions:

(A) Assure payment of benefits arising under the contractual obligations, except for terms of conversion and nonrenewability, for:

(i) with respect to a group covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or forty-five (45) days, but not less than thirty (30) days, after the coverage date for the insolvent insurer; and

(ii) with respect to a nongroup covered policy, claims incurred not later than the earlier of the next renewal date under the covered policy or one (1) year, but in no event less than thirty (30) days, after the coverage date for the insolvent insurer.

(B) Make diligent efforts to provide each:

(i) known insured or annuitant, for a nongroup covered policy; and

(ii) owner, for a group covered policy;

at least thirty (30) days notice of the termination of the benefits provided.

(C) Make available substitute coverage, on an individual basis, to each:

(i) owner of a nongroup covered policy if the owner had a right to continue the nongroup covered policy in force until a specified age or for a specified period, during which time the insurer had no unilateral right to make changes in the nongroup covered policy's provisions or had only a unilateral right to make changes in premiums only by class; and

(ii) insured or annuitant under a group covered policy if the insured or annuitant is not eligible for any replacement group coverage and had a right, before termination of the group covered policy, to convert to individual coverage.

(D) In making available any substitute coverage under clause (C), the association may offer to reissue the terminated coverage or to issue an alternative policy or contract. If made available under clause (C), alternative or reissued policies and contracts must be offered without requiring evidence of insurability and must not impose any waiting period or coverage exclusion, other than a waiting period or coverage exclusion provided for in this chapter, that would not have applied under the terminated covered policy. The association may cause any alternative or reissued policy or contract to be assumed or reinsured.

(E) Use of alternative policies and contracts by the association is subject to the approval of the commissioner. The association may adopt alternative policies and contracts of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies and contracts must contain at least the minimum statutory provisions required in Indiana and provide benefits that are reasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium must:

(i) reflect the amount of insurance to be provided and the age and class of risk of each insured; and

(ii) not reflect changes in the health of the insured after the terminated covered policy was last underwritten.

Subject to coverage exceptions, exclusions, and limitations provided for in this chapter, an alternative policy or contract issued by the association must provide coverage similar, in material respects, to the coverage under the terminated covered policy as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from the premium rate charged under the terminated covered policy, the association shall set the premium in accordance with a table of rates adopted by the association. The premium:

(i) must reflect the amount of insurance to be provided and the age and class of risk of each insured; and

(ii) is subject to approval of the commissioner.

(G) The association's obligations with respect to coverage under a covered policy of an insolvent insurer or under a reissued or alternative policy or contract ceases on the date the coverage or covered policy is replaced by another similar policy by the policy owner, insured, or association.

(H) Subject to subsection (u), when proceeding under this subdivision with respect to a covered policy carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 2.3(e)(3) of this chapter.

(3) Take any combination of the actions set forth in subdivisions (1) and (2).

(d) The association may provide money, pledges, loans, notes, or guarantees, or use other means that the association, in the association's sole discretion, determines are necessary or appropriate to discharge the association's duties under subsection (c).

(e) Failure to pay premiums within thirty-one (31) days after the date that payment is due under the terms of a guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under this chapter with respect to the policy, contract, or coverage, except with respect to claims incurred or net cash surrender value due under this chapter.

(f) Premiums due for coverage after the coverage date for an impaired insurer or insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums payable to policy or contract owners with respect to premiums received by the association.

(g) The protection provided by this chapter does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state of the impaired insurer or insolvent insurer if the domiciliary state is a state other than Indiana.

(h) In carrying out its duties under subsection (c), the association may, subject to approval by a court in Indiana, impose:

(1) permanent policy or contract liens, if the association finds that:

(A) the amounts that can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter; or

(B) economic or financial conditions, as they affect member insurers, are sufficiently adverse so as to render the imposition of the permanent policy or contract liens to be in the public interest; and

(2) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with a covered policy, in addition to any contractual provisions for deferral of cash or policy loan value.

In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payments of cash values or policy loans or any other right to withdraw funds held in conjunction with a covered policy out of the assets of the impaired insurer 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.

