OFFICIAL CODE OF GEORGIA ANNOTATED

With Provision for Subsequent Pocket Parts

Prepared by

The Code Revision Commission
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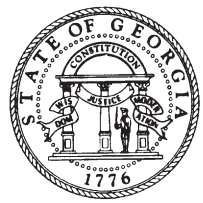
and
The Editorial Staff of LexisNexis®



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Title 33. Insurance
(Chapters 1 to 22)

Including Acts of the 2020 Session of the General Assembly of Georgia
and Annotations taken from the Georgia Reports
and the Georgia Appeals Reports

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THE STATE OF GEORGIA

OFFICE OF SECRETARY OF STATE

I, Brad Raffensperger, Secretary of State of the State of Georgia, do hereby certify that

the statutory portion of the Official Code of Georgia Annotated contained in this volume is a true and correct copy of such material as enacted by the General Assembly of Georgia; all as the same appear on file and record in this office.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the seal of my office, at the Capitol, in the City of Atlanta, this 18th Day of September, in the year of our Lord Two Thousand and Twenty and of the Independence of the United States of America the Two Hundred and Forty-Fifth.

Brad Raffensperger

Brad Raffensperger, Secretary of State

Preface

This volume cumulates and replaces the 2014 edition of Volume 24 of the Official Code of Georgia Annotated, as supplemented by the 2019 Cumulative Supplement. The 2014 Volume 24 and its 2019 Supplement may be recycled or, if so desired, retained for historical purposes.

This volume contains all laws specifically codified in Chapters 1 through 22 of Title 33 by the General Assembly through the 2020 Session. This volume also contains case annotations reflecting decisions posted to LexisNexis® through August 7, 2020. These annotations will appear in the following traditional reporter sources: Georgia Supreme Court Opinions; Georgia Appeals Court Opinions; Southeastern Reporter, Second Series; Supreme Court Reporter; Federal Reporter, Third Series; Federal Supplement, Second Series; Federal Rules Decisions; and Bankruptcy Reporter. As official and traditional citations become available, substitutions for the LexisNexis® citations will be made.

Additionally, LexisNexis® has prepared annotations and references to Attorney General Opinions, law reviews, and other research sources that we hope will be beneficial as you utilize this product. A complete listing of those sources is as follows: Official and Unofficial Attorney General Opinions; Opinions of the Judicial Qualifications Commission; Advisory Opinions of the State Disciplinary Board of the State Bar; Formal Advisory Opinions of the State Disciplinary Board of the State Bar, issued by the Supreme Court of Georgia; Emory Law Journal; Georgia Law Review; Georgia State University Law Review; John Marshall Law Review; Mercer Law Review; Georgia State Bar Journal; American Law Reports; American Jurisprudence 2d; American Jurisprudence Pleading and Practice; American Jurisprudence Proof of Facts; American Jurisprudence Trials; Corpus Juris Secundum; and Uniform Laws Annotated. Also included, where appropriate, are cross references to the Official Code of Georgia Annotated.

This volume retains amendment notes and effective date notes for Acts passed during the 2018, 2019, and 2020 Sessions of the General Assembly. In order to determine the changes which were made or the effective date applied to a Code section by an Act passed prior to the 2018 Session of the General Assembly, the user should consult the Georgia Laws.

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User's Guide

In order to assist both the legal profession and the layperson in obtaining the maximum benefit from the Official Code of Georgia Annotated, a User's Guide containing comments and information on the many features found within the Code has been included in Volume 1 of the Official Code of Georgia Annotated.

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Cross references. — Specific limitations on corporations, Ga. Const. 1983, Art. III, Sec. VI, Para. V and T. 14, C. 4. Insurance regulation generally, Ga. Const. 1983, Art. III, Sec. VIII. Requirement that banks obtain and maintain deposit insurance, § 7-1-244. Credit Union Deposit Insurance Corporation, T. 7, C. 2. Secretary of State, corporations, generally, T. 14, C. 4. Purchase of liability insurance for school officials and employees, § 20-2-990 et seq. Joint purchase of

insurance and joint formation of self-insurance programs by boards of education, § 20-2-2001 et seq. Nuclear facility liability insurance for schools under control of board of regents, § 20-3-71. Liability insurance requirements for persons importing, transporting, or otherwise handling inherently dangerous wild animals, § 27-5-4. Joint purchase of insurance and joint formation of self-insurance programs by municipalities and counties, T. 36, C. 85. Public liability insurance requirements for operators of motor vehicle racetracks, § 43-25-4. Purchase of liability insurance for public officers and employees generally, § 45-9-1 et seq. State employees' insurance and benefit plans, T. 45, C. 18.

Editor's notes. — Former Code 1933, § 56-115, enacted by Ga. L. 1960, p. 289, § 1, provided that the Georgia Insurance Code would become effective on January 1, 1961, except as otherwise expressly provided.

Law reviews. — For article, "No-Fault Insurance for Injuries Arising from Medical Treatment: A Proposal for Elective Coverage," see 24 Emory L.J. 21 (1975). For article discussing developments in Georgia insurance law in 1976 to 1977, see 29 Mercer L. Rev. 157 (1977). For article surveying Georgia cases in the area of insurance from June 1977 through May 1978, see 30 Mercer L. Rev. 105 (1978). For annual survey on insurance, see 36 Mercer L. Rev. 217 (1984). For article surveying insurance law in 1984-1985, see 37 Mercer L. Rev. 275 (1985). For annual survey of insurance law, see 39 Mercer L. Rev. 241 (1987). For annual survey of insurance law, see 42 Mercer L. Rev. 259 (1990). For annual survey of insurance law, see 43 Mercer L. Rev. 285 (1991). For annual survey article on insurance law, see 45 Mercer Law Rev. 253 (1993). For annual survey article on insurance law, see 46 Mercer L. Rev. 261 (1994). For annual survey article on insurance law, see 49 Mercer L. Rev. 175 (1997). For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999). For annual survey article on insurance law, see 52 Mercer L. Rev. 303 (2000). For article, "When Do State Laws Determine ERISA Plan Benefit Rights," see 47 J. Marshall L. Rev. 145 (2014). For article, "Nondiscrimination in Insurance: The Next Chapter," see 49 Ga. L. Rev. 1 (2014). For article, "Public Officers and Employees: Employees' Insurance and Benefit Plans," see 31 Georgia St. U.L. Review 177 (2014). For annual survey on insurance law, see 68 Mercer L. Rev. 133 (2016). For article, "Price Transparency and Incomplete Contracts in Health Care," see 67 Emory L.J. 1 (2017). For annual survey on health care law, see 69 Mercer L. Rev. 1209 (2018).

For note discussing the relationship of federal and state regulation of insurance, in light of In the Matter of American Hospital and Life Insurance Co., C.C.H. Trade Reg. Rep. ¶25,954 (FTC, April 24, 1956), see 5 J. of Pub. L. 494 (1956). For note, "The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation," see 44 Ga. L. Rev. 511 (2010). For note, "When an Idea is More Than Just an Idea: Insurance Coverage of Business Method Patent Infringement Suits Under Advertising Injury Provisions of Commercial General Liability Policies," see 18 J. Intell. Prop. L. 631 (2011). For note, "Phishing for Computer Fraud Insurance Coverage," see 36 Ga. St. U.L. Rev. 407 (2020).

JUDICIAL DECISIONS

In 1960 the Insurance Code became, by law, a part of every policy thereafter issued in the state. Chicago Ins. Co. v. Camors, 296 F. Supp. 1335 (N.D. Ga. 1969), aff'd, 420 F.2d 376 (5th Cir. 1970).

Title not retroactive. — Insurance Code, enacted by Ga. L. 1960, p. 289, was not intended to and could not have had any retroactive effect. Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971).

All aspects of insurance industry regulated. — Insurance Code extensively and exhaustively regulates, at the state level, all aspects of the insurance industry in Georgia. Cotton States Mut. Ins. Co. v. DeKalb County, 251 Ga. 309, 304 S.E.2d 386 (1983).

Scope of Commissioner's investigative powers. — Investigative powers of the Insurance Commissioner under the Insurance Code are not restricted only to those instances in which a hearing is pending. Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

Cited in Scott v. State Grand Lodge No. 1, 110 Ga. App. 762, 140 S.E.2d 86 (1964); Miller v. National Fid. Life Ins. Co., 588 F.2d 185 (5th Cir. 1979).

OPINIONS OF THE ATTORNEY GENERAL

Employee of an industrial loan licensee may conduct the business of insurance provided that that person is duly licensed as an insurance agent and provided that the customer is not misled into thinking that the customer's ability to procure a loan is contingent upon an agreement to purchase this insurance or otherwise to transact business in the industrial loan office. 1984 Op. Att'y Gen. No. U84-54.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 1 et seq.

ALR. — Misrepresentation by one other than insurance agent as to coverage, exclusion, or legal effect of insurance policy, as actionable, 29 A.L.R.2d 213.

Liability insurer's waiver of right, or estoppel, to set up breach of cooperation clause, 30 A.L.R.4th 620; 65 A.L.R.5th 272.

Acts in self-defense as within provision of liability insurance policy expressly excluding coverage for damage or injury intended or expected by insured, 34 A.L.R.4th 761.

Liability of insurer or agent of insurer for failure to advise insured as to coverage needs, 88 A.L.R.4th 249.

Validity and operation of "step-down" provision of automobile liability policy reducing coverage for permissive users, 29 A.L.R.5th 469.

Construction and application of preemption exemption, under Employee Retirement Income Security Act (29 USC § 1001 et seq.), for state laws regulating insurance, banking, or securities (29 USC § 1144(b)(2)), 87 A.L.R. Fed. 797.

Exemption or immunity from federal antitrust liability under McCarran-Ferguson Act (15 USCS §§ 1011-1013) and state action and Noerr-Pennington Doctrines for business of insurance and persons engaged in it, 116 A.L.R. Fed. 163.

CHAPTER 1

GENERAL PROVISIONS

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33-1-17. Special Insurance Fraud Fund.
33-1-18. Housing tax credit for qualified projects; rules and regulations.
33-1-19. Special Advisory Commission on Mandated Health Insurance Benefits [Repealed].
33-1-20. Health care sharing ministry.
33-1-21. Certain subscription agreements for prepaid air ambulance service not contract of insurance; definitions.
33-1-22. English language version of policy controls.
33-1-23. Establishment of exchange.
33-1-24. Insurance requirements for transportation network companies and their drivers.
33-1-25. Georgia Agribusiness and Rural Jobs Act.
33-1-26. Governor's request for waiver from federal Patient Protection and Affordable Care Act; expiration of authority.

33-1-1. Short title.

This title shall be known and may be cited as the "Georgia Insurance Code."

History. — Code 1933, § 56-101, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1965, p. 371, § 2.

Editor's notes. — Former Code 1933, § 56-115, enacted by Ga. L. 1960, p. 289, § 1, provided that the Georgia Insurance Code would become effective on January 1, 1961, except as otherwise expressly provided.

JUDICIAL DECISIONS

Section 7-1011(1), DeKalb County Code, a business license ordinance, is repealed by implication by the Georgia Insurance Code. Georgia Farm Bureau Mut. Ins. Co. v. DeKalb County, 167 Ga. App. 577, 306 S.E.2d 924 (1983) (on motion for rehearing).

Cited in Federated Mut. Implement & Hdwe. Ins. Co. v. Barker, 123 Ga. App. 259, 180 S.E.2d 559 (1971).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 2.

ALR. — Liability of insurance agent or broker on ground of inadequacy of liability-insurance coverage procured, 60 A.L.R.5th 165.

Waiver or estoppel of insurer on basis of statements or omissions in promotional, illustrative, or explanatory materials given to insured, 63 A.L.R.5th 427.

33-1-2. Definitions.

As used in this title, the term:

(1) "Commissioner of Insurance" or "Commissioner" means the Commissioner of Insurance of the State of Georgia.

(2) "Department of Insurance" or "department" means the Department of Insurance established by Code Section 33-2-1.

(3) "Health benefit policy," "health benefit plan," or other similar terms shall not include limited benefit insurance policies designed, advertised, and marketed to supplement major medical insurance such as accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other type of accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, or major medical insurance.

(4) "Insurance" means a contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies.

(5) "Insurer" means any person engaged as indemnitor, surety, or contractor who issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Burial associations, health care plans, and health maintenance organizations are insurers within the meaning of this title.

(6) "Natural person" means an individual human being and does not include any firm, partnership, association, corporation, or trust.

(7) "Person" means an individual, insurer, company, association, trade association, organization, society, reciprocal or interinsurance exchange, partnership, syndicate, business trust, corporation, Lloyd's association, and associations, groups, or department of underwriters, and any other legal entity.

(8) "Security," "security deposit," "special deposit," or "deposit," when used to refer to posted deposits required to be placed in the possession of the Commissioner, shall mean the actual physical evidence of a security, such as a certificate, or an entry made through the federal reserve book-entry system. The federal reserve book-entry system shall be limited in meaning to the computerized systems sponsored by the United States Department of Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in federal reserve banks through banks which are members of the Federal Reserve System or which otherwise have access to such computerized systems.

(9) "Transact," with respect to insurance, includes any of the following:

(A) Solicitation and inducement;

(B) Preliminary negotiations;

(C) Effectuation of a contract of insurance; or

(D) Transaction of matters subsequent to effectuation of the contract and arising out of it.

History. — Code 1933, §§ 56-102, 56-103, 56-104, 56-105, 56-106, 56-107, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 693, § 1; Ga. L. 1989, p. 1119, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2003, p. 387, § 1.1; Ga. L. 2003, p. 872, § 1; Ga. L. 2017, p. 164, § 3/HB 127; Ga. L. 2019, p. 337, § 1-1/SB 132.

The 2019 amendment, effective July 1, 2019, added paragraph (2); deleted former paragraph (3), which read: "'Insurance Department' or 'department' means the Insurance Department established by Code Section 33-2-1."; redesignated former paragraphs (1.1) through (6) as present paragraphs (3) through (9), respectively; and, in paragraph (3), substituted "terms shall not" for "terms do not", "CHAMPUS" for "Champus", and "medicare" for "Medicare".

Cross references. — Designation of Comptroller General as Insurance Commissioner, § 33-2-1. Investigation, adjustment, and litigation of claims as not constituting "transacting of insurance," § 33-3-2(b). Lending institutions being authorized to underwrite credit life and accident and sickness insurance, § 33-3-23.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1989, the definitions of "Insurance" and "Commissioner of Insurance" have been renumbered and "Commissioner of Insurance" has been substituted for "Insurance Commissioner" in two places in paragraph (1).

Law reviews. — For article discussing interpretation in Georgia of insurance policies containing evidentiary conditions, see 12 Ga. L. Rev. 783 (1978). For annual survey article on insurance law, see 49 Mercer L. Rev. 175 (1997).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions in this title, decisions under former Code 1933, § 56-901, repealed by Ga. L. 1960, p. 289, which, as amended, enacted this title, are included in the annotations for this section.

Purpose, effect, contents, and import determine if contract is "insurance." — Whether a contract is one of insurance is to be determined by its purpose, effect, contents, and import and not necessarily by the terminology used even though it contains declarations to the contrary. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935).

A contract to underwrite a hole-in-one give-away by indemnifying the sponsor of a golf tournament for the cost of the prize awarded for a hole-in-one on a particular hole was an "insurance" contract. Golf Mktg., Inc. v. Atlanta Classic Cars, Inc., 245 Ga. App. 720, 538 S.E.2d 809 (2000).

Loss need not be paid directly to contractee. — It is not essential that loss, damage, or expense indemnified against be paid to the contractee. The contract may constitute "insurance" if it is for his benefit and is a contract on which he, in case of breach, may assert a cause of action. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935).

Contract will be construed most favorably for contractee. — Where the contract is ambiguous on the question of whether it should be treated as having a value commensurate with the amount paid in or as securing to the holder the element of a life insurance policy, it should, under the proper rule of construction, be given a meaning most favorable to the holder and least favorable to the company on this question. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935).

Employer not "insurer." — In an action by a former employee to enforce an agreement by his former employer to pay the proceeds of a "key man" life insurance policy to the employee's estate, the trial court did not err in failing to charge on the definition of life insurance since the agreement was not a contract of life insurance and the employer was not an insurer. Primus Pharmaceuticals, Inc. v. Glovier, 215 Ga. App. 411, 450 S.E.2d 832 (1994).

Period of coverage. — Mere idea of retroactive insurance coverage defied common sense; according to O.C.G.A. § 33-1-2(2) (now paragraph (4)), insurance was a contract which was an integral part of a plan for distributing individual losses whereby one undertook to indemnify another or to pay a specified amount or benefits upon determinable contingencies. Coverage for an event that already occurred contravened the very definition of insurance; a reasonable person speaking with any insurance agent would not reasonably believe that an insurance agent has the authority to provide retroactive coverage. Rutland v. State Farm Mut. Auto. Ins. Co., 392 Fed. Appx. 721 (11th Cir. 2010) (Unpublished).

Selling memberships in automobile clubs was "insurance." — Based on the fact that selling memberships in automobile clubs was considered "insurance" under O.C.G.A. § 33-1-2(2) (now paragraph (4)) and application of the Federal Arbitration Act (FAA), 9 U.S.C. §§ 1-16, would impair O.C.G.A. § 9-9-2(c)(3), the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, preempted the FAA and prohibited enforcement of the parties' arbitration agreement. Love v. Money Tree, Inc., 279 Ga. 476, 614 S.E.2d 47 (2005).

Funeral service contracts held "insurance." — Under the evidence judge was authorized to find that contracts issued by defendant company amounted in substance and effect to policies of life insurance, and that company, in the issuance of such contracts, was doing a life insurance business contrary to the laws of this state, notwithstanding the contracts issued to the holders were called stock certificates and entitled the holders to stated mortuary service or merchandise on conditions prescribed by the charter and bylaws of the company. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935).

Where it was shown that in consideration of the initial and installment payments provided for by each contract the

defendants had agreed that so long as the contract remained of force they would render to the person to whom the contract was issued all of the services customarily rendered by undertakers or funeral directors, including hearse service, all necessary embalming, directing, and conducting of funerals, etc., within a radius of 25 road miles, and to sell at wholesale cost price (plus transportation charges only) caskets, burial clothes, etc., to any contract holder for use in the funeral of any member of his or her family or dependents, the evidence authorized the grant of an interlocutory injunction on the ground that the contracts issued by the company constituted policies of life insurance, and that the company, in the issuance of such contracts, was doing a life insurance business contrary to law. Clark v. Harrison, 182 Ga. 56, 184 S.E. 620 (1936); South Ga. Funeral Homes v. Harrison, 182 Ga. 60, 184 S.E. 875, later appeal, 183 Ga. 379, 188 S.E. 529 (1936).

Where undertaking business was executing contracts and issuing certificates to furnish funeral merchandise and funeral services upon death and purchasers were obligated to make installment payments, it was, for a consideration, assuming an obligation to be performed upon the death of the purchaser, namely, to furnish the goods and render the stipulated service, and the business was to be characterized as a life insurance business within the meaning of Ga. L. 1937, p. 702 (now repealed), and was subject to the legal regulatory provisions relating to life insurance generally. Harrison v. Tanner-Poindexter Co., 187 Ga. 678, 1 S.E.2d 646 (1939).

Only "insurer" is liable for penalties for refusing to pay. — Former Code 1933, § 56-1206 (see O.C.G.A. § 33-4-6(a)) applies only to an "insurer" as defined by paragraph (4) (see now paragraph (5)) of this section. McGhee v. Kroger Co., 150 Ga. App. 291, 257 S.E.2d 361 (1979).

Individual agent not insurer. — Defendant could not be considered an "insurer" where defendant was allegedly acting falsely as an individual insurance agent, not as an entity issuing contracts of insurance to insureds, and in any event, no insurance contract was ever consummated. Gilbert v. Van Ord, 203 Ga. App. 660, 417 S.E.2d 390, cert. denied, 203 Ga. App. 906, 417 S.E.2d 390 (1992), cert. denied, 203 Ga. App. 906, 417 S.E.2d 390 (1992).

Arbitration agreements. — O.C.G.A. § 9-9-2(c)(3) invalidates arbitration agreements in insurance contracts as defined in O.C.G.A. § 33-1-2, with the exception that it does not prohibit enforcement of arbitration agreements in contracts between insurance companies; simply stated, in Georgia a contract of insurance is not subject to arbitration unless the contract is between insurance companies. Davis v. Zurich Am. Ins. Co. (In re TFI Enters.), No. 05-40683 RFH, 2008 Bankr. LEXIS 1059 (Bankr. M.D. Ga. Apr. 9, 2008).

Employer is not liable under statute penalizing workers' compensation insurer. — Where an employer is not an "insurer" as defined by paragraph (4) of this section, it cannot be held liable for penalty and attorney fees provided for under former Code 1933, § 56-1206 (see O.C.G.A. § 33-4-6(a)), covering workers' compensation insurer's initial failure to pay employee's indebtedness to a hospital. McGhee v. Kroger Co., 150 Ga. App. 291, 257 S.E.2d 361 (1979).

United States deemed "person." — The United States is a "person" within the meaning of O.C.G.A. § 33-36-3(2)(F) (see O.C.G.A. § 33-36-3(10)). United States v. Rutland, Inc., 849 F. Supp. 806 (S.D. Ga. 1994), aff'd, 46 F.3d 71 (11th Cir. 1995).

"Person" does not include state or its agencies. — Since the definition of "person" in paragraph (5) of this Code section does not specifically include the state or its agencies, the Insurance Code does not apply to the board of regents. Board of Regents v. Tyson, 261 Ga. 368, 404 S.E.2d 557 (1991).

County deemed "person." — A county is a "legal entity" within the meaning of paragraph (5) (now paragraph (7)) of this Code section and is, therefore, a "person" within the meaning of this Code section and of O.C.G.A. § 33-36-3(2)(F) (see O.C.G.A. § 33-36-3(10)). As a "person," if its stipulated net worth is more than $1 (now $3) million, its claim is not covered

by the Georgia Insurers Insolvency Pool Act. Georgia Insurers Insolvency Pool v. Elbert County, 258 Ga. 317, 368 S.E.2d 500 (1988).

Employee had no authority to offer retroactive coverage. — When an insured was in a car crash after an insurer canceled the policy for failing to pay the premium and an insurance employee allegedly told the insured that the insurer would provide retroactive coverage for the crash if the insured paid the past-due amount, the insurer had no duty to defend the insured because, inter alia, the insurance employee did not have the actual or apparent authority to bind the insurer to retroactive coverage of the crash. Rutland v. State Farm Mut. Auto. Ins. Co., 426 Fed. Appx. 771 (11th Cir. 2011) (Unpublished).

When foreign law governs. — Where money contracts are valid in the state where they are made and to be performed, the laws of that state shall govern the obligation, even though it is a usurious one under Georgia law. Commercial Credit Plan, Inc. v. Parker, 152 Ga. App. 409, 263 S.E.2d 220 (1979).

What statute of limitations applies to insurance. — Insurance is a matter of contract, the applicable statute of limitations on a simple contract being six years. Smith v. State Farm Mut. Auto. Ins. Co., 152 Ga. App. 825, 264 S.E.2d 296 (1979), rev'd on other grounds, 245 Ga. 654, 266 S.E.2d 505 (1980).

Insurance law not applicable to suretyship contract. — Insurance law was not applicable in a case involving liability under a suretyship contract. American Mfg. Mut. Ins. Co. v. Tison Hog Mkt., Inc., 182 F.3d 1284 (11th Cir. 1999), cert. denied, 531 U.S. 819, 121 S. Ct. 59, 148 L. Ed. 2d 26 (2000).

Cited in Bentley v. Allstate Ins. Co., 227 Ga. 708, 182 S.E.2d 770 (1971); Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972); Olukoya v. American Ass'n of Cab Cos., 219 Ga. App. 508, 465 S.E.2d 715 (1995); Villa Sonoma at Perimeter Summit Condo. Ass'n v. Commercial Indus. Bldg. Owners Alliance, Inc., 349 Ga. App. 666, 824 S.E.2d 738 (2019).

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Assumption or distribution of risk is essential of "insurance." — The assumption of or the actuarial distribution of a loss risk is an essential ingredient in any contract of "insurance." 1972 Op. Att'y Gen. No. 72-62.

Contract to provide burial space for cemetery lot purchaser's children held "insurance." — Where a private company engaged in the business of maintaining a cemetery and selling cemetery lots gives to each purchaser a supplemental written agreement to the effect that if any one or more of purchaser's unmarried children between the ages of one and 19 die, then the cemetery company will furnish without cost such space or spaces for interment of the deceased child or children, provided that at that time no installment payments on the lot purchase agreement are in arrears, the contract is a contract of insurance, and such a contract may not be lawfully made by a concern which is not licensed to engage in the life insurance business, in view of former Code 1933, § 56-9901 (see O.C.G.A. § 33-24-43). 1963-65 Op. Att'y Gen. p. 367.

Contract to furnish tuition grant to student on sponsor's death held "life insurance." — Where a college, in consideration of monthly payments pursuant to an agreement with a student and a sponsor, assumes the obligation of furnishing a 100 percent tuition grant and refunding all moneys paid, to be performed upon the death of the sponsor, the contract constitutes a contract of life insurance. Such an obligation is one to pay a sum of money as well as to furnish a thing of value, and it is immaterial whether the cost or value of such an undertaking on the part of the college is more or less than the consideration flowing to it. 1963-65 Op. Att'y Gen. p. 367.

Cancellation of debt on death of debtor held "insurance." — An agreement to cancel a debt in the event of the death of the debtor is insurance. 1967 Op. Att'y Gen. No. 67-170.

Contract to waive installment payments upon borrower's loss of employment held insurance. — A contract between a borrower and a lender to waive installment payments upon the borrower's loss of employment would amount to the conducting of the business of insurance under Georgia law if there is a distribution of risk among the various borrowers. 1990 Op. Att'y Gen. No. 90-28.

National bank must comply with title if it enters into cancellation agreement. — A national bank operating in Georgia may not enter into a debt cancellation contract providing that the debt will be automatically cancelled in the event of the borrower's death without complying with this title. 1963-65 Op. Att'y Gen. p. 457.

Credit union may not guarantee or insure loans and deposits. — Although there is no cost to the insureds, an agreement by a credit union to indemnify or pay to another a certain sum in the event of certain determinable contingencies would constitute a contract of insurance; a credit union has no power or authority to legally act as a guarantor or insurer of loans and deposits of the credit union. 1967 Op. Att'y Gen. No. 67-170.

Agreement to repair or replace eyeglasses held "insurance." — An eyeglass agreement which provides that the issuer will make any repairs to damaged or broken glasses, provided that the patient pays a small replacement fee, amounts to a contract of "insurance" within the meaning of this section; moreover, the stipulation of an unreasonably low replacement fee in the eyeglass agreement could result in a contract of "insurance." 1972 Op. Att'y Gen. No. 72-62.

Prepaid legal service plan held "insurance." — Where a prepaid legal service plan, which has been brought to the attention of the Insurance Department, has been submitted by an institution which is apparently operated on a profit-making basis and which has prior experience in the insurance industry and includes a proposed "policy" which incorporates a schedule of benefits providing for such services as will drafting, general counseling, defense representation in criminal and certain civil cases, and representation in adoption, divorce, and bankruptcy proceedings and does not appear to contemplate contractual relations between the offering company and attorneys but rather, attorneys would be retained by the "policy holders" and would be in no way answerable to or subject to any instructions of the "issuer," except instructions with regard to procedure to be followed in filing claims, and under the terms of the "policy" the "insured" could receive maximum benefits many times greater than the sum of his monthly premiums, it constitutes "insurance." 1974 Op. Att'y Gen. No. 74-48. (See O.C.G.A. §§ 33-35-1 through 33-35-23).

Automobile club held to offer "insurance." — An automobile or motor club whose members are entitled to benefits including, but not limited to, emergency road service, reimbursement for attorney's fees, arrest and bail bonds, reimbursement for personal expenses such as food, lodging, car rental, etc., is offering a contract of indemnity against expenses resulting from a member's ownership, maintenance, or use of an automobile and hence is offering "insurance" within the definition of this section. 1976 Op. Att'y Gen. No. 76-59.

Contract whereby tire dealer and sponsoring company agree with tire purchaser to replace tire under certain conditions constitutes offering of insurance. 1982 Op. Att'y Gen. No. 82-75.

Dental discount plan not within definition of "insurance." — A dental discount plan offered as part of a membership package made available to employers, which does not involve the distribution of risks, is not within the definition of "insurance," as where payments by plan members at least approximate the dentists' actual costs in providing the specific services performed. 1989 Op. Att'y Gen. No. 89-12.

Corporate guarantee for subsidiary's liability. — Issuance by a parent corporation of a guarantee for its subsidiary's liability for hazardous waste treatment, storage or disposal facilities would not constitute engaging in the business of insurance. 1986 Op. Att'y Gen. No. 86-35.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 1 et seq., 250.

C.J.S. — 44 C.J.S., Insurance, § 1 et seq.

ALR. — Full faith and credit provision as affecting insurance contracts, 41 A.L.R. 1386; 114 A.L.R. 250; 119 A.L.R. 483; 173 A.L.R. 1138.

Meaning of term "solicit" in statute relating to insurance agents, 48 A.L.R. 1173.

What constitutes insurance, 63 A.L.R. 711; 100 A.L.R. 1449; 119 A.L.R. 1241.

Undertaking to defend suit or furnish legal services in certain future contingencies as insurance, 71 A.L.R. 695.

Construction and application of "key man" life insurance, 12 A.L.R.7th 6.

33-1-3. Application of title to fraternal benefit societies and farmers' mutual fire insurance companies.

Reserved. Repealed by Ga. L. 2019, p. 337, § 1-2/SB 132, effective July 1, 2019.

Editor's notes. — This Code section was based on Ga. L. 1960, p. 289, § 1; Ga. L. 1977, p. 1229, § 1; Ga. L. 2017, p. 164, § 4/HB 127.

33-1-4. Use of existing forms and filings.

Every form of insurance document and every rate or other filing lawfully in use immediately prior to January 1, 1961, may continue to be so used or be effective until the Commissioner otherwise prescribes in accordance with this title, except that, before the expiration of one year from and after January 1, 1961, neither this title nor the Commissioner shall prohibit the use of any such document, rate, or filing because of any power, prohibition, or requirement contained in this title which did not exist under laws in force immediately prior to January 1, 1961.

History. — Code 1933, § 56-110, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

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Cited in Thompson v. Metropolitan Life Ins. Co., 115 Ga. App. 724, 155 S.E.2d 728 (1967).

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Charter must be amended if it did not authorize participation policies. — A Georgia stock insurance company chartered after 1950 but before the adoption of the present provisions of this title must amend its charter in order to issue participating policies, if no reference is made to such policies in the charter. 1965-66 Op. Att'y Gen. No. 66-51.

33-1-5. Provisions of title relating to particular matters to prevail over general provisions.

Provisions of this title relating to a particular kind of insurance or to a particular type of insurer or to a particular matter prevail over provisions relating to insurance in general or to insurers in general.

History. — Code 1933, § 56-113, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Thompson v. Metropolitan Life Ins. Co., 115 Ga. App. 724, 155 S.E.2d 728 (1967); Kirkpatrick v. Mackey, 162 Ga. App. 876, 293 S.E.2d 461 (1982).

33-1-6. Requirements for action as insurer generally.

No person shall act as an insurer as defined in Code Section 33-1-2 in this state without complying with the applicable provisions of this title.

History. — Code 1933, § 56-109, enacted by Ga. L. 1960, p. 289, § 1.

33-1-7. Issuance or delivery of policy in violation of title.

Any insurer, or any officer or agent thereof, issuing or delivering to any person in this state any policy in violation of any provision of this title shall be guilty of a misdemeanor, except as otherwise provided.

History. — Code 1933, § 56-9907, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-3/SB 132.

The 2019 amendment, effective July 1, 2019, added ", except as otherwise provided" at the end of this Code section.

33-1-8. Making of false statements; reporting of such statements.

Any director, officer, agent, or employee of any insurance company who willfully and knowingly subscribes, makes, or concurs in making any annual or other statement required by law containing any material statement which is false shall be guilty of a misdemeanor. It shall be the duty of the Commissioner to report all such misrepresentations and false statements to the appropriate prosecuting attorney of the circuit or county in which they shall occur, except as otherwise provided.

History. — Code 1933, § 56-9908, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-4/SB 132.

The 2019 amendment, effective July 1, 2019, in the second sentence, substituted "appropriate prosecuting attorney" for "district attorney" and added ", except as otherwise provided" at the end.

33-1-9. Insurance fraud; venue; penalty; exemption.

(a) Any natural person who knowingly or willfully:

(1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:

(A) In any written statement or certificate;

(B) In the filing of a claim;

(C) In the making of an application for a policy of insurance;

(D) In the receiving of such an application for a policy of insurance; or

(E) In the receiving of money for such application for a policy of insurance

for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

(2) Receives money for the purpose of purchasing insurance and converts such money to such person's own benefit;

(3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or

(4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer

commits the crime of insurance fraud.

(b) Any natural person who knowingly and willfully or with reckless disregard engages in the following activities, either directly or indirectly, as an agent for, as a representative of, or on behalf of an insurer not authorized to transact insurance in this state commits the crime of insurance fraud:

(1) Soliciting, negotiating, procuring, or effectuating insurance or annuity contracts or renewals thereof;

(2) Soliciting, negotiating, procuring, or effectuating any contract relating to benefits or services;

(3) Disseminating information as to coverage or rates;

(4) Forwarding applications;

(5) Delivering policies or contracts;

(6) Inspecting or assessing risk;

(7) Fixing of rates;

(8) Investigating or adjusting claims or losses;

(9) Collecting or forwarding of premiums; or

(10) In any other manner representing or assisting such an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state.

(c) Any natural person who knowingly and willfully with intent to defraud subscribes, makes, or concurs in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false commits the crime of insurance fraud.

(d) In any prosecution under this Code section, the crime shall be considered as having been committed in the county of the purported loss, in the county in which the insurer or the insurer's agent received the fraudulent or false claim or application, in the county in which money was received for the fraudulent application, or in any county where any act in furtherance of the criminal scheme was committed.

(e) A natural person convicted of a violation of this Code section shall be guilty of a felony and shall be punished by imprisonment for not less than two nor more than ten years, or by a fine of not more than $10,000.00, or both.

(f) Subsection (b) of this Code section shall not apply to a contract of insurance entered into in accordance with Article 2 of Chapter 5 of this title.

History. — Code 1933, § 56-9910, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1985, p. 723, § 1; Ga. L. 1991, p. 1608, § 1.1; Ga. L. 1997, p. 1296, § 1; Ga. L. 1998, p. 1064, § 1; Ga. L. 2003, p. 387, § 1.2; Ga. L. 2003, p. 641, § 1; Ga. L. 2004, p. 754, § 1A.

Cross references. — Fraud generally, § 16-9-50 et seq.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "Commissioner" was substituted for "commission" in subsection (c).

Editor's notes. — Ga. L. 1998, p. 1064, § 12, not codified by the General Assembly, provides that the 1998 amendment to this Code section applies to offenses committed on or after July 1, 1998, and shall not apply to or affect conduct or offenses committed prior to July 1, 1998.

Law reviews. — For review of 1998 legislation relating to insurance, see 15 Ga. St. U.L. Rev. 153 (1998).

For note on 1991 amendment of this Code section, see 8 Ga. St. U.L. Rev. 99 (1992).

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Venue for staged accidents. — Because a staged wreck was clearly an act in furtherance of a criminal scheme, venue was proper in the county where the wreck occurred. Callaway v. State, 247 Ga. App. 310, 542 S.E.2d 596 (2000).