(i) A deposit in Indiana, held by law or required by the commissioner for the benefit of creditors, including policy owners, that is not turned over to the domiciliary receiver before or promptly after the coverage date for an impaired insurer or insolvent insurer under IC 27-9-4-3 must be promptly paid to the association. The association:

(1) may retain a part of an amount paid to the association under this subsection equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to the impairment or insolvency for which the association provides statutory benefits by the aggregate amount of all policy owners' claims in Indiana related to the impairment or insolvency; and

(2) shall remit to the domiciliary receiver the difference between the amount paid to the association and the amount retained by the association under this subsection.

An amount retained by the association under this subsection must be treated as a distribution of estate assets under IC 27-9-3-32 or similar provision of the state of domicile of the impaired insurer or insolvent insurer.

(j) If the association fails to act within a reasonable period of time as provided in subsection (c) with respect to an insolvent insurer, the commissioner has the powers and duties of the association under this chapter with respect to the insolvent insurer.

(k) The association may, upon the commissioner's request, assist and advise the commissioner concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired insurer or insolvent insurer.

(l) The association has standing and the right to appear or intervene before a court or an

agency in Indiana or elsewhere with jurisdiction over an impaired insurer or insolvent insurer for which the association is or may become obligated under this chapter or with jurisdiction over a person or property against which the association may have rights through subrogation or otherwise. Standing extends to all matters germane to the rights, powers, and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired insurer or insolvent insurer and the determination of the policies or contracts and contractual obligations.

(m) A person receiving benefits under this chapter is considered to have assigned:

(1) the person's rights under; and

(2) any cause of action against another person for losses arising under, resulting from, or otherwise relating to;

the covered policy to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations or continuation of coverage or provision of substitute or alternative coverage. The association may require an assignment to it of those rights and causes of action by a payee, policy or contract owner, certificate holder, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter on the person.

(n) The subrogation rights of the association under subsections (m) and (o) have the same priority against the assets of the impaired insurer or insolvent insurer as those possessed by the person entitled to receive benefits under this chapter.

(o) In addition to the rights conferred by subsections (m) and (n), the association has all common law rights of subrogation and any other equitable or legal remedy with respect to a covered policy that would have been available to the:

(1) impaired insurer or insolvent insurer;

(2) owner, beneficiary, enrollee, health care provider, or payee of a policy or contract with respect to the policy or contract, including, in the case of a structured settlement annuity, rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under this chapter, against a person:

(A) who is originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity; and

(B) whose responsibility is not solely because of the person serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code; and

(3) certificate holder, or the beneficiary or payee of the certificate holder, with respect to a certificate.

(p) If subsection (m), (n), or (o) is invalid or ineffective with respect to a person or claim, the amount payable by the association with respect to the related covered policies must be reduced by the amount realized by another person with respect to the person or claim that is attributable to the covered policies.

(q) If the association provides benefits with respect to a covered policy and a person recovers amounts to which the association has rights as described in subsection (m), (n), or (o), the person shall pay to the association the part of the recovery attributable to the covered policies.

(r) The association may do the following:

(1) Enter into contracts necessary or appropriate to carry out the provisions and purposes of this chapter.

(2) Sue or, subject to section 14 of this chapter, be sued, including taking legal actions necessary or appropriate to recover unpaid assessments under section 6 of this chapter and to resolve claims or potential claims against or on behalf of the association.

(3) Borrow money to effect the purposes of this chapter and issue notes or other evidences of indebtedness of the association with respect to borrowings. Notes or other evidences of indebtedness described in this subdivision that are not in default are legal investments for domestic member insurers and may be carried as admitted assets.

(4) Employ or retain persons necessary or appropriate to handle the financial transactions of the association and to perform other functions necessary or appropriate under this chapter.

(5) Take legal action necessary or appropriate to avoid or recover payment of improper claims.

(6) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life or health insurer. However, in no case may the association issue policies or contracts other than those issued to perform the association's obligations under this chapter.

(7) Request information from a person seeking coverage from the association to aid the association in determining and discharging the association's obligations under this chapter with respect to the person. The person shall promptly comply with the request.

(8) Settle claims and potential claims by or against the association.

(9) Exercise all rights, privileges, and powers granted to the association by any other laws of Indiana or another jurisdiction.

(10) In accordance with the terms of the policy or contract, file for an actuarially justified rate or premium increase for a covered policy.

(11) Take other necessary or appropriate action to discharge the association's duties and obligations under this chapter or to exercise the association's rights and powers under this chapter.

(s) The association may belong to one (1) or more organizations of one (1) or more other state associations of similar purpose to further the purpose and administer the powers and duties of the association.

(t) The association has discretion and may exercise reasonable business judgment to determine the means by which the association is to discharge, in an economical and efficient manner, the association's obligations under this chapter.

(u) In discharging the association's obligations and exercising the association's rights and powers under subsections (a) and (c), the association may, subject to approval of the receivership court, provide substitute coverage for a covered policy that provides for the covered policy's interest rate, crediting rate, or similar factor employed in calculating returns or changes in value to be determined by use of an index or other external referent stated in the covered policy by issuing an alternative policy or contract in accordance with the following provisions:

(1) Instead of the index or other external referent stated in the covered policy, the alternative policy or contract may provide for:

(A) a fixed interest rate;

(B) payment of dividends with minimum guarantees; or

(C) a different method for calculating returns or changes in value.

(2) A:

(A) requirement for evidence of insurability; or

(B) waiting period or an exclusion, other than a waiting period or an exclusion provided for in this chapter;

that would not have applied under the covered policy may not be imposed.

(3) The alternative policy or contract must provide coverage similar, in material respects, to the coverage under the covered policy, after taking into account the exceptions, exclusions, and limitations provided for in this chapter, as determined by the association.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.166-1986, SEC.1; P.L.130-1994, SEC.44; P.L.116-1994, SEC.62; P.L.251-1995, SEC.21; P.L.193-2006, SEC.14; P.L.208-2018, SEC.17.

IC 27-8-8-5.2 Association election to succeed to rights and duties of impaired or insolvent insurer; reinsurance

Sec. 5.2. (a) At any time within one (1) year after the coverage date for an impaired insurer or insolvent insurer, the association may elect, subject to subdivisions (1) through (4), to succeed to the rights and obligations of the impaired insurer or insolvent insurer that accrue on or after the coverage date and that relate to covered policies under one (1) or more indemnity reinsurance agreements entered into by the impaired insurer or insolvent insurer as a ceding insurer. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the impaired insurer or insolvent insurer has previously and expressly disaffirmed the reinsurance agreement. The election by the association must be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers specifying the reinsurance agreement concerning which the association has made the foregoing election. If the association makes an election, the following apply with respect to the agreements selected by the association:

(1) The association is responsible for:

(A) all unpaid premiums due under the agreements for periods before and after the coverage date; and

(B) the performance of all other obligations of the impaired insurer or insolvent insurer to be performed after the coverage date;

that relate to covered policies. The association may charge covered policies that are only partially covered by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association.

(2) The association is entitled to any amount payable by the reinsurer under the selected agreements:

(A) with respect to losses or events that occur during periods after the coverage date; and

(B) that relate to covered policies.

Of the amount received from the reinsurer, the association is obliged to pay to the beneficiary under the covered policy on account of which the amount was paid a portion of the amount equal to the excess of the amount received by the association over benefits paid by the association on account of the covered policy less the retention of the impaired insurer or insolvent insurer applicable to the loss or event.

(3) Within thirty (30) days after the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by the:

(A) impaired insurer or insolvent insurer, or the impaired insurer's or insolvent insurer's receiver, rehabilitator, or liquidator; or

(B) indemnity reinsurer;

during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other not more than five (5) days after the completion of the calculation. If the receiver, rehabilitator, or liquidator has received any amount due the association under subdivision (2), the receiver, rehabilitator, or liquidator shall remit the amount to the association as promptly as practicable.

(4) If the association, within sixty (60) days of the election, pays the premiums due for periods before and after the coverage date that relate to covered policies, the reinsurer is not entitled to:

(A) terminate the reinsurance agreements insofar as the agreements relate to covered policies; or

(B) set off any unpaid premium due for periods before the coverage date against amounts due the association.

(b) If the association transfers any of the association's obligations to another insurer, and if the association and the other insurer agree, the other insurer succeeds to the rights and obligations of the association under subsection (a) with respect to the transferred obligations

effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to in subsection (a), except that the:

(1) indemnity reinsurance agreements automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary; and

(2) obligations of the association described in subsection (a)(2) no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer.

This subsection does not apply if the association has previously notified the receiver, rehabilitator, or liquidator and the affected reinsurer in writing that the association will not exercise the election referred to in subsection (a).