When the defendant, an attorney, knew that the client had received approxi-

mately $15,000 at closing, but told the client's insurer that the client had not been paid for the sale of the property, because the indictment specifically charged the defendant with violating the insurance fraud statute; and the indictment further indicated, tracking the statute's own language, that the fraudulent misrepresentation was the statement of the client that the client had suffered a loss of $117,849.82, the indictment was sufficient to withstand a general demurrer. Sallee v. State, 329 Ga. App. 612, 765 S.E.2d 758 (2014), cert. denied, 136 S. Ct. 199, 193 L. Ed. 2d 128 (U.S. 2015).

Evidence sufficient for conviction. — Callaway v. State, 247 Ga. App. 310, 542 S.E.2d 596 (2000).

Evidence sufficient to convict attorney for role in insurance scheme. — Evidence was sufficient to convict the defendant of insurance fraud as the defendant, an attorney, aided the client in making a false or fraudulent written statement for the purpose of procuring or attempting to procure the payment of a false claim because, even though the defendant knew that the client's loan on the property had been paid off on August 4, 2006, at the closing, the defendant nonetheless filed the client's signed proof of loss statement with the client's insurer on December 8, 2008, in which the client falsely claimed a loss of approximately $118,000 under the insurance policy. Sallee v. State, 329 Ga. App. 612, 765 S.E.2d 758 (2014), cert. denied, 136 S. Ct. 199, 193 L. Ed. 2d 128 (U.S. 2015).

Sentencing for violations. — Defendant was properly sentenced to separate terms for insurance fraud violations committed by several coconspirators; each fraudulent claim made was a separate offense and did not merge under O.C.G.A. § 16-1-7. Crowder v. State, 222 Ga. App. 351, 474 S.E.2d 246 (1996).

Cited in Dover v. State, 192 Ga. App. 429, 385 S.E.2d 417 (1989); McClellan v. Evans, 294 Ga. App. 595, 669 S.E.2d 554 (2008).

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Dentist violation for filing claim for insurance payment while waiving patient's copayment. — A dentist who files a claim for third party payment in which the dentist asserts a certain fee charged, when in fact the dentist has waived or intends to waive the patient's copayment for the service, without full disclosure to the third party insurer that such waiver has or will be taking place, may be subject to disciplinary action by the Georgia Board of Dentistry under O.C.G.A. § 43-11-47(a)(2) and may be guilty of a violation of O.C.G.A. § 33-1-9. 1983 Op. Att'y Gen. No. 83-25.

RESEARCH REFERENCES

ALR. — Criminal offense of obtaining money under false pretenses, or attempting to do so, predicated upon receipt or claim of benefits under insurance policy, 135 A.L.R. 1157.

Insured's cooperation with claimant in establishing valid claim against insurer as breach of cooperation clause, 8 A.L.R.3d 1345.

When does the statute of limitations begin to run in action under the False Claims Act (31 USCS §§ 3729-3733), 139 A.L.R. Fed 645.

33-1-9.1. Crimes of staging a collision or filing a fraudulent claim; penalty.

(a) A person shall be guilty of the crime of staging a collision when, with intent to commit insurance fraud as defined in Code Section 33-1-9, such person does any of the following:

(1) Intentionally causes or attempts to cause a motor vehicle collision; or

(2) Engages in a scheme to fabricate evidence of a motor vehicle collision that did not occur.

Staging a collision shall constitute a felony punishable by no less than one year nor more than five years imprisonment.

(b) A person shall be guilty of the crime of aggravated staging of a collision when, with intent to commit insurance fraud as defined in Code Section 33-1-9, such person commits acts in violation of subsection (a) of this Code section which result in serious personal injury to another. Aggravated staging of a collision shall constitute a felony punishable by no less than two years nor more than ten years imprisonment.

(c) A person shall be guilty of the crime of making a fraudulent claim related to a staged collision when such person makes, or assists in making, a claim for insurance benefits of any type or brings, or assists in bringing, a civil lawsuit against another seeking monetary damages with knowledge that the injuries for which insurance benefits or monetary damages are sought resulted from a staged collision, or seeks to obtain any benefit to which such claimant is not legally entitled. Making a fraudulent claim related to a staged collision shall constitute a felony and shall be punishable by no less than one year nor more than five years imprisonment.

History. — Code 1981, § 33-1-9.1, enacted by Ga. L. 2019, p. 147, § 1/HB 353; Ga. L. 2020, p. 493, § 33/SB 429.

Effective date. — This Code section became effective April 25, 2019.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (a).

RESEARCH REFERENCES

C.J.S. — 46 C.J.S., Insurance, § 1468 et seq.

33-1-10. Limitations upon right to choose funeral services for insured.

It shall be unlawful for any insurer to designate in any policy, contract, certificate, or otherwise the person, firm, or corporation to conduct the funeral of the insured; or to organize, promote, or operate any enterprise or plan; or to enter into any contract with such insured or with any other person, which plan or contract tends to limit or restrict the freedom of choice in the open market of the person or persons having the legal right of such choice regarding contracts,

purchases, and arrangements with reference to any part of a funeral service for such insured.

History. — Code 1933, § 56-9902, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 136, § 33.

Cross references. — Declaration that contracts in general restraint of trade are contrary to public policy, § 13-8-2. Funeral directors, and embalmers, T. 43, C. 18.

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions rendered under Ga. L. 1935, p. 392 are included in the annotations for this Code section.

Policies designating funeral director or restricting purchase of services may not be sold. — A licensed or unlicensed insurance company or agent may not sell policies which designate the person to conduct the funeral of the insured, restrict the right to purchase funeral services in the open market, or provide for payment in funeral services, merchandise, or other than legal tender of the United States. 1945-47 Op. Att'y Gen. p. 366 (rendered under Ga. L. 1935, p. 392).

RESEARCH REFERENCES

ALR. — Construction and effect of contracts or insurance policies providing preneed coverage of burial expense or services, 67 A.L.R.4th 36.

33-1-11. Entry into contracts by life insurers with funeral directors or undertakers for conduct of funerals of persons insured.

It shall be unlawful for any insurer writing any type of life insurance, by whatever term described, upon the lives of citizens of this state to enter into any contract with any funeral director or undertaker, providing that such funeral director or undertaker shall conduct the funeral of persons insured by such insurer.

History. — Code 1933, § 56-9904, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Funeral directors, and embalmers, T. 43, C. 18.

RESEARCH REFERENCES

ALR. — Construction and effect of contracts or insurance policies providing pre-need coverage of burial expense or services, 67 A.L.R.4th 36.

33-1-12. Entry into contracts by life insurers for provision of funeral merchandise or services to persons insured.

It shall be unlawful for any insurer writing any type of life insurance upon the lives of citizens of this state to enter into any contract with any citizen of this state contracting and agreeing to furnish funeral merchandise or services upon the death of any person insured.

History. — Code 1933, § 56-9905, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Funeral directors, and embalmers, T. 43, C. 18.

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Preneed funeral service contract. — A three-party transaction between the plaintiffs, a funeral home, and an insurance company involved in a preneed funeral service contract as defined in paragraph (6) of former O.C.G.A. § 43-18-92, where plaintiffs each purchased from the insurer a single premium annuity policy with a death benefit, then executed a document purporting to be an irrevocable assignment of the policy to the funeral home and in consideration of that assignment, the funeral home agreed to provide burial services for plaintiffs, was revocable as a matter of law. Johnson v. Morris, 186 Ga. App. 522, 367 S.E.2d 841 (1988).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions decided under former Ga. L. 1935, p. 392 are included in the annotations for this Code section.

Policies providing for furnishing funeral services may not be sold. — A licensed or unlicensed insurance company or agent may not sell policies which designate the person to conduct the funeral of the insured, restrict the right to purchase funeral services in the open market, or provide for payment in funeral services, merchandise, or other than legal tender of the United States. 1945-47 Op. Att'y Gen. p. 366 (rendered under Ga. L. 1935, p. 392).

Burial supplies and equipment. — Personal property sold in advance of need as a device for the burial of human remains and which functions both as a burial casket and underground burial vault, but which cannot be used to encase a casket, such as the "chapel vault system," is one of the articles classified as burial supplies and equipment by former O.C.G.A. § 43-18-92. 1989 Op. Att'y Gen. 89-43.

33-1-13. Receiving of compensation from undertakers on account of employment; giving of compensation by undertakers.

No person, firm, or corporation engaged in the life insurance business shall contract for or receive any compensation or gratuity, directly or indirectly, on account of the employment of any undertaker in connection with a burial or preparation for burial of any person whose life is insured by said company; and no undertaker shall give or agree to give any such compensation or commission to such person, firm, or corporation engaged in the insurance business.

History. — Ga. L. 1933, p. 186, § 1; Code 1933, § 56-9907; Code 1933, § 56-9903, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-5/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "or the industrial life insurance business" following "life insurance business" near the beginning.

Cross references. — Funeral directors, and embalmers, T. 43, C. 18.

JUDICIAL DECISIONS

Undertakers entitled to enjoin insurance company without seeking administrative relief. — Where the plaintiffs were engaged in the undertaking business and were suffering special injury from the alleged illegal acts of the defendant insurance company in issuing burial policies naming a certain firm as undertakers and receiving commissions from this firm in violation of this section, the plaintiffs were entitled to maintain the suit for injunction in their own names, without first seeking relief from the Insurance Commissioner, and without abiding the action of this or any other officer in behalf of the state. Blackmon v. Gulf Life Ins. Co., 179 Ga. 343, 175 S.E. 798 (1934).

33-1-14. Regulation of certain persons providing coverage for medical or dental services.

(a) Notwithstanding any other provision of law and except as provided in this Code section, any person, other than an authorized insurer, the state and its instrumentalities, or political subdivisions of the state and their instrumentalities, who provides coverage in this state for medical, surgical, chiropractic, physical therapy, optometry, speech pathology, podiatry, audiology, psychology, pharmaceutical, dental, or hospital services, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Department of Insurance, unless the person shows that, while providing coverage for such services, such person is subject to the jurisdiction of an insurance supervisory official of another state or specifically subject to the exclusive jurisdiction of the federal government.

(b) Any person may show that such person is subject to the jurisdiction of an insurance supervisory official of another state or specifically subject to the exclusive jurisdiction of the federal government by providing to the Commissioner the appropriate certificate, license, or document, issued by the insurance supervisory official of another state or specifically issued to such person by an appropriate official or agency of the federal government which permits such person to provide such coverages.

(c) Any such person who is unable to show under subsection (b) of this Code section that such person is subject to the jurisdiction of an insurance supervisory official of another state or specifically subject to the exclusive jurisdiction of the federal government shall submit to an examination by the Commissioner to determine the organization and solvency of the person and to determine whether or not such person complies with the applicable provisions of this title.

(d) Any person unable to show under subsection (b) of this Code section that such person is subject to the jurisdiction of an insurance supervisory official of another state or specifically subject to the

exclusive jurisdiction of the federal government shall be subject to all appropriate provisions of this title regarding the conduct of such person's business.

(e)(1) Any production agency or administrator which advertises, sells, transacts, or administers the coverage in this state described in subsection (a) of this Code section and which is required to submit to an examination by the Commissioner under subsection (c) of this Code section shall, if said coverage is not fully insured or otherwise fully covered by an authorized insurer, advise every purchaser, prospective purchaser, and covered person of such lack of insurance or other coverage.

(2) Any administrator which advertises or administers the coverage in this state described in subsection (a) of this Code section and which is required to submit to an examination by the Commissioner under subsection (c) of this Code section shall advise any production agency of the elements of the coverage, including the amount of "stop-loss" insurance in effect.

(f) As used in this Code section, the term "authorized insurer" means any insurer authorized to sell accident and sickness policies, subscriber contracts, certificates, or agreements of any form under Chapter 15, 20, 21, 29, or 30 of this title.

History. — Code 1981, § 33-1-14, enacted by Ga. L. 1985, p. 723, § 2; Ga. L. 1987, p. 3, § 33; Ga. L. 2019, p. 337, § 1-6/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in the middle of subsection (a); and deleted "18, 19," following "Chapter 15," at the end of subsection (f).

33-1-15. Affidavit that insured's motor vehicle stolen.

(a) In any case where an insured has executed an affidavit affirming that such insured's motor vehicle has been stolen, the insurer shall be required to accept by-hand delivery of such affidavit from such insured.

(b) It shall be unlawful for any person who executes the affidavit provided for in subsection (a) of this Code section knowing that it purports to be an acknowledgment of a lawful oath or affirmation to hand deliver such affidavit if such person knowingly and willfully made a false statement in such affidavit.

(c) Any person who violates subsection (b) of this Code section shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than one nor more than five years or by a fine of not more than $10,000.00, or both.

History. — Code 1981, § 33-1-15, enacted by Ga. L. 1989, p. 328, § 1.

33-1-16. Investigation of fraudulent insurance act; collection of evidence; immunity from liability; public inspection; enforcement.

(a) For the purposes of this Code section, a person commits a "fraudulent insurance act" if he:

(1) Knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy, or a claim for payment or other benefit pursuant to an insurance policy, which he knows to contain materially false information concerning any fact material thereto or if he conceals, for the purpose of misleading another, information concerning any fact material thereto; or

(2) Knowingly and willfully transacts any contract, agreement, or instrument which violates this title.

(b) If, by his own inquiries or as a result of information received, the Commissioner has reason to believe that a person has engaged in, or is engaging in, a fraudulent insurance act, the Commissioner may administer oaths and affirmations, request the attendance of witnesses or proffering of matter, and collect evidence. The Commissioner shall not compel the attendance of any person or matter in any such investigation except pursuant to subsection (d) of this Code section.

(c) If matter that the Commissioner seeks to obtain by request is located outside the state, the person so requested may make it available to the Commissioner or his representative to examine the matter at the place where it is located. The Commissioner may designate representatives, including officials of the state in which the matter is located, to inspect the matter on his behalf, and he may respond to similar requests from officials of other states.

(d)(1) The Commissioner may request that an individual who refuses to comply with any such request be ordered by the superior court to provide the testimony or matter. The court shall not order such compliance unless the Commissioner has demonstrated to the satisfaction of the court that the testimony of the witness or the matter under request has a direct bearing on the commission of a fraudulent insurance act or is pertinent or necessary to further such investigation.

(2) Except in a prosecution for perjury, an individual who complies with a court order to provide testimony or matter after asserting a privilege against self-incrimination, to which he is entitled by law,

may not be subjected to a criminal proceeding or to a civil penalty with respect to the act concerning which he is required to testify or produce relevant matter.

(3) In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports, without malice, or furnishing other information, without malice, required by this Code section or required by the Commissioner under the authority granted in this Code section, and no civil cause of action of any nature shall arise against such person:

(A) For any information relating to suspected fraudulent insurance acts furnished to or received from law enforcement officials, their agents, or employees;

(B) For any such information relating to suspected fraudulent insurance acts furnished to or received from other persons subject to the provisions of this title; or

(C) For any such information furnished in reports to the Commissioner or the National Association of Insurance Commissioners.

(4) The Commissioner or any employee or agent is not subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature exists against such persons by virtue of the execution of activities or duties of the Commissioner under this Code section or by virtue of the publication of any report or bulletin related to the activities or duties of the Commissioner under this Code section.

(5) This Code section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

(e) The papers, documents, reports, or evidence relative to the subject of an investigation under this Code section shall not be subject to public inspection for so long as the Commissioner deems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to be in the public interest. Further, such papers, documents, reports, or evidence relative to the subject of an investigation under this Code section shall not be subject to subpoena until opened for public inspection by the Commissioner, unless the Commissioner consents, or until, after notice to the Commissioner and a hearing, a superior court determines the Commissioner would not be unnecessarily hindered by such subpoena. The Commissioner or his employees or agents shall not be subject to subpoena in civil actions by any court of this state to testify concerning any matter of which they have knowledge pursuant to pending investigations of fraudulent insurance acts.

(f) Any person, other than an insurer, agent, or other person licensed under this title, or an employee thereof, having knowledge of or who believes that a fraudulent insurance act is being or has been committed may send to the Commissioner a report of information pertinent to such knowledge of or belief and such additional information relative thereto as the Commissioner may request. Any insurer, agent, or other person licensed under this title, or an employee thereof, having knowledge of or who believes that a fraudulent insurance act is being or has been committed shall send to the Commissioner a report or information pertinent to such knowledge or belief and such additional information relative thereto as the Commissioner or his employees or agents may require. The Commissioner or his employees or agents shall review such information or reports as, in the judgment of the Commissioner or such employees or agents, may require further investigation. The Commissioner shall then cause an investigation of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent insurance act is being committed and shall report any alleged violations of law which the investigations disclose to the appropriate prosecuting attorney having jurisdiction with respect to any such violation. If prosecution by the prosecuting attorney is not begun within 90 days of the report, the prosecuting attorney shall inform the Commissioner of the reasons for the lack of prosecution.

(g) Notwithstanding the provisions of subsection (f) of this Code section, when an insurer or an insured knows or has reasonable grounds to believe that a person committed a fraudulent insurance act and which the insurer reasonably believes not to have been reported to a law enforcement agency in this state, then, for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf or the insured may notify such law enforcement agency of such knowledge or reasonable belief and provide such information relevant to the fraudulent insurance act, including, but not limited to, insurance policy information, including the application for insurance; policy premium payment records; history of previous claims made by the insured; and other information relating to the investigation of the claim, including statements of any person, proofs of loss, and notice of loss. In the absence of fraud or bad faith, no insurer or agent authorized by an insurer to act on its behalf, law enforcement agency, or their respective employees or an insured shall be subject to any civil liability for libel, slander, or related cause of action by virtue of filing reports or for releasing or receiving any information pursuant to this subsection. For the purposes of this Code section, the term "law enforcement agency" shall mean and include any federal, state, county, or consolidated police or law enforcement department and any prosecuting official of the federal, state, county, local, or consolidated government. For the purposes of this Code section, the term "insured" shall

mean and include any person who is a named insured or beneficiary under a policy or contract of insurance or a person who is not a named insured or beneficiary under a policy or contract of insurance due to the fraudulent action of another but who in good faith believes himself to be such an insured or beneficiary.

(h) Personnel employed by the Commissioner under this Code section shall have the power to make arrests for criminal violations established as a result of investigations only. The general laws applicable to arrests by peace officers of this state shall also be applicable to such personnel. Such personnel shall have the power to execute arrest warrants and search warrants for the same criminal violations; to serve subpoenas issued for the examination, investigation, and trial of all offenses determined by their investigations; and to arrest upon probable cause without warrant any person found in the act of violating any of the provisions of applicable laws. Personnel empowered to make arrests under this Code section shall be empowered to carry firearms or other weapons in the performance of their duties. It is unlawful for any person to resist an arrest authorized by this Code section or in any manner to interfere, either by abetting or assisting such resistance or otherwise interfering, with personnel employed by the Commissioner under this Code section in the duties imposed upon them by law.

History. — Code 1981, § 33-1-16, enacted by Ga. L. 1990, p. 1477, § 1; Ga. L. 1991, p. 1608, §§ 1.2, 1.3.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, "he" was substituted for "the" at the end of the introductory language in subsection (a) and a comma was deleted following "agent" near the beginning of paragraph (4) of subsection (d).

Law reviews. — For note on 1991 amendment of this Code section, see 8 Ga. St. U.L. Rev. 99 (1992).

JUDICIAL DECISIONS

Cited in Nat'l Viatical, Inc. v. State, 258 Ga. App. 408, 574 S.E.2d 337 (2002).

33-1-17. Special Insurance Fraud Fund.

(a) The General Assembly finds that the proper and expeditious investigation and prosecution of fraudulent insurance acts are beneficial to the public interest. The General Assembly further finds that proper investigation of fraudulent insurance acts, followed by vigorous prosecution of insurance fraud, will bring about lower insurance rates for the citizens of this state.

(b) There is created a Special Insurance Fraud Fund for the purpose of funding the investigation and prosecution of insurance fraud.

(c)(1) The Commissioner shall prepare, on an annual basis, a separate budget request to the General Assembly which sets forth the

anticipated cost and expense of funding the investigation and prosecution of insurance fraud in this state for the ensuing 12 months. Such budget request shall set forth the annual cost and expense of the investigation and prosecution of insurance fraud in Georgia for the preceding 12 months.

(2) There is imposed upon each foreign, alien, and domestic insurance company doing business in the state an annual assessment under a formula to be established by regulation promulgated by the Commissioner. The formula shall be calculated such that the total proceeds paid or collected from such assessments for any year shall not exceed the amounts appropriated by the General Assembly pursuant to paragraph (3) of this subsection, which appropriation shall be based upon the budget request setting forth the applicable annual cost and expense of the investigation and prosecution of insurance fraud in Georgia submitted by the Commissioner. Such assessments may be measured by kind of company, kind of insurance, income, volume of transactions, or such other factors as the Commissioner determines appropriate. Assessments based on the annual appropriation shall be due on September 1 of the year of the assessment. Any insurance company which fails to report and pay any such assessment shall be subject to penalties and interest as provided by subsection (d) of Code Section 33-8-6. The Commissioner shall provide by regulation for such other terms and conditions for the payment or collection of such assessments as may be necessary to ensure the proper payment and collection thereof. Notwithstanding the foregoing, the provisions of this Code section shall not apply to an agency captive insurance company, dormant captive insurance company, industrial insured captive insurance company, sponsored captive insurance company (including a protected cell thereof), or pure captive insurance company. Foreign and alien captive insurance companies doing business in Georgia shall, however, pay a fixed amount of $100.00 per year into the Special Insurance Fraud Fund without regard to the amount of the Georgia premium written by such foreign or alien captive. No additional amount shall be assessed against the foreign or alien captive insurance company.

(3) The General Assembly may appropriate funds to the department for the investigation of insurance fraud and for the funding of the prosecution of insurance fraud. The Commissioner is authorized to use such funds for investigation of insurance fraud and to reimburse prosecuting attorneys for some or all of the costs of retaining assistant prosecuting attorneys to prosecute insurance fraud cases. The Commissioner shall provide by regulation for such other terms and conditions for the use of the funds for the investigation, reimbursement, and prosecution contemplated by the terms of this paragraph.

(d) Insurers shall make personnel involved in investigating insurance fraud and any files relating to insurance fraud investigation available to the Commissioner, the Attorney General, local prosecuting officials, special prosecuting attorneys, or other law enforcement agencies as needed in order to further the investigation and prosecution of insurance fraud. Information supplied by an insurer and contained in such files shall upon receipt become part of the investigative file and subject to the provisions of Code Section 50-18-72. The insurer and its employees and agents shall be entitled to immunity as provided in Code Section 33-1-16.

(e) Any expenses incurred by insurers as a result of this Code section shall be defrayed by such insurers from their own funds and shall not be borne by the state or by the Special Insurance Fraud Fund.

History. — Code 1981, § 33-1-17, enacted by Ga. L. 1995, p. 1242, § 1; Ga. L. 2019, p. 337, § 1-7/SB 132; Ga. L. 2019, p. 533, § 2-15/HB 99; Ga. L. 2020, p. 140, § 1/HB 893.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, in subsection (c), substituted "Such budget" for "Beginning with the year 1997, such budget" at the beginning of the second sentence of paragraph (1), and, in paragraph (3), substituted "appropriate funds to the department" for "appropriate to the Insurance Department funds" in the first sentence. The second 2019 amendment, effective July 1, 2019, added the seventh through ninth sentences in paragraph (c)(2).

The 2020 amendment, effective July 1, 2020, in paragraph (c)(2), substituted the present fourth sentence for the former provisions, which read: "Assessments shall be due and payable for each calendar quarter at the times specified in subsection (b) of Code Section 33-8-6." and deleted "installment of" preceding "such assessment" in the fifth sentence.

Administrative rules and regulations. — Special Insurance Fraud Fund, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General Office of Commissioner of Insurance, Chapter 120-2-72.

33-1-18. Housing tax credit for qualified projects; rules and regulations.

(a) As used in this Code section, the term:

(1) "Federal housing tax credit" means the federal tax credit as provided in Section 42 of the Internal Revenue Code of 1986, as amended.

(2) "Median income" means those incomes that are determined by the federal Department of Housing and Urban Development guidelines and adjusted for family size.

(3) "Project" means a housing project that has restricted rents that do not exceed 30 percent of median income for at least 40 percent of its units occupied by persons or families having incomes of 60 percent or less of the median income or at least 20 percent of the units

occupied by persons or families having incomes of 50 percent or less of the median income.

(4) "Qualified basis" means that portion of the tax basis of a qualified Georgia project eligible for the federal housing tax credit, as that term is defined in Section 42 of the Internal Revenue Code of 1986, as amended.

(5) "Qualified Georgia project" means a qualified low-income building as that term is defined in Section 42 of the Internal Revenue Code of 1986, as amended, that is located in Georgia.

(b)(1) A tax credit against the taxes imposed under Code Sections 33-5-31, 33-8-4, and 33-40-5, to be termed the Georgia housing tax credit, shall be allowed with respect to each qualified Georgia project placed in service after January 1, 2001. The amount of such credit shall, when combined with the total amount of credit authorized under Code Section 48-7-29.6, in no event exceed an amount equal to the federal housing tax credit allowed with respect to such qualified Georgia project.

(2)(A) If under Section 42 of the Internal Revenue Code of 1986, as amended, a portion of any federal housing tax credit taken on a project is required to be recaptured as a result of a reduction in the qualified basis of such project, the taxpayer claiming any state tax credit with respect to such project shall also be required to recapture a portion of any state tax credit authorized by this Code section. The state recapture amount shall be equal to the proportion of the state tax credit claimed by the taxpayer that equals the proportion the federal recapture amount bears to the original federal housing tax credit amount subject to recapture. The tax credit under this Code section shall not be subject to recapture if such recapture is due solely to the sale or transfer of any direct or indirect interest in such qualified Georgia project.

(B) In the event that recapture of any Georgia housing tax credit is required, any amended return submitted to the Commissioner as provided in this Code section shall include the proportion of the state tax credit required to be recaptured, the identity of each taxpayer subject to the recapture, and the amount of tax credit previously allocated to such taxpayer.

(3) In no event shall the total amount of the tax credit under this Code section for a taxable year exceed the taxpayer's tax liability under Code Sections 33-5-31, 33-8-4, and 33-40-5. Any unused tax credit shall be allowed to be carried forward to apply to the taxpayer's next three succeeding years' tax liability. No such tax credit shall be allowed the taxpayer against prior years' tax liability.

(4) The tax credit allowed under this Code section, and any recaptured tax credit, shall be allocated among some or all of the

partners, members, or shareholders of the entity owning the project in any manner agreed to by such persons, whether or not such persons are allocated or allowed any portion of the federal housing tax credit with respect to the project.

(c) The commissioner and the state department designated by the Governor as the state housing credit agency for purposes of Section 42(h) of the Internal Revenue Code of 1986, as amended, shall each be authorized to promulgate any rules and regulations necessary to implement and administer this Code section.

History. — Code 1981, § 33-1-18, enacted by Ga. L. 2001, p. 1181, § 2; Ga. L. 2002, p. 415, § 33; Ga. L. 2003, p. 640, § 1.

Editor's notes. — Ga. L. 2001, p. 1181, § 3, not codified by the General Assembly, provides that this Code section shall be applicable to all taxable years beginning on or after January 1, 2002.

U.S. Code. — Section 42 of the Internal Revenue Code of 1986, referred to in this Code section, is codified as 26 U.S.C. § 42.

Law reviews. — For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U.L. Rev. 217 (2011).

33-1-19. Special Advisory Commission on Mandated Health Insurance Benefits.

Reserved. Repealed by Ga. L. 2019, p. 919, § 13-1/HB 553, effective July 1, 2019.

Code Commission notes. — Former Code Section 33-1-19 was repealed by Ga. L. 2019, p. 919, § 13-1/HB 553, effective July 1, 2019. However, Ga. L. 2019, p. 337, § 1-8/SB 132, effective July 1, 2019, purported to amend this Code section by substituting "department" for "Insurance Department" in paragraphs (d)(1) and (d)(2) and "Department of Insurance" for "Insurance Department" in subsection (f). For effect of subsequent amendment of a repealed statute, see Lampkin v. Pike, 115 Ga. 827 (1902).

Editor's notes. — This Code section was based on Code 1981, § 33-1-19, enacted by Ga. L. 2011, p. 329, § 1/SB 17; Ga. L. 2012, p. 775, § 33/HB 942.

Ga. L. 2019, p. 919, § 13-2/HB 553, not codified by the General Assembly, provides: "Any assets of the Special Advisory Commission on Mandated Health Insurance Benefits existing as of June 30, 2019, shall devolve by operation of law and without further action to the State of Georgia on July 1, 2019. Any liabilities and obligations of the Special Advisory Commission on Mandated Health Insurance Benefits existing as of June 30, 2019, shall be transferred to and assumed by the State of Georgia, by such instruments as may be required to maintain the same."

33-1-20. Health care sharing ministry.

(a) As used in this Code section, the term "health care sharing ministry" means a faith based, nonprofit organization that is tax exempt under the Internal Revenue Code which:

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

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

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

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

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

(6) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment for medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."

(b) A health care sharing ministry which has entered into a health care cost-sharing arrangement with its participants shall not be considered an insurance company, health maintenance organization, or health benefit plan of any class, kind, or character and shall not be subject to any laws respecting insurance companies, health maintenance organizations, or health benefit plans of any class, kind, or character in this state or subject to regulation under such laws, including, but not limited to, the provisions of this title, and shall not be subject to the jurisdiction of the Commissioner of Insurance.

History. — Code 1981, § 33-1-20, enacted by Ga. L. 2011, p. 350, § 1/HB 248; Ga. L. 2020, p. 493, § 33/SB 429.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsections (a) and (b).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-1-19, as enacted by Ga. L. 2011, p. 350, § 1/HB 248, was redesignated as Code Section 33-1-20 and Code Section 33-1-20, as enacted by Ga. L. 2011, p. 350, § 1/HB 248, was redesignated as Code Section 33-1-21.

JUDICIAL DECISIONS

Ministry entitled to interlocutory injunction to prevent loss of status. — Interlocutory injunction was proper against a for-profit health care insurance company that had allegedly pirated a non-profit health care sharing ministry's customers and funds after termination of the parties' licensing contract; the ministry's loss of status as an Affordable Care Act, 42 U.S.C. § 18021 et seq., approved ministry would constitute irreparable harm. Aliera Healthcare, Inc. v. Anabaptist Healthshare, 355 Ga. App. 381, 844 S.E.2d 268 (2020).

33-1-21. Certain subscription agreements for prepaid air ambulance service not contract of insurance; definitions.

(a) As used in this Code section, the term:

(1) "Air ambulance" means any rotary-wing aircraft used or intended to be used for hire for transportation of sick or injured persons who may need medical attention during transport.

(2) "Air ambulance service" means the for hire providing of emergency care and transportation by means of an air ambulance for an injured or sick person to or from a place where medical or hospital care is furnished.

(3) "Membership fees" means amounts collected by a membership provider as consideration for a membership subscription.

(4) "Membership provider" means an entity that is licensed to provide air ambulance services pursuant to Chapter 11 of Title 31.

(5) "Membership subscription" means an agreement where a membership provider's charges to a subscription member for air ambulance services are discounted or are prepaid, but only for charges that are not otherwise covered by a third party.

(6) "Subscription member" means an individual who is the beneficiary of a membership subscription.

(b)(1) The solicitation of membership subscriptions, the acceptance of applications for membership subscriptions, the charging of membership fees, and the furnishing of prepaid or discounted air ambulance service to subscription members by a membership provider shall not constitute the writing of insurance.

(2) A membership subscription shall not constitute a contract of insurance.

History. — Code 1981, § 33-1-21, enacted by Ga. L. 2011, p. 350, § 1/HB 248; Ga. L. 2020, p. 493, § 33/SB 429.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in paragraph (a)(2).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-1-20, as enacted by Ga. L. 2011, p. 350, § 1/HB 248, was redesignated as Code Section 33-1-21.

33-1-22. English language version of policy controls.

In the event of a dispute or complaint wherein an insurer provided any material in a language other than English, the English language version of the policy, as that term is defined in Code Section 33-24-1, shall control the resolution of such dispute or complaint; provided, however, that nothing contained in this Code section shall abrogate or supersede the provisions set forth in Chapter 6 of this title, relating to unfair trade practices.

History. — Code 1981, § 33-1-22, enacted by Ga. L. 2012, p. 1350, § 8A/HB 1067.

Cross references. — English designated as official language, § 50-3-100.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2012, Code Section 33-1-22, as enacted by Ga. L. 2012, p. 348, § 1/HB 785, was redesignated as Code Section 43-1-32.

33-1-23. Establishment of exchange.

(a) As used in this Code section, the term "exchange" shall have the same meaning provided for in paragraph (1) of Code Section 33-23-201.

(b) No department, agency, instrumentality, or political subdivision of this state shall:

(1) Establish any program; promulgate any rule, policy, guideline, or plan; or change any program, rule, policy, or guideline to implement, establish, create, administer, or otherwise operate an exchange; or

(2) Apply for, accept, or expend federal moneys related to the creation, implementation, or operation of an exchange.

(c) Nothing in this Code section shall apply to the Commissioner of Insurance in the implementation or enforcement of the provisions of Article 3 of Chapter 23 of this title.

(d) Neither the state nor any department, agency, bureau, authority, office, or other unit of the state, including the University System of Georgia and its member institutions, nor any political subdivision of the state shall establish, create, implement, or operate a navigator

program or its equivalent as defined in Code Section 33-23-201; provided, however, that any grant regarding a navigator program in effect on April 15, 2014, shall be permitted to continue for the term of such grant but shall then terminate upon the expiration of the term of such grant and shall not be renewed, notwithstanding any provision contained within such grant allowing for automatic renewal under certain circumstances.

(e) Nothing in this Code section shall be construed to preclude the state from participating in any Medicaid program.

History. — Code 1981, § 33-1-23, enacted by Ga. L. 2014, p. 243, § 1-3/HB 943; Ga. L. 2020, p. 493, § 33/SB 429.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "Medicaid" for "MEDICAID" in subsection (e).

Cross references. — Advocating for voluntary expansion by the state of eligibility for medical assistance in furtherance of the federal Patient Protection and Affordable Care Act, § 31-1-40.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2014, "April 15, 2014," was substituted for "the effective date of this Code section" in subsection (d).

Editor's notes. — Ga. L. 2014, p. 243, § 1-1/HB 943, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Georgia Health Care Freedom Act.'"

33-1-24. Insurance requirements for transportation network companies and their drivers.

(a) As used in this Code section, the term:

(1) "Personal vehicle" means a registered motor vehicle that is used by a transportation network company driver in connection with providing services for a transportation network company.

(2) "Transportation network company" means a corporation, partnership, sole proprietorship, or other entity that uses a digital network or other means to connect customers to transportation network company drivers for the purposes of providing transportation for compensation, including, but not limited to, payment, donation, or other item of value. The term shall not include emergency or nonemergency medical transports.

(3) "Transportation network company customer" or "customer" means an individual who uses a transportation network company to connect with a driver to obtain services in such driver's personal vehicle, from an agreed upon point of departure to an agreed upon destination.

(4) "Transportation network company driver" or "driver" means an individual who uses or permits to be used his or her personal vehicle to provide transportation network company services. Such driver need not be an employee of a transportation network company.

(5) "Transportation network company services" or "services" means:

(A) The period of time a driver is logged on to the transportation network company's digital network and available to accept a ride request until the driver is logged off, except for that time period described in subparagraph (B) of this paragraph; and

(B) The period of time a driver accepts a ride request on the transportation network company's digital network until the driver completes the transaction or the ride is complete, whichever is later.