(c) Subsections (a) and (b) supersede any other law or affected reinsurance agreement that provides for or requires payment of reinsurance proceeds, on account of losses or events that occur after the coverage date, to the receiver, liquidator, or rehabilitator of the impaired insurer or insolvent insurer. The receiver, rehabilitator, or liquidator remains entitled to amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur before the coverage date, subject to applicable setoff provisions.

(d) Except as provided in subsections (a), (b), and (c), this chapter does not alter or modify the terms and conditions of indemnity reinsurance agreements of the insolvent insurer.

(e) This chapter does not:

(1) abrogate or limit the rights of a reinsurer to claim that the reinsurer is entitled to rescind a reinsurance agreement; or

(2) give a policy owner, insured, or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

As added by P.L.193-2006, SEC.15. Amended by P.L.208-2018, SEC.18.

IC 27-8-8-5.4 Association obligations to person entitled to coverage

Sec. 5.4. If the association has arranged or offered to discharge the association's obligations under this chapter with respect to contractual obligations owed to a person entitled to coverage under this chapter:

(1) the person, and any other person claiming by, through, or under the person, is not entitled to benefits from the association in addition to or other than benefits arranged or offered by the association; and

(2) the association is relieved of further obligation with respect to the contractual obligations if the person rejects, declines, or otherwise fails to accept the association's arrangement or offer.

As added by P.L.193-2006, SEC.16.

IC 27-8-8-5.5 Venue; appeal bond

Sec. 5.5. (a) Venue in a suit against the association is in Marion County.

(b) The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under or with respect to this chapter.

As added by P.L.193-2006, SEC.17.

IC 27-8-8-6 Assessments

Sec. 6. (a) For the purpose of providing funds necessary to carry out the powers and duties of the association and necessary to pay administrative costs and expenses incurred by the commissioner in supervising the association and discharging the commissioner's obligations under this chapter, the board shall assess the member insurers, separately for each account, at a time and for amounts as the board finds necessary. Assessments are due not less than thirty (30) days after prior written notice to the member insurers and accrue interest at six percent (6%) per annum on and after the due date.

(b) There are two (2) classes of assessments as follows:

(1) Class A assessments are assessments that are authorized and called by the board for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired insurer or insolvent insurer.

(2) Class B assessments are assessments that are authorized and called by the board to the extent necessary to carry out the powers and duties of the association under this chapter with regard to an impaired insurer or insolvent insurer.

(c) The amount of a Class A assessment must 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 the assessment be credited against future Class B assessments.

(d) The amount of a Class B assessment, except for assessments related to long term care insurance, must be allocated for assessment purposes:

(1) between the accounts; and

(2) among the subaccounts of the life insurance and annuity account;

under an allocation formula that may be based on the premiums or reserves of the impaired insurer or insolvent insurer or another standard considered by the board in the board's sole discretion as fair and reasonable under the circumstances.

(e) The amount of a Class B assessment related to long term care insurance must be allocated for assessment purposes according to the following:

(1) The allocation to:

(A) accident and health insurance member insurers is fifty percent (50%) of the assessment; and

(B) life insurance and annuity member insurers is fifty percent (50%) of the assessment.

(2) The share of the assessment that must be allocated to the life insurance and annuity account must be determined as follows:

STEP ONE: Determine the life insurance and annuity member insurers' share of the following:

(i) The health account.

(ii) The life insurance and annuity account.

STEP TWO: Determine the remainder of:

(i) fifty-hundredths (0.50); minus

(ii) the life insurance and annuity member insurers' share of the health account.

STEP THREE: Determine the remainder of:

(i) the life insurance and annuity member insurers' share of the life insurance and annuity account; minus

(ii) the life insurance and annuity member insurers' share of the health account.

STEP FOUR: Divide the remainder determined under STEP TWO by the remainder determined under STEP THREE.

For purposes of this subsection, "life insurance and annuity member insurer" means a member insurer for which the sum of the member insurer's assessable life insurance premiums and annuity premiums is equal to or greater than the member insurer's total assessable health insurance premiums, including assessable health maintenance organization premiums and excluding assessable premiums written for disability insurance and long term care insurance. For purposes of this subsection, "accident and health insurance member insurer" means a member insurer that is not a life insurance and annuity member insurer. For purposes of this subsection, assessable premiums must be measured within Indiana.

(f) Class B assessments against member insurers for each account and subaccount with respect to an impaired insurer or insolvent insurer must be allocated among the assessed member insurers in the proportion that the premiums received in Indiana by each assessed member insurer on policies and contracts covered by the account or subaccount during the assessment base year for the impaired insurer or insolvent insurer bears to premiums received

in Indiana by all assessed members on policies and contracts covered by the same account or subaccount during the same assessment base year.

(g) Assessments for funds to meet the requirements of the association with respect to an impaired insurer or insolvent insurer must not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) and computation of assessments under subsections (c), (d), (e), and (f) must be made with a reasonable degree of accuracy, recognizing that exact determinations are not always possible. The association shall notify each member insurer of the member insurer's anticipated share of an assessment that has been authorized but not yet called not more than one hundred eighty (180) days after the assessment is authorized.

(h) 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 policy and contract obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may 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 assessments that were deferred under a repayment plan approved by the association.

(i) Subject to subsection (j), the total of all assessments authorized by the association in one (1) calendar year against a member insurer for a given subaccount of the life insurance and annuity account or for the health account with respect to any single assessment base year must not exceed two percent (2%) of the member insurer's premiums received in Indiana on the policies and contracts covered by the subaccount or account during the applicable assessment base year.

(j) If two (2) or more assessments are authorized in one (1) calendar year with respect to impaired insurers or insolvent insurers having different assessment base years, the annual premium used for purposes of determining the aggregate assessment percentage limitation referenced in subsection (i) must be equal to the higher of the annual premiums for the applicable subaccount or account as calculated under this section.

(k) If the maximum assessment, together with other assets of the association in an account, does not provide in one (1) year in the account an amount sufficient to carry out the responsibilities of the association, additional funds must be assessed as soon as permitted by this chapter.

(l) The board may provide in the plan of operation a method of or procedure for allocating funds among claims relating to one (1) or more impaired insurers or insolvent insurers when the maximum assessment is insufficient to cover anticipated claims.

(m) If the maximum assessment for a subaccount of the life insurance and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, the board shall, under subsection (f), access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in subsections (i) and (j).

(n) The board may, by an equitable method or procedure as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to the account, the amount by which the assets of the account exceed the amount the board determines is necessary to carry out the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for the future discharge of the association's obligations.

(o) It is proper for a member insurer, in determining its premium rates and policyowner dividends as to any type of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(p) The association shall issue to each member insurer paying an assessment under this

chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates are 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 the form and for the amount and period of time as the commissioner may approve.
As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.16-1984, SEC.17; P.L.166-1986, SEC.2; P.L.130-1994, SEC.45; P.L.116-1994, SEC.63; P.L.193-2006, SEC.18; P.L.208-2018, SEC.19.

IC 27-8-8-6.2 Member protesting assessment

Sec. 6.2. (a) A member insurer that wishes to protest all or part of an assessment made under section 6 of this chapter shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment is available to meet association obligations during the pendency of the protest or a subsequent appeal. Payment must be accompanied by a statement in writing that the payment is made under protest and set forth a brief statement of the grounds for the protest.

(b) Not more than sixty (60) days after the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of the association's 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) Not more than sixty (60) days after receipt of notice of the association's determination with respect to a protest, the protesting member insurer may appeal the determination to the commissioner.

(d) Instead of making a determination with respect to a protest based on a question regarding the assessment base, the association may refer the protest to the commissioner for a determination, with or without a recommendation from the association.

(e) If a protest of an assessment is upheld, the amount paid by the protesting member insurer in error or excess must be returned to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate actually earned by the association.
As added by P.L.193-2006, SEC.19.

IC 27-8-8-6.5 Association requests for information

Sec. 6.5. (a) The association may request information from a member insurer to aid in the exercise of the association's power under sections 6 and 6.2 of this chapter.

(b) A member insurer that receives a request under subsection (a) shall promptly comply with the request.
As added by P.L.193-2006, SEC.20.

IC 27-8-8-7 Association plan of operation

Sec. 7. (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation that are necessary or appropriate to assure the fair, reasonable, and equitable administration of the association. The plan of operation and an amendment to the plan of operation are effective:

(1) if the plan or amendment is not disapproved by the commissioner within thirty (30) days after being submitted to the commissioner; or

(2) upon the commissioner's written approval, if sooner than the time set in subdivision (1).