Transportation network company services shall not include transportation provided using a taxi, a limousine carrier as defined in Code Section 40-1-151, or any other commercially registered motor vehicle and commercially licensed driver.

(b) A transportation network company shall maintain or cause to be maintained a primary motor vehicle insurance policy that:

(1) Recognizes the driver as a transportation network company driver and explicitly covers the driver's provision of transportation network company services as defined in paragraph (5) of subsection (a) of this Code section;

(2) During the time period defined in subparagraph (a)(5)(A) of this Code section, provides a minimum of $100,000.00 for bodily injuries to or death of all persons in any one accident with a maximum of $50,000.00 for bodily injuries to or death of one person and $50,000.00 for loss of or damage to property of others, excluding cargo, in any one accident; and

(3) During the time period defined in subparagraph (a)(5)(B) of this Code section, provides a minimum of $1 million for death, personal injury, and property damage per occurrence and provides uninsured and underinsured motorist coverage of at least $1 million per incident.

(c) The requirements of subsection (b) of this Code section may be satisfied by either:

(1) A commercial motor vehicle insurance policy purchased by the transportation network company or the driver that provides coverage that meets the requirements set forth in subsection (b) of this Code section; or

(2) An insurance rider to, an endorsement of, or an express provision of coverage for transportation network company services within the driver's personal private passenger motor vehicle insurance policy required by Code Section 40-9-34 which may be combined

with an excess policy provided by the transportation network company to meet the requirements set forth in subsection (b) of this Code section.

(d) A transportation network company that purchases an insurance policy to satisfy any of the requirements under subsection (b) of this Code section shall provide the insurance policy to the Commissioner.

(e) An insurance policy required by subsection (b) of this Code section shall be placed with an insurer licensed under this title or with a surplus lines insurer eligible under Chapter 23 of this title.

(f) To the extent the coverage requirements in subsection (b) of this Code section are met by a driver, then such driver shall submit verification of such coverage to the transportation network company. In the event that the insurance maintained by a driver to fulfill the requirements of subsection (b) of this Code section has lapsed or ceases to exist, then the transportation network company shall provide coverage which shall become primary beginning with the first dollar of a claim.

(g)(1) Nothing in this Code section shall be construed to require a personal vehicle insurance policy to provide primary or excess coverage for transportation network company services.

(2) Insurers that write motor vehicle insurance policies in this state may exclude any and all coverage afforded under the owner's insurance policy for any loss or injury that occurs while a driver is logged on to a transportation network company's digital network or while a driver provides transportation network company services. Notwithstanding any other law, a personal vehicle insurer may, at its discretion, offer a personal vehicle insurance policy, or an amendment or endorsement to an existing policy, that covers a driver's vehicle while being used for transportation network company services during the time period specified in this paragraph, with or without a separate charge, or the policy contains an amendment or an endorsement to provide such coverage, for which a separately stated premium may be charged.

(h) The transportation network company shall comply with the following requirements for each driver:

(1) The driver shall be provided a disclosure from the transportation network company containing:

(A) All information and documentation required for compliance with Code Section 40-6-10 if the transportation network company provides any insurance policy required by subsection (b) of this Code section;

(B) Notice that the driver's personal vehicle insurance policy may exclude any and all coverage for injuries to the driver and to others and may exclude the duty to defend or indemnify any person or organization for liability for any loss or injury that occurs while providing transportation network company services; and

(C) Notice that the driver's personal vehicle insurance policy may exclude coverage for damage to the personal vehicle, medical payments coverage, uninsured and underinsured motorist coverage, and other first-party claims;

(2) Such transportation network company shall make the following disclosure to a driver in the driver's terms of service: "If the vehicle with which you provide transportation network company services has a lien against it, you must notify the lienholder that you provide transportation network company services with such vehicle. Providing such transportation network company services may violate the terms of your contract with the lienholder.";

(3) The transportation network company shall include the disclosures required by this subsection in the driver's terms of service in a distinctive clause; and

(4) For purposes of claims coverage investigation and upon request of the transportation network company driver's personal vehicle insurer, the transportation network company shall provide, within 15 days of such insurer's request, the date and times at which an accident occurred that involved a transportation network company driver and the precise times in the 12 hours preceding and following the accident that the driver logged on and off the transportation network company network or application or otherwise signified availability to provide transportation network company services. Coverage under a motor vehicle insurance policy maintained by the transportation network company shall not be dependent on a personal vehicle insurer first denying a claim nor shall a personal vehicle insurance policy be required to first deny a claim.

(i) In the event the transportation network company is providing primary insurance coverage under subsection (b) of this Code section, the transportation network company's insurer shall assume the costs of defense and indemnification. The transportation network company shall notify the driver and the driver's insurer of any dispute concerning primary coverage within 25 business days of receiving notice of the accident that gives rise to such claim. A personal vehicle insurer that defends or indemnifies a claim against a driver that is excluded under the terms of its policy shall have a right of contribution against other insurers that provide motor vehicle insurance to the same driver in satisfaction of the coverage requirements of this Code section at the time of loss.

(j) In the event the transportation network company is providing primary insurance coverage under subsection (b) of this Code section and the driver or the driver's insurer is named as a defendant in a civil action for any loss or injury that occurs while a personal vehicle is available to provide transportation network company services, the transportation network company's insurer shall have the duty to defend and indemnify the driver and the driver's insurer.

History. — Code 1981, § 33-1-24, enacted by Ga. L. 2015, p. 1280, § 1/HB 190; Ga. L. 2016, p. 864, § 33/HB 737.

Law reviews. — For article on the 2015 enactment of this Code section, see 32 Ga. St. U. L. Rev. 177 (2015). For annual survey on trial practice and procedure, see 67 Mercer L. Rev. 257 (2015).

For note, "Disability Rights in the Age of Uber: Applying the Americans with Disabilities Act of 1990 to Transportation Network Companies," see 33 Ga. St. U. L. Rev. 517 (2017).

33-1-25. Georgia Agribusiness and Rural Jobs Act.

(a) This Code section shall be known and may be cited as the "Georgia Agribusiness and Rural Jobs Act."

(b) As used in this Code section, the term:

(1) "Affiliate" means an entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another entity. For the purposes of this Code section, an entity is "controlled by" another entity if the controlling entity holds, directly or indirectly, the majority voting or ownership interest in the controlled entity or has control over the day-to-day operations of the controlled entity by contract or by law.

(2) "Applicable percentage" means 0 percent for the first two credit allowance dates and 15 percent for the next four credit allowance dates.

(3) "Capital investment" means any equity investment in a rural fund by a rural investor that:

(A) Is acquired after July 1, 2017, at its original issuance solely in exchange for cash;

(B) Has 100 percent of its cash purchase price used by the rural fund to make qualified investments in eligible businesses located in this state by the second anniversary of the initial credit allowance date; and

(C) Is designated by the rural fund as a capital investment under this Code section and is certified by the department pursuant to subsection (e) of this Code section. This term shall include any capital investment that does not meet the provisions of

subsection (e)(1)(A) of this Code section if such investment was a capital investment in the hands of a prior holder.

(4) "Credit allowance date" means the date on which a capital investment is made and each of the five anniversary dates of such date thereafter.

(5) "Department" means the Department of Community Affairs.

(6) "Eligible business" means a business that, at the time of the initial qualified investment in the company:

(A) Has less than 250 employees; and

(B)(i) Has its principal business operations in one or more rural areas in this state; and

(ii) Produces or provides any goods or services produced in Georgia normally used by farmers, ranchers, or producers and harvesters of aquatic products in their business operations, or to improve the welfare or livelihood of such persons, or is involved in the processing and marketing of agricultural products, farm supplies, and input suppliers, or is engaged in agribusiness as defined by the United States Department of Agriculture, or is engaged in manufacturing, health care, technology, transportation, or related services, or if not engaged in such industries, the department determines that such investment will be beneficial to the rural area and the economic growth of the state. Any business which is classified as an eligible business at the time of the initial investment in said business by a rural fund shall remain classified as an eligible business and may receive follow-on investments from any rural fund, and such follow-on investments shall be qualified investments even though such business may not meet the definition of an eligible business at the time of such follow-on investments.

(7) "Eligible distribution" means:

(A) A distribution of cash to one or more equity owners of a rural investor to fully or partially offset a projected increase in the owner's federal or state tax liability, including any penalties and interest, related to the owner's ownership, management, or operation of the rural investor;

(B) A distribution of cash as payment of interest and principal on the debt of the rural investor or rural fund; or

(C) A distribution of cash related to the reasonable costs and expenses of forming, syndicating, managing, and operating the rural investor or the rural fund, or a return of equity to affiliates of a rural investor or rural fund. Such distributions may include

reasonable and necessary fees paid for professional services, including legal and accounting services, related to the formation and operation of the rural fund and an annual management fee that shall not exceed 2 percent of the rural fund's qualified investment authority.

(8) "Principal business operations" means the location where at least 60 percent of a business's employees work or where employees who are paid at least 60 percent of such business's payroll work. A business that has agreed to relocate employees using the proceeds of a qualified investment to establish its principal business operations in a new location shall be deemed to have its principal business operations in such new location if it satisfies these requirements no later than 180 days after receiving a qualified investment.

(9) "Purchase price" means the amount paid to the rural fund that issues a capital investment which shall not exceed the amount of capital investment authority certified pursuant to subsection (e) of this Code section.

(10) "Qualified investment" means any investment in an eligible business or any loan to an eligible business with a stated maturity date of at least one year after the date of issuance, excluding revolving lines of credit and senior secured debt unless the eligible business has a credit refusal letter or similar correspondence from a depository institution or a referral letter or similar correspondence from a depository institution referring the business to a rural fund; provided that, with respect to any one eligible business, the maximum amount of investments made in such business by one or more rural funds, on a collective basis with all of the businesses' affiliates, with the proceeds of capital investments shall be the greater of 20 percent of the rural fund's capital investment authority or $6.5 million, exclusive of investments made with repaid or redeemed investments or interest or profits realized thereon.

(11) "Rural area" means any county of this state that has a population of less than 50,000 according to the latest decennial census of the United States.

(12) "Rural fund" means an entity certified by the department under subsection (e) of this Code section.

(13) "Rural investor" means an entity that makes a capital investment in a rural fund.

(14) "State tax liability" means any liability incurred by any entity under Code Sections 33-3-26 and 33-8-4 or Code Sections 48-7-21 and 48-7-27, or, if such taxes are eliminated or reduced, the term shall also mean any tax liability imposed on an entity or other person that had tax liability under the laws of this state.

(c) Upon making a capital investment in a rural fund, a rural investor earns a vested right to a credit against such entity's state tax liability that may be utilized on each credit allowance date of such capital investment in an amount equal to the applicable percentage for such credit allowance date multiplied by the purchase price paid to the rural fund for the capital investment. The amount of the credit claimed by a rural investor shall not exceed the amount of such entity's state tax liability for the tax year for which the credit is claimed. Any amount of credit that a rural investor is prohibited from claiming in a taxable year as a result of this Code section may be carried forward for use in any subsequent taxable year. It is the intent of this Act that a rural investor claiming a credit under this Code section is not required to pay any additional tax that may arise as a result of claiming such credit.

(d) No credit claimed under this Code section shall be refundable or saleable on the open market. Credits earned by or allocated to a partnership, limited liability company, or S-corporation may be allocated to the partners, members, or shareholders of such entity for their direct use in accordance with the provisions of any agreement among such partners, members, or shareholders, and a rural fund must notify the department of the names of the entities that are eligible to utilize credits pursuant to an allocation of credits or a change in allocation of credits or due to a transfer of a capital investment upon such allocation, change, or transfer. Such allocation shall be not considered a sale for purposes of this Code section.

(e)(1) A rural fund that seeks to have an equity investment certified as a capital investment and eligible for credits under this Code section shall apply to the department. The department shall begin accepting applications within 90 days of July 1, 2017. The rural fund shall include the following:

(A) The amount of capital investment requested;

(B) A copy of the applicant's or an affiliate of the applicant's license as a rural business investment company under 7 U.S.C. Section 2009cc or as a small business investment company under 15 U.S.C. Section 681 and a certificate executed by an executive officer of the applicant attesting that such license remains in effect and has not been revoked;

(C) Evidence that, as of the date the application is submitted, the applicant or affiliates of the applicant have invested at least $100 million in nonpublic companies located in rural areas within the United States;

(D) An estimate of the number of jobs that will be created or retained in this state as a result of the applicant's qualified investments;

(E) A business plan that includes a revenue impact assessment projecting state and local tax revenue to be generated by the applicant's proposed qualified investments prepared by a nationally recognized, third-party, independent economic forecasting firm using a dynamic economic forecasting model that analyzes the applicant's business plan over the ten years following the date the application is submitted to the department; and

(F) A nonrefundable application fee of $5,000.00 payable to the department.

(2) Within 30 days after receipt of a completed application, the department shall grant or deny the application in full or in part. The department shall deny the application if:

(A) The applicant does not satisfy all of the criteria described in paragraph (1) of this subsection;

(B) The revenue impact assessment submitted with the application does not demonstrate that the applicant's business plan will result in a positive economic impact on this state over a ten-year period that exceeds the cumulative amount of tax credits that would be issued to the applicant if the application were approved; or

(C) The department has already approved the maximum amount of capital investment authority under paragraph (6) of this subsection.

If the department denies any part of the application, it shall inform the applicant of the grounds for the denial. If the applicant provides any additional information required by the department or otherwise completes its application within 15 days of the notice of denial, the application shall be considered completed as of the original date of submission. If the applicant fails to provide the information or fails to complete its application within the 15 day period, the application remains denied and must be resubmitted in full with a new submission date.

(3) If the application is complete, the department shall certify the proposed equity investment as a capital investment that is eligible for credits under this Code section, subject to the limitations contained in paragraph (6) of this subsection. The department shall provide written notice of the certification to the rural fund.

(4) The department shall certify capital investments in the order that the applications were received by the department. Applications received on the same day shall be deemed to have been received simultaneously.

(5) For applications that are complete and received on the same day, the department shall certify applications in proportionate percentages based upon the ratio of the amount of capital investments requested in an application to the total amount of capital investments requested in all applications.

(6) The department shall certify $100 million in capital investments pursuant to this Code section.

(7) Within 60 days of the applicant receiving notice of certification, the rural fund shall issue the capital investment to and receive cash in the amount of the certified amount from a rural investor. At least 50 percent of the rural investor's capital investment shall be composed of capital raised by the rural investor from sources, including directors, members, employees, officers, and affiliates of the rural investor, other than the amount of capital invested by the allocatee claiming the tax credits in exchange for such allocation of tax credits. The rural fund shall provide the department with evidence of the receipt of the cash investment within 65 days of the applicant receiving notice of certification. If the rural fund does not receive the cash investment and issue the capital investment within such time period following receipt of the certification notice, the certification shall lapse and the rural fund shall not issue the capital investment without reapplying to the department for certification. Lapsed certifications revert to the authority and shall be reissued pro rata to applicants whose capital investment allocations were reduced pursuant to paragraph (5) of this subsection and then in accordance with the application process.

(f)(1) The department may recapture, from a rural investor that claimed the credit on a tax return, the credit allowed under this Code section if:

(A) The rural fund does not invest 100 percent of its capital investment authority in qualified investments in this state within two years of the closing date, with at least 10 percent of its capital investment authority initially invested in eligible businesses engaged in agribusiness as defined by the United States Department of Agriculture and at least 10 percent of such investment shall be equity investments;

(B) The rural fund, after satisfying subparagraph (A) of this paragraph, fails to maintain qualified investments equal to 100 percent of its capital investment authority until the fifth anniversary of the credit allowance date. For the purposes of this subsection, a qualified investment is considered maintained even if the qualified investment was sold or repaid so long as the rural fund reinvests an amount equal to the capital returned or recovered by

the rural fund from the original investment, exclusive of any profits realized, in other qualified investments in this state within 12 months of the receipt of such capital. Amounts received periodically by a rural fund shall be treated as continually invested in qualified investments if the amounts are reinvested in one or more qualified investments by the end of the following calendar year. A rural fund shall not be required to reinvest capital returned from qualified investments after the fourth anniversary of the credit allowance date, and such qualified investments shall be considered held continuously by the rural fund through the fifth anniversary of the credit allowance date;

(C) The rural fund, before exiting the program in accordance with subsection (i) of this Code section, makes a distribution or payment that results in the rural fund having less than 100 percent of its capital investment authority invested in qualified investments in this state or available for investment in qualified investments and held in cash and other marketable securities; or

(D) The rural fund violates subsection (h) of this Code section.

(2) Recaptured credits and the related capital investment authority revert to the department and shall be reissued pro rata to applicants whose capital investment allocations were reduced pursuant to paragraph (5) of subsection (e) of this Code section and then in accordance with the application process.

(g) Enforcement of each of the recapture provisions of paragraph (1) of subsection (f) of this Code section shall be subject to a six-month cure period. No recapture shall occur until the rural fund has been given notice of noncompliance and afforded six months from the date of such notice to cure the noncompliance.

(h) No eligible business that receives a qualified investment under this chapter, or any affiliates of such eligible business, may directly or indirectly:

(1) Own or have the right to acquire an ownership interest in a rural fund or member or affiliate of a rural fund, including, but not limited to, a holder of a capital investment issued by the rural fund; or

(2) Loan to or invest in a rural fund or member or affiliate of a rural fund, including, but not limited to, a holder of a capital investment issued by a rural fund, where the proceeds of such loan or investment are directly or indirectly used to fund or refinance the purchase of a capital investment under this Code section.

(i) On or after the sixth anniversary of the closing date, a rural fund may apply to the department to exit the program and no longer be

subject to regulation under this Code section. The department shall respond to the exit application within 30 days of receipt. In evaluating the exit application, the fact that no credits have been recaptured and that the rural fund has not received a notice of recapture that has not been cured pursuant to subsection (g) of this Code section shall be sufficient evidence to prove that the rural fund is eligible for exit. The department shall not unreasonably deny an exit application submitted under this subsection. If the exit application is denied, the notice shall include the reasons for the determination. The state shall receive a 10 percent share of any distributions annually from a rural fund that made a capital investment, other than the amount in excess of equity invested in the rural fund and tax distributions made by the rural fund. A rural fund shall distribute all amounts not held in qualified investments no later than the fourteenth anniversary of the closing date. No claimant of credits pursuant to subsection (c) of this Code section shall receive distributions in excess of an amount that would result in an internal rate of return on capital invested that is more than 20 percent if the number of jobs created is:

(1) Less than 60 percent of the projected jobs in the rural fund's approved business plan, then the state shall receive a penalty of 10 percent of the total tax credits distributed to the rural fund; or

(2) Greater than 60 percent but less than 80 percent of the projected jobs in the rural fund's approved business plan, then the state shall receive a penalty of 5 percent of the total tax credits distributed to the rural fund.

(j) A rural fund, before making a qualified investment, may request from the department a written opinion as to whether the business in which it proposes to invest is an eligible business. The department, not later than the twentieth business day after the date of receipt of such request, shall notify the rural fund of its determination. If the department fails to notify the rural fund of its determination by the twentieth business day, the business in which the rural fund proposes to invest shall be considered an eligible business.

(k)(1) Rural funds shall submit a report to the department within the first 15 business days after the second anniversary of the initial credit allowance date that provides documentation as to the investment of 100 percent of the purchase price of such capital investment in qualified investments. Such report shall include:

(A) The location of each eligible business receiving a qualified investment;

(B) Bank statements of such rural fund evidencing each qualified investment;

(C) A copy of the written opinion of the department set forth in subsection (j) of this Code section or evidence that such business

was an eligible business at the time of such qualified investment, as applicable;

(D) The number of employment positions created and retained as a result of qualified investments;

(E) The average annual salary of positions described in subparagraph (D) of this paragraph; and

(F) Such other information required by the department.

(2) Thereafter, rural funds shall submit an annual report to the department within 45 days of the beginning of the calendar year during the compliance period. The report shall include but is not limited to the following:

(A) The number of employment positions created and retained as a result of qualified investments; and

(B) The average annual salary of positions described in subparagraph (A) of this paragraph.

History. — Code 1981, § 33-1-25, enacted by Ga. L. 2017, p. 637, § 1-1/SB 133; Ga. L. 2019, p. 1056, § 33/SB 52.

The 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, substituted "'Credit allowance date' means the date" for "'Credit allowance date' mean the date" in paragraph (b)(4).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2017, "July 1, 2017," was substituted for "the effective date of this Code section" in subparagraph (b)(4)(A) [now (b)(3)(A)], and "July 1, 2017" was substituted for "the effective date of this Act" in the second sentence of paragraph (e)(1).

Pursuant to Code Section 28-9-5, in 2017, paragraphs (b)(4), (b)(5), and (b)(5.1) were redesignated as paragraphs (b)(3) through (b)(5), respectively.

Editor's notes. — Ga. L. 2017, p. 637, § 3-1(a)/SB 133, not codified by the General Assembly, provides, in part, that this Act shall be applicable to all taxable years beginning on or after January 1, 2018.

33-1-26. Governor's request for waiver from federal Patient Protection and Affordable Care Act; expiration of authority.

(a) The Governor is hereby authorized to submit one or more applications to the United States Secretaries of Health and Human Services and the Treasury for waiver of applicable provisions of the federal Patient Protection and Affordable Care Act (P. L. 111-148) under Section 1332 with respect to health insurance coverage or health insurance products. Any such submission to obtain a state innovation waiver may include multiple waiver submissions. On or after January 1, 2020, upon approval of one or more waivers, the state is authorized to implement such waiver or waivers as provided under Section 1332 of such federal act in a manner consistent with state and federal law.

(b) The authority granted to the Governor in subsection (a) of this Code section to submit one or more applications shall expire on December 31, 2021.

History. — Code 1981, § 33-1-26, enacted by Ga. L. 2019, p. 2, § 3-2/SB 106.

Effective date. — This Code section became effective March 27, 2019.

Editor's notes. — Ga. L. 2019, p. 2, § 1-1/SB 106, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Patients First Act.'"

Ga. L. 2019, p. 2, § 3-1/SB 106, not codified by the General Assembly, provides: "The General Assembly finds that:

"(1) For Georgians in recent years, private sector health insurance choices have decreased and the costs of insurance coverage have increased;

"(2) Through the granting of Section 1332 innovation waivers, the federal government allows states to pursue innovative strategies for providing their residents with access to high quality, comprehensive, and affordable health insurance while retaining the basic protections for consumers; and

"(3) Such waivers may be narrowly tailored to address specific problems and may address, among other things, the creation of state reinsurance programs, high-risk health conditions, changes to premium tax credits and cost-sharing arrangements, consumer-driven health care accounts, the creation of new health insurance products, the implementation of health care delivery systems, or the redefinition of essential health benefits."

Law reviews. — For article on the 2019 enactment of this Code section, see 36 Ga. St. U.L. Rev. 207 (2019).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 544 et seq.

70C Am. Jur. 2d, Social Security and Medicare, § 1905.

CHAPTER 2

DEPARTMENT AND COMMISSIONER

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33-2-32. Fees.
33-2-33. List of written requests for assistance by citizens against insurers [Repealed].

Sec.
33-2-34. Insurance compliance self-evaluative privilege.

Cross references. — Requirements pertaining to regulations, standards, and plans required to be filed by Insurance Commissioner with Secretary of State, § 50-13-21.

Administrative rules and regulations. — Organization, practice and procedure, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General Office of Commissioner of Insurance, Chapters 120-2-1 through 120-2-2.

JUDICIAL DECISIONS

Investigation does not require hearing. — The investigative powers of the Insurance Commissioner under this title are not restricted only to those instances in which a hearing is pending. Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

If hearing held, procedural requirements must be met. — In the event a hearing does take place, the Commissioner must accord all the procedural safeguards provided as hearing requirements of this title before there can be any final decisions, orders, or actions adverse to any member of the insurance industry. Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

Action involving insurance violations. — A consumer class action complaint asserting various claims against an insurance company, including claims for fraud, Georgia RICO, and breach of contract was erroneously dismissed on the basis that the Insurance Commissioner had exclusive jurisdiction and that plaintiffs were required to exhaust their administrative remedies before the Insurance Commissioner before filing an action in court. Griffeth v. Principal Mut. Ins. Co., 243 Ga. App. 618, 533 S.E.2d 126 (2000).

OPINIONS OF THE ATTORNEY GENERAL

Rule-making procedures. — The Insurance Department may utilize rule-making procedures of T. 33, C. 2 in lieu of rule-making procedures outlined in § 50-13-21. 1982 Op. Att'y Gen. No. 82-10.

33-2-1. Creation of department; Commissioner chief officer of department; powers and duties of department and Commissioner generally.

There is created the Department of Insurance of the State of Georgia. The chief officer of such department shall be the Commissioner of Insurance. The purpose and function of the department and the duties and powers of the Commissioner shall be those created and vested by this title.

History. — Ga. L. 1912, p. 119, § 1; Code 1933, § 56-101; Code 1933, § 56-201, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1986, p. 855, § 12; Ga. L. 1987, p. 3, § 33; Ga. L. 2019, p. 337, § 1-9/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in the first sentence.

JUDICIAL DECISIONS

Cited in Brown v. Quality Fin. Co., 112 Ga. App. 369, 145 S.E.2d 99 (1965); Ferguson v. United Ins. Co. of Am., 163 Ga. App. 282, 293 S.E.2d 736 (1982).

OPINIONS OF THE ATTORNEY GENERAL

Commissioner lacks power to make binding tax claim settlement. — The Insurance Commissioner does not have the authority to accept payment of taxes for a five-year period and sign a binding agreement that this amount satisfies all claims by the state against the insurer. 1969 Op. Att'y Gen. No. 69-396.

33-2-2. Seal of Commissioner.

The Commissioner shall have an official seal of such design as he or she shall select with the approval of the Governor.

History. — Code 1933, § 56-202, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2011, p. 99, § 45/HB 24.

Editor's notes. — Ga. L. 2011, p. 99, § 101/HB 24, not codified by the General Assembly, provides that the amendment to this Code section by that Act shall apply to any motion made or hearing or trial commenced on or after January 1, 2013.

Law reviews. — For article, "Evidence," see 27 Ga. St. U.L. Rev. 1 (2011). For article on the 2011 amendment of this Code section, see 28 Ga. St. U.L. Rev. 1 (2011).

33-2-3. Organization of department by Commissioner.

The Commissioner shall set up within the department such divisions or sections as he may deem necessary for the appropriate performance of the duties of the department and the proper exercise of the powers vested in the department. Such organization shall proceed along functional lines and shall have as its purpose efficiency in operation and service to the public.

History. — Code 1933, § 56-205, enacted by Ga. L. 1960, p. 289, § 1.

33-2-4. Appointment and removal of chief deputy insurance commissioner and other deputies.

Reserved. Repealed by Ga. L. 2019, p. 337, § 1-10/SB 132, effective July 1, 2019.

Editor's notes. — This Code section was based on Ga. L. 1960, p. 289, § 1.

33-2-5. Appointment of personnel; possession of financial interest; additional remuneration for services.

(a) The Commissioner may appoint and prescribe the duties of such assistants, examiners, actuaries, clerks, and employees as may be necessary to discharge the duties placed upon the department by this title. The Commissioner shall fix the compensation of all such personnel.

(b) The Commissioner or any deputy, examiner, actuary, clerk, or any employee of the department shall not be financially interested, directly or indirectly, in any insurer, agency, or insurance transaction except as a policyholder or claimant under a policy; however, as to such matters wherein a conflict of interests does not exist on the part of any such individual, the Commissioner may employ from time to time insurance actuaries or other technicians who are independently practicing their professions even though similarly employed by insurers and others.

(c) The Commissioner or any deputy, examiner, actuary, clerk, or employee of the department shall not be given or receive any fee, compensation, loan, gift, or other thing of value in addition to the compensation and expense allowance provided by law for any service or pretended service either rendered or to be rendered as such Commissioner, deputy, examiner, actuary, clerk, or employee.

History. — Code 1933, § 56-207, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Conflicts of interest generally, § 45-10-20 et seq.

33-2-6. Delegated authority.

(a) Any authority, power, or duty vested in the Commissioner by any provision of this title may be exercised, discharged, or performed by any deputy, assistant, examiner, or employee of the department acting in the Commissioner's name and by his delegated authority.

(b) The Commissioner shall be responsible for the official acts of such persons who act in his name and by his authority.

History. — Code 1933, § 56-213, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

OPINIONS OF THE ATTORNEY GENERAL

Limitation on authority of Commissioner to delegate duties. — Commissioner of Insurance may not delegate to the chief deputy insurance commissioner his membership or duties on the State Depository Board, the State Indemnification Commission, the Board of Trustees for the Subsequent Injury Trust Fund, or the State Commission on Condemnation of Public Property. 1995 Op. Att'y Gen. No. 95-11.

RESEARCH REFERENCES

ALR. — Personal liability of public officials or bond for permitting insurance company or other corporation to engage or continue in business without complying with statutory requirement, 131 A.L.R. 275.

33-2-7. Maintenance of records, books, or papers by Commissioner generally; furnishing of copies; disposal of records.

(a) The Commissioner shall enter in permanent form records of the official transactions, filings, examinations, investigations, and proceedings of his office and shall keep all records, books, and papers pertaining thereto in his office. Such records, books, and papers shall be deemed public records of the state except as may be provided otherwise in this chapter.

(b) Upon the request of any person and the payment of the applicable fee, the Commissioner shall supply a certified copy of any record in his office which is then subject to public inspection.

(c) The Commissioner may destroy or otherwise dispose of all records entered in his office in accordance with the rules and procedures provided for in Part 1A of Article 2 of Chapter 3 of Title 20; provided, however, that filings may be destroyed by direction of the Commissioner when superseded.

History. — Code 1933, § 56-203, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2013, p. 594, § 2-6/HB 287.

Cross references. — Management, printing, and public inspection of state documents, T. 50, C. 18.

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions rendered under former Code 1933, §§ 56-504a and 56-504b are included in the annotations for this Code section.

Copyrighted filings may be copied without infringement. — Copying of copyrighted manuals, rates, and rules which must be filed with the Insurance Commissioner would not constitute an unfair use and hence would not amount to an infringement, but to the contrary would constitute a fair use and one within the purpose for which the filing was made with the Commissioner. 1965-66 Op. Att'y Gen. No. 66-178 (rendered under former Code 1933, §§ 56-504a and 56-504b, repealed by Ga. L. 1967, p. 684).

List of licensed agents. — Insurance Department is not required to create a list

of all licensed insurance agents in order to provide copies of such a list of requesting citizens. 1982 Op. Att'y Gen. No. 82-50.

33-2-8 through 33-2-8.2.

Reserved. Repealed by Ga. L. 2019, p. 337, §§ 1-11—1-13/SB 132, effective July 1, 2019.

Editor's notes. — These Code sections, relating to reports of the Commissioner, were based on Ga. L. 1960, p. 289, § 1; Ga. L. 1976, p. 538, § 1; Ga. L. 1989, p. 885, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1990, p. 1496, § 1; Ga. L. 1996, p. 705, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2005, p. 1036, § 25/SB 49; Ga. L. 2012, p. 218, § 8/HB 397; Ga. L. 2013, p. 135, § 12/HB 354.

33-2-9. Rules and regulations.

(a) The Commissioner shall have full power and authority to make rules and regulations for the following purposes:

(1) To organize the department and to assign duties to members of the staff;

(2) To promulgate any rules and regulations as are reasonably necessary to implement this title;

(3) To promulgate any rules and regulations as are reasonably necessary to conform with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as said federal Act existed on January 1, 1997;

(4) To issue interpretative rulings or to prescribe forms required to carry out the responsibilities of his or her office; or

(5) To govern the procedure to be followed in the proceedings before the department.

(b) Before any rule or regulation shall become effective or before any amendment or repeal of any rule shall become effective, the proposed rule or regulation or amendment or repeal shall have been on file as a public record in the office of the Commissioner for at least ten days.

(c) Prior to the adoption of any rule or regulation or the amendment or repeal thereof, the Commissioner shall publish or otherwise circulate notice of his intended action and afford interested persons opportunity to submit data or views either orally or in writing.

(d) The Commissioner shall compile and keep on file in his office as a public record a set of such rules and regulations which are in effect and shall prepare copies of such rules and regulations which shall be available upon request. The Commissioner shall fix a price covering such compilation which shall cover costs of preparation and mailing.

(e) Neither the Commissioner, whether acting as Commissioner of Insurance or Safety Fire Commissioner, nor the department, nor the Safety Fire Division of the office of the Commissioner shall propose or adopt rules or regulations relating to the sale or dispensing of gasoline or diesel fuel to the general public by any business entity unless such rules or regulations require such sale or dispensing to be under the direct control and visual supervision of an on-site employee of such business entity.

History. — Code 1933, § 56-216, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1997, p. 1462, § 2; Ga. L. 1998, p. 1064, § 2; Ga. L. 2019, p. 474, § 2/SB 156.

The 2019 amendment, effective July 1, 2019, deleted "shall be approved as to legality by the Attorney General and" preceding "shall have been on file" in subsection (b).

Cross references. — Rules and regulations of Safety Fire Commissioner, § 25-2-4. Filing requirements for regulations, standards, and plans of Commissioner, § 50-13-21.

Editor's notes. — Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that the Act, which amended this Code section, is intended to comply with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as well as to provide an acceptable alternative mechanism for the availability of individual health insurance coverage as contemplated by that federal Act. Section 1 further provides that the Georgia Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

Administrative rules and regulations. — Regulations regarding agents, subagents, counselors, adjusters, surplus lines brokers, and agencies, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-3.

Life and annuity tables, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-39.

Readability standards for personal lines policies, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-42.

Administrative supervision, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-55.

Law reviews. — For review of 1998 legislation relating to insurance, see 15 Ga. St. U.L. Rev. 153 (1998).

JUDICIAL DECISIONS

Cited in Standard Guar. Ins. Co. v. Davis, 145 Ga. App. 147, 243 S.E.2d 531 (1978); Ferguson v. United Ins. Co. of Am., 163 Ga. App. 282, 293 S.E.2d 736 (1982); White v. State Farm Fire & Casualty Co., 291 Ga. 306, 728 S.E.2d 685 (2012).

OPINIONS OF THE ATTORNEY GENERAL

Rules and regulations may be made as to reciprocal or interinsurance exchange. — The general power to make rules and regulations conferred upon the Insurance Commissioner by this section is ample authority for the making of appropriate rules and regulations with respect to reciprocal or interinsurance exchange. 1950-51 Op. Att'y Gen. p. 101.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 27 et seq.

C.J.S. — 44 C.J.S., Insurance, § 45 et seq.

33-2-10. Issuance and service of orders and notices.

(a) Orders and notices of the Commissioner shall be effective only when they are in writing and signed by him or by his authority.

(b) Every such order shall state its effective date and shall state concisely:

(1) Its intent or purpose;

(2) The grounds on which it is based; and

(3) The provisions of this title pursuant to which action is taken or proposed to be taken; but failure to designate any provision shall not deprive the Commissioner of the right to rely thereon.

(c) An order or notice may be served by delivery to the person to be ordered or notified or by mailing it, postage prepaid, addressed to him at his principal place of business or last address of record in the Commissioner's office.

(d) In addition to the service provisions set forth in subsection (c) of this Code section, any order of the Commissioner issued to multiple recipients in the form of a general directive, data call, or bulletin may be served by sending it by email, so that receipt is acknowledged by the recipient, to the email address on record in the Commissioner's office. The Commissioner shall also post such general directive, data call, or bulletin contemporaneously on the department's website.