(b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days from September 1, 1978, or if at any other time the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary to effectuate the provisions of this chapter. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) A member insurer shall comply with the plan of operation.

(d) The plan of operation must, in addition to requirements stated elsewhere in this chapter establish:

(1) procedures for handling the assets of the association;

(2) the amount and method of reimbursing members of the board under section 4 of this chapter;

(3) regular places and times for meetings, including, if desired by the association, telephone conference calls, of the board;

(4) procedures for records to be kept of all financial transactions of the association, its agents, and the board;

(5) procedures whereby selections for the board will be made and submitted to the commissioner; and

(6) any additional procedures for assessments under sections 6 and 6.2 of this chapter.

The plan of operation may contain additional provisions necessary or appropriate for the execution of the powers and duties of the association.

(e) The plan of operation may provide that any or all powers and duties of the association, except those under sections 5(r)(3), 6, 6.2, and 6.5 of this chapter, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two (2) or more states. The corporation, association, or organization must be reimbursed for payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes effect only with the approval of both the board and the commissioner and may be made only to a corporation, association, or organization that extends protection that is not substantially less favorable and effective than that provided by this chapter.

(f) To the extent and in the manner specified in the plan of operation, the board may create one (1) or more committees, each of which may exercise the authority of the board to the extent specified in the plan of operation or by the board.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.21.

IC 27-8-8-8 Powers and duties of commissioner; appeals to commissioner; notice of effect of chapter

Sec. 8. (a) The commissioner shall do the following:

(1) Upon request of the board, provide the association with a statement of the premiums in Indiana and other appropriate states for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand on the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders. The failure of the impaired insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this chapter.

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in Indiana of a member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on a member insurer that fails to pay an assessment when due. A forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(c) A final action of the association or the board may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court with jurisdiction in accordance with the Indiana law that

applies to the actions or orders of the commissioner.

(d) The liquidator, rehabilitator, or conservator of an impaired insurer or insolvent insurer may notify all interested persons of the effect of this chapter.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.22; P.L.208-2018, SEC.20.

IC 27-8-8-9 Detection and prevention of insurer insolvencies or impairments; actions of board of directors

Sec. 9. (a) To aid in the detection and prevention of member insurer insolvencies or impairments, the commissioner shall do the following:

(1) Notify the insurance regulatory authorities of all the other states not more than thirty (30) days after the date an action taken by the commissioner occurs when the commissioner takes any of the following actions against a member insurer:

(A) Revokes the member insurer's certificate of authority.

(B) Suspends the member insurer's certificate of authority.

(C) Issues a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from Indiana, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(2) Report to the association when the commissioner takes any of the actions set forth in subdivision (1) or when the commissioner has received a report from any other insurance regulatory authority indicating that an action has been taken in another state. The report to the association must contain all significant details of the action taken or of the report received from another insurance regulatory authority.

(3) Report to the association when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be impaired or insolvent.

(4) Furnish to the association the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The association may use the information contained in the ratios and listings in carrying out its duties and responsibilities under this chapter. The report and the information contained in the report must be kept confidential by the association until made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the association concerning a matter affecting the commissioner's duties and responsibilities in regard to the financial condition of member insurers and insurers seeking admission to transact insurance business in Indiana.

(c) The association may, upon majority vote by the board, make reports and recommendations to the commissioner on any matter germane to the solvency, liquidation, rehabilitation, or conservation of a member insurer or germane to the solvency of any insurer seeking to do an insurance business in Indiana. The reports and recommendations are not public documents.

(d) The association may, upon majority vote by the board, notify the commissioner of any information indicating that a member insurer may be impaired or insolvent.

(e) The association may, upon majority vote by the board, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.23; P.L.208-2018, SEC.21.

IC 27-8-8-10 Records of board meetings; disclosure of records; association status as creditor; application of impaired or insolvent insurer's assets

Sec. 10. (a) Records must be kept of all meetings of the board to discuss the activities of the association in carrying out its powers and duties under sections 5, 5.2, and 5.4 of this chapter. Records of the association with respect to an impaired insurer or insolvent insurer must not be disclosed except:

(1) after the termination of the liquidation, rehabilitation, or conservation proceeding involving the impaired insurer or insolvent insurer; or

(2) upon the order of a court with jurisdiction if the order is made before the time described in subdivision (1).

This subsection does not limit the duty of the association to submit a report of its activities under section 12 of this chapter.

(b) For the purpose of carrying out its obligations under this chapter, the association is a creditor of the impaired insurer or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts that the association has received, from a person other than the impaired insurer or insolvent insurer, as subrogee under section 5(m), 5(o), and 5(q) of this chapter. Assets of the impaired insurer or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired insurer or insolvent insurer as required by this chapter. "Assets attributable to covered policies", as used in this subsection, is that proportion of the assets that the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired insurer or insolvent insurer.

(c) As a creditor of an impaired insurer or insolvent insurer under subsection (b) and consistent with IC 27-9-3-32, the association and other similar associations are entitled to receive disbursements of assets out of the marshaled assets, as the assets become available to reimburse the association or another similar association, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days after a member insurer becomes an insolvent insurer, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association is entitled to make application to the receivership court for approval of the association's own proposal to disburse the assets.

(d) Before the termination of a liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, the policy owners, and the insureds of the impaired insurer or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired insurer or insolvent insurer. In making the determination, the court shall consider the welfare of the policy owners and insureds of the continuing or successor member insurer.

(e) A distribution to stockholders of an impaired insurer or insolvent insurer must not be made until the total amount of valid claims of the association, with interest, for funds expended in carrying out the association's powers and duties under sections 5, 5.2, 5.4, and 5.5 of this chapter with respect to the impaired insurer or insolvent insurer, have been fully recovered by the association.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.24; P.L.208-2018, SEC.22.

IC 27-8-8-11 Distributions to affiliates; recovery

Sec. 11. (a) Subject to subsections (b) through (d), if an order for liquidation or rehabilitation of a member insurer domiciled in Indiana has been entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the filing of the petition for liquidation or rehabilitation.

(b) A distribution described in subsection (a) is not recoverable if the member insurer shows that when the distribution was paid the distribution was lawful and reasonable, and that

the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill the member insurer's policy and contract obligations.

(c) A person who was an affiliate that controlled the member insurer at the time a distribution described in subsection (a) was paid is liable up to the amount of distributions the person received. A person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable up to the amount of distributions that would have been received if the distributions had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the policy and contract obligations of the insolvent insurer.

(e) If a person liable under subsection (c) is insolvent, the affiliates that controlled the person at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.25; P.L.208-2018, SEC.23.

IC 27-8-8-12 Examination and regulation of association; financial report

Sec. 12. (a) The association is subject to examination and regulation by the commissioner. The association shall annually submit to the commissioner, not later than one hundred twenty (120) days after the end of the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

(b) Upon the request of a member insurer, the association shall provide to the member insurer a copy of the reports described in subsection (a).

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.26.

IC 27-8-8-13 Association tax and fee exemption

Sec. 13. The association is exempt from payment of all fees and all taxes levied by Indiana or any of its political subdivisions, except taxes levied on real property.

As added by Acts 1978, P.L.129, SEC.3.

IC 27-8-8-14 Liability for performance under chapter

Sec. 14. (a) A member insurer and the member insurer's agents and employees, the association and the association's agents and employees, members of the board and representatives of the members of the board, and the commissioner and the commissioner's representatives are not liable for and no cause of action of any nature arises or may be brought against them for or in connection with an action or omission by any of them in the exercise and performance of their rights, powers, and duties under this chapter.

(b) Immunity under this section extends to:

(1) the participation in an organization of one (1) or more other state associations of similar purpose; and

(2) an organization described in subdivision (1) and an agent or employee of the organization.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.27.

IC 27-8-8-15 Insolvent insurer proceedings; stay; setting aside judgment

Sec. 15. All proceedings in which an insolvent insurer is a party in any court in Indiana shall be stayed for one hundred eighty (180) days from the date an order of liquidation is entered to permit proper legal action by the association on matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and is entitled to defend against the suit on the merits.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.28; P.L.276-2013, SEC.34.