History. — Code 1933, § 56-217, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2004, p. 754, § 1; Ga. L. 2020, p. 493, § 33/SB 429.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "email" for "electronic mail" twice in the first sentence of subsection (d).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity to provisions of this title, decisions under former Code 1933, Chs. 20 and 21, repealed by Ga. L. 1960, p. 289, which, as amended, enacted this title, are included in the annotations for this section.

Ex parte suspension of previously approved rate filings held void. — Commissioner's ex parte order purporting to suspend rate filings which had previously been approved by him, without notice or hearing provided for by statute, was issued without lawful authority and void. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958); Cravey v. General Accident Fire & Life Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Cited in Caldwell v. Liberty Mut. Ins. Co., 248 Ga. 282, 282 S.E.2d 885 (1981).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 45 et seq.

33-2-11. Examination of insurers and organizations; effect of insurer's change of domicile from Georgia.

(a) Whenever the Commissioner shall deem it expedient, the Commissioner shall examine, either in person or by some examiner duly authorized by the Commissioner, the affairs, transactions, accounts, records, documents, and assets of each insurer authorized to do business in this state and any other facts relative to its business methods, management, and dealings with policyholders. At least once every five years, the Commissioner shall so examine each domestic insurer. Examination of an alien insurer shall be limited to its insurance transactions in the United States.

(b) Whenever he shall deem it necessary at least once in five years, the Commissioner shall fully examine each rating organization which is licensed in this state. As often as he shall deem it necessary, he may examine each advisory organization and each joint underwriting or joint reinsurance group, association, or organization.

(c) The Commissioner shall in like manner examine each insurer or rating organization applying for authority to do business in this state.

(d) In lieu of an examination under this Code section of any foreign or alien insurer licensed in this state, the Commissioner may accept an examination report on such insurer as prepared by the insurance department of such insurer's state of domicile or port-of-entry state until January 1, 1994. On and after January 1, 1994, such reports may be accepted only if:

(1) The insurance department was, at the time the examination was conducted, accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program; or

(2) The examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(e) Any insurer authorized to transact insurance in this state which changes its domicile from Georgia to another state on or after April 1, 1988, may be examined by the Commissioner once a year for five years,

beginning on or after the occurrence of the change in domicile; provided, however, this subsection shall not apply to an insurer which changes its domicile from Georgia to another state as long as it retains in this state its principal place of business and the complete records of its assets, transactions, and affairs.

History. — Code 1933, § 56-208, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1988, p. 692, § 1; Ga. L. 1989, p. 562, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1992, p. 2877, § 1; Ga. L. 2000, p. 1246, § 1; Ga. L. 2008, p. 1090, § 1/SB 471.

Law reviews. — For comment on Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), see 14 Ga. B.J. 468 (1952).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, a decision under former Code 1933, § 56-104, repealed by Ga. L. 1960, p. 289, which, as amended, enacted this title, are included in the annotations for this Code section.

Commissioner has power and duty to examine records. — By conferring the power to examine records on the Commissioner, the law, in equal measure, lays upon him the duty to do so whenever there is an apparent need for information concerning a company. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Commissioner may not require insurer to copy them. — Having the power and duty to investigate an insurance company, to inspect its original records, and to take the sworn testimony of its agents, the Commissioner has a duty to do so and is unauthorized to impose upon the company a duty to copy its records and refuse a renewal of its license upon its failure in that respect. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Full performance of Commissioner's duties will give Commissioner all information. — There is nothing in the law placing upon the insurance company a duty to copy its records and mail them to the Commissioner; when he has fully performed his duties and employed the powers given him by law, he will have all the information that he could obtain by requiring copies of the company's records to be mailed to him. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions rendered under former Code 1933, § 56-104 are included in the annotations for this Code section.

Examination of organization operating like fraternal benefit society authorized. — The Insurance Commissioner may legally cause an investigation and examination of unlicensed and unincorporated organizations doing business in this state and operating in a manner similar to that of fraternal benefit societies, upon notice and an opportunity for a hearing being provided. 1952-53 Op. Att'y Gen. p. 373 (rendered under former Code 1933, § 56-104, repealed by Ga. L. 1960, p. 289).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, §§ 66, 134 et seq.

33-2-12. Examination of agents, solicitors, brokers, counselors, adjusters, managers, and promoters.

For the purpose of ascertaining their compliance with this title, when he deems it necessary in the public interest, the Commissioner may examine the affairs, accounts, records, documents, and transactions of:

(1) Any insurance agent, subagent, broker, counselor, adjuster, or any other person licensed under this title;

(2) Any person having a contract under which he enjoys in fact the exclusive or dominant right to control an insurer;

(3) Any person holding the shares of capital stock or policyholder proxies of a domestic insurer for the purpose of control of its management either as voting trustee or otherwise;

(4) Any person engaged in the promotion or formation of a domestic insurer, or insurance holding corporation, or corporation to finance a domestic insurer or the production of its business;

(5) Any other person transacting the business of insurance, whether authorized or unauthorized;

(6) Any person or affiliate of such person who proposes or makes application to acquire any domestic insurer or any affiliate of a domestic insurer; and

(7) Any person seeking to acquire any other person subject to the jurisdiction of the Commissioner pursuant to this title.

History. — Code 1933, § 56-209, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 2.

JUDICIAL DECISIONS

Cited in Clinton v. State Farm Mut. Auto. Ins. Co., 110 Ga. App. 417, 138 S.E.2d 687 (1964); Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 45 et seq.

ALR. — Public regulation or control of insurance agents or brokers, 10 A.L.R.2d 950.

33-2-13. Access of Commissioner to records; correction of inadequate or incorrect accounts.

(a) Every person being examined, its officers, employees, and representatives shall produce and make freely accessible to the Commis-

sioner the accounts, records, documents, and files in his possession or control relating to the subject of the examination. Such officers, employees, and representatives shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(b) If the Commissioner finds the accounts to be inadequate or incorrectly kept or posted, he may employ experts to rewrite, post, or balance such records at the expense of the person being examined, if such person has failed to correct such accounting within 60 days after the Commissioner has given him notice to do so.

History. — Code 1933, § 56-210, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Inspection of public records, § 50-18-70 et seq.

JUDICIAL DECISIONS

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 52.

33-2-14. Preparation of written reports of examinations generally; certification of reports; admissibility in evidence; notice and hearing on reports; use of examination documents.

(a) The Commissioner may make a full written report of each examination made by him containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of witnesses.

(b) The report shall be certified by the Commissioner or by the examiner in charge of the examination and when so certified, after filing as provided in subsection (c) of this Code section, shall be admissible in evidence in any proceeding brought by the Commissioner against the person examined or any officer or agent of such person and shall be prima-facie evidence of the facts stated therein.

(c) The Commissioner shall furnish a copy of the proposed report to the person examined not less than 20 days prior to filing the report. If such person so requests in writing within such 20 day period or such longer period as the Commissioner may grant, the Commissioner shall grant a hearing with respect to the report and shall not so file the report until after the hearing and such modifications have been made therein as the Commissioner may deem proper.

(d) The Commissioner may withhold from public inspection the report of any examination or investigation for so long as he deems it to

be in the public interest or necessary to protect the person examined from unwarranted injury.

(e) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. In such event, the findings of fact and conclusions made pursuant to said examination and prior to any hearing as set forth in subsection (c) of this Code section shall be prima-facie evidence in any legal or regulatory action.

(f) In the event the Commissioner determines that regulatory action is appropriate as a result of any examination, he or she may initiate any proceeding or actions as provided by law.

(g) Notwithstanding the provisions of Article 4 of Chapter 18 of Title 50, relating to the inspection of public records, all work papers, analysis, information, documents, information received from another state, and any other materials created, produced, or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this chapter or in the course of analysis by the Commissioner of the financial condition or market conduct of a company must be given confidential treatment and are not subject to subpoena and may not be made public by the Commissioner or any other person. Access may be granted to authorized representatives of the National Association of Insurance Commissioners. Such representatives must agree in writing prior to receiving the information to treat such information confidentially as required by this Code section, unless the prior written consent of the company to which it pertains has been obtained.

(h) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to use any preliminary or final examination or company work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

(i) Nothing contained in this Code section shall prevent or be construed as prohibiting the Commissioner from disclosing the work papers, analysis, information, or a document described in subsection (g) of this Code section to state, federal, or international regulatory agencies or state, federal, or international law enforcement authorities so long as such recipient agrees in writing to treat such report confidentially and in a manner consistent with this title.

History. — Code 1933, § 56-211, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 3; Ga. L. 2008, p. 1090, § 2/SB 471; Ga. L. 2012, p. 1117, § 1/SB

385.

Cross references. — Inspection of public records, § 50-18-70 et seq.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-2-15. Payment of expenses of examinations; immunity of examiners.

(a) At the direction of the Commissioner, the insurer or other person so examined shall pay all the actual travel and living expenses of the examination. When the examination is made by an examiner who is not a regular employee of the department, the person examined shall pay the proper charges for the services of the examiner and his or her assistants and the actual travel and living expenses incurred by such examiners and assistants in an amount approved by the Commissioner. A consolidated account for the examination shall be filed by the examiner with the Commissioner. No person shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted in whole or in part by regular salaried employees of the department, payment for such services and proper expenses shall be made by the person examined to the Commissioner, and such payment shall be deposited in the state treasury; provided, however, that, when an agent, broker, solicitor, counselor, or adjuster is examined because of a complaint filed against such agent, broker, solicitor, counselor, or adjuster and when the Commissioner finds that the complaint was not justified, the expenses of the examination shall not be assessed against the agent, broker, solicitor, counselor, or adjuster but shall be borne by the department.

(b) An examiner or other person appointed or authorized by the Commissioner, while participating in an examination conducted under this chapter, shall enjoy the same immunities as those of a regular employee of the department under similar circumstances.

History. — Code 1933, § 56-212, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1985, p. 1087, § 1; Ga. L. 2008, p. 1090, § 3/SB 471.

33-2-16. Powers of Commissioner as to evidence and witnesses; payment of witness fees and expenses; subpoenas; giving of false testimony.

(a) With respect to the subject of any examination, investigation, or hearing conducted by him or his duly authorized representative, the Commissioner may take depositions, subpoena witnesses, administer

oaths or affirmations, examine any individual under oath, and compel the production of records, books, papers, and other documents.

(b) Witness fees and mileage, if claimed, shall be allowed as for witnesses appearing in superior court. Witness fees, mileage, and the actual expense necessarily incurred in securing attendance of witnesses and their testimony shall be itemized and shall be paid by the person being examined or investigated, if in the proceedings in which the witness is called such person is found to be in violation of the law, or paid by the person, if other than the Commissioner, at whose request the hearing is held.

(c) Subpoenas of witnesses shall be served in the same manner as if issued by a superior court. If any individual fails to obey a subpoena issued and served under this subsection with respect to any matter concerning which he may be lawfully interrogated, on application of the Commissioner the superior court of the county in which the proceeding is pending at which such individual was so required to appear may issue an order requiring such individual to comply with the subpoena and to testify.

(d) Any person willfully testifying falsely under oath as to any matter material to any such examination, investigation, or hearing shall have committed the offense of false swearing.

(e) In addition to any other liability or punishment prescribed, any person who without just cause fails or refuses to attend and testify or to answer any lawful inquiry or to produce any books, papers, or records in obedience to a lawful subpoena issued by the Commissioner or by his authority shall be guilty of a misdemeanor.

History. — Code 1933, § 56-215, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Penalty for false swearing, § 16-10-71. Subpoenas for attendance of witnesses, § 24-13-20 et seq. Witness fees and mileage, § 24-13-25.

JUDICIAL DECISIONS

Subsection (c) provides an adequate remedy to contest the lawfulness of the Commissioner's subpoena action. Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

33-2-17. Conduct of hearings by Commissioner generally; demands for hearings.

(a) The Commissioner may hold hearings for any purpose within the scope of this title as he may deem necessary.

(b) He shall hold a hearing:

(1) If required by any provision of this title; or

(2) Upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the Commissioner to act if such failure is deemed an act under any provision of this title or by any report, promulgation, or order of the Commissioner, other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party or order pursuant to the order on such hearing.

(c) Any demand for a hearing pursuant to this Code section shall specify in what respects such person is aggrieved and the grounds to be relied upon as a basis for the relief to be demanded at the hearing; and, unless postponed by mutual consent, the hearing shall be held within 30 days after receipt by the Commissioner of the demand for a hearing. Such hearing shall be held only if the Commissioner shall find that the demand for a hearing is made in good faith, that the applicant would be aggrieved, and that such grounds otherwise justify holding such hearing.

(d) Pending the hearing and decision on holding the hearing, the Commissioner may suspend or postpone the effective date of his previous action.

History. — Code 1933, § 56-218, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Administrative hearings in contested cases generally, § 50-13-13 et seq.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, Chs. 56-20 and 56-21, repealed by Ga. L. 1960, p. 289, which, as amended, enacted this title, are included in the annotations for this Code section.

Section inapplicable to workers' compensation rate hearing. — A hearing as to workers' compensation insurance rates before the Insurance Commissioner is rightly held pursuant to authority of former Code 1933, § 114-609 (see O.C.G.A. § 34-9-130) and pursuant to former Code Section 3A-114 (see O.C.G.A. § 50-13-13) and not pursuant to this Code section. This is so because the workers' compensation insurance rate-making function (although performed by the Insurance Commissioner) is not within the scope of this title, but is within the scope of T. 34, C. 9. National Council on Comp. Ins. v. Caldwell, 154 Ga. App. 528, 268 S.E.2d 793 (1980).

Ex parte order suspending previously, approved rate filing held void. — Commissioner's ex parte order purporting to suspend rate filings which had previously been approved by him, without notice or hearing provided for by statute was issued without lawful authority, and void. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958). See also Cravey v. General Accident Fire & Life Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Entitlement to equitable relief. — Authorized rating organizations, having made substantial allegations showing that an invalid order issued by the Insurance Commissioner would work great hardship on them, causing irreparable injury to their business and property rights, and being without an adequate remedy at law, were entitled to equitable relief. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958); Cravey v. General Accident Fire & Life

Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Administrative review not required. — Authorized rating organizations are not required to seek administrative review of a rate suspension order, alleged to be void for want of authority in the Commissioner to issue it, before resorting to the courts. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958); Cravey v. General Accident Fire & Life Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972); Caldwell v. Liberty Mut. Ins. Co., 248 Ga. 282, 282 S.E.2d 885 (1981); Darden v. Ford Consumer Fin. Co., 200 F.3d 753 (11th Cir. 2000); Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

33-2-18. Place of hearings; hearings to be open to public.

The hearing shall be held at the place designated by the Commissioner and shall be open to the public.

History. — Code 1933, § 56-219, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Administrative hearings in contested cases generally, § 50-13-13 et seq.

JUDICIAL DECISIONS

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

33-2-19. Notice of hearings generally.

Not less than ten days in advance the Commissioner shall give notice of the time and place of the hearing stating the matters to be considered at the hearing. If the persons to be given notice are not specified in the provision pursuant to which the hearing is held, the Commissioner shall give notice to all persons directly affected by such hearing. In the event all persons directly affected are unknown, notice may be perfected by publication in a newspaper of general circulation in this state at least ten days prior to the hearing.

History. — Code 1933, § 56-220, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Notice requirements for administrative hearings generally, § 50-13-13.

JUDICIAL DECISIONS

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 27.

C.J.S. — 44 C.J.S., Insurance, § 67 et seq.

33-2-20. Notice to show cause.

If any person is entitled to a hearing by any provision of this title before any proposed action is taken, the notice of the proposed action may be in the form of a notice to show cause stating that the proposed action may be taken, unless such person shows cause at a hearing to be held as specified in the notice why the proposed action should not be taken and stating the basis of the proposed action.

History. — Code 1933, § 56-221, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Notice requirements for administrative hearings generally, § 50-13-13.

JUDICIAL DECISIONS

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 27.

C.J.S. — 44 C.J.S., Insurance, § 67 et seq.

33-2-21. Presiding officer at hearing; rights of parties; intervention; pleading and evidence; record of proceedings; rehearing or reargument.

(a) The hearing shall be presided over by the Commissioner or his designated representative.

(b) The Commissioner shall allow any party to the hearing to appear in person or by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the Commissioner to compel attendance of witnesses and production of evidence in his behalf.

(c) The Commissioner shall permit to become a party to the hearing by intervention, if timely, only such persons who may be aggrieved by the Commissioner's order made upon the hearing.

(d) Formal rules of pleading or evidence need not be observed at any hearing.

(e) Upon written request seasonably made by a party to the hearing and at such person's expense, the Commissioner shall cause a full record of the proceedings to be made. If transcribed, a copy of such record shall be furnished to the Commissioner without cost to the Commissioner or the state and shall be a part of the Commissioner's record of the hearing. If so transcribed, a copy of the record shall be

furnished to any other party to the hearing at the request and expense of the other party. If no record is made or transcribed, the Commissioner shall prepare an adequate record of the evidence and of the proceedings.

(f) Upon written request of a party to a hearing filed with the Commissioner within 30 days after any order made pursuant to a hearing has been mailed or delivered to the persons entitled to receive the same, the Commissioner may in his discretion grant a rehearing or reargument of the matters involved in such hearing; and notice of the rehearing or reargument shall be given as provided in Code Section 33-2-19.

History. — Code 1933, § 56-222, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Intervention in administrative hearings generally, § 50-13-14. Rules of evidence in administrative hearings generally, § 50-13-15.

JUDICIAL DECISIONS

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance § 27.

C.J.S. — 44 C.J.S., Insurance, § 67 et seq.

33-2-22. Adjournment of hearings; effect of nonattendance.

(a) The Commissioner may adjourn any hearing from time to time and from place to place without other notice of the adjourned hearing than announcement thereof at the hearing.

(b) The validity of any hearing held in accordance with the notice thereof shall not be affected by failure of any person to attend the hearing or to remain in attendance.

History. — Code 1933, § 56-223, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 27.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-2-23. Issuance of order on hearing; contents.

(a) Within 30 days after termination of the hearing or of any rehearing or reargument, the Commissioner shall make his order thereon covering matters involved in the hearing and in any rehearing or reargument and shall give a copy of the order to the same persons given notice of the hearing.

(b) The order shall contain a concise statement of the facts as found by the Commissioner, a concise statement of his conclusions therefrom, and the effective date of the order.

(c) The order may affirm, modify, or nullify action theretofore taken or may constitute the taking of new action within the scope of the notice of hearing.

History. — Code 1933, § 56-224, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Thirty-day provision not mandatory. — Provision that the commissioner "shall" issue an order within 30 days after the hearing was not mandatory, but was directory, in the absence of injury to the defendant and in the absence of a penalty for failure to comply with O.C.G.A. § 33-2-23. Commissioner of Ins. v. Stryker, 218 Ga. App. 716, 463 S.E.2d 163 (1995).

Cited in Southeastern Adjusters, Inc. v. Caldwell, 229 Ga. 4, 189 S.E.2d 76 (1972); Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 20.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-2-24. Enforcement of title and rules, regulations, and orders; issuance of orders without hearings; civil actions; criminal violations; penalties.

(a) Whenever it may appear to the Commissioner, either upon investigation or otherwise, that any person has engaged in, is engaging in, or is about to engage in any act, practice, or transaction which is prohibited by this title or by any rule, regulation, or order of the Commissioner promulgated or issued pursuant to this title or which is declared to be unlawful under this title, the Commissioner may at his discretion issue an order, if he deems it to be appropriate in the public interest or for the protection of policyholders or the citizens of this state, prohibiting such person from continuing such act, practice, or transaction.

(b) Notwithstanding any other provision of this title, in situations where persons otherwise would be entitled to a hearing prior to an

order, the Commissioner may issue a proposed order to be effective upon a later date without hearing, unless persons subject to the order request a hearing within ten days after receipt of the order. Failure to make the request shall constitute a waiver of any provision of law for the hearing. The order shall contain or shall be accompanied by a notice of opportunity for hearing which clearly explains that the opportunity must be requested within ten days of receipt of the order and notice. The order and notice shall be served in person by the Commissioner or his agent or by registered or certified mail or statutory overnight delivery, return receipt requested.

(c) Notwithstanding any other provision of this title, in situations where persons otherwise would be entitled to a hearing prior to an order, the Commissioner may issue an order to be effective immediately, if the Commissioner has reasonable cause to believe: that an act, practice, or transaction is occurring or is about to occur; that the situation constitutes a situation of imminent peril to the public health, safety, or welfare; and that the situation therefore imperatively requires emergency action. The emergency order shall contain findings to this effect and reasons for the determination. The order shall contain or be accompanied by a notice of opportunity for hearing which may provide that a hearing will be held if and only if a person subject to the order requests a hearing within ten days of receipt of the order and notice. The order and notice shall be served by delivery by the Commissioner or his agent or by registered or certified mail or statutory overnight delivery, return receipt requested.

(d) The Commissioner may institute actions or other legal proceedings as may be required for the enforcement of any provisions of this title. If the Commissioner has reason to believe that any person has violated any provision of this title for which criminal prosecution is provided, he shall so inform the prosecuting attorney in whose circuit or jurisdiction such violation may have occurred.

(e) The Commissioner may prosecute an action in any superior court of proper venue to enforce any order made by him pursuant to this title.

(f) In cases in which the Commissioner institutes an action or other legal proceeding in a superior court of this state or prosecutes an action in a superior court to enforce his order, the superior court may among other appropriate relief issue an injunction restraining persons and those in active concert with them, including agents, employees, partners, officers, and directors, from engaging in acts prohibited by orders of the Commissioner or his rules or regulations or made unlawful or prohibited by this title.

(g) In addition to all other penalties provided for under this title, the Commissioner shall have the authority:

(1) To place any person duly licensed under this title on probation for a period of time not to exceed one year for each and every act in violation of this title or of the rules, regulations, or orders of the Commissioner; and

(2) To subject any person duly licensed or that should be licensed under this title to a monetary penalty of up to $2,000.00 for each and every act in violation of this title or of the rules, regulations, or orders of the Commissioner, unless such person knew or reasonably should have known he or she was in violation of this title or of the rules, regulations, or orders of the Commissioner, in which case the monetary penalty provided for in this paragraph may be increased to an amount up to $5,000.00 for each and every act in violation.

(h) The Commissioner may not institute any action or impose any penalty against an insurer because an insurer engages in transactions consistent with the provisions of Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," or Code Section 33-24-14.

History. — Code 1933, § 56-214, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1975, p. 1245, § 1; Ga. L. 1976, p. 411, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 136, § 33; Ga. L. 2000, p. 1589, § 3; Ga. L. 2005, p. 563, § 1/HB 407; Ga. L. 2010, p. 9, § 1-63/HB 1055; Ga. L. 2014, p. 818, § 1/HB 840; Ga. L. 2014, p. 829, § 1/HB 645.

JUDICIAL DECISIONS

Cited in Consumer Life Ins. Co. v. United States, 524 F.2d 1167 (Ct. Cl. 1975); State Farm Fire & Cas. Co. v. Sweat, 547 F. Supp. 233 (N.D. Ga. 1982); Am. Ass'n of Cab Cos. v. Parham, 291 Ga. App. 33, 661 S.E.2d 161 (2008); State Farm Mut. Auto. Ins. Co. v. Hernandez Auto Painting & Body Works, 312 Ga. App. 756, 719 S.E.2d 597 (2011).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 27 et seq.

C.J.S. — 44 C.J.S., Insurance, § 67 et seq.

ALR. — Personal liability of public officials or bond for permitting insurance company or other corporation to engage or continue in business without complying with statutory requirement, 131 A.L.R. 275.

33-2-25. Effect of chapter upon power of Commissioner or superior courts to enforce title; construction of grants of power contained in chapter.

Nothing contained in this chapter is intended to limit or repeal any power or authority elsewhere granted the Commissioner or the superior courts in the enforcement of this title. Nor shall any grant of authority or power contained in this chapter be read to imply that such grant of authority or power was not conferred by a preexisting law.

History. — Ga. L. 1976, p. 411, § 2.

33-2-26. Persons entitled to appeal; procedure generally.

An appeal from the Commissioner shall be taken only from an order on hearing or with respect to a matter as to which the Commissioner has refused or failed to grant or hold a hearing after demand therefor under Code Section 33-2-17 or as to a matter as to which the Commissioner has refused or failed to make his order on hearing as required by Code Section 33-2-23. Any person who was a party to the hearing or whose pecuniary interests are directly and immediately affected by the refusal or failure to grant a hearing and who is aggrieved by the order, refusal, or failure may appeal from the order on hearing or as to any such matter within 30 days after:

(1) The order on hearing has been mailed or delivered to the persons entitled to receive the same;

(2) The Commissioner's order denying rehearing or reargument has been so mailed or delivered;

(3) The Commissioner has refused or failed to make his order on hearing as required under Code Section 33-2-23; or

(4) The Commissioner has refused or failed to grant or hold a hearing as required under Code Section 33-2-17.

History. — Code 1933, § 56-225, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Judicial review of contested cases before administrative agencies generally, § 50-13-19.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, Chs. 56-20 and 56-21, repealed by Ga. L. 1960, p. 289, which, as amended, enacted this title, are included in the annotations for this Code section.

Authorized rating organizations have the right to seek equitable relief in their own right as well as in their representative capacities for the insurers which are members of the various associations. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958).

While the statutes do not expressly confer under rating bureaus the power to sue and be sued generally, since they do empower them to appeal from orders and decisions of the Commissioner after the proper administrative procedures have been taken, under a proper construction of these statutes authorized rating organizations are legal entities and have the necessary standing to seek to enjoin an alleged invalid order or decision of the Commissioner, provided, of course, that all prerequisites for such relief are established. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958).

Against invalid order of Commissioner. — Authorized rating organizations, having made substantial allegations showing that an invalid order issued by the Insurance Commissioner would work great hardship on them, causing irreparable injury to their business and property rights, and being without an adequate remedy at law, were entitled to

equitable relief. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958). See also Cravey v. General Accident Fire & Life Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Administrative review not required. — Authorized rating organizations are not required to seek administrative review of a rate suspension order, alleged to be void for want of authority in the Commissioner to issue it, before resorting to the courts. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958). See also Cravey v. General Accident Fire & Life Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Review of order on plan of conversion. — The orders encompassed by O.C.G.A. § 33-2-26 include hearings to determine the propriety of plans of conversion set forth in O.C.G.A. § 33-20-34. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

Cited in First Union Nat'l Bank v. Independent Ins. Agents of Ga., Inc., 197 Ga. App. 227, 398 S.E.2d 254 (1990).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 32.

C.J.S. — 44 C.J.S., Insurance, § 70 et seq.

33-2-27. Pleading and procedure of judicial review; powers of reviewing court generally.

(a) The form of proceeding for judicial review shall be by a petition in the Superior Court of Fulton County, a copy of which shall be served upon the Commissioner immediately.

(b) The proceedings shall follow the course which is now or may hereafter be prescribed for civil actions in the superior courts, provided that the reviewing court may by order extend the time required for filing any pleadings or motions. In addition, the reviewing court may provide by order for expeditious hearing or trial of any such proceedings as justice or the public interest may require.

(c) The petition or other pleading in which judicial review shall be sought shall plainly specify the action complained of and shall set forth the relief sought and, without excessive detail, the facts and circumstances supporting the petitioner's right to such relief.

(d) Pending judicial review pursuant to any proceeding authorized for the purpose, the Commissioner, if the action has not become effective, may postpone the effective date of the action complained of. Upon such conditions as may be required and to the extent necessary to preserve the status of proceedings or the rights of the parties or to prevent irreparable injury, in any proceeding for judicial review the reviewing court or any appellate court is authorized to issue all necessary and appropriate orders to postpone the effective date of any action or temporarily to grant or extend relief denied or withheld.

(e) Whether or not prayed for, the court may remand the matter for further proceedings or findings on terms specified by order or may

require the parties to complete any record found to be inaccurate or inadequate for decision.

History. — Code 1933, § 56-226, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For article surveying developments in Georgia workers' compensation law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 323 (1981). For article, "Administrative Law," see 53 Mercer L. Rev. 81 (2001).

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Review of order on plan of conversion. — The orders encompassed by O.C.G.A. § 33-2-26 on appeals from actions of the Commissioner include hearings to determine the propriety of plans of conversion set forth in O.C.G.A. § 33-20-34. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

Cited in National Council on Comp. Ins. v. Caldwell, 154 Ga. App. 528, 268 S.E.2d 793 (1980).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 32.

C.J.S. — 44 C.J.S., Insurance, § 70 et seq.

33-2-28. Scope of judicial review; disposition of action by reviewing court.

(a) Unless review of the action complained of is required by law to be de novo:

(1) In cases in which proceedings have been held before the Commissioner, the Commissioner shall file with his reply to the reviewing court a certified transcript of all such proceedings and all evidence before him in such proceedings; provided, however, that the parties may by written stipulation agree to an abbreviated record including so much of the transcript as shall be necessary to determine the questions under review;

(2) The reviewing court's decision shall be upon the basis of the pleadings and the record so presented;

(3) The findings of the Commissioner as to any fact, if supported by substantial evidence upon consideration of the record as a whole, shall be conclusive;

(4) If issues of fact outside the record shall be made by the pleadings, they may be determined by the court.

(b) Judicial review of any fact determined by the Commissioner shall be de novo unless:

(1) The determination was made after a hearing required or authorized by this title; or

(2) The determination is one committed by law to the Commissioner's discretion.

(c) So far as necessary to decision and where presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of any department action. The court shall:

(1) Compel department action unlawfully withheld or unreasonably delayed; and

(2) Hold unlawful and set aside department action, findings, and conclusions found to be:

(A) Arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) Contrary to legal or constitutional right, power, privilege, or immunity;

(C) In excess of statutory jurisdiction, authority, or limitations or short of statutory right;

(D) Without observance of procedure required by law;

(E) Unsupported by substantial evidence upon consideration of the record as a whole in cases determined pursuant to paragraphs (2) and (3) of subsection (a) of this Code section;

(F) Unwarranted by the facts in cases in which the facts are subject to trial de novo by the reviewing court.

(d) In making the determinations called for in subparagraphs (A) through (F) of paragraph (2) of subsection (c) of this Code section, the court shall review the whole record or such portions of the record as may be cited by any party; and due account shall be taken of the rule of prejudicial error.

(e) The reviewing court may also grant such further relief either legal or equitable, or both, as the interest of the public and the aggrieved parties in such proceedings shall require.

History. — Code 1933, § 56-227, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

This section presents a broader scope for judicial inquiry on review than in most appeals from fact-finding bodies (e.g., those from the State Board of Workers' Compensation). Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Reviewing court is limited to pleadings and record made below. — Under paragraph (2) of subsection (a) of this section, the superior court in reviewing

the merits of a ruling of the commissioner is limited to the pleadings and the record made before the Commissioner. Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

Decision must be based on whole record. — A reviewing court's decision must be based on the record as a whole and not simply on those parts of it regarded as favorable to the commissioner's conclusion. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

It is the court's duty, when reviewing proceedings held before the Commissioner of Insurance, to consider evidence in the record that is favorable as well as that which is unfavorable to the commissioner's decision and then determine whether the decision is, in light of the whole record, supported by substantial evidence, and if it is not, it should be reversed. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Findings not supported by substantial evidence in whole record are not binding. — Findings of fact arbitrarily, capriciously, or indifferently drawn without substantial evidence supporting them in the record as a whole are not binding on reviewing courts. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Finding reasonable competition did not exist. — To authorize the Commissioner's conclusion of law that an insurer's rates were excessive because a reasonable degree of competition did not exist in the area with respect to the classification to which the rates were applicable, the evidence must substantially support the principle that the insurer was not reasonably competitive with other companies collectively. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Cited in National Council on Comp. Ins. v. Caldwell, 154 Ga. App. 528, 268 S.E.2d 793 (1980).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 32.

C.J.S. — 44 C.J.S., Insurance, § 70 et seq.

33-2-29. Disposition of amounts collected under title generally; allowance of refunds and credits.

The Commissioner shall promptly pay all taxes, fees, dues, charges, and penalties and interest which he is authorized to collect under this title to the Office of the State Treasurer to the credit of the general fund. The Commissioner, however, is authorized to make refunds of or to allow credits for any amounts which have been illegally or erroneously paid or collected pursuant to any provision of this title; and such payments to the Office of the State Treasurer shall be less the amount of any such refunds or credits, provided that no refunds or credits shall be allowed under this Code section unless a written request for such refund or credit is filed with the Commissioner within seven years from the date of payment or collection of the amount for which a refund or credit is claimed.

History. — Code 1933, § 56-228, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1976, p. 1080, § 1; Ga. L. 1993, p. 1402, § 18; Ga. L. 2010, p. 863, § 2/SB 296.

33-2-30. Limitation period for issuance of notice of deficiency assessment or execution thereon; waiver of limitations.

(a) Except in the case of fraud or failure to file a return required by this title, every notice of a deficiency assessment or the issuance of an execution thereon shall be given within seven years from the date on which such return is filed. In the case of failure to file a return, the notice of a deficiency assessment or the issuance of an execution thereon shall be given within ten years from the date on which such return is due. In the case of fraud there shall be no time limitation.

(b) If, before the expiration of the time prescribed in this Code section for giving of a notice of deficiency assessment or before the issuance of an execution thereon, the taxpayer has consented in writing to the giving of the notice after such time, the notice may be given at any time prior to the expiration of the time agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

History. — Code 1933, § 56-228.1, enacted by Ga. L. 1976, p. 1080, § 1.

RESEARCH REFERENCES

ALR. — Effect of fraud to toll the period for bringing action prescribed in statute creating the right of action, 15 A.L.R.2d 500.

Validity, and applicability to causes of action not already barred, of a statute enlarging limitation period, 79 A.L.R.2d 1080.

33-2-31. Extension of time for filing tax return or paying tax; payment of interest by taxpayer granted extension.

The Commissioner for good cause shown may extend for no more than 30 days the time for filing a tax return or paying any amount required to be paid with any return. The extension may be granted at any time, provided that a request therefor is filed with the Commissioner within or prior to the period for which the extension may be granted. Any taxpayer to whom an extension is granted shall pay, in addition to the tax, interest at the rate of 1 percent per month or fraction thereof until the date of payment.

History. — Code 1933, § 56-228.2, enacted by Ga. L. 1976, p. 1080, § 1.

33-2-32. Fees.

(a) Each corporation or individual, of whatever name or class, which now has or which may hereafter have bonds or securities on deposit as

the law provides, is required, on or before January 15 of each year, to pay fees in amounts as provided in Code Section 33-8-1.

(b) All fees collected under subsection (a) of this Code section shall be paid into the general fund of the state treasury.

(c) If a fee prescribed in subsection (a) of this Code section has not been paid on or before January 15, the Commissioner shall refuse to accept the deposits required by law and shall not certify their acceptance until the fee is fully paid. The Commissioner shall suspend or revoke the license of the delinquent company or individual until the fee is fully paid.

History. — Ga. L. 1909, p. 145, § 2; Ga. L. 1927, p. 131, § 2; Code 1933, § 40-1202; Code 1981, § 33-2-32, enacted by Ga. L. 1984, p. 22, § 33; Ga. L. 1992, p. 2725, § 7.

Editor's notes. — The provisions of this Code section were previously enacted in substantially similar form by the Acts and codes listed in the historical citation. However, those provisions were not originally enacted as part of the O.C.G.A. by the Code enactment Act (Ga. L. 1981, Ex. Sess., p. 8).

33-2-33. List of written requests for assistance by citizens against insurers.

Reserved. Repealed by Ga. L. 2019, p. 337, § 1-14/SB 132, effective July 1, 2019.

Editor's notes. — This Code section was repealed prior to becoming effective and was based on Ga. L. 1989, p. 633, § 1.

33-2-34. Insurance compliance self-evaluative privilege.

(a) To encourage insurance companies and persons conducting activities regulated under this title, both to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with state and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communications relating to voluntary internal compliance audits. The General Assembly hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this state's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance issues. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Code section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

(b) As used in this Code section, the term:

(1) "Insurance compliance audit" means a voluntary, internal evaluation, review, assessment, or audit not otherwise expressly required by law of an insurer or an activity regulated under this title, or other state or federal law applicable to an insurer, or of management systems related to the insurer or activity, that is designed to identify and prevent noncompliance and to improve compliance with those statutes, rules, or orders. An insurance compliance audit may be conducted by the insurer, its employees, or independent contractors.

(2) "Insurance compliance self-evaluative audit document" means any document prepared as a result of or in connection with and not prior to an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, computer generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided that this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document may also include any of the following:

(A) An insurance compliance audit report prepared by an auditor, who may be an employee of the insurer or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(B) Memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(C) An implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(D) Analytic data generated in the course of conducting the insurance compliance audit.

(c)(1) An insurance compliance self-evaluative audit document is privileged information and is not admissible as evidence in any legal action in any civil, criminal, or administrative proceeding, except as provided in subsections (d) and (e) of this Code section. Documents, communications, data, reports, or other information created as a result of a claim involving personal injury or workers' compensation made against an insurance policy are not insurance compliance self-evaluative audit documents and are admissible as evidence in

civil proceedings as otherwise provided by applicable rules of evidence or civil procedure, subject to any applicable statutory or common law privilege, including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(2) If any insurer, person, or entity performs or directs the performance of an insurance compliance audit, an officer or employee involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, shall not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this Code section. This paragraph shall not apply if the privilege set forth in paragraph (1) of this subsection is determined under subsection (d) or (e) of this Code section not to apply.

(3) An insurer may voluntarily submit, in connection with examinations conducted under this Code section, an insurance compliance self-evaluative audit document to the Commissioner, or his or her designee, as a confidential document under subsection (g) of Code Section 33-2-14 without waiving the privilege set forth in this Code section to which the insurer would otherwise be entitled. However, the provision permitting the Commissioner to provide access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document so voluntarily submitted. Nothing contained in this subsection shall give the Commissioner any authority to compel an insurer to disclose involuntarily or otherwise provide an insurance compliance self-evaluative audit document.

(d)(1) The privilege set forth in subsection (c) of this Code section shall not apply to the extent that it is expressly waived by the insurer that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in subsection (c) of this Code section is asserted, if the court determines that:

(A) The privilege is asserted for a fraudulent purpose;

(B) The material is not subject to the privilege; or

(C) Even if subject to the privilege, the material shows evidence of noncompliance with state or federal statutes, rules, and orders and the insurer failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time.

(3) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in subsection (c) of this Code section is asserted, if the court determines that:

(A) The privilege is asserted for a fraudulent purpose;

(B) The material is not subject to the privilege;

(C) Even if subject to the privilege, the material shows evidence of noncompliance with state or federal statutes, rules, and orders and the insurer failed to undertake reasonable corrective action or eliminate such noncompliance within a reasonable time; or

(D) The material contains evidence relevant to the commission of a criminal offense under this title and:

(i) The Commissioner has a compelling need for the information;

(ii) The information is not otherwise available; and

(iii) The Commissioner is unable to obtain the substantial equivalent of the information by any means without incurring unreasonable cost and delay.

(e)(1) Within 30 days after the Commissioner makes a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this subsection, the insurer that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Code section or subject to disclosure. The court has jurisdiction over a petition filed by an insurer under this subsection requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the insurer to file a petition waives the privilege.

(2) An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its petition for an in camera hearing all of the information set forth in paragraph (5) of this subsection.

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within 45 days after the filing of the petition, an in camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Code section or subject to disclosure.

(4) The court, after an in camera review, may require disclosure of material for which the privilege in subsection (c) of this Code section

is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in paragraph (2) of subsection (d) of this Code section is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in paragraph (3) of subsection (d) of this Code section is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) An insurer asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall provide to the Commissioner at the time of filing any objection to the disclosure:

(A) The date of the insurance compliance self-evaluative audit document;

(B) The identity of the entity conducting the audit;

(C) The general nature of the activities covered by the insurance compliance audit; and

(D) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(f)(1) An insurer asserting the insurance compliance self-evaluative privilege set forth in subsection (c) of this Code section has the burden of demonstrating the applicability of the privilege. Once an insurer has established the applicability of the privilege, a party seeking disclosure under paragraph (2) or (3) of subsection (d) of this Code section has the burden of proving that the privilege is asserted for a fraudulent purpose or that the insurer failed to undertake reasonable corrective action or eliminate the noncompliance within a reasonable time. The Commissioner, in seeking disclosure under paragraph (3) of subsection (d) of this Code section, has the burden of proving the elements set forth in paragraph (3) of subsection (d) of this Code section.

(2) The parties may at any time stipulate in proceedings under subsection (d) or (e) of this Code section to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under subsection (c) of this Code section.

(g) The privilege set forth in subsection (c) of this Code section shall not extend to:

(1) Documents, communications, data, reports, or other information required to be collected, developed, maintained, reported, or otherwise made available to a regulatory agency pursuant to this title or other federal or state law, rule, or order;

(2) Information obtained by observation or monitoring by any regulatory agency; or

(3) Information obtained from a source independent of the insurance compliance audit.

(h) Nothing in this Code section shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege, including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

History. — Code 1981, § 33-2-34, enacted by Ga. L. 2015, p. 839, § 1/HB 162; Ga. L. 2016, p. 864, § 33/HB 737; Ga. L. 2018, p. 1084, § 1/HB 592.

The 2018 amendment, effective July 1, 2018, deleted former subsection (i), which read: "This Code section shall apply to self-evaluative audits completed before June 30, 2018, but shall not apply to any such audits completed on or after July 1, 2018, unless authorized by the General Assembly prior to that date."

CHAPTER 3

AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE

Sec.

33-3-1. Definitions.

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33-3-4. Kinds of insurance in which insurers may transact.

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33-3-13. Information required in or attached to application for certificate of authority.

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33-3-22. Reports of insurers authorized to transact product liability insurance.

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33-3-26. Retaliation.

33-3-27. Reports of awards under medical malpractice insurance policies.

33-3-28. Request by claimant for information as to name of insurer, name of each insured, and limits of coverage.

Sec.
33-3-29. Licensing of foreign state insurers as domestic insurers.
33-3-30. Principal United States place of business of alien insurer entering through this state.

Administrative rules and regulations. — Administrative supervision, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-55.

Business requirements, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-18.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1910, §§ 2414, 2415, and 2553; Ga. L. 1912, p. 119, § 4, former Code 1933, § 56-901; and Ga. L. 1935, p. 139 are included in the annotations for this Code section. Thompson v. New York Life Ins. Co., 644 F.2d 439 (5th Cir. 1981).

Court restricted to determining whether challenged activity exempt from antitrust liability. — Whether restrictive covenants in an insurance agency contract precluding agent from engaging in any other business or occupation for remuneration or profit without written consent of insurance company is a good policy is not a decision for the United States Court of Appeals for the fifth circuit to make; rather, the United States Court of Appeals is merely required to determine if the challenged activity is the business of insurance and, thus, exempt from antitrust liability, because Congress has determined that the states are the proper regulators of such business activity. Thompson v. New York Life Ins. Co., 644 F.2d 439 (5th Cir. 1981).

33-3-1. Definitions.

As used in this chapter, the term:

(1) "Administrative supervision" means the continued operation of the company under supervision of the Commissioner in accordance with regulations promulgated by the Commissioner.

(2) "Alien" insurer means an insurer formed under the laws of a country other than the United States.

(3) "Charter" means articles of incorporation, articles of agreement, articles of association, or other basic constituent document of a corporation; subscribers' agreement and power of attorney of a reciprocal insurer; or underwriters' agreement and power of attorney of a Lloyd's insurer.

(4) "Domestic" insurer means an insurer formed under the laws of Georgia.

(5) "Foreign" insurer means an insurer formed under the laws of another state or government of the United States.

(6) "State" means any state, commonwealth, territory, or district of the United States.

(7) "United States" includes the states, territories, districts, and commonwealths of the United States.

History. — Code 1933, § 56-301, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 4.

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

JUDICIAL DECISIONS

Cited in Aetna Cas. & Sur. Co. v. Sampley, 108 Ga. App. 617, 134 S.E.2d 71 (1963).

33-3-2. Certificate of authority required for transaction of insurance within state; exceptions.

(a) No person shall act as an insurer and no insurer shall transact insurance in Georgia except as authorized by a subsisting certificate of authority granted to it by the Commissioner, except as to any transactions as are expressly otherwise provided for in this title.

(b) The mere investigation and adjustment of any claim in this state arising under an insurance contract and litigation in connection therewith shall not be deemed to constitute the transacting of insurance in this state.

(c) An insurer not transacting new insurance business in Georgia but continuing collection of premiums on and servicing of policies remaining in force as to residents of or risks located in Georgia is transacting insurance in Georgia for the purpose of premium tax requirements only and is not required to have a certificate of authority therefor.

(d) As to an insurance coverage on a subject of insurance not resident, located, or expressly to be performed in Georgia at time of issuance and solicited, written, and delivered outside Georgia, no certificate of authority shall be required of an insurer as to subsequent transactions in Georgia on account of such insurance; and this title shall not apply to such insurance or insurance coverage, except for the purpose of premium tax requirements.

History. — Code 1933, § 56-302, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Cross references. — Persons deemed subject to laws regulating life insurance companies, § 33-7-10.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1910, §§ 2414, 2415, and 2553; Ga. L. 1912, p. 119, § 4, former Code 1933, § 56-901; and Ga. L. 1935, p. 139 are included in the annotations for this Code section.

State may not restrict citizen from contracting for insurance outside state. — There is a vital distinction between acts done within and acts done without the jurisdiction of the state; and since under the fourteenth amendment to the United States Constitution a citizen of a state has a right to contract outside of the state for insurance on his property, the power of the state does not extend to such extra-territorial transactions, and a statute imposing restrictions thereon is in violation of the due process provision of that amendment. Cooper Co. v. State, 187 Ga. 497, 1 S.E.2d 436 (1939) (decided under Ga. L. 1935, p. 139).

State may constitutionally impose conditions on intrastate business. — As a necessary consequence of a state's possession of powers, the state has the right to enforce any conditions imposed by the laws as preliminary to the transaction of business within its confines by a foreign corporation, and the state has also the further right to prohibit a citizen from contracting within its jurisdiction with any foreign company which has not acquired the privilege of engaging in business therein, either in his own behalf or through an agent empowered to that end. Such an intrastate transaction does not fall within the guaranty of the Fourteenth Amendment of the federal Constitution. Cooper Co. v. State, 187 Ga. 497, 1 S.E.2d 436 (1939) (decided under Ga. L. 1935, p. 139).

Preservation of right to raise untimely notice of objection. — Surplus insurers were authorized to file a declaratory judgment action to preserve their right to raise untimely notice of an occurrence as a defense to coverage even without a certificate of authority to conduct business in the State of Georgia. Kay-Lex Co. v. Essex Ins. Co., 286 Ga. App. 484, 649 S.E.2d 602 (2007).

Nonresident fidelity companies must comply with limitations on domestic companies. — It is presumed that in providing for the licensing of nonresident companies it was the intention of the lawmakers to permit such companies to conduct a fidelity business only in the manner recognized by the Georgia laws and upon the terms and conditions prescribed for the conduct of such business by domestic companies. Nowell v. Mayor of Monroe, 177 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933) (decided under former Civil Code 1910, §§ 2414, 2415).

Insurance on local property by unlicensed insurer unenforceable. — No contract of insurance on property located in this state is enforceable in this state unless the insurer, when the policy was written, was duly licensed to do business in this state. Jalonick v. Greene County Oil Co., 7 Ga. App. 309, 66 S.E. 815 (1910) (decided under former Civil Code 1910, § 2414).

Regulatory provisions held applicable to companies issuing funeral-service contracts. — Where it was shown that in consideration of the initial and installment payments provided by each contract the defendants had agreed that so long as the contract remained of force they would render to the person to whom the contract was issued all of the services customarily rendered by undertakers or funeral directors, including hearse service, all necessary embalming, directing, and conducting of funerals, etc., within a radius of 25 road miles, and to sell at wholesale cost price (plus transportation charges only) caskets, burial clothes, etc., to any contract holder for use in the funeral of any member of his or her family or dependents, the evidence authorized the grant of an interlocutory injunction on the ground that the contracts issued by the company constituted policies of life insurance, and that the company, in the issuance of such contracts, was doing a life insurance business contrary to law. Clark v. Harrison, 182 Ga. 56, 184 S.E. 620 (1936) (decided under former Code 1933, § 56-901, repealed by Ga. L. 1960,

p. 289); South Ga. Funeral Homes v. Harrison, 182 Ga. 60, 184 S.E. 875, later appeal, 183 Ga. 379, 188 S.E. 529 (1936) (decided under former Code 1933, § 56-901, repealed by Ga. L. 1960, p. 289).

When undertaking business was executing contracts and issuing certificates to furnish funeral merchandise and funeral services upon death and purchasers were obligated to make installment payments, it was, for a consideration, assuming an obligation to be performed upon the death of the purchaser, namely, to furnish the goods and render the stipulated service, and the business was to be characterized as a life insurance business within the meaning of Ga. L. 1937, p. 702 (now repealed), and was subject to the legal regulatory provisions relating to life insurance generally. Harrison v. Tanner-Poindexter Co., 187 Ga. 678, 1 S.E.2d 646 (1939) (decided under former Code 1933, § 56-901, repealed by Ga. L. 1960, p. 289).

Regulatory provisions inapplicable to contracts insuring against breakage of automobile gears using insurer's lubricant. — This section, requiring insurance companies to procure licenses, was not rendered applicable to the plaintiff by its contract insuring the defendants against breakage of gears of automobiles on which lubricant bought from it was used. Evans & Tate v. Premier Ref. Co., 31 Ga. App. 303, 120 S.E. 553 (1923) (decided under former Ga. L. 1912, p. 119, § 4).

Illegal marketing of self-insurance plan. — Self-insured taxicab association's provision of insurance coverage to third parties involving the conveyance by taxicab owners of the title in their vehicles jointly to the association constituted the illegal sale or transaction of insurance without a license. Olukoya v. American Ass'n of Cab Cos., 219 Ga. App. 508, 465 S.E.2d 715 (1995).

Unauthorized insurer doing business in state is subject to suit therein. — A life insurance company not authorized to transact business in Georgia because of failure to obtain a certificate of authority from the Insurance Commissioner is nevertheless doing business, although illegally, in the state by accepting an application for insurance from a resident of the state, delivering the application to the resident by mail, and by mailing premium notices to or accepting premiums from the resident during the life of the policy, so as to render it subject to suit and judgment in this state. Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966).

Venue of foreign insurer lies where it has agent or place of doing business. — A foreign fidelity insurance company may be sued in any county in this state in which it has an agent or place of doing business; and the principal in a guardian's bond for which the company is surety, although living in another county, may be sued jointly with the surety in any county in which jurisdiction over the surety may be obtained. Gross v. Butler, 48 Ga. App. 750, 173 S.E. 866 (1934) (decided under former Civil Code 1910, § 2553).

Using mails to collect premiums constitutes subsequent transactions. — Mere use of the mails to collect premiums from the insured was a "subsequent transaction" within the meaning of O.C.G.A. § 33-3-2. Bishopsgate Ins. Co. v. Cactus Club, Inc., 176 Ga. App. 354, 335 S.E.2d 685 (1985).

Cited in Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971); Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972); Sloan v. Continental Cas. Co., 131 Ga. App. 377, 205 S.E.2d 925 (1974); Ferguson v. United Ins. Co. of Am., 163 Ga. App. 282, 293 S.E.2d 736 (1982).

OPINIONS OF THE ATTORNEY GENERAL

National bank issuing debt cancellation contract must comply with title. — A national bank operating in Georgia may not enter into a debt cancellation contract providing that the debt will be automatically canceled in the event of the borrower's death without complying with this title. 1963-65 Op. Att'y Gen. p. 457.

Credit unions may not issue insurance contracts. — If a credit union is

issuing insurance contracts, then there can be little question but that such activity is unauthorized; such contracts generally may be issued only by licensed insurers under the provisions of this title. 1967 Op. Att'y Gen. No. 67-170 (credit union may not guarantee or insure loans and deposits).

License necessary for group variable annuity contracts. — Group variable annuity contracts must be issued by a life insurance company licensed to do business in this state. 1970 Op. Att'y Gen. No. 70-22.

Insurance license necessary for church property. — An insurance company writing insurance policies only for the church property of a certain denomination may not enter into these insurance contracts within this state without having first obtained a certificate of authority to transact insurance. 1971 Op. Att'y Gen. No. 71-142.

An insurance company that has not met the requirements imposed upon risk retention groups by the state in which it is chartered as an insurance company may not underwrite homeowners' warranties in Georgia without a certificate of authority authorizing the transaction of insurance in Georgia. 1982 Op. Att'y Gen. No. 82-104.

RESEARCH REFERENCES

ALR. — Full faith and credit provision as affecting contracts, 41 A.L.R. 1386; 114 A.L.R. 250; 119 A.L.R. 483; 173 A.L.R. 1138.

What constitutes insurance, 63 A.L.R. 711; 100 A.L.R. 1449; 119 A.L.R. 1241.

What constitutes doing business within state by foreign insurance corporation, 137 A.L.R. 1128.

Collateral business activities incident to, or in aid of, interstate transportation as related to interstate commerce, 152 A.L.R. 1078.

Decision of United States Supreme Court that insurance is interstate commerce as affecting state statutes relating to foreign insurance companies, 164 A.L.R. 500.

Right to enjoin business competitor from unlicensed or otherwise illegal acts or practices, 90 A.L.R.2d 7.

Right of insurance agent to sue in his own name for unpaid premium, 90 A.L.R.2d 1291.

33-3-3. Qualifications for transaction of insurance generally; transaction of insurance by insurers owned by states, foreign governments.

(a) To qualify for and hold authority to transact insurance in Georgia an insurer must be otherwise in compliance with the provisions of this title and with its charter powers and must be an incorporated stock insurer, an incorporated mutual insurer, a fraternal benefit society, a farmers' mutual fire insurance company, a Lloyd's association, or a reciprocal insurer of the same general type as may be formed as a domestic insurer under this title, except that no foreign or alien insurer shall be authorized to transact insurance in Georgia which does not maintain reserves as required by Chapter 10 of this title applicable to the kind or kinds of insurance transacted in the United States by such insurer.

(b) No certificate of authority or license to transact any kind of insurance business in this state shall be issued, renewed, or continued in effect to any domestic, foreign, or alien insurance company or other

insurance entity which is owned or financially controlled in whole or in substantial part by any state of the United States, by a foreign government, or by any political subdivision, instrumentality, or agency of either or which is an agency of such state or foreign government or any political subdivision, instrumentality, or agency of either unless such company or entity was so owned, controlled, or constituted prior to January 1, 1957, and was authorized to do business in this state on or prior to said date.

(c) Membership in a mutual insurer, subscribership in a reciprocal insurer, or supervision of an insurer by a public insurance supervisory authority shall not be deemed to be an ownership, control, or operation of the insurer for the purposes of subsection (b) of this Code section.

History. — Code 1933, § 56-303, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2017, p. 164, § 5/HB 127.

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

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Annual report required of all domestic and foreign corporations. — Each corporation, domestic and foreign, authorized to transact business in this state is required to file an annual report with the Secretary of State's office, regardless of where its authority to transact business may have originated. 1977 Op. Att'y Gen. No. 77-62 (rendered prior to 1989 revision of Chapter 2 of Title 14).

RESEARCH REFERENCES

ALR. — Power of mutual benefit society to waive restrictions upon eligibility to membership, 28 A.L.R. 93.

33-3-4. Kinds of insurance in which insurers may transact.

An insurer which otherwise qualifies to transact insurance in Georgia may be authorized to transact any one kind or combination of kinds of insurance as defined in Chapter 7 of this title except:

(1) A reciprocal insurer shall not transact life insurance;

(2) A Lloyd's insurer shall not transact life insurance; and

(3) A title insurer shall be a stock insurer and shall be authorized to transact only title insurance and closing protection letters, pursuant to Code Section 33-7-8.1.

History. — Code 1933, § 56-304, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 1077, § 1/SB 331; Ga. L. 2019, p. 337, § 1-15/SB 132.

The 2019 amendment, effective July

1, 2019, deleted ", except that, if immediately prior to January 1, 1961, any title insurer lawfully held a subsisting certificate of authority granting it the right to transact in Georgia additional classes of insurance other than title insurance, so long as the insurer is otherwise in compliance with this title, the Commissioner shall continue to authorize such insurer to transact the same classes of insurance as those specified in such prior certificate of authority" following "Code Section 33-7-8.1" at the end of paragraph (3).

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Cited in United States Life Title Ins. Co. v. Hutsell, 164 Ga. App. 443, 296 S.E.2d 760 (1982).

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Paragraph (3) refers only to insurers licensed to transact title insurance in state. — The language used in this section with reference to title insurers was intended to mean only those insurers which had complied with the applicable provisions of the insurance laws, including the procuring of a license to transact title insurance in this state. 1963-65 Op. Att'y Gen. p. 334.

Foreign title insurer may be licensed to transact other classes. — An insurer which has charter power to write title insurance, along with one or more other classes of insurance, may be licensed in Georgia to write such other class or classes of insurance so long as it is not licensed to write title insurance in Georgia. 1963-65 Op. Att'y Gen. p. 334.

Company does not lose right if authorized to write title insurance elsewhere. — A company licensed in Georgia to write fire insurance or some other class of insurance would not lose that right upon being authorized by the state of its domicile to write title insurance. 1963-65 Op. Att'y Gen. p. 334.

Mobile homes as real property. — Mobile homes deemed by parties to sales transaction to be a part of real property upon which they are located may be the subjects of title insurance. 1982 Op. Att'y Gen. No. 82-52.

RESEARCH REFERENCES

ALR. — Power of mutual benefit society to waive restrictions upon eligibility to membership, 28 A.L.R. 93.

33-3-5. Classification of kinds of insurance.

For the purpose of this chapter, the kinds of insurance defined in Chapter 7 of this title shall be arranged in the following six classes:

(1) Life, accident, and sickness;

(2) Property, marine, and transportation;

(3) Casualty;

(4) Surety;

(5) Title; and

(6) Health maintenance organization.

Each of the groups numbered (1) through (6) shall constitute a class of insurance.

History. — Code 1933, § 56-305, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1990, p. 1275, § 1; Ga. L. 2019, p. 337, § 1-16/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Health maintenance organization" for "Health Maintenance Organization" in paragraph (6).

Editor's notes. — Ga. L. 1990, p. 1275, § 7, not codified by the General Assembly, provides that the 1990 amendment is "effective for purposes of application to new or newly admitted insurers on January 1, 1991, and effective for all purposes on July 1, 1992."

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

JUDICIAL DECISIONS

Class (1) includes credit life insurance. — Credit life insurance, being a form of life insurance, is a part of that "class" of insurance as defined in this section, whether it is level or reducing term. Cullers v. Home Credit Co., 130 Ga. App. 441, 203 S.E.2d 544 (1973).

Cited in United States Life Title Ins. Co. v. Hutsell, 164 Ga. App. 443, 296 S.E.2d 760 (1982).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 34.

C.J.S. — 44 C.J.S., Insurance, § 7 et seq.

ALR. — Power of mutual benefit society to waive restrictions upon eligibility to membership, 28 A.L.R. 93.

33-3-6. Requirements as to capital stock or surplus generally.

(a) On or after July 1, 2000, to qualify for an original certificate of authority to transact one or more classes of insurance, an insurer shall possess and thereafter maintain a minimum of $1.5 million in capital stock or in surplus.

(b) As to surplus required for initial qualification to transact one kind of insurance and thereafter to be maintained, domestic mutual insurers shall be governed by Chapter 14 of this title and domestic reciprocal insurers shall be governed by Chapter 17 of this title. Farmers' mutual fire insurance companies shall be governed by Chapter 16 of this title.

History. — Code 1933, § 56-306, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1984, p. 1080, § 1; Ga. L. 1985, p. 149, § 33; Ga. L. 1990, p. 1275, § 2; Ga. L. 1992, p. 1539, § 1; Ga. L. 1995, p. 637, § 1; Ga. L. 2000, p. 1246, § 2; Ga. L. 2017, p. 164, § 6/HB 127.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, a comma was inserted following "insurance" in paragraph (1) of subsection (a).

Editor's notes. — Ga. L. 1990, p. 1275, § 7, not codified by the General Assembly, provides that the 1990 amendment is "effective for purposes of application to new or newly admitted insurers on January 1,

1991, and effective for all purposes on July 1, 1992."

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

JUDICIAL DECISIONS

Capital requirement may not be lowered by special act. — An amendment to the charter of a corporation by the Legislature, reducing its capital below the amount required by a general law like this section before transacting business, is invalid. Georgia Empire Mut. Ins. Co. v. Wright, 118 Ga. 796, 45 S.E. 606 (1903) (decided under former Civil Code 1895, § 2034).

A general law like this section being of force, it was not competent for the General Assembly to pass an amendment to the charter of an insurance company authorizing it to transact business without having the required amount of capital stock or assets. Such an amendment was a special law within the meaning of the Constitution in a case already provided for by a general law. Georgia Empire Mut. Ins. Co. v. Wright, 118 Ga. 796, 45 S.E. 606 (1903) (decided under former Civil Code 1895, § 2034).

The selling of stock is not transacting or doing insurance business in the sense of this section. Piedmont Life Ins. Co. v. Bell, 109 Ga. App. 251, 135 S.E.2d 916 (1964).

Regulatory provisions held applicable to funeral service contracts. — Where undertaking business was executing contracts and issuing certificates to furnish funeral merchandise and funeral services upon death and purchasers were obligated to make installment payments, it was, for a consideration, assuming an obligation to be performed upon the death of the purchaser, namely, to furnish the goods and render the stipulated service, and the business was to be characterized as a life insurance business within the meaning of Ga. L. 1937, p. 702 (now repealed), and was subject to the legal regulatory provisions relating to life insurance generally. Harrison v. Tanner-Poindexter Co., 187 Ga. 678, 1 S.E.2d 646 (1939) (decided under former Code 1933, § 56-209, repealed by Ga. L. 1960, p. 289).

Cited in Retail Union Health & Welfare Fund v. Seabrum, 242 S.E.2d 18 (1978).

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Charter application need not set minimum capital for commencing business. — Since this section provides the minimum amount of capital with which the insurer may obtain a license and commence business, it would not be necessary to provide for a minimum in the application for a charter; it would only be necessary to set the authorized capital in accordance with the provisions of this Code section and former Code 1933, § 56-307 (see O.C.G.A. § 33-3-7). 1963-65 Op. Att'y Gen. p. 451.

If section met, all stock need not be subscribed. — An insurance corporation may perfect its organization and lawfully obtain a license and commence the insurance business provided it meets the capital paid-in and expendable surplus requirements of former Code 1933, §§ 56-306 and 56-307 (see O.C.G.A. §§ 33-3-6 and 33-3-7); it would not be necessary to have the entire authorized capital stock subscribed even though the charter states no minimum with which the corporation shall begin business, since the provisions of this chapter set the minimum. 1963-65 Op. Att'y Gen. p. 451.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 36.

C.J.S. — 44 C.J.S., Insurance, § 162 et seq.

33-3-7. Requirement of surplus for new insurers.

In addition to the minimum paid-in capital or minimum surplus of insurers required by this title, an insurer shall possess when first authorized in this state and thereafter maintain surplus or additional surplus equal to the larger of $1.5 million if a stock, mutual, or reciprocal insurer or 50 percent of its paid-in capital stock if a stock insurer or of its surplus if a mutual or reciprocal insurer otherwise required under Code Section 33-3-6 for the kinds of insurance to be transacted.

History. — Code 1933, § 56-307, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1984, p. 1080, § 2; Ga. L. 1990, p. 1275, § 3; Ga. L. 1992, p. 1539, § 2; Ga. L. 1995, p. 637, § 2.

Editor's notes. — Ga. L. 1990, p. 1275, § 7, not codified by the General Assembly, provides that the 1990 amendment is "effective for purposes of application to new or newly admitted insurers on January 1, 1991, and effective for all purposes on July 1, 1992."

JUDICIAL DECISIONS

Insurance law not applicable to suretyship contract. — Insurance law was not applicable in a case involving liability under a suretyship contract. American Mfg. Mut. Ins. Co. v. Tison Hog Mkt., Inc., 182 F.3d 1284 (11th Cir. 1999), cert. denied, 531 U.S. 819, 121 S. Ct. 59, 148 L. Ed. 2d 26 (2000).

Cited in Piedmont Life Ins. Co. v. Bell, 109 Ga. App. 251, 135 S.E.2d 916 (1964).

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Section governs in case of conflict with the more general mandatory refusal, revocation, or suspension provision. — As a matter of statutory construction, the more specific statute, i.e., this section, governs in case of a seeming conflict with a more general one such as paragraph (2) of former Code 1933, § 56-316 (see O.C.G.A. § 33-3-19). 1963-65 Op. Att'y Gen. p. 216.

Surplus is initial, but not continuing, requirement. — The surplus is required in order to ensure that newly formed insurance companies will be financially able to survive their first years of operation; therefore, it is an initial requirement but not a continuing one. 1963-65 Op. Att'y Gen. p. 216.

It is not synonymous with "capital." — The words "deficiency in assets" in paragraph (2) of former Code 1933, § 56-316 (see O.C.G.A. § 33-3-19) are intended to apply primarily to such items as "impairment of capital" and "insufficiency of policy reserves"; if both capital and expendable surplus were required to be maintained at all times they would be synonymous; the separate provisions for "capital" and for "expendable surplus" make it evident that the two are not synonymous. 1963-65 Op. Att'y Gen. p. 216.

Charter application need not set minimum capital. — Since former Code 1933, § 56-306 (see O.C.G.A. § 33-3-6) provides the minimum amount of capital with which the insurer may obtain a license and commence business, it would not be necessary to provide for a minimum in the application for a charter; it would

only be necessary to set the authorized capital in accordance with the provisions of § 56-306 and this section. 1963-65 Op. Att'y Gen. p. 451.

Corporation may commence business on complying with statutes. — An insurance corporation may perfect its organization and lawfully obtain a license and commence the insurance business provided it meets the capital paid-in and expendable surplus requirements of former Code 1933, § 56-306 (see O.C.G.A. § 33-3-6) and this section; it would not be necessary to have the entire authorized capital stock subscribed even though the charter states no minimum with which the corporation shall begin business, since this chapter sets the minimum. 1963-65 Op. Att'y Gen. p. 451.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 37.

C.J.S. — 44 C.J.S., Insurance, § 162 et seq.

33-3-7.1. Compliance with minimum surplus requirements for mutual insurers.

Repealed by Ga. L. 2000, p. 1246, § 3, effective July 1, 2000.

Editor's notes. — This Code section was based on Code 1981, § 33-3-7.1, enacted by Ga. L. 1994, p. 1931, § 1.

33-3-8. Requirements as to deposit of securities generally.

(a) The Commissioner shall not issue a certificate of authority to transact insurance to any insurer unless the insurer has deposited in trust with this state securities eligible for the investment of capital funds of domestic insurers under this title in an amount not less than that required in subsection (b) of this Code section. This Code section does not apply to farmers' mutual fire insurance companies.

(b)(1) Except as otherwise provided in this subsection, the amount of the deposit required under this Code section for a certificate to transact any one class of insurance shall be $100,000.00; to transact each additional class of insurance, the amount of deposit shall be $25,000.00, subject to the limitation that not more than $200,000.00 total deposit shall be required for any combination of classes.

(2) As to any foreign insurer, in lieu of such deposit or part of such deposit in this state, the Commissioner shall accept the current certificate in proper form of the public official having supervision over insurers in any other state to the effect that a like deposit or part of like deposit by such insurer is being maintained in public custody in such state in trust for the purpose, among other reasonable purposes, of protection of policyholders and creditors or of the protection of all the insurer's policyholders or of all of its policyholders and obligees.

(3) As to any alien insurer, other than a title insurer, which has entered through and the United States branch of which is licensed to

transact insurance in another state, in lieu of such deposit or part thereof in this state, the Commissioner shall accept the certificate of the official having supervision over insurance of such other state in the United States, given under his or her hand and seal, that the insurer maintains within the United States by way of deposits with public depositories, or in trust institutions within the United States approved by such official, assets available for discharge of its United States insurance obligations, which assets shall be in an amount not less than the outstanding liabilities of the insurer arising out of its insurance transactions in the United States together with the larger of the following sums: the largest deposit required by this title to be made in this state by any type of domestic insurer transacting like kinds of insurance or $300,000.00.

(4) As to any alien insurer entering through this state to transact insurance in the United States through a United States branch, such insurer shall deposit in accordance with Chapter 12 of this title assets available for discharge of its United States insurance obligations, which assets shall be in an amount not less than the outstanding liabilities of the insurer arising out of its insurance transactions in the United States together with the larger of the following sums: the largest deposit required by this title to be made in this state by any type of domestic insurer transacting like kinds of insurance or $300,000.00.

History. — Code 1933, § 56-309, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1999, p. 584, § 1.

Cross references. — Administration of deposits, T. 33, C. 12.

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1895, §§ 2035-2043 and former Code 1933, § 22-1210 and Ch. 56-3 are included in the annotations for this Code section.

Purpose of foreign insurer's deposit. — The bonds which a foreign insurance corporation doing business in this state is required to deposit are to prevent a suit against a dissolved corporation from being futile and unavailing. Manufacturing Lumberman's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3, repealed by Ga. L. 1960, p. 289).

The statute as to the depositing of bonds and retaining them so long as there is a pending claim in the state (see O.C.G.A. §§ 33-3-8, 33-3-10, 33-12-1, and 33-12-8) and the statute providing for the prosecution of pending suits after the dissolution of a foreign corporation are a part of the general scheme of the Georgia law to protect Georgia citizens in the collection of just claims against foreign corporations which are dissolved and which have their principal assets in another state. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, § 22-1210, repealed by Ga. L. 1968,

p. 585, and former Code 1933, Ch. 56-3, repealed by Ga. L. 1960, p. 289).

Local action necessary for appropriation of deposit. — A suit brought in a local court is a condition precedent to the appropriation of the bonds deposited by a foreign insurance corporation to the payment of a fire loss. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3, repealed by Ga. L. 1960, p. 289).

Death of a nonresident fire insurance company does not terminate a suit. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3, repealed by Ga. L. 1960, p. 289).

Deposit remains subject to claims of Georgia citizens over foreign receivers. — Nonresident fire insurance companies doing business in this state are required to deposit certain bonds. These bonds are for the protection of the citizens of Georgia who have insurance with the nonresident company, and if the foreign company ceases to do business, the bonds remain on deposit until such company shall have settled all claims against it in this state and are subject to the claims of Georgia citizens under certain prescribed conditions. As long as there are any claimants to these bonds under the laws of Georgia, a receiver in another state would have no right to interfere with proceedings of the courts of Georgia instituted to assert the rights of a Georgia claimant in whose behalf the bonds were deposited. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3, repealed by Ga. L. 1960, p. 289).