IC 27-8-8-16 Recoupment of assessments

Sec. 16. A member insurer may take as a credit against premium taxes, adjusted gross income taxes, or any combination of them imposed by the state upon the member insurer's revenue or income not more than twenty percent (20%) of the amount of each assessment described in section 6 of this chapter for each calendar year following the year in which the assessment was paid until the assessment has been offset by either credits against the taxes or refunds from the association. If the member insurer ceases doing business, all uncredited assessments may be credited against the member insurer's premium taxes, adjusted gross income taxes, or a combination of the premium taxes and adjusted gross income taxes of the member insurer for the year the member insurer ceases doing business.

As added by Acts 1978, P.L.129, SEC.3. Amended by Acts 1979, P.L.255, SEC.2; Acts 1980, P.L.173, SEC.1; P.L.163-1986, SEC.2; P.L.192-2002(ss), SEC.168; P.L.193-2006, SEC.29.

IC 27-8-8-16.2 Premium surcharge or assignment in lieu of credit

Sec. 16.2. (a) A member insurer that is not eligible to take a credit under section 16 of this chapter may, after approval by the commissioner, place a surcharge on the member insurer's premiums in a sum reasonably calculated to recoup the member insurer's assessments over a reasonable period, as approved by the commissioner.

(b) Any amount recouped under subsection (a) is not considered to be a premium for any other purpose, including computation of gross premium tax, medical loss ratio, or insurance producer commission.

(c) In lieu of the surcharge allowed by subsection (a), a member insurer that is not eligible to take a credit under section 16 of this chapter may assign the credit to the member insurer's affiliate (as defined in IC 27-1-23-1(b)).

As added by P.L.208-2018, SEC.24.

IC 27-8-8-17 Refunds from association

Sec. 17. (a) Sums acquired by refund under section 6(m) of this chapter from the association by member insurers and offset against taxes as provided by section 16 of this chapter shall be paid by the member insurers to the state in the manner required by the tax authorities.

(b) The association shall notify the commissioner when refunds under section 6 of this chapter have been made.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.193-2006, SEC.30.

IC 27-8-8-18 Advertising referring to association; association summary document

Sec. 18. (a) A person, including a member insurer, insurance producer, employee, agent, or affiliate of a member insurer, shall not make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, an advertisement, an announcement, or a statement, written or oral, that uses the existence of the association for the purpose of the sale of, solicitation of, or inducement to purchase any form of insurance covered by this chapter. This section does not apply to the association or any other entity that does not sell or solicit insurance.

(b) The association shall:

(1) prepare a summary document:

(A) describing the general purposes and current limitations of this chapter; and

(B) complying with subsection (c); and

(2) submit the summary document to the commissioner for approval.

Sixty (60) days after the date on which the commissioner approves the summary document, a member insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document must also be available upon request by a policy owner. The distribution, delivery, or contents or interpretation of the summary document does not guarantee that the policy or contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The summary document must be revised by the association as amendment to this chapter requires. Failure to receive the summary document does not give a policy owner, a contract owner, a certificate holder, or an insured greater rights than the rights specified in this chapter.

(c) The summary document prepared under subsection (b) must contain a clear and conspicuous disclaimer on the face of the summary document. The commissioner shall approve the form and content of the disclaimer. The disclaimer must, at a minimum, convey all the following:

(1) State the name and address of the association and the department of insurance.

(2) Prominently warn that:

(A) the association might not cover the policy or contract; and

(B) even if coverage were currently provided, coverage is:

(i) subject to substantial limitations and exclusions;

(ii) generally conditioned on continued residence in Indiana; and

(iii) subject to possible change as a result of future amendments to this chapter and court decisions.

(3) State the types of policies for which the association currently provides coverage.

(4) State that the member insurer and the member insurer's agents are prohibited by law from using the existence of the association for the purpose of selling, soliciting, or inducing purchase of any form of insurance.

(5) State that the policy owner or contract owner should not rely on coverage under this chapter when selecting an insurer.

(6) Explain:

(A) rights available following; and

(B) procedures for filing a complaint to allege;

a violation of any provision of this chapter.

(7) Provide other information as directed by the commissioner, including sources for information that:

(A) is not proprietary; and

(B) is subject to disclosure under IC 5-14-3;

concerning the financial condition of an insurer.

(d) A member insurer shall retain evidence of compliance with subsection (b) until the policy or contract for which the notice is given is no longer in effect.

As added by Acts 1978, P.L.129, SEC.3. Amended by P.L.178-2003, SEC.62; P.L.193-2006, SEC.31; P.L.208-2018, SEC.25.