Deposit primarily secures losses. — The primary purpose of the deposit is to secure the payment of fire losses, which are the only losses insured against, although it also secures, secondarily, other claims arising on policies, such as the repayment, after the termination of the risk, of unearned premiums paid; even when a company becomes insolvent and the deposit is brought into a court of equity for distribution, fire losses are entitled to priority of payment from the fund over claims for unearned premiums. Kelsey v. Cogswell, 112 F. 599 (N.D. Ga. 1901) (decided under former Civil Code 1895, §§ 2035-2043).

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Deposit and surplus requirements for fire insurer to issue "homeowner" policies. — Before a company presently writing fire insurance can be authorized to issue "homeowner" policies, it would be required to meet the surplus requirements of former Code 1933, § 56-1510 (see O.C.G.A. § 33-14-61), as to mutual insurers, that is $200,000.00 for each class of insurance written, and the deposit requirements of this section, that is $100,000.00 for one class and $25,000.00 for each additional class of insurance written. 1960-61 Op. Att'y Gen. p. 274.

Eligibility of securities on deposit in 1960. — The "savings clause" of former Code 1933, § 56-1002(2), expended to any securities which a domestic insurer may have had on deposit with this state prior to the enactment of this title by Ga. L. 1960, p. 289, and such securities were "eligible for the investment of capital funds of domestic insurers" within the meaning of this section, although such securities did not meet specific qualitative restrictions elsewhere contained in this title. 1971 Op. Att'y Gen. No. 71-170.

Former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42) vests in the Insurance Commissioner the discretionary determination whether securities deposited in this state by foreign or alien insurers are "of a quality substantially as high" as those required of domestic insurers under this section, as construed in conjunction with former Code 1933, § 56-1002(2), and this is true even though such securities may not meet the specific qualitative restrictions contained in this title, provided such securities are authorized by the law of the insurer's domicile. 1971 Op. Att'y Gen. No. 71-170.

Priority of claims. — Claims under policies for losses incurred take priority

over claims for the refund of unearned premiums against general or special deposits posted by insurance companies pursuant to O.C.G.A. §§ 33-3-8(b) and 33-3-9. 1984 Op. Att'y Gen. No. 84-5.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 33, 37.

C.J.S. — 44 C.J.S., Insurance, §§ 82 et seq., 142, 178, 194 et seq.

33-3-9. Requirement of additional deposits of securities by foreign and alien insurers.

In those instances in which the Commissioner in his or her judgment shall deem it to be in the best interests of the citizens of this state, no certificate of authority shall be issued by the Commissioner to any foreign and alien insurer nor shall any certificate of authority be renewed for any such insurer unless such insurer shall deposit with the Commissioner securities eligible for the investment of capital funds in such amount as the Commissioner shall require. This deposit and the deposit required by paragraph (1) of subsection (b) of Code Section 33-3-8 shall be administered as provided for in Chapter 12 of this title. Deposits under this Code section shall be held for the protection of the insurer's policyholders in this state and others in this state entitled to the proceeds of its policies.

History. — Code 1933, § 56-310, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1967, p. 765, § 1; Ga. L. 1972, p. 1015, § 14; Ga. L. 2016, p. 519, § 1/HB 884; Ga. L. 2019, p. 337, § 1-17/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "In those instances" for "On and after July 1, 1967, in those instances" at the beginning of this Code section.

Cross references. — Administration of deposits, T. 33, C. 12.

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, Ch. 56-3 are included in the annotations for this Code section.

Purpose of deposit. — The bonds which a foreign insurance corporation doing business in this state is required to deposit are to prevent a suit against a dissolved corporation from being futile and unavailing. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3).

The former statute as to the depositing of bonds and retaining them so long as there is a pending claim in the state and the former statute providing for the prosecution of pending suits after the dissolution of a foreign corporation are a part of the general scheme of the Georgia law to protect Georgia citizens in the collection of just claims against foreign corporations which are dissolved and which have their principal assets in another state. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code

1933, Ch. 56-3).

Local action necessary for appropriation of deposit. — A suit brought in a local court is a condition precedent to the appropriation of the bonds deposited by a foreign insurance corporation held by the state treasurer to the payment of a fire loss. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3).

The death of a nonresident fire insurance company does not terminate a suit. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3).

Deposit remains subject to claims of Georgia citizens over foreign receivers. — Nonresident fire insurance companies doing business in this state are required to deposit certain bonds. These bonds are for the protection of the citizens of Georgia who have insurance with the nonresident company, and if the foreign company ceases to do business, the bonds remain on deposit until such company shall have settled all claims against it in this state, and are subject to the claims of Georgia citizens under certain prescribed conditions. As long as there are any claimants to these bonds under the laws of Georgia, a receiver in another state would have no right to interfere with proceedings of the courts of Georgia instituted to assert the rights of a Georgia claimant in whose behalf the bonds were deposited. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, Ch. 56-3).

Cited in Preferred Ins. Co. v. Bentley, 223 Ga. 735, 157 S.E.2d 737 (1967); Garamendi v. Ryles, 204 Ga. App. 747, 420 S.E.2d 633 (1992).

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General scheme of Georgia law to protect Georgia citizens. — This section and the provision requiring insurers to extinguish all liability before releasing deposits securing the liability are part of the general scheme of Georgia law to protect Georgia citizens in the collection of just claims against foreign corporations which are dissolved and which have their principal assets in other states. 1965-66 Op. Att'y Gen. No. 66-25.

Federal National Mortgage Association participation certificates are authorized securities and may be accepted for deposit under this section. 1969 Op. Att'y Gen. No. 69-346.

Termination of liability allowing release of deposit may be by reinsurance. — The extinguishment of liability provision of former Ga. L. 1887, p. 113; Civil Code 1895, §§ 2039, 2041; Civil Code 1910, §§ 2423, 2425; Code 1933, §§ 56-323, 56-324; Code 1933, § 56-1108, enacted by Ga. L. 1960, p. 289, § 1 (see O.C.G.A. § 33-12-8(1)) was intended to mean that an insurer, before being allowed to take down its deposits, must extinguish, that is, put an end to all of its liability for the security of which the deposit is held and that, in addition to any other means by which this might be accomplished, it could also be accomplished by the means of reinsurance; to be accomplished by reinsurance would require a reinsurance contract whereby a second insurer is substituted for the first or withdrawing insurer, with the consent of the insured, which, of course, would release the first insurer from all liability to the insured. 1965-66 Op. Att'y Gen. No. 66-25.

Priority of claims. — Claims under policies for losses incurred take priority over claims for the refund of unearned premiums against general or special deposits posted by insurance companies pursuant to O.C.G.A. §§ 33-3-8(b) and 33-3-9. 1984 Op. Att'y Gen. No. 84-5.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 37, 46.

C.J.S. — 44 C.J.S., Insurance, §§ 82 et seq., 142, 178, 194 et seq.

33-3-10. Requirement of additional special deposits of securities by domestic, foreign, or alien insurers.

(a) In addition to the deposits required by Code Sections 33-3-8 and 33-3-9, the Commissioner may require any domestic, foreign, or alien insurer to make such additional special deposits of securities eligible for the investment of capital funds of domestic insurers under this title as he may deem reasonable and necessary for the protection of the public whenever the Commissioner shall determine that the adverse financial condition of the insurer requires such action.

(b) Such additional special deposits shall be deposited with the Commissioner in trust for the protection of all policyholders of the insurer and all others entitled to the proceeds of its policies except in the case of foreign or alien insurers, in which case such additional special deposits shall be deposited with the Commissioner in trust for the protection of all the insurer's policyholders in Georgia and all others in Georgia entitled to the proceeds of its policies.

(c) The deposits provided for under this Code section shall be administered by the Commissioner in accordance with Chapter 12 of this title.

History. — Code 1933, § 56-310.1, enacted by Ga. L. 1977, p. 878, § 1.

Cross references. — Administration of deposits, T. 33, C. 12.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 37, 46.

C.J.S. — 44 C.J.S., Insurance, §§ 82 et seq., 142, 178, 194 et seq.

33-3-11. Requirement of licensed resident agent.

Reserved. Repealed by Ga. L. 1999, p. 578, § 1, effective July 1, 1999.

Editor's notes. — This Code section was based on Code 1933, § 56-320, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1998, p. 1091, § 1.

33-3-12. Requirements as to name of insurer.

(a) No insurer shall be authorized to transact insurance in Georgia which has or uses a name so similar to that of any insurer already so authorized as to cause uncertainty or confusion, except that, in case of conflict of names between two insurers, the Commissioner may permit or require as a condition to the issuance of an original certificate of authority to an insurer making application therefor that the insurer use in Georgia any supplementation or modification of its name as may reasonably be necessary to avoid a conflict.

(b) No insurer shall be authorized to transact business in Georgia which has or uses a name which would deceptively mislead as to the type of organization of the insurer.

History. — Code 1933, § 56-318, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Cross references. — Corporate names generally, §§ 14-2-401 et seq., 14-3-401 et seq.

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Changing name releases old name if not used. — An amendment of an insurance company's charter changing the name of that insurance company would automatically release that name for immediate use by another insurance company where the original company did no insurance business under its old name; that is, it neither issued policies, paid claims, nor advertised its name or reputation in any way with the general public. 1967 Op. Att'y Gen. No. 67-457.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 1573.

33-3-13. Information required in or attached to application for certificate of authority.

To apply for an original certificate of authority an insurer shall file with the Commissioner its application therefor showing its name, location of its home office or its existing or proposed principal office in the United States if an alien insurer, kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, the names and addresses of all general officers of the company with the number of shares of capital stock of the company held by or for each such general officer or by others for his or her benefit, and the percentage of the total capital stock of the company held by each such general officer, the date on which the company began to do business, the states in which it is admitted to do business, and such additional information as the Commissioner may require, together with the following applicable documents:

(1) A copy of its corporate charter with all amendments thereto certified by the public officer with whom the originals are on file in the state or country of domicile;

(2) A copy of its bylaws, as amended, certified by its secretary or other officer having custody thereof;

(3) If a foreign or alien insurer, a copy of its annual statement as of December 31 of the preceding year in a form approved for current use by the Commissioner and certified by two officers of the company. The annual statement of an alien insurer which has entered through and

the United States branch of which is licensed to transact insurance in another state shall relate only to the transactions and affairs in the United States unless the Commissioner requires otherwise;

(4) A copy of report of the last examination, if any, made of the insurer, certified by the insurance supervisory official of its state or country of domicile or of entry into the United States;

(5) If a foreign or alien insurer, a copy of the appointment of the Commissioner as its attorney to receive service of legal process;

(6) If a foreign or alien insurer, a certificate of the public official having supervision of insurance in its state or country of domicile showing that it is authorized to transact the kinds of insurance proposed to be transacted in Georgia;

(7) If an alien insurer, a copy of the appointment and authority of its United States manager certified by its officer having custody of its records;

(8) If a foreign or alien insurer, certificate as to deposit if to be tendered pursuant to Code Section 33-3-8; and

(9) If an alien insurer entering through this state to transact insurance in the United States through a United States branch, an English language translation, as necessary, of any of the documents required under this Code section.

History. — Code 1933, § 56-312, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1974, p. 465, § 1; Ga. L. 1999, p. 584, § 2.

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1910, §§ 2414, 2415 are included in the annotations for this Code section.

Nonresident fidelity companies must comply with limitations on domestic companies. — It is presumed that in providing for the licensing of nonresident companies it was the intention of the lawmakers to permit such companies to conduct a fidelity business only in the manner recognized by the Georgia laws and upon the terms and conditions prescribed for the conduct of such business by domestic companies. Nowell v. Mayor of Monroe, 177 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933) (decided under former Civil Code 1910, §§ 2414, 2415).

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 27, 31, 45.

33-3-14. Application fee.

Every original application shall be accompanied by the fee required by Code Section 33-8-1, which shall be returned to the applicant if the application is finally denied.

History. — Code 1933, § 56-313, enacted by Ga. L. 1960, p. 289, § 1.

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Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

33-3-15. Issuance or refusal of certificate of authority generally; determining whether insurer meets definition of reinsurer; designation on certificate.

(a) Upon filing of an application for an original certificate of authority, the Commissioner shall have 90 days in which to approve the application by issuing an appropriate certificate of authority or disapprove the application by issuing an order setting forth the grounds for such disapproval. The Commissioner may extend such 90 day period for an additional 90 days by notifying the applicant in writing of such extension. If the application is not approved or disapproved within such time period or periods, the application shall be deemed approved and the Commissioner shall thereupon issue the appropriate certificate of authority.

(b) The certificate, if issued, shall specify the kind or kinds of insurance the insurer is authorized to transact in Georgia. At the insurer's request, the Commissioner may issue a certificate of authority limited to particular types of insurance included within a kind of insurance as defined in this title.

(c) The Commissioner shall determine if the insurer is a reinsurer and shall so designate on the certificate. As used in this subsection, the term "reinsurer" means an insurer that is principally engaged in the business of reinsurance, does not conduct significant amounts of direct insurance as a percentage of its net premiums, and is not engaged in an ongoing basis in the business of soliciting direct insurance.

History. — Code 1933, § 56-314, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2011, p. 622, § 1/SB 252.

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 27, 30.

C.J.S. — 44 C.J.S., Insurance, §§ 139, 149.

33-3-16. Expiration of certificate; procedure for renewal; amendment of certificate by Commissioner.

(a) All certificates of authority shall expire at 12:00 Midnight on June 30 of the year following date of issuance or renewal. An insurer desiring renewal shall file on March 1 preceding expiration a copy of its annual statement of December 31 of the preceding year in a form approved for current use by the Commissioner. On or before March 1 of each year, each insurer at its expense shall publish in a newspaper of general circulation published in this state a copy of such statement in short form showing income, assets, expenditures, and liabilities in gross as of December 31 of the preceding year to be sworn to by the officer or agent making the same; and such statement so published must be filed with the Commissioner with a copy of the statement as published attached thereto. Notwithstanding the March 1 deadline, the Commissioner may for good cause grant an extension of time for filing such annual statement not to exceed 60 days. If the insurer qualifies, its certificate shall be renewed annually; provided, however, that any certificate of authority shall continue in full force and effect until the new certificate is issued or specifically refused.

(b) The Commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter or insuring powers.

History. — Code 1933, § 56-315, enacted by Ga. L. 1960, p. 289, § 1.

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Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

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The Commissioner does not have the authority to issue permanent certificates of authority that would not expire or require renewal. 1979 Op. Att'y Gen. No. 79-78.

Renewal filing may be reviewed. — The Department of Insurance need not issue a renewal certificate of authority to an insurer automatically upon the submission of a completed renewal filing, but

may instead review that filing prior to issuing a renewal certificate. 1979 Op. Att'y Gen. No. 79-78.

Subsection (a) of this section does not require the commissioner to issue an insurer's renewal certificate of authority as a routine matter upon completion of its requirements, but instead anticipates that the commissioner and his staff will review the filing prior to either issuing or refusing to issue a renewal certificate of authority. 1979 Op. Att'y Gen. No. 79-78.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 27, 30.

C.J.S. — 44 C.J.S., Insurance, §§ 77 et seq., 139 et seq.

33-3-17. Discretionary refusal, revocation, or suspension of certificate generally.

In addition to any other grounds set forth in this title, the Commissioner may refuse to issue a certificate of authority or after a hearing refuse to renew or may revoke or suspend an insurer's certificate of authority or place an insurer under administrative supervision if the insurer:

(1) Violates any provision of this title other than those as to which refusal, suspension, or revocation is mandatory;

(2) Knowingly fails to comply with or violates any rule, regulation, or order of the Commissioner;

(3) Is found by the Commissioner to be in unsound condition or in such condition as to render its further transaction of insurance in Georgia hazardous to its policyholders or to the public;

(4) As a general scheme or plot without just cause compels claimants to accept less than the amount due them or to bring an action against it to secure full payment thereof;

(5) Refuses to be examined or to produce its accounts, records, and files for examination by the Commissioner when required; or refuses to furnish such other additional information as the Commissioner may deem necessary to consider the application for renewal of such insurer's certificate of authority;

(6) Fails to pay any final judgment rendered against it in Georgia within 30 days after such judgment becomes final; or

(7) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in Georgia without having a certificate of authority therefor, except as permitted to a surplus line insurer under Chapter 5 of this title or an insurance holding company under Chapter 13 of this title.

History. — Code 1933, § 56-317, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 5.

Law reviews. — For comment on Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), see 14 Ga. B.J. 468 (1952).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, § 56-104 are included in the annotations to this Code section.

Commissioner may not arbitrarily refuse to renew license. — The law does not confer upon the individual who happens to be Commissioner unlimited power to entertain dissatisfaction or opinions arbitrarily and capriciously as a basis for refusal to renew the license. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Unjustified refusal is basis for mandamus. — Where the refusal of the Commissioner to renew an insurance company's license is without justification, the failure to perform this official duty will irreparably injure the company, and therefore its petition alleges a cause of action for mandamus. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Commissioner may not refuse renewal for failure to copy records. — Having the power to investigate an insurance company, to inspect its original records, and to take the sworn testimony of its agents, the Commissioner has a duty to do so and is unauthorized to impose upon the company a duty to copy its records and refuse a renewal of its license upon its failure in that respect. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

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State Health Benefit Plan is not subject to the Georgia Insurance Code, and neither the State Personnel Board nor the entity administering self-insured plans for the State Personnel Board would be subject to any administrative fines or sanctions under the insurance code for administration of such plans. 1982 Op. Att'y Gen. No. 82-70.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 42, 43.

C.J.S. — 44 C.J.S., Insurance, §§ 63 et seq, 79, 139 et seq.

33-3-18. Administrative supervision or suspension of certificate of authority for cause.

The Commissioner may, without advance notice or a hearing thereon, place an insurer under administrative supervision or suspend immediately the certificate of authority of any insurer:

(1) As to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings have been commenced in any state by the public insurance supervisory official of such state;

(2) Whose authority to do business in any state has been revoked, suspended, or restricted in any way by the public insurance supervisory official of such state; or

(3) If upon examination or at any other time it appears in the Commissioner's discretion that:

(A) The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;

(B) The insurer exceeded its powers granted under its certificate of authority and applicable law;

(C) The insurer has failed to comply with the applicable provisions of this title;

(D) The business of the insurer is being conducted fraudulently; or

(E) The insurer gives its consent.

History. — Code 1933, § 56-317.2, enacted by Ga. L. 1969, p. 585, § 1; Ga. L. 1991, p. 1424, § 1; Ga. L. 1992, p. 2877, § 6.

Law reviews. — For note on 1991 amendment of this Code section, see 8 Ga. St. U.L. Rev. 89 (1992).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 30.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-3-19. Mandatory refusal, revocation, or suspension of certificate.

The Commissioner shall refuse to issue or to renew or shall revoke or suspend an insurer's certificate of authority:

(1) If such action is required by any provision of this title; or

(2) If the insurer no longer meets the requirements for the authority originally granted on account of deficiency in assets or otherwise.

History. — Code 1933, § 56-316, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

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Former Code 1933, § 56-307 controlled in conflict with this section. — As a matter of statutory construction, the more specific statute, i.e., former Code 1933, § 56-307 (see O.C.G.A. § 33-3-7), governs in case of a seeming conflict with a more general one such as paragraph (2) of Ga. L. 1960, p. 289, § 1 (see O.C.G.A. § 33-3-19). 1963-65 Op. Att'y Gen. p. 216.

Words "deficiency in assets" are intended to apply primarily to such items as "impairment of capital" and "insufficiency of policy reserves"; if both capital and expendable surplus were required to be maintained at all times they would be synonymous; the separate provisions for "capital" and for "expendable surplus" make it evident that the two are not synonymous. 1963-65 Op. Att'y Gen. p. 216.

Commissioner may allow reduction of paid-in surplus. — Although paid-in surplus is required of all companies upon their authorization to do business in the State of Georgia, it is within the discretion of the Commissioner to determine at what time the particular company is in such sound financial position as to no longer require this account to be maintained at its original level. 1963-65 Op. Att'y Gen. p. 216.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 30, 33.

C.J.S. — 44 C.J.S., Insurance, §§ 63 et seq., 79, 139 et seq.

33-3-20. Imposition of administrative fine upon insurer for certain acts of officers, employees, agents, or representatives.

(a) The Commissioner may, after a hearing, impose upon an insurer an administrative fine if he finds that such insurer through the acts of its officers, employees, agents, or representatives has with such frequency as to indicate its general business practice in this state:

(1) Failed to use due diligence in processing all claims, failed to pay claims in a timely manner, failed to provide proper notice when required with respect to the reasons for the insurer's failure to make claims payments when due, or refused without just cause to pay proper claims arising under coverage provided by its policies, whether the claim is in favor of an insured or in favor of a third person with respect to the liability of an insured to a third person or in favor of any other person entitled to the proceeds of a policy;

(2) Compelled, without just cause, insureds, claimants, or other persons entitled to the proceeds of its policies in this state to accept less than the amount due them or to bring an action against the insurer or an insured to secure full payment or settlement thereof; or

(3) Accepted money, trade stamps, gifts, or other remuneration of any kind in return for referring automobile and other property repair business including glass breakage to a particular automobile repairer, glass company, construction company, or other repair company of any kind.

(b) The administrative fine imposed for violations set forth in paragraph (1), (2), or (3) of subsection (a) of this Code section shall not exceed $1,000.00 for each act of misconduct constituting a violation; provided, however, a fine of not more than $5,000.00 for each act of willful misconduct constituting a violation may be imposed.

(c) For the purposes of this Code section, the term "insurer" shall include any insurer, nonprofit organization, or any other person authorized to sell accident and sickness insurance policies, subscriber contracts, certificates, or agreements of any form under Chapter 15, 20, 21, 29, or 30 of this title.

History. — Code 1933, § 56-317.1, enacted by Ga. L. 1969, p. 585, § 1; Ga. L. 1973, p. 668, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 1678, §§ 1, 4; Ga. L. 1984, p. 22, § 33; Ga. L. 2019, p. 337, § 1-18/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "18, 19," following "Chapter 15," near the end of subsection (c).

Cross references. — Liability of insurer refusing in bad faith to pay claim, § 33-4-6.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 20.

C.J.S. — 44 C.J.S., Insurance, § 67 et seq.

ALR. — Necessity and sufficiency, or waiver, of demand as a condition of statutory liability of insurer for failure to pay delay in paying loss, 145 A.L.R. 343.

33-3-21. Reports of business affairs and operations of insurers generally.

On or before March 1 in each year after it shall have commenced to do business pursuant to a certificate of authority, every insurer shall make and file with the Commissioner a report of its affairs and operations during the year ending on December 31 of the preceding year. This annual report shall be made in such form and contain such information as the Commissioner may prescribe by regulation from time to time and may require in protecting the public interest, the interest of the policyholders of any insurer, and the interest of the investors in the securities issued by any insurer. The Commissioner may require by regulation any additional periodic reports as he or she may prescribe from time to time as necessary or appropriate for the protection of policyholders, investors, and the public and necessary to ensure the solvency of any insurer, to inform and protect the investors in any insurer, and to assure fair dealing in the securities of any insurer. The Commissioner may require that the reports be verified under oath by any appropriate officers or agents as he or she may designate by regulation and may require the same to be published. Compliance with this Code section shall be a condition to the renewal of a certificate of authority under Code Section 33-3-16.

History. — Ga. L. 1887, p. 113, § 16; Civil Code 1895, § 2064; Civil Code 1910, § 2458; Ga. L. 1912, p. 119, § 9; Code 1933, §§ 56-108, 56-232; Code 1933, § 56-319, enacted by Ga. L. 1965, p. 378, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2019, p. 337, § 1-19/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "the Commissioner" in the first sentence and inserted "or she" in the third and fourth sentences.

Administrative rules and regulations. — Business requirements, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-18.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 35.

C.J.S. — 44 C.J.S., Insurance, § 63.

33-3-21.1. Submission of reports by property and casualty insurers; types of insurance to which requirement applies; contents of report; public inspection.

(a) By rule or regulation, the Commissioner may require each insurer licensed to write property and casualty insurance by the Commissioner to submit a report on a form furnished by the Commissioner showing its direct writings in this state.

(b) The report permitted by subsection (a) of this Code section may include but not be limited to the following types of insurance written by such insurer:

(1) Motor vehicle bodily injury liability insurance, including medical pay insurance;

(2) Products liability insurance;

(3) Medical malpractice insurance;

(4) Architect and engineer malpractice insurance;

(5) Attorney malpractice insurance;

(6) Motor vehicle personal injury protection insurance;

(7) Motor vehicle property liability insurance;

(8) Uninsured motorist insurance;

(9) Underinsured motorist insurance; and

(10) Commercial casualty or property insurance as defined in paragraph (1) of Code Section 33-7-3 or Code Section 33-7-6.

(c) Additionally, the report shall include the following information:

(1) Direct premiums written;

(2) Direct premiums earned;

(3) Net investment income, including net realized capital gains and losses, using appropriate estimates where necessary;

(4) Incurred claims, developed as a sum of, and with figures provided for, the following:

(A) Dollar amount of claims closed with payment; plus

(B) Reserves for reported claims at the end of the current year; minus

(C) Reserves for reported claims at the end of the previous year; plus

(D) Reserves for incurred but not reported claims at the end of the current year; minus

(E) Reserves for incurred but not reported claims at the end of the previous year; plus

(F) Reserves for loss adjustment expense at the end of the current year; minus

(G) Reserves for loss adjustment expense at the end of the previous year;

(5) Actual incurred expenses allocated separately to loss adjustment, commissions, other acquisition costs, general office expenses, taxes, licenses, fees, and all other expenses;

(6) Net underwriting gain or loss; and

(7) Net operation gain or loss, including net investment income.

(d) Any reports provided under this Code section shall be made available to the public for inspection.

History. — Code 1981, § 33-3-21.1, enacted by Ga. L. 1986, p. 896, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 2014, p. 128, § 1/HB 229.

Administrative rules and regulations. — Life and annuity tables, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-39.

33-3-21.2. Analysis of adequacy of loss and loss adjustment expense reserves when reserves outside standard range.

(a) As used in this Code section, the term "qualified independent loss reserve specialist" means a person who is not an employee, principal, director, or indirect owner of the insurer and either is a member of the casualty actuarial society or possesses such other experience acceptable

to the Commissioner to assure a professional opinion on the adequacy of the loss and loss adjustment expense reserves of the insurer.

(b) Every property and casualty insurer required to file an annual report with the Commissioner which has not filed a statement of opinion relating to loss and loss adjustment expense reserves in connection with its last annual statement on file with the department shall engage, whenever the insurer's loss and loss adjustment expense reserves are outside the standard or average range as designated by the Commissioner and based upon reliable and credible current information, a qualified independent loss reserve specialist to analyze the adequacy of such reserves and file a report with the Commissioner on a date to be specified by the Commissioner.

History. — Code 1981, § 33-3-21.2, enacted by Ga. L. 1989, p. 674, § 1.

Law reviews. — For note on 1989 enactment of this Code section, see 6 Ga. St. U.L. Rev. 261 (1989).

33-3-21.3. Annual filings with National Association of Insurance Commissioners; agents of Commissioner not subject to civil liability; confidentiality of information.

(a) This Code section shall apply to all domestic, foreign, and alien insurers who are authorized to transact business in this state.

(b)(1) Each domestic, foreign, and alien insurer who is authorized to transact insurance in this state shall file annually on or before March 1 of each year with the National Association of Insurance Commissioners a copy of its annual statement convention blank along with such additional filings as prescribed by the Commissioner for the preceding year. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the Commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the Commissioner shall also be filed with the National Association of Insurance Commissioners.

(2) Foreign insurers that are domiciled in a state which has a law substantially similar to paragraph (1) of this subsection shall be deemed in compliance with this subsection.

(c) In the absence of actual malice, members of the National Association of Insurance Commissioners; their duly authorized committees, subcommittees, and task forces; their delegates; employees of the National Association of Insurance Commissioners; and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the Commis-

sioner under the authority of this Code section and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, analysis, and dissemination of the data and information collected from the filings required under this Code section.

(d) Notwithstanding any provision of Article 4 of Chapter 18 of Title 50 to the contrary, all financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department with an expectation of confidentiality by the National Association of Insurance Commissioners' Insurance Regulatory Information System shall be confidential and may not be disclosed by the department.

(e) The Commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the Commissioner, for good cause, may have granted.

History. — Code 1981, § 33-3-21.3, enacted by Ga. L. 1991, p. 1424, § 2.

Editor's notes. — Section 9 of SB 347 (Ga. L. 1991, p. 1424), not codified by the General Assembly, contained inconsistencies in references to the sections of the bill due to differences in the section numbers contained in the Senate version of the bill and the final version of the bill. Subsection (b) of Section 9 refers to Code Section 33-7-14 in the Senate version of SB 347. Ga. L. 1991, p. 1424, § 9(b), not codified by the General Assembly, provides that this Code section is applicable to all reinsurance cessions after July 1, 1991, which have had an inception, anniversary, or renewal date not less than six months after July 1, 1991.

Law reviews. — For note on 1991 enactment of this Code section, see 8 Ga. St. U.L. Rev. 89 (1992).

33-3-22. Reports of insurers authorized to transact product liability insurance.

The Commissioner by rule and regulation may require each insurer providing product liability insurance in this state to provide reports of its affairs and operations regarding product liability insurance covering risks located in this state with such frequency and in such form as the Commissioner deems necessary.

History. — Code 1933, § 56-319.1, enacted by Ga. L. 1978, p. 2023, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1985, p. 228, § 1.

Cross references. — Product liability actions generally, § 51-1-11.

Law reviews. — For article surveying Georgia cases in the area of tort law from June 1, 1977 through May 1978, see 30 Mercer L. Rev. 215 (1978).

For comment, "Solving The Products Liability Insurance Crisis: A Study of the Role of Economic Theory in the Legislative Reform Process," see 31 Mercer L. Rev. 755 (1980).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 35.

C.J.S. — 46 C.J.S., Insurance, § 1420 et seq.

ALR. — Clause excluding "products liability" from coverage of liability insurance policy, 54 A.L.R.2d 518; 58 A.L.R.3d 12.

Aviation: helicopter accidents, 35 A.L.R.3d 707.

Products liability insurance coverage as extending only to product-caused injury to person or other property, as distinguished from mere product failure, 91 A.L.R.3d 921.

Validity and construction of "sistership" clause of products liability insurance policy excepting from coverage cost of product recall or withdrawal of product from market, 32 A.L.R.4th 630.

33-3-23. Transaction restrictions on lending institutions and bank holding companies.

(a) For the purposes of this Code section, the term:

(1) "Bank holding company" means the definition as set forth in Code Section 7-1-600 and in Section 2 of an act of Congress entitled the Bank Holding Company Act of 1956, as amended.

(2) "Lending institution" means any domestic institution that accepts deposits from the public and lends money, including banks and savings and loan associations.

(b) A lending institution, bank holding company, or subsidiary or affiliate of either of the foregoing doing business in this state, or any officer or employee of any of the foregoing, may be licensed to sell insurance, including but not limited to credit insurance, in this state and may engage in underwriting and act as an underwriter for credit life insurance and credit accident and sickness insurance subject to the provisions of this title and in conformity with rules and regulations promulgated by the Commissioner.

(c) Nothing in this chapter shall prohibit the purchase of mortgage guaranty insurance, also called credit loss insurance, by a lending institution from a mortgage guaranty insurance company directly or indirectly.

(d) No lending institution, bank holding company, or any subsidiary or affiliate of any of the foregoing doing business in this state that was not in the business of selling title insurance on or before April 1, 2000, shall be permitted to sell title insurance.

History. — Code 1933, § 56-322, enacted by Ga. L. 1974, p. 1101, §§ 1, 2; Ga. L. 1983, p. 3, § 24; Ga. L. 1989, p. 14, § 33; Ga. L. 2000, p. 1218, § 1; Ga. L. 2019, p. 337, § 1-20/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" at the end of subsection (b).

U.S. Code. — Section 2 of the federal Bank Holding Company Act of 1956, referred to in paragraph (a)(1) of this Code section, is codified as 12 U.S.C. § 1841.

For authority of states to regulate sales of insurance by depository institutions, see Gramm-Leach-Bliley Act, Pub. L. No. 106-102, § 104, 113 Stat. 1338, 1352 (1999).

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Operation of general insurance agency. — The operation of a general insurance agency is not a power enumerated in O.C.G.A. § 7-1-261 and a state bank does not have either express statutory authority or an incidental power to operate a general insurance agency in a town with a population of less than 5,000. Independent Ins. Agents of Ga., Inc. v. Department of Banking & Fin., 248 Ga. 787, 285 S.E.2d 535 (1982).

Cited in Alabama Ass'n of Ins. Agents v. Board of Governors, 533 F.2d 224 (5th Cir. 1976).

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Separation between banking and insurance businesses must be maintained. — While there is no express prohibition against ownership of insurance agency stock by bank officials and immediate family members, bank board members, or bank holding company members, such ownership must be compatible with this section and subjected to close scrutiny to insure that the separation between the banking and insurance businesses is maintained. 1989 Op. Att'y Gen. U89-18.

"Domestic" institutions. — The term domestic, as used in this section, should be read to limit this section's coverage to lending institutions doing business in this state. 1983 Op. Att'y Gen. No. 83-41.

Federally chartered banks and savings and loan associations are within the coverage of this section. 1983 Op. Att'y Gen. No. 83-41.

Federally chartered banks within a bank holding company system are covered by this section since such a bank would be an affiliate or subsidiary of a bank holding company. 1983 Op. Att'y Gen. No. 83-41.

Subsidiary of federal savings and loan association. — A subsidiary of a federal savings and loan association may not engage in the sale of insurance in Georgia in a municipality with a population greater than 5,000 unless it has been licensed and in continuous operation since January 1, 1974. 1983 Op. Att'y Gen. No. 83-72.

Acquisition of domestic company by foreign association. — A holding company which is a wholly-owned subsidiary of a foreign savings and loan association may not acquire a Georgia domestic insurance company if the foreign savings and loan association is doing business in Georgia. Any determination of whether a foreign savings and loan association, which does not itself have an office in Georgia, is doing business in the state through its Georgia mortgage company subsidiary could only be resolved on a case-by-case basis. 1988 Op. Att'y Gen. No. 88-20.

Employees of newly created subsidiaries or affiliates of lending institutions may not be licensed to sell insurance in Georgia if the subsidiary or affiliate is operating in a municipality which has a population that exceeds 5,000 persons. 1983 Op. Att'y Gen. No. 83-41.

Previously unlicensed employee of institution conducting business since January 1, 1974. — A previously unlicensed employee of a lending institution that has been conducting business in conformity with all state and federal laws continuously since January 1, 1974, may obtain a license to sell insurance in Georgia. 1983 Op. Att'y Gen. No. 83-41.

Entitlement to former subsection (f) grandfather status. — Financial institutions and related entities are not entitled to grandfather status under former subsection (f) of this section unless they were engaged in the insurance business on January 1, 1974. 1984 Op. Att'y Gen. No. 84-22.

Preemption by federal law. — The Gramm-Leach-Bliley Act (Pub. L. No. 106-102, 113 Stat. 1338 (1999)) preempts the provisions of this section restricting lending institutions, bank holding companies, and their subsidiaries and affiliates from selling insurance in municipalities with populations exceeding 5,000. 2000 Op. Att'y Gen. No. 2000-4.

33-3-24. Transaction restrictions on institutions of Farm Credit System.

(a) No institution included in the Farm Credit System as set forth and identified in 12 U.S.C.A., Section 2002 (Pub. Law 92-181, Sec. 1.2, Dec. 10, 1971, 85 Stat. 583), any subsidiary or affiliate of such institution doing business in this state, any officer or employee of any institution included in the Farm Credit System, or any subsidiary or affiliate of any institution may directly or indirectly be licensed to sell or solicit any type of insurance, except the following:

(1) Credit life and accident and health in an amount appropriate to insure repayment of the loan;

(2) Crop hail, hail, or wind damage to crops; or

(3) Insurance against loss of any collateral securing a loan extended by an affiliate bank or association of the Farm Credit System for the full value of such collateral. The right to place collateral insurance, however, shall continue only so long as the underlying loan remains outstanding or until the expiration of the policy, but in no event longer than 12 months from the last day the loan was outstanding.

(b) For purposes of this Code section, "collateral securing a loan" shall include only that property which is subject to the formal security interest granted in connection with the secured loan and duly filed and recorded in the county where the debtor resides; provided, however, "collateral securing a loan" shall not include any property acquired by the debtor after the date the underlying loan was made unless the secured party shall make an advance to the debtor or otherwise give new value which is to be secured in whole or in part by after-acquired property.

(c) For the purposes of this Code section, institutions constituting the Farm Credit System shall include the federal land banks, the federal land bank associations, the federal intermediate credit banks, the production credit associations, the banks for cooperatives, and such other institutions as may be made part of the system, all of which are chartered by and subject to the supervision of the Farm Credit Administration; provided, however, that the types of insurance described in paragraphs (1), (2), and (3) of subsection (a) of this Code section may only be transacted, sold, or solicited for the purposes of protecting loans made for agricultural purposes to farmers by an institution of the Farm Credit System or any subsidiary or affiliate thereof doing business in this state.

(d) Any person holding a license to sell or solicit insurance on April 8, 1977, and disqualified under the terms of subsection (a) of this Code

section upon termination of his association as an employee or officer, or both, of any Farm Credit System institution or affiliate or subsidiary thereof shall have his license reissued upon request without the necessity of taking or passing any examination. Applications shall be made within 60 days from the date of termination of such employment.

History. — Code 1933, § 56-323, enacted by Ga. L. 1977, p. 1283, § 1; Ga. L. 1982, p. 3, § 33.

33-3-25. Language simplification and reading ease standards; applicability of Code section.

(a) All homeowner's insurance policies, including tenant homeowner's insurance policies, personal automobile insurance policies, individual life or accident and sickness insurance policies, all certificates of group life or accident and sickness insurance coverage, and all coverage booklets provided by insurers to group life or accident and sickness insurance certificate holders which are issued, delivered, or issued for delivery in this state on or after July 1, 1988, shall be written in a simplified form, shall be divided into logically arranged, captioned sections, and shall contain readable language which complies with the standards prescribed in such rules and regulations as may be promulgated by the Commissioner after due notice and hearing.

(b) In establishing the policy language simplification and reading ease standards for such policies, certificates, and coverage booklets, the Commissioner may utilize a minimum score of 40 on the "Flesch reading ease test" as the basic standard, or such other nationally recognized reading ease standards or tests as would produce comparable policy language simplification and readability results, and may also provide for exceptions thereto by appropriate rules and regulations.

(c) This Code section shall apply to all insurers issuing the kinds of insurance policies described in subsection (a) of this Code section in this state, including all insurers, nonprofit corporations, or other organizations issuing policies or contracts of life or accident and sickness coverage under Chapter 15, 20, 21, 29, or 30 of this title.

History. — Code 1981, § 33-3-25, enacted by Ga. L. 1982, p. 1244, § 1; Ga. L. 1983, p. 3, § 24; Ga. L. 1983, p. 473, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1987, p. 1047, § 1; Ga. L. 1988, p. 13, § 33; Ga. L. 2019, p. 337, § 1-21/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" near the end of subsection (a) and in subsection (b); in subsection (b), inserted a comma after "basic standard" and substituted "readability results, and may also provide" for "readability results and he may also provide"; and deleted "18, 19," following "Chapter 15," near the end of subsection (c).

Administrative rules and regulations. — Readability standards for personal lines policies, Official Compilation of the Rules and Regulations of the State of

Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-42.

33-3-26. Retaliation.

(a) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees in the aggregate and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Georgia insurers or upon the agents or representatives of such insurers which are in excess of such taxes, licenses, and other fees in the aggregate or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the agents or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees in the aggregate or fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the Commissioner upon the insurers or upon the agents or representatives of such insurers of such other state or country doing business or seeking to do business in Georgia. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Georgia insurers or their agents or representatives shall be deemed to be imposed by such state or country within the meaning of this Code section.

(b) The Commissioner may waive any retaliatory obligations, prohibitions, or restrictions that would prohibit entry into this state of any insurer domiciled in another state and that would otherwise be imposed by subsection (a) of this Code section if, in his or her discretion, the entry of such insurer would be expected to enhance competition in this state and would be in the best interests of the citizens of this state. The discretion provided by this subsection shall not extend to any retaliatory taxes, fees, fines, penalties, or deposit requirements.

(c) This Code section shall not apply as to personal income taxes, as to ad valorem taxes on real or personal property, or as to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the Commissioner in determining the propriety and extent of retaliatory action under this Code section.

(d) For the purposes of this Code section, the domicile of an alien insurer other than insurers formed under the laws of Canada shall be

that state designated by the insurer in writing filed with the Commissioner at the time of admission to this state and may be any one of the following states:

(1) This state if the insurer is entering through this state to transact insurance in the United States through a United States branch;

(2) That in which the insurer was first authorized to transact insurance;

(3) That in which is located the insurer's principal place of business in the United States; or

(4) That in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

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

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

History. — Ga. L. 1869, p. 127, § 5; Code 1873, § 2848; Code 1882, § 2848; Ga. L. 1887, p. 124, § 12; Civil Code 1895, § 2060; Civil Code 1910, § 2449; Code 1933, § 56-315; Code 1933, § 56-321, enacted by Ga. L. 1960, p. 289, § 1; Code 1981, § 33-3-25; Ga. L. 1982, p. 3, § 33; Code 1981, § 33-3-26, as redesignated by Ga. L. 1982, p. 1244, § 1; Ga. L. 1999, p. 584, § 3; Ga. L. 2008, p. 482, § 1/SB 213.

Law reviews. — For article discussing restrictions on the establishment and transaction of business by a foreign insurer in Georgia with emphasis on threshold requirements for establishment by alien insurers, see 27 Mercer L. Rev. 629 (1976).

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Determination of amount of retaliatory tax. — Where the aggregate fee and tax burden imposed upon a Georgia insurer by another state exceeds the aggregate fee and tax burden imposed upon insurers by Georgia, this section imposes an additional retaliatory tax upon insurers from such other state in an amount equal to the amount by which the aggregate fees and taxes of the other state exceed the aggregate fees and taxes imposed upon similar insurers by Georgia. 1982 Op. Att'y Gen. No. 82-2.

Examination of foreign insurer's investments in Georgia is required in calculating the retaliatory tax liability imposed by this section if the foreign insurer's home state imposes a premium tax rate which varies with an insurer's investments in that state. 1982 Op. Att'y Gen. No. 82-2.

Retaliatory tax added after figuring abatement of gross premium tax. — This section and the provisions pertaining to abatement of taxes on insurance premiums (see O.C.G.A. § 33-8-5) are not mu-

tually exclusive; a company having met the statutory standards could qualify for the abatement provisions allowed on the gross premium tax; the same company could also be subject to retaliation because of the existing tax structure of its home state; thus, a foreign insurer coming within both provisions, i.e., abatement and retaliation, would first have the gross premium tax figured at the applicable rate; to this dollar amount would be added the amount of retaliatory tax, if any, computed against the foreign insurer because of the existing differential between the Georgia aggregate tax and fee structure and that of the foreign state in which the company is based. 1963-65 Op. Att'y Gen. p. 138.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 54, 55.
C.J.S. — 44 C.J.S., Insurance, § 136.

33-3-27. Reports of awards under medical malpractice insurance policies.

(a) For the purposes of this Code section, the term:

(1) "High/low agreement" means a settlement in which a defendant agrees to pay the plaintiff a minimum recovery in return for the plaintiff's agreement to accept a maximum amount regardless of the outcome of the trial.

(2) "Low payment" means the defendant pays the plaintiff the minimum recovery under a high/low agreement where the court rules in favor of the defendant.

(3) "Medical malpractice claim" means any claim for damages resulting from the death of or injury to any person arising out of health, medical, or surgical service, diagnosis, prescription, treatment, or care rendered by a person authorized by law to practice medicine in this state or by any person acting under such person's supervision and control.

(b) Every insurer providing medical malpractice insurance coverage in this state shall notify in writing the Georgia Composite Medical Board when it pays a judgment or enters into an agreement to pay an amount to settle a medical malpractice claim, other than a low payment under a high/low agreement, against a person authorized by law to practice medicine in this state. Such judgments or agreements shall be reported to the board regardless of the dollar amount. Such notice shall be sent within 30 days after the judgment has been paid or the agreement has been entered into by the parties involved in the claim.

History. — Code 1981, § 33-3-27, enacted by Ga. L. 1983, p. 882, § 2; Ga. L. 1992, p. 6, § 33; Ga. L. 2005, p. 1, § 8/SB 3; Ga. L. 2009, p. 859, § 2/HB 509; Ga. L. 2019, p. 826, § 1/HB 128.

The 2019 amendment, effective July

1, 2019, rewrote subsection (a), which read: "For the purposes of this Code section, the term 'medical malpractice claim' means any claim for damages resulting from the death of or injury to any person arising out of health, medical, or surgical service, diagnosis, prescription, treatment, or care rendered by a person authorized by law to practice medicine in this state or by any person acting under such person's supervision and control."; and in subsection (b), inserted ", other than a low payment under a high/low agreement," in the first sentence.

Editor's notes. — Ga. L. 2005, p. 1, § 1/SB 3, not codified by the General Assembly, provides that: "The General Assembly finds that there presently exists a crisis affecting the provision and quality of health care services in this state. Hospitals and other health care providers in this state are having increasing difficulty in locating liability insurance and, when such hospitals and providers are able to locate such insurance, the insurance is extremely costly. The result of this crisis is the potential for a diminution of the availability of access to health care services and a resulting adverse impact on the health and well-being of the citizens of this state. The General Assembly further finds that certain civil justice and health care regulatory reforms as provided in this Act will promote predictability and improvement in the provision of quality health care services and the resolution of health care liability claims and will thereby assist in promoting the provision of health care liability insurance by insurance providers. The General Assembly further finds that certain needed reforms affect not only health care liability claims but also other civil actions and accordingly provides such general reforms in this Act."

Law reviews. — For article on 2005 amendment of this Code section, see 22 Ga. St. U. L. Rev. 221 (2005).

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Reporting payments in medical malpractice case. — A physician licensed by the Georgia Composite Medical Board is required to report to the Board a payment made as a result of a high-low agreement in a medical malpractice case, even if there is a judgment in favor of the physician. 2016 Op. Att'y Gen. No. 16-6.

33-3-28. Request by claimant for information as to name of insurer, name of each insured, and limits of coverage.

(a)(1) Every insurer providing liability or casualty insurance coverage in this state and which is or may be liable to pay all or a part of any claim shall provide, within 60 days of receiving a written request from the claimant, a statement, under oath, of a corporate officer or the insurer's claims manager stating with regard to each known policy of insurance issued by it, including excess or umbrella insurance, the name of the insurer, the name of each insured, and the limits of coverage. Such insurer may provide a copy of the declaration page of each such policy in lieu of providing such information. The claimant's request shall set forth under oath the specific nature of the claim asserted and shall be mailed to the insurer by certified mail or statutory overnight delivery.

(2) The insured, within 30 days of receiving a written request from a claimant or the claimant's attorney, shall disclose to the claimant or his attorney the name of each known insurer which may be liable to the claimant upon such claim.

(b) If the request provided in subsection (a) of this Code section contains information insufficient to allow compliance, the insurer or insured upon whom the request was made may so state in writing, stating specifically what additional information is needed, and such compliance shall constitute compliance with this Code section.

(c) The information provided to a claimant or his attorney as required by subsection (a) of this Code section shall not create a waiver of any defenses to coverage available to the insurer and shall not be admissible in evidence unless otherwise admissible under Georgia law.

(d) The information provided to a claimant or his attorney as required by subsection (a) of this Code section shall be amended upon the discovery of facts inconsistent with or in addition to the information provided.

History. — Code 1981, § 33-3-28, enacted by Ga. L. 1989, p. 676, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2000, p. 1589, § 3.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

Law reviews. — For annual survey on insurance, see 65 Mercer L. Rev. 135 (2013).

JUDICIAL DECISIONS

Subsection (d) of O.C.G.A. § 33-3-28 did not create liability on the part of an insurer to a claimant for failure to timely amend previously furnished information from the insurer to the claimant. Generali-U.S. Branch v. Southeastern Sec. Ins. Co., 229 Ga. App. 277, 493 S.E.2d 731 (1997).

A violation of subsection (d) of O.C.G.A. § 33-3-28 did not give rise to an action based on negligence per se. Generali-U.S. Branch v. Southeastern Sec. Ins. Co., 229 Ga. App. 277, 493 S.E.2d 731 (1997).

Improper insurance reporting may result in liability. — Since defendant insurance company failed to disclose the existence of an umbrella policy until after the claimant had settled for what she thought were the policy limits, the trial court erred in granting summary judgment to the company on the claimant's allegations of fraud, misrepresentation and false swearing, based on its conclusion that the parties had no contract because the parties' settlement agreement was contingent on the company having disclosed all applicable policies. Merritt v. State Farm Mut. Auto. Ins. Co., 247 Ga. App. 442, 544 S.E.2d 180 (2000).

Cause of action not found. — Insurer's breach of this section did not create a cause of action and the right to seek damages under O.C.G.A. §§ 51-1-6 and 51-1-8. Parris v. State Farm Mut. Auto. Ins. Co., 229 Ga. App. 522, 494 S.E.2d 244 (1997).

Failing to disclose existence of insurance was willful and malicious act. — Debtor performed a willful and malicious act, 11 U.S.C. § 523(a)(6), by failing to disclose the existence of insurance. Contrary to the mandate of O.C.G.A. § 33-3-28(a)(2), the debtor did not comply with the creditor's personal injury attorney's request for insurance information and instead gave the creditor false and misleading information; the debtor's concealment of insurance information caused harm to the creditor that was both willful and malicious. Blair v. Boughter (In re Boughter), 463 B.R. 908 (Bankr. S.D. Ga. 2003).

Cited in State Farm Mut. Auto. Ins. Co. v. Hernandez Auto Painting & Body

Works, 312 Ga. App. 756, 719 S.E.2d 597 (2011).

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An insurance company may not bill a requesting claimant for the time and expense involved in complying with a request for coverage information pursuant to O.C.G.A. § 33-3-28. 1990 Op. Att'y Gen. No. U90-10.

Providing a copy of the declaration page of each policy, in lieu of providing the requested information, is the only permissible statutory exception to the requirement that an insurance company disclose policy limits and other information within 60 days of receiving a request from a claimant. 1990 Op. Att'y Gen. No. U90-10.

33-3-29. Licensing of foreign state insurers as domestic insurers.

(a) Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of this title relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a location in this state. Upon satisfaction of such requirements, the insurer shall be issued a certificate of authority and license to transact business in this state and shall be subject to the authority and jurisdiction of this state as a domestic insurer. The redomesticated insurer may choose to retain its original date of incorporation in lieu of its date of redomestication, provided that the retention of an earlier incorporation date shall not affect the operation or application of other laws.

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

(c) The certificate of authority, agent appointments and licenses, rates, and other items which the Commissioner allows, in his discretion, and which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly authorized to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by

the Commissioner. Every transferring insurer shall file new policy forms with the Commissioner on or before the effective date of the transfer but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner. Every such transferring insurer shall notify the Commissioner of the details of the proposed transfer and shall file promptly any forms, documents, or amendments to forms or documents with the Commissioner. The Commissioner may promulgate rules and regulations necessary to carry out the purposes of this Code section.

History. — Code 1981, § 33-3-29, enacted by Ga. L. 1989, p. 1127, § 1.

Code Commission notes. — This Code section was enacted as § 33-3-28, but has been renumbered as § 33-3-29, pursuant to Code Section 28-9-5, since Ga. L. 1989, p. 676, § 1, also enacted a § 33-3-28.

33-3-30. Principal United States place of business of alien insurer entering through this state.

(a) Each alien insurer which enters through this state to transact insurance in the United States through a United States branch shall establish and maintain in this state such insurer's principal place of business in the United States, and shall keep in such principal place of business complete records of the assets, transactions, and affairs in accordance with the methods and systems which are customary or suitable as to the kind or kinds of insurance transacted in the United States.

(b) Concealment from the Commissioner or removal from this state of any material part of the records required to be kept in this state under subsection (a) of this Code section, except for any reasonable purposes and periods of time as may be approved by the Commissioner in writing in advance of such removal, is prohibited. The certificate of authority to do business of any alien insurer which removes or attempts to remove any material part of such records from the principal place of business of the insurer in this state with the intent to remove the same from this state or conceals or attempts to conceal the same from the Commissioner in violation of this subsection shall be revoked. Upon any removal or attempted removal of such records or upon retention of such records or material part of such records outside this state beyond the period specified in the Commissioner's consent under which such records were permitted to be removed or upon concealment of or attempts to conceal such records in violation of this subsection, the Commissioner may institute proceedings against the insurer pursuant to Chapter 37 of this title.

(c) This Code section shall not be deemed to prohibit or prevent an alien insurer from establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to

the transaction of its business and keeping therein the detailed records customary and necessary for the servicing of the insurance in force in the jurisdiction served by such an office as long as such records are made readily available at such office for examination by the Commissioner at his request.

History. — Code 1981, § 33-3-30, enacted by Ga. L. 1999, p. 584, § 4.

CHAPTER 4

ACTIONS AGAINST INSURANCE COMPANIES

Sec.
33-4-1. Venue of actions.
33-4-2. Domestic insurers, service of process.
33-4-3. Alien or foreign insurers, service of process generally.
33-4-4. Alien or foreign insurers, duplicate copies of process upon designated agent or Commissioner.
33-4-5. Service of process upon chief executive officer by alien or foreign insurers.
33-4-6. Liability of insurer for damages and attorney's fees; notice to Commissioner and consumers' insurance advocate.
33-4-7. Affirmative duty to fairly and promptly adjust in incidents covered by motor vehicle liability policies; actions for bad faith; notice to Commissioner and consumers' insurance advocate.

Law reviews. — For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999).

For comment on McGee v. International Life Ins. Co., 355 U.S. 220, 78 S. Ct. 199, 2 L. Ed. 2d 223 (1957), holding that for a state to assert jurisdiction over a foreign insurance company it is sufficient for due process purposes if the contract on which the case is based has a substantial connection with that state, see 21 Ga. B.J. 113 (1958).

JUDICIAL DECISIONS

Proper plaintiff. — Absent the assignment of an insurance policy, a suit on the policy must be brought by the policyholder. Phillips v. Bacon, 245 Ga. 814, 267 S.E.2d 249 (1980).

Judgment prerequisite to action. — Without some specific statutory authorization, an action cannot proceed directly against the liability insurance carrier until a judgment is obtained against the tortfeasor or his liability is otherwise fixed. Smith v. Commercial Union Assurance Co., 246 Ga. 50, 268 S.E.2d 632 (1980).

RESEARCH REFERENCES

ALR. — Statutory or contractual limitation where presumption of death of the insured from seven years' absence is relied upon, 61 A.L.R. 686; 119 A.L.R. 1308.

Right of owner to sue on fire or marine policy taken out by warehouseman, bailee, or carrier, 61 A.L.R. 720.

Unincorporated association issuing insurance contract as subject to suit as entity in the name in which it contracts, 88 A.L.R. 164.

Appraiser's award in insurance cases as subject to attack because appraiser had previously acted for party naming him, 104 A.L.R. 563.

Conflict of laws as regards statutory or contractual provisions relating to right of injured person to maintain action against tortfeasor's insurer, 120 A.L.R. 855.

Judgment in favor of tortfeasor's insurer in an action by injured person as res judicata in similar action by another person injured in same accident, 137 A.L.R. 1016.

Burden of proof, in action upon an accident policy or accident feature of life policy, as regards conditions which, by the terms of the policy, limit or exclude coverage, 142 A.L.R. 742.

Compromise by insured as affecting

right to recover against liability or indemnity insurer, either where claim exceeds limit of liability under policy, or where insurer denies liability on policy, refuses to defend, or otherwise delays taking action, 142 A.L.R. 809.

Different benefits or claims of benefit under a policy of insurance as constituting a single cause of action or separate causes, 159 A.L.R. 563.

Basis and manner of distribution among multiple claimants of proceeds of liability insurance policy inadequate to pay all claims in full, 70 A.L.R.2d 416.

Timely suit to enforce policy as interrupting limitations against claimant's later suit or amended pleading to reform it, or vice versa, 92 A.L.R.2d 168.

Beneficiary's ignorance of existence of life or accident policy as excusing failure to give notice, make proofs of loss, or bring action within time limited by policy or statute, 28 A.L.R.3d 292.

Right of injured person recovering excess judgment against insured to maintain action against liability insurer for wrongful failure to settle claim, 63 A.L.R.3d 677.

Limitation of action against insurer for breach of contract to defend, 96 A.L.R.3d 1193.

Insurer's tort liability for consequential or punitive damages for wrongful failure or refusal to defend insured, 20 A.L.R.4th 23.

Policy provision limiting time within which action may be brought on the policy as applicable to tort action by insured against insurer, 66 A.L.R.4th 859.

Admissibility of polygraph or similar lie detector test results, or willingness to submit to test, on issues of coverage under insurance policy, or insurer's good-faith belief that claim was not covered, 7 A.L.R.5th 143.

33-4-1. Venue of actions.

Except for actions arising against unauthorized insurers or under surplus line contracts which are provided for in Chapter 5 of this title, whenever any person shall have a claim or demand on any insurer, such person may bring an action in any of the following places:

(1) In the county where the principal office of the company is located;

(2) In any county where the company shall have an agent or place of doing business;

(3) In any county where such agent or place of doing business was located at the time the cause of action accrued or the contract was made out of which such cause of action arose; or

(4) In any county where the property covered by an insurance contract upon which an action is brought is located or where the person entitled to the proceeds of an insurance contract upon which action is brought maintains his legal residence. For the purpose of this paragraph, personal property shall be deemed to be located in the county of the legal residence of the owner of such personal property, and, for the purpose of bringing an action under this paragraph, a company which has written a contract of insurance upon persons or property located in a particular county or which has become surety for the performance of an obligation in a particular county shall be deemed to be transacting business in such county and

shall be deemed to be a legal resident of such county; provided, further, that any action on the bond of a sheriff or other arresting or law enforcement officer or superior court clerk or deputy clerk or clerk or deputy of any court of record, upon which any guaranty or surety company or fidelity insurance company is bound and obligated as surety, shall be instituted in the county of the residence of the officer and not in any other county; and the county of the residence of the officer is hereby fixed as the venue of any action on such bond; and the officer may be made a party defendant or may by intervention become a party defendant.

History. — Ga. L. 1861, p. 58, § 1; Code 1868, § 3331; Code 1873, § 3408; Ga. L. 1878-79, p. 54, § 1; Code 1882, § 3408; Civil Code 1895, § 2145; Ga. L. 1902, p. 53, § 1; Civil Code 1910, § 2563; Code 1933, § 56-601; Code 1933, § 56-1201, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1969, p. 740, § 1.

Cross references. — Venue generally, Ga. Const. 1983, Art. VI, Sec. II and § 9-10-30 et seq.

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981). For annual survey article discussing trial practice and procedure, see 51 Mercer L. Rev. 487 (1999). For survey article on real property law for the period from June 1, 2002 to May 31, 2003, see 55 Mercer L. Rev. 397 (2003).

For note discussing problems with venue in Georgia, and proposing statutory revisions to improve the resolution of venue questions, see 9 Ga. St. B.J. 254 (1972).

JUDICIAL DECISIONS

Analysis

General Consideration
Application

General Consideration

Constitutionality. — The constitutional power of the General Assembly to enact the provision authorizing action to be brought in any county where company has an agent or place of doing business at the time the cause of action accrued or contract out of which the cause of action arose was made has been recognized and settled by the Supreme Court. Davis v. Central R.R. & Banking Co., 17 Ga. 323 (1855); Merritt v. Cotton States Life Ins. Co., 55 Ga. 103 (1875), later appeal. 59 Ga. 664 (1877).

The provision authorizing action to be brought in any county where company has an agent or place of doing business at the time the cause of action accrued or contract out of which the cause of action arose was made is not in conflict with the Constitution of this state or with the federal Constitution. Jefferson Fire Ins. Co. v. Brackin, 140 Ga. 637, 79 S.E. 467 (1913), later appeal 147 Ga. 47, 92 S.E. 930 (1917).

The provision authorizing action to be brought in any county where the insured property is located or where the person entitled to the insurance proceeds maintains a legal residence is not unconstitutional as violative of Ga. Const. 1976, Art. VI, Sec. XIV, Para. VI (see Ga. Const. 1983, Art. VI, Sec. II, Para. VI). Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962).

The provision authorizing action to be brought in any county where the insured property is located or where the person entitled to the insurance proceeds maintains a legal residence does not deny due process of law. Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962).

A classification of insurance companies,

General Consideration (Cont'd)

which excepts insurance companies which are bound and obligated as sureties upon the bonds of law enforcement officers is not unreasonable and does not violate Ga. Const. 1976, Art. I, Sec. II, Para. III (see Ga. Const. 1983, Art. I, Sec. I, Para. II). Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962).

The primary purpose of the proviso to the provision authorizing action to be brought in any county where the insured property is located or where the person entitled to the insurance proceeds maintains a legal residence is to protect sheriffs and law enforcement officers, whose duties are primarily performed in the county of their residence. The peculiar nature of their duties, requiring the arrest and imprisonment of those charged with violations of the laws, dealing with dangerous criminals, or with drunk or disorderly persons, lunatics and others of warped mind, subjecting them to unusual danger and requiring extraordinary action on their part, thereby increasing the risk of liability to unfounded actions against them, justifies the classification and renders it reasonable. Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962); Busbee v. Reserve Ins. Co., 147 Ga. App. 451, 249 S.E.2d 279 (1978), rev'd on other grounds, 243 Ga. 371, 254 S.E.2d 324 (1979).

Venue of action against a sheriff and his bondsman based on the provision authorizing action to be brought in any county where the insured property is located or where the person entitled to the insurance proceeds maintains a legal residence does not violate Ga. Const. 1976, Art. VI, Sec. XIV, Para. IV (see Ga. Const. 1983, Art. VI, Sec. II, Para. IV) since the General Assembly has declared the residence of the surety for the performance of the obligation to be the county in which the obligation is to be performed. White v. Fireman's Fund Ins. Co., 233 Ga. 919, 213 S.E.2d 879 (1975).

Construction of paragraph (2). — Nothing in the language of paragraph (2) of O.C.G.A. § 33-4-1 indicates that it is intended to apply only to claims under insurance contracts. Patterman v. Travelers, Inc., 235 Ga. App. 784, 510 S.E.2d 307 (1998), aff'd, 272 Ga. 251, 527 S.E.2d 187 (2000).

To the extent that there is any limitation to the application of the statute, such limitation is not based on the words "claim or demand," but on the word "insurer." Patterman v. Travelers, Inc., 235 Ga. App. 784, 510 S.E.2d 307 (1998), aff'd, 272 Ga. 251, 527 S.E.2d 187 (2000).

Venue is proper under this Code section if a claim arises out of the defendant's "role as an insurer" or "business as an insurer." Patterman v. Travelers, Inc., 235 Ga. App. 784, 510 S.E.2d 307 (1998), aff'd, 272 Ga. 251, 527 S.E.2d 187 (2000).

Paragraph (2) of O.C.G.A. § 33-4-1 can be used to fix venue for a tort action in any county where a defendant insurance company has an agent, as long as the action involves the defendant's insurance business. Travelers, Inc. v. Patterman, 272 Ga. 251, 527 S.E.2d 187 (2000).

Due process does not require that an action against a defendant be brought in the county of residence. Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962).

Contractual limitation of venue held unenforceable as against public policy. — The provisions of a labor and materials payment bond, limiting venue solely to forums of the county or other political subdivision where the project is situated, are unenforceable as contrary to public policy. Fidelity & Deposit Co. v. Gainesville Iron Works, Inc., 125 Ga. App. 829, 189 S.E.2d 130 (1972).

Section does not conflict with former Civil Code 1895, § 2057. — Former Civil Code 1895, § 2057 (see O.C.G.A. § 33-4-3) merely requires insurance companies doing business here to file with the Insurance Commissioner a written power of attorney appointing some person who shall be authorized to acknowledge service for such company, or upon whom process may be served, and is entirely compatible with former Civil Code 1895, §§ 2145 and 2146 (see O.C.G.A. §§ 33-4-1 and 33-4-5). Gaines v. Bankers' Alliance, 113 Ga. 1138, 39 S.E. 502 (1901).

All statutes as to venue must be strictly construed. Lumbermen's Underwriting Alliance v. First Nat'l Bank &

Trust Co., 98 Ga. App. 289, 105 S.E.2d 585 (1958).

The terms "law enforcement officer" and "peace officer" are synonymous for the purpose of paragraph (4) of this section. Busbee v. Reserve Ins. Co., 147 Ga. App. 451, 249 S.E.2d 279 (1978), rev'd on other grounds, 243 Ga. 371, 254 S.E.2d 324 (1979).

The state revenue commissioner is a "law enforcement officer" within the meaning of paragraph (4) of this section. Vandiver v. Williams, 106 Ga. App. 435, 127 S.E.2d 168, cert. dismissed, 218 Ga. 496, 128 S.E.2d 749 (1962).

Venue provisions do not limit general jurisdiction. — Generally, constitutional and statutory provisions for venue confer a personal privilege upon defendants and do not limit the jurisdiction of courts having general jurisdiction. George Washington Life Ins. Co. v. Peacock, 90 Ga. App. 296, 82 S.E.2d 875 (1954).

The General Assembly has the power to declare the residence of corporations. Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962); White v. Fireman's Fund Ins. Co., 233 Ga. 919, 213 S.E.2d 879 (1975).

Cited in Vandiver v. Williams, 218 Ga. 60, 126 S.E.2d 210 (1962); Aetna Cas. & Sur. Co. v. Sampley, 108 Ga. App. 617, 134 S.E.2d 71 (1963); Lott v. Liberty Mut. Ins. Co., 154 Ga. App. 474, 268 S.E.2d 686 (1980); Cloud v. Brantley Constr. Co., 163 Ga. App. 235, 293 S.E.2d 510 (1982); Currahee Constr. Co. v. Rabun County Sch. Dist., 180 Ga. App. 471, 349 S.E.2d 487 (1986); Klein v. Allstate Ins. Co., 202 Ga. App. 188, 413 S.E.2d 777 (1991); Jackson v. Sluder, 256 Ga. App. 812, 569 S.E.2d 893 (2002).

Application

Section applies to action involving unknown uninsured motorist. — As former Code 1933, § 56-407A (see O.C.G.A. § 33-7-11) did not contain any provisions in respect of venue of an action against an unknown uninsured motorist, this section relating to such actions against insurance companies, is applicable. Mercer v. Doe, 134 Ga. App. 818, 216 S.E.2d 339, cert. dismissed, 235 Ga. 207, 219 S.E.2d 144 (1975).

Insureds were authorized to bring their action against their insurer, seeking uninsured motorist coverage, in the county of their residence pursuant to O.C.G.A. § 33-4-1(4) and, accordingly, the trial court erred in transferring their case to another county pursuant to the insurer's motion alleging improper venue; the matter of whether venue was proper was reviewable by the appellate court pursuant to O.C.G.A. § 5-6-34(d) where the insureds' matter had been dismissed by the trial court and they sought review thereof. Morton v. Fuller, 264 Ga. App. 799, 592 S.E.2d 460 (2003).

Section does not apply to tort actions. — The provisions of the introduction and paragraph (3) of this section, authorizing venue for actions on any "claim or demand" on insurance companies in any county where the company's "agent or place of doing business was located at the time the cause of action accrued or the contract was made out of which such cause of action arose," do not apply to tort actions. The object of the legislation is to fix the venue of actions against insurers on their contracts of insurance. Mavity v. First of Ga. Ins. Co., 115 Ga. App. 763, 156 S.E.2d 191 (1967).

Pleading seeking equitable relief. — The provisions of this section do not authorize the filing of a pleading seeking purely equitable relief against an insurance company having its principal office in this state, as the sole defendant, in a county other than where such principal office is located. Porter v. State Mut. Life Ins. Co., 145 Ga. 543, 89 S.E. 609 (1916).

Columbia County Superior Court did not have personal jurisdiction over an insurance policy beneficiary who resided in another county sufficient to impose equitable relief against the beneficiary, pursuant to Ga. Const. 1983, Art. VI, Sec. II, Para. III. Joinder of the beneficiary was not proper even if jurisdiction was proper as to the insurer under O.C.G.A. § 33-4-1(4) because the complaint did not seek equitable relief common to both the non-resident beneficiary and the insurer. Skaliy v. Metts, 287 Ga. 777, 700 S.E.2d 357 (2010).

Claims arising out of business of insurance. — When plaintiffs' allega-

Application (Cont'd)

tions involved claims that the defendants or their agents committed fraud and unfair or deceptive acts by inducing policyholders to surrender their existing policies and purchase policies issued by defendants, the claims constituted claims arising out of the business of insurance, and the trial court erred in holding that O.C.G.A. § 33-4-1 was inapplicable. Patterman v. Travelers, Inc., 235 Ga. App. 784, 510 S.E.2d 307 (1998), aff'd, 272 Ga. 251, 527 S.E.2d 187 (2000).

Former O.C.G.A. § 46-7-17 (see O.C.G.A. § 40-1-117) did not have the effect of making a motor carrier and its insured joint tortfeasors or joint obligors for purposes of venue so that proper venue as to a suit against one is the proper venue in a suit against the other. Thomas v. Bobby Stevens Hauling Contractors, 165 Ga. App. 710, 302 S.E.2d 585 (1983).

Having agent or place of business in county determines venue. — Since the passage of Ga. L. 1902, p. 53, the venue of an action against an insurance company has been determined by the fact of the company having an "agent" or place of doing business in the county. Great E. Cas. Co. v. Haynie, 16 Ga. App. 643, 85 S.E. 938 (1915).

Insurer may be sued where it had agent when contract was executed. — Under this section the city court of La Grange had jurisdiction in an action against a nonresident insurance company of the subject-matter and of the defendant, inasmuch as the defendant had an agency (now agent) at that city at the time of the execution of the contract sued on. United States Cas. Co. v. Newman, 137 Ga. 447, 73 S.E. 667 (1912) (service not properly effected).

A petition (now complaint) against an insurance company, where it is alleged that at the time of the issuance of the policy sued on the defendant was represented by named agents in the county in which the suit was filed, alleges jurisdiction in that county, as provided in this section. Process issued thereon is valid. Hagler v. Pacific Fire Ins. Co., 36 Ga. App. 530, 137 S.E. 293, cert. denied, 36 Ga. App. 825, (1927).

When an action is brought against an insurance company and plaintiff's pleading shows that at the time of the issuance of the policy on which suit was brought, the defendant was represented by an agent in the county in which the suit was filed, jurisdiction lies in such county. Lumbermen's Underwriting Alliance v. First Nat'l Bank & Trust Co., 98 Ga. App. 289, 105 S.E.2d 585 (1958).

Even though it has no agent there at time of suit. — Under paragraph (3) of this section a nonresident insurance company may be sued in the county where the company had an agent and place of doing business when the contract of insurance was made and the cause of action arose, although the company has abandoned its agency in that county and has no agent there at the time of the suit. Peters v. Queen Ins. Co., 137 Ga. 440, 73 S.E. 664, answer conformed to, 10 Ga. App. 479, 73 S.E. 856 (1912); Guarantee Trust Life Ins. Co. v. Ricker, 93 Ga. App. 554, 92 S.E.2d 323 (1956).

Paragraph (3), to the effect that an insurance company can be sued, inter alia, in the county where its agent or place of business was located at the time the cause of action arose or the contract was made, is applicable to a reciprocal exchange, and venue is properly laid in county in which defendant had an agent at the time of the loss, even though when suit is filed, this agent has left and service is had upon individual designated by defendant for acceptance of service. Lumbermen's Underwriting Alliance v. First Nat'l Bank & Trust Co., 98 Ga. App. 289, 105 S.E.2d 585 (1958); Lumbermen's Underwriting Alliance v. Jessup, 98 Ga. App. 305, 105 S.E.2d 596 (1958).

Section does not apply if there is no agent or place of business in state. — When there was no agency and no place of doing business in this state or any principal office located in this state, former Civil Code 1910, § 2563 (see O.C.G.A. § 33-4-1) did not apply to an action against an insurer doing business under former Civil Code 1910, § 2446 (see O.C.G.A. § 33-4-3). Export Ins. Co. v. Womack, 165 Ga. 815, 142 S.E. 851, answer conformed to, 38 Ga. App. 75, 143 S.E. 151 (1928).

Federal preemption of state law claims. — Because policies purchased by a clinic association for the benefit of doctors constituted a plan governed by the Employee Retirement Income Security Act, and the plaintiff's state law claims "related to" the plan, the state law claims (e.g., to recover benefits, bad-faith refusal to pay, and attorney fees under O.C.G.A. § 33-4-1) were preempted by 29 U.S.C. § 1144(a). Stefansson v. Equitable Life Assur. Soc'y, No. 5:04CV40 (DF), 2005 U.S. Dist. LEXIS 21723 (M.D. Ga. Sept. 19, 2005).

Licensed agent with headquarters in county suffices. — An authorized agent of an insurance company who at the time the suit against the company was instituted, and at the time the cause of action accrued, and at the time of the making of the contract out of which the cause of action arose, was acting, under a state agent for the company and had his headquarters and place of business as such agent of the insurance company in that county within the meaning of paragraph (3) of this section. Great E. Cas. Co. v. Haynie, 16 Ga. App. 643, 85 S.E. 938 (1915).

Legal residence of agent is immaterial. — It is immaterial that the agent had in another county his legal residence for voting, etc., as indicated by the domicile of his family. Great E. Cas. Co. v. Haynie, 16 Ga. App. 643, 85 S.E. 938 (1915).

Subordinate lodge may be agent of fraternal benefit society. — Under this section a subordinate lodge was the agent of a fraternal benefit society in the county in which the suit was pending, and the court had jurisdiction. Hurley v. District Grand Lodge No. 1, 24 Ga. App. 197, 100 S.E. 233 (1919).

Depending on constitution and bylaws of superior lodge. — Whether a subordinate lodge is an agent depends on the constitution and bylaws of the superior lodge. Jones v. District Grand Lodge No. 18, 12 Ga. App. 273, 76 S.E. 279 (1913).

If venue against surety is proper, principals may be joined. — The principals in an administrator's bond on which a nonresident fidelity insurance company is surety may be joined with the surety in a suit brought in any county wherein jurisdiction over the surety may be obtained. Morris v. George, 3 Ga. App. 413, 59 S.E. 1116 (1908).

Surety living in another county. — A foreign fidelity insurance company may be sued in any county in this state in which it has an agent or place of doing business; and the principal in a guardian's bond for which the company is surety, although living in another county, may be sued jointly with the surety in any county in which jurisdiction over the surety may be obtained. Gross v. Butler, 48 Ga. App. 750, 173 S.E. 866 (1934).

Insurer cannot claim improper venue merely because insured cannot be sued in venue selected. — Just as a motor carrier cannot be required to defend a tort suit in a county solely because venue in that county would otherwise be proper as to its insurer, the insurer cannot avoid defending an ex contractu action otherwise properly brought in that county under this section solely because its insured cannot be sued there on the underlying tort. Thomas v. Bobby Stevens Hauling Contractors, 165 Ga. App. 710, 302 S.E.2d 585 (1983).

Waiver of objection to venue. — Appearance and pleading to the merits without objecting to the venue of the suit or reserving the right to do so as is a waiver of the right to be sued in the place provided by law. George Washington Life Ins. Co. v. Peacock, 90 Ga. App. 296, 82 S.E.2d 875 (1954).

If a defendant waives his right to be sued in the venue provided by law, he cannot afterwards attack the judgment rendered. George Washington Life Ins. Co. v. Peacock, 90 Ga. App. 296, 82 S.E.2d 875 (1954).

A defendant cannot later withdraw his responsive pleading and move to dismiss the petition on the ground that it does not show the proper venue. George Washington Life Ins. Co. v. Peacock, 90 Ga. App. 296, 82 S.E.2d 875 (1954). See § 9-11-12(h).

Paragraph (2) makes foreign insurer's liability asset of deceased insured's estate in county of place of business. — Since under paragraph (2) of

Application (Cont'd)

this section a foreign insurance company doing business within the state may be sued in any county of the state where it maintains an agent or place of business, the potential liability of an insurance company to the decedent's estate was an asset of that estate located in Bartow County, in which the company had an agent and place of business, for the purpose of founding an administration on that estate in that county under the provision of former Code 1933, § 113-1211. Tweed v. Houghton, 103 Ga. App. 57, 118 S.E.2d 496 (1961) (decided under former Code 1933, § 56-1201).

Where an owner's suit did not arise out of a title insurance company's business as an insurer, pursuant to Ga. Const. 1983, Art. VI, Sec. II, Para. III, the trial court erred in finding venue under O.C.G.A. § 33-4-1(2); in addition, the grant of an interlocutory injunction was error because there was no showing that the title company had any opportunity to challenge the applicability of an amendment to add a quiet title action under O.C.G.A. § 23-3-62 to the complaint. First Am. Title Ins. Co. v. Broadstreet, 260 Ga. App. 705, 580 S.E.2d 676 (2003).

33-4-2. Domestic insurers, service of process.

Service of process against a domestic insurer may be made upon the insurer corporation in the manner provided by laws applying to corporations generally or upon the insurer's attorney in fact if a reciprocal insurer or a Lloyd's association.

History. — Code 1933, § 56-1202, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Cross references. — Service of process generally, § 9-11-4.

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Cited in Thaxton v. Georgia Insurer's Insolvency Pool, 158 Ga. App. 407, 280 S.E.2d 421 (1981); Kirkpatrick v. Mackey, 162 Ga. App. 876, 293 S.E.2d 461 (1982).

RESEARCH REFERENCES

ALR. — Validity of substituted service of process upon liability insurer of unavailable tortfeasor, 17 A.L.R.4th 918.

33-4-3. Alien or foreign insurers, service of process generally.

Each authorized alien or foreign insurer shall make the following appointments for service of process:

(1) Each insurer shall file with the Commissioner a power of attorney appointing a person who is a resident of this state to receive service of legal process issued against it in this state upon any cause of action arising from its transactions of business in this state. The power of attorney shall be irrevocable and may only be terminated by the filing of a new appointment by the insurer; and

(2) Each insurer shall appoint the Commissioner as its attorney to receive service of legal process issued against it in this state upon any cause of action arising from its transactions of business in this state. The appointment shall be irrevocable, shall bind any successor, and shall remain in effect as long as there is in force in this state any contract made by the insurer or obligations arising therefrom. Each insurer at time of application for a certificate of authority shall file with the Commissioner the designation of the name and address of the person to whom process against it served upon the Commissioner is to be forwarded. The insurer may change such designation by a new filing. Service of process upon the Commissioner, however, shall only be made when service cannot be effected in this state by serving the attorney in fact appointed by the insurer as provided under paragraph (1) of this Code section.

History. — Ga. L. 1887, p. 113, § 10; Civil Code 1895, § 2057; Civil Code 1910, § 2446; Code 1933, § 56-603; Code 1933, § 56-1203, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Service of process on unauthorized insurers, § 33-5-50 et seq.

JUDICIAL DECISIONS

The evident purpose of the General Assembly in providing for the appointment of some person resident in this state who should be authorized to acknowledge or receive service of process was to require every foreign insurance company, as a condition precedent to acquiring a right to carry on business in Georgia, to submit itself to the jurisdiction of the courts of this state and the federal courts located therein. Equity Life Ass'n v. Gammon, 118 Ga. 236, 44 S.E. 978 (1903).

It was the purpose of the legislature to remove the hazards of uncertainty and delay attendant upon efforts to perfect service by requiring each foreign insurance company desiring to transact business in this state to appoint in writing some person as its resident agent or attorney in fact upon whom service might be perfected, and to file the power of attorney with the insurance commissioner as authentic information to any person interested. Seminole County Bd. of Educ. v. American Ins. Co., 180 Ga. 661, 180 S.E. 229 (1935).

Section does not conflict with former Civil Code 1895, §§ 2145 and 2146. — Former Civil Code 1895, § 2057 (see O.C.G.A. § 33-4-3) merely required insurance companies doing business in this state to file with the insurance commissioner a written power of attorney appointing some person who shall be authorized to acknowledge service for such company, or upon whom process may be served, and is entirely compatible with former Civil Code 1895, §§ 2145 and 2146 (see O.C.G.A. §§ 33-4-1 and 33-4-5). Gaines v. Bankers' Alliance, 113 Ga. 1138, 39 S.E. 502 (1901) (decided under former Civil Code 1895, § 2057).

This section patently applies only to insurance companies authorized to do business in Georgia, and substituted service lies only in an action arising from the insurance company's transaction of business in Georgia. Smith v. Lloyd's of London, 568 F.2d 1115 (5th Cir. 1978).

Former Code 1933, §§ 56-1203 and 56-1204 (see O.C.G.A. §§ 33-4-3 and 33-4-4) provide an independent mode of service, which may be pursued by any plaintiff, regardless of whether the company may have an agent in the county where the suit is filed. Seminole County Bd. of Educ. v. American Ins. Co., 180 Ga. 661, 180 S.E. 229 (1935).

Appointment does not give foreign insurer residence in agent's county. — A foreign insurance company which fails to maintain an agency does not, by appointing, or having the Commissioner of Insurance to appoint, an agent upon whom service may be perfected under this section, acquire a fixed residence in the county of such agent's residence. Equity Life Ass'n v. Gammon, 119 Ga. 271, 46 S.E. 100 (1903).

Failure of agent to notify insurer not grounds for vacating default judgment. — Failure of the agent upon whom service was perfected to inform the nonresident corporation of the service, thus preventing it from making a defense to the action, is not an unavoidable casualty, accident, or misfortune so as to authorize the vacation of a default judgment. United Bonding Ins. Co. v. Bray Lumber Co., 226 Ga. 765, 177 S.E.2d 227 (1970).

Service proper although no power of attorney appointing agent was filed. — Service of process on the Insurance Commissioner, who then forwarded a copy to the defendant foreign insurance carrier by registered mail in accordance with O.C.G.A. § 33-4-4, was proper when a power of attorney appointing an agent for service had not been filed. American Bankers Ins. Co. v. Andre, 157 Ga. App. 661, 278 S.E.2d 427 (1981).

Purported agent's refusal to admit to agency status. — When the person believed to be the defendant's designated agent for service of process refuses to accept such service on the grounds that the person is not the defendant's designated agent, this is an insufficient showing that service could not be made upon the proper agent, and service of process upon the Insurance Commissioner pursuant to O.C.G.A. § 33-4-3 is not justified. Wilkerson v. Voyager Cas. Ins. Co., 171 Ga. App. 834, 321 S.E.2d 346 (1984).

Cited in Aetna Cas. & Sur. Co. v. Sampley, 108 Ga. App. 617, 134 S.E.2d 71 (1963).

RESEARCH REFERENCES

ALR. — Full faith and credit provision as affecting insurance contracts, 41 A.L.R. 1386; 114 A.L.R. 250; 119 A.L.R. 483; 173 A.L.R. 1138.

Statute regarding automobile liability or indemnity insurance of state where injury occurred as applicable to a pol of another state, 137 A.L.R. 656.

Foreign insurance company as subject to service of process in action on policy, 44 A.L.R.2d 416.

33-4-4. Alien or foreign insurers, duplicate copies of process upon designated agent or Commissioner.

(a) In addition to other methods of service provided by law, a foreign or alien insurer may be served with legal process by service of duplicate copies of the legal process on the agent for service designated under Code Section 33-4-3 or upon the Commissioner. At the time of service the plaintiff shall pay a fee in an amount as provided in Code Section 33-8-1, taxable as cost in the action. Upon receiving such service the Commissioner shall promptly forward a copy of such service by registered or certified mail or statutory overnight delivery to the person last so designated by the insurer to receive the same.

(b) Process served upon the Commissioner and a copy of such process forwarded as provided in this Code section shall constitute service of such legal process upon the insurer so long as the insurer shall have any obligations or liabilities outstanding, although the company may

have withdrawn, have been excluded from, or have ceased to do business in this state.

History. — Code 1933, § 56-1204, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1985, p. 1399, § 1; Ga. L. 1992, p. 2725, § 8; Ga. L. 2000, p. 1589, § 3.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or before July 1, 2000.

JUDICIAL DECISIONS

Long-arm jurisdiction established over withdrawing insurers. — This section establishes long-arm jurisdiction over any insurance company that, having done business in Georgia, withdraws from the state and leaves behind outstanding obligations. Smith v. Lloyd's of London, 568 F.2d 1115 (5th Cir. 1978).

Substituted service may be used although no agent in county of suit. — Former Code 1933, §§ 56-603, 56-1203, and 56-1204 (see O.C.G.A. §§ 33-4-3 and 33-4-4) provide an independent mode of service which may be pursued by any plaintiff, regardless of whether the company may have an agent in the county where the suit is filed. Seminole County Bd. of Educ. v. American Ins. Co., 180 Ga. 661, 180 S.E. 229 (1935).

Section permits service by methods not provided in title. — The phrase "in addition to other methods of service provided by law" in this section means methods provided by law other than in this title. Aetna Cas. & Sur. Co. v. Sampley, 108 Ga. App. 617, 134 S.E.2d 71 (1963).

Service under laws as to corporations. — The reference to other methods of service in this section included that of serving "any agent" of the company as provided in former Code 1933, § 22-1101 (see O.C.G.A. § 9-11-4). Aetna Cas. & Sur. Co. v. Sampley, 108 Ga. App. 617, 134 S.E.2d 71 (1963).

This chapter authorizes service on a foreign insurance company by methods of service provided by law other than in this title, hence on its local agent as provided by former Code 1933, § 22-1101 (see O.C.G.A. § 9-11-4(d)), as well as on the appointed process agent. Beard v. Calvert Fire Ins. Co., 114 Ga. App. 249, 150 S.E.2d 711 (1966).

Alternative recipient, not alternative manner of service. — The purpose of this section is to specify an alternative recipient of legal process, and not an alternative manner of service, and formal service of process is required. Wilkerson v. Voyager Cas. Ins. Co., 171 Ga. App. 834, 321 S.E.2d 346 (1984).

Service proper although no power of attorney appointing agent was filed. — Service of process on the Insurance Commissioner, who then forwarded a copy to the defendant foreign insurance carrier by registered mail in accordance with this section, was proper where a power of attorney appointing an agent for service had not been filed. American Bankers Ins. Co. v. Andre, 157 Ga. App. 661, 278 S.E.2d 427 (1981).

RESEARCH REFERENCES

ALR. — Foreign insurance company as subject to service of process in action on policy, 44 A.L.R.2d 416.

33-4-5. Service of process upon chief executive officer by alien or foreign insurers.

In actions upon any certificate or policy issued by a nonresident religious or mutual aid society, cooperative, or assessment life insurance company or society, service upon the chief executive officer, or the person acting officially for or as the chief executive officer of a local lodge, shall be sufficient service upon the society or company. In carrying out the purpose of this Code section, officers of local lodges are deemed to be agents of the nonresident societies or companies and the local lodges are deemed to be agencies of said companies or societies.

History. — Ga. L. 1861, p. 58, § 2; Code 1868, § 3332; Code 1873, § 3409; Code 1882, § 3409; Ga. L. 1890-91, p. 75, § 1; Civil Code 1895, § 2146; Civil Code 1910, § 2564; Code 1933, § 56-604; Code 1933, § 56-1205, enacted by Ga. L. 1960, p. 289, § 1.

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No conflict. — Former Civil Code 1895, § 2057 (see O.C.G.A. § 33-4-3) merely required insurance companies doing business here to file with the Insurance Commissioner a written power of attorney appointing some person who shall be authorized to acknowledge service for such company, or upon whom process may be served, and was entirely compatible with former Civil Code 1895, §§ 2145 and 2146 (see O.C.G.A. §§ 33-4-1 and 33-4-5). Gaines v. Bankers' Alliance, 113 Ga. 1138, 39 S.E. 502 (1901).

33-4-6. Liability of insurer for damages and attorney's fees; notice to Commissioner and consumers' insurance advocate.

(a) In the event of a loss which is covered by a policy of insurance and the refusal of the insurer to pay the same within 60 days after a demand has been made by the holder of the policy and a finding has been made that such refusal was in bad faith, the insurer shall be liable to pay such holder, in addition to the loss, not more than 50 percent of the liability of the insurer for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action against the insurer. The action for bad faith shall not be abated by payment after the 60 day period nor shall the testimony or opinion of an expert witness be the sole basis for a summary judgment or directed verdict on the issue of bad faith. The amount of any reasonable attorney's fees shall be determined by the trial jury and shall be included in any judgment which is rendered in the action; provided, however, that the attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services based on the time spent and legal and factual issues involved in accordance with prevailing fees in the locality where the action is pending; provided, further, that the trial court shall have the discretion, if it finds the jury verdict fixing

attorney's fees to be greatly excessive or inadequate, to review and amend the portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and the plaintiff's attorney for the services of the attorney in the action against the insurer.

(b) In any action brought pursuant to subsection (a) of this Code section, and within 20 days of bringing such action, the plaintiff shall, in addition to service of process in accordance with Code Section 9-11-4, mail to the Commissioner of Insurance a copy of the demand and complaint by first-class mail. Failure to comply with this subsection may be cured by delivering same.

History. — Ga. L. 1872, p. 43, § 1; Code 1873, § 2850; Code 1882, § 2850; Civil Code 1895, § 2140; Civil Code 1910, § 2549; Code 1933, § 56-706; Code 1933, § 56-1206, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 712, § 1; Ga. L. 2001, p. 784, § 1; Ga. L. 2015, p. 1088, § 21/SB 148; Ga. L. 2016, p. 864, § 33/HB 737.

Cross references. — Imposing administrative fine for acts of representatives, including refusal to pay claims without cause, § 33-3-20. Liability of unauthorized foreign or alien insurer failing to pay according to terms of insurance contract, § 33-5-58. Liability for failing or refusing in bad faith to pay under uninsured motorist coverage, § 33-7-11(j). Prompt payment of health benefit claims, § 33-24-59.5.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, "first-class mail" was substituted for "first class mail" in subsection (b).

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979). For article discussing Georgia provisions concerning damages for insurer's failure to pay first-party claims, see 14 Ga. L. Rev. 497 (1980). For article surveying Georgia cases in the area of insurance from June 1979 through May 1980, see 32 Mercer L. Rev. 79 (1980). For article discussing imposition of liability on insurer, "The Liability Insurance Policy — Above and Beyond Coverage: Extra-Contractual Rights and Duties," see 22 Ga. St. B.J. 134 (1986). For annual survey of insurance law, see 42 Mercer L. Rev. 259 (1990). For article, "Insurance," see 53 Mercer L. Rev. 281 (2001). For article, "Bad Faith in Insurance Claim Handling in Georgia: An Overview and Update," see 9 Ga. St. B.J. 10 (2003). For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004). For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007). For annual survey on insurance, see 61 Mercer L. Rev. 179 (2009). For article, "What Does ERISA Have to do with Insurance?," see 14 (No. 7) Ga. St. B.J. 19 (2009). For annual survey on insurance law, see 64 Mercer L. Rev. 151 (2012). For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014). For annual survey of insurance law, see 67 Mercer L. Rev. 73 (2015). For article, "An Insurer's Duty to Settle: The Law in Georgia," see 22 Ga. St. B.J. 19 (Aug. 2016). For article, "The Peculiarities of Georgia Insurance Law," see 24 Ga. St. B.J. 18 (April 2019).

For note, "Wrongful Refusal to Pay Insurance Claims in Georgia," see 13 Ga. L. Rev. 935 (1979). For note on the 2001 amendment to this Code section, see 18 Ga. St. U.L. Rev. 167 (2001).

For comment on Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949), see 12 Ga. B.J. 337 (1950). For comment on Spicer v. American Home Assurance Co., 292 F. Supp. 27 (N.D. Ga. 1967), see 6 Ga. St. B.J. 225 (1969).

JUDICIAL DECISIONS

Analysis

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Procedure
1. Generally
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5. Verdict and Judgment
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Section is constitutional. — This section is not violative of U.S. Const. amend. 14, § 1, nor of Ga. Const. 1976, Art. I, Sec. I, Paras. I, IX, and Sec. II, Para. III (see Ga. Const. 1983, Art. I, Sec. I, Paras. I, XII, and Sec. V, Para. II). Harp v. Fireman's Fund Ins. Co., 130 Ga. 726, 61 S.E. 704, 14 Ann. Cas. 299 (1908).

It is intention of O.C.G.A. § 33-4-6 to penalize insurers for resisting and delaying payment unless good cause is shown. Georgia Int'l Life Ins. Co. v. Harden, 158 Ga. App. 450, 280 S.E.2d 863 (1981).

Specific penalty provisions control. — Where the General Assembly has provided a specific procedure and a limited penalty for noncompliance with a specific enactment (e.g., uninsured motorist coverage), the specific procedure and limited penalty are intended by the General Assembly to be the exclusive procedure and penalty, and recovery under general penalty provisions, such as O.C.G.A. §§ 13-6-11, 33-4-6 (now subsection (a)), 51-12-5, and 51-12-6, will not be allowed. McCall v. Allstate Ins. Co., 251 Ga. 869, 310 S.E.2d 513 (1984); Howell v. Southern Heritage Ins. Co., 214 Ga. App. 536, 448 S.E.2d 275 (1994); United Servs. Auto. Ass'n v. Carroll, 226 Ga. App. 144, 486 S.E.2d 613 (1997).

As an insured's counterclaim for tortious interference with a contract failed against an insurer due to the lack of evidence regarding direct inducement, the insured's counterclaims for lost profits and punitive damages that were necessarily predicated on that counterclaim failed; the counterclaims for lost profits and punitive damages were not predicated on a bad faith refusal to pay counterclaim pursuant to O.C.G.A. § 33-4-6, as the penalties provided therein were the exclusive remedies for any liability on the part of an insurer. Great Southwest Express Co. v. Great Am. Ins. Co., 292 Ga. App. 757, 665 S.E.2d 878, cert. denied, 293 Ga. App. 365, 667 S.E.2d 192 (2008).

Because an insurer obligated itself under the terms of its policy to pay all expenses, attorney fees and expenses constituted a "loss that was covered by the policy of insurance" within the purview of a O.C.G.A. § 33-6-4 award; the coverage under the terms of the policy, which was expressly in addition to and above the liability limits of the policy, contemplated "all expenses" in the defense of a covered suit, as well as "all reasonable expenses" incurred by the insured in assisting in the defense, which would both of necessity include attorney fees. Transp. Ins. Co. v. Piedmont Constr. Group, LLC, 301 Ga. App. 17, 686 S.E.2d 824 (2009), cert. denied, No. S10C0507, 2010 Ga. LEXIS 312 (Ga. 2010).

Section is virtually identical to O.C.G.A. § 10-7-30, except that it deals with the liability of insurance companies on their insurance contracts rather than the liability of corporate sureties on their suretyship contracts. Columbus Fire & Safety Equip. Co. v. American Druggist Ins. Co., 166 Ga. App. 509, 304 S.E.2d 471 (1983).

Construction with § 33-4-7. — Because a party mischaracterized O.C.G.A. § 33-4-7 as a "companion" to O.C.G.A. § 33-4-6 and erroneously contended that

the General Assembly intended to extend the same rights to a third party, or a party other than the policy holder, and thus, the appellate court should therefore read § 33-4-7 as applying, like § 33-4-6, in the event of any covered loss, those arguments were rejected as specious. Mills v. Allstate Ins. Co., 288 Ga. App. 257, 653 S.E.2d 850 (2007).

Section is not exclusive avenue for recovery of attorney's fees. — O.C.G.A. § 33-4-6 is not the exclusive avenue for recovery of attorney's fees in Georgia; O.C.G.A. § 13-6-11 imposes liability for attorney's fees on a party in a contract action for bad faith or stubborn litigiousness. American Family Life Assurance Co. v. United States Fire Co., 885 F.2d 826 (11th Cir. 1989); American Family Life Assurance Co. v. United States Fire Co., 885 F.2d 826 (11th Cir. 1989); Colonial Oil Indus., Inc. v. Underwriters Subscribing to Policy Nos. T031504670 & T031504671, 910 F. Supp. 655 (S.D. Ga. 1995).

Section provides exclusive remedy for bad faith refusal to pay. — Claims for attorney fees and expenses are not authorized under O.C.G.A. § 13-6-11; the penalties contained in O.C.G.A. § 33-4-6 are the exclusive remedies for an insurer's bad faith refusal to pay insurance proceeds. American Family Life Assurance Co. v. United States Fire Co., 885 F.2d 826 (11th Cir. 1989); Colonial Oil Indus., Inc. v. Underwriters Subscribing to Policy Nos. T031504670 & T031504671, 910 F. Supp. 655 (S.D. Ga. 1995).

Because the penalties contained in O.C.G.A. § 33-4-6 were the exclusive remedies for an insurer's bad faith refusal to pay insurance proceeds, attorney fees under O.C.G.A. § 13-6-11 were unavailable to an insured who prevailed on the insured's coverage claim before a jury. Johnston v. Companion Prop. & Cas. Ins. Co., 318 Fed. Appx. 861 (11th Cir. 2009) (Unpublished).

In a suit by a mortgagee against an insurer for bad faith, the insurer should have been granted summary judgment on the mortgagee's claims for bad faith damages and attorney fees under O.C.G.A. § 33-4-6 for a refusal to pay and attorney fees under O.C.G.A. § 13-6-11 because the insurer had paid the claim to the mortgagor and the mortgagee jointly and the mortgagor's agent had fraudulently endorsed the check; attorney's fees were not available because penalties were the exclusive remedy. Auto-Owners Ins. Co. v. Hale Haven Props., 346 Ga. App. 39, 815 S.E.2d 574 (2018), cert. denied, No. S18C1423, 2019 Ga. LEXIS 75, cert. denied, No. S18C1418, 2019 Ga. LEXIS 88, cert. denied, No. S18C1421, 2019 Ga. LEXIS 92 (Ga. 2019), cert. denied, No. S18C1417, 2019 Ga. LEXIS 93 (Ga. 2019).

Penalties exclusive. — Trial court erred in denying the insurer's motion for summary judgment on the insured's claim for attorney fees under O.C.G.A. § 13-6-11 because the penalties contained in O.C.G.A. § 33-4-6 were the exclusive remedies for a bad faith claim. Thompson v. Homesite Insurance Company of Ga., 345 Ga. App. 183, 812 S.E.2d 541 (2018), cert. denied, No. S18C1044, 2018 Ga. LEXIS 738 (Ga. 2018).

Section provides exclusive remedy for bad faith denial of benefits. — O.C.G.A. § 33-4-6 is the exclusive remedy for bad faith denial of benefits and did not apply in an action involving negligent representations by an insurer in connection with the issuance of a policy. Collins v. Life Ins. Co., 228 Ga. App. 301, 491 S.E.2d 514 (1997).

The damages set forth in O.C.G.A. § 33-4-6 are the exclusive remedy for bad faith denial of insurance benefits, so that litigation expenses under O.C.G.A. § 13-6-11 are not recoverable. Atl. Title Ins. Co. v. Aegis Funding Corp., 287 Ga. App. 392, 651 S.E.2d 507 (2007), cert. denied, No. S08C0137, 2008 Ga. LEXIS 107 (Ga. 2008).

The recovery of attorney's fees under this section is a penalty, not favored in the law, and the right thereto must clearly appear. Love v. National Liberty Ins. Co., 157 Ga. 259, 121 S.E. 648 (1924); Canal Ins. Co. v. Woodard, 121 Ga. App. 356, 173 S.E.2d 727 (1970); Progressive Cas. Ins. Co. v. Avery, 165 Ga. App. 703, 302 S.E.2d 605 (1983).

Penalty must be strictly construed. The provision for damages and attorney's fees, being in the nature of a penalty, must be strictly construed. Interstate Life & Accident Ins. Co. v. Williamson, 220 Ga.

General Consideration (Cont'd)

323, 138 S.E.2d 668, answer conformed to, 110 Ga. App. 557, 139 S.E.2d 429 (1964); Progressive Cas. Ins. Co. v. Avery, 165 Ga. App. 703, 302 S.E.2d 605 (1983).

Since the provision for damages and attorney's fees is in the nature of a penalty, it must be strictly construed, and in order for these items of recovery to be authorized, it must first appear that the company acted in bad faith in refusing to pay the claim. United States Fid. & Guar. Co. v. Biddy Lumber Co., 114 Ga. App. 358, 151 S.E.2d 466 (1966).

Section sets forth insured's remedy for insurer's bad faith refusal to pay loss. — The remedy provided a plaintiff on an unliquidated claim for damages under an insurance policy, where the defendant refuses in bad faith to pay the amount of the loss within 60 days after demand, is set forth in this section. Insurance Co. of N. Am. v. Folds, 42 Ga. App. 306, 155 S.E. 782 (1930).

Which remedy is exclusive. Damages sought to be recovered in an attempt tort action based upon an insurance contract are in the nature of a penalty, which the plaintiff claimed the defendant owed him because of its failure to promptly settle his claim. The penalties imposed against insurance companies doing business in Georgia for their failure or refusal to pay claims within a reasonable time after demand has been made are fixed by this section, which remedy is exclusive. Leonard v. Firemen's Ins. Co., 100 Ga. App. 434, 111 S.E.2d 773 (1959).

When the insured sought to recover $10.00 per day from the insurer for the loss of the insured vehicle, which the insured claimed was owed the insured because of failure of insurer to promptly settle the insured's claim, the trial court did not err in dismissing the action, since the damages sought to be recovered were in the nature of a penalty and the penalties imposed against insurance companies for failure or refusal to pay claims within a reasonable time after demand has been made are fixed by O.C.G.A. § 33-4-6, which provides the exclusive remedy. Leonard v. Firemen's Ins. Co., 100 Ga. App. 434, 111 S.E.2d 773 (1959); Globe Life & Accident Ins. Co. v. Ogden, 182 Ga. App. 803, 357 S.E.2d 276, cert. denied, 182 Ga. App. 910, 357 S.E.2d 276 (1987).

Insured's claim for penalties and attorney fees under O.C.G.A. § 33-4-6 was the insured's exclusive remedy for any failure of the insurer to pay benefits within 60 days of the insured's demand. Lincoln Nat'l Life Ins. Co. v. Davenport, 201 Ga. App. 175, 410 S.E.2d 370 (1991).

It is exception to rule disallowing exemplary damages in contract cases. — Former Civil Code 1910, § 4393 (see O.C.G.A. § 13-6-10) declared that exemplary damages can never be allowed in cases arising on contracts, but, while this rule is a very strict and well-nigh universal one, it is still not a rule without any exception whatever, such as this section. Copeland v. Dunehoo, 36 Ga. App. 817, 138 S.E. 267 (1927).

This section provides for punitive damages where an insurer is guilty of bad faith in refusing to pay under the terms of an insurance policy, and the plaintiff's petition elsewhere seeks to recover such damages, but in the absence of such authority, exemplary or punitive damages are not recoverable for the breach of a contract. Kilgore v. National Life & Accident Ins. Co., 110 Ga. App. 280, 138 S.E.2d 397 (1964).

Where the trial court found that defendant insurer was not liable to the insured since the plaintiff breached three separate conditions precedent in the policy, plaintiff's claim for bad faith penalties likewise failed. Hill v. Safeco Ins. Co. of Am., 93 F. Supp. 2d 1375 (M.D. Ga. 1999).

Reasonable grounds to contest preclude bad faith penalties. — When as a matter of law, insurer had reasonable grounds to contest claim, then insurer could not have been held liable, under O.C.G.A. § 33-4-6, either for the imposition of bad faith penalties or for attorney fees. Rice v. State Farm Fire & Cas. Co., 208 Ga. App. 166, 430 S.E.2d 75 (1993).

Evidence adduced upon insurer's motion for summary judgment was sufficient to demonstrate that insurer had reasonable grounds to contest claimant's action for bad faith penalties, as insurer demonstrated that it did not refuse payment on policy for "frivolous" or "unfounded" rea-

sons. Southern Fire & Cas. Ins. Co. v. Northwest Ga. Bank, 209 Ga. App. 867, 434 S.E.2d 729 (1993).

Insured's duty to cooperate as condition precedent. — Because the insurance policy provided that the insured had to cooperate in an investigation of a claim, but the insured refused to provide the requested financial information to the insurer after the insured's home was destroyed by fire and the insurer believed the timing was suspicious and fraudulent, the insured's suit to recover under the policy and under O.C.G.A. § 33-4-6 failed. Farmer v. Allstate Ins. Co., 396 F. Supp. 2d 1379 (N.D. Ga. 2005).

Failure to pay loss gives cause of action under section, not in tort. — Where the duties in question arose out of the insurance contract and there was a breach of contract on the part of the defendant by failing to pay the plaintiff the full amount of damages owed under the terms thereof, the damages sought to be recovered by the plaintiff are limited to the "bad faith" provisions of this section and the plaintiff does not have a cause of action in tort. Tate v. Aetna Cas. & Sur. Co., 149 Ga. App. 123, 253 S.E.2d 775 (1979).

Contract may supersede general statutory limitations on right of action. — Regardless of the form of the action, if the source of the right claimed has evolved from a written contract of insurance, the limitations contained in it supersede any other general statutory limitations. Modern Carpet Indus., Inc. v. Factory Ins. Ass'n, 125 Ga. App. 150, 186 S.E.2d 586 (1971).

Contractual postponement of right to bring suit. — Where the policy provides that no suit shall be brought for a recovery on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy, there can be no recovery by the beneficiary for damages and attorney's fees as provided by law for bad faith on the part of the insurance company in failing to pay the loss unless the company had failed to pay the loss within 60 days after the right to bring suit upon the policy and accrued and a demand for payment made. Adams v. Washington Fid. Nat'l Ins. Co., 48 Ga. App. 753, 173 S.E. 247 (1934).

Section does not apply to contract made out of state. — This section does not apply to contract made in another state under the laws of that state covering property located in Georgia where insured resides. Coffin v. London & Edinburgh Ins. Co., 27 F.2d 616 (N.D. Ga. 1928). But see O.C.G.A. § 33-5-58, as to contracts with unauthorized foreign or alien insurers issued or delivered in this state or to resident or corporation authorized to do business in this state.

Recovery authorized by other state can be recovered by Georgia citizens. — Such damages and attorney's fees as would be recoverable by citizens of another state can likewise be recovered by citizens of this state, where the contract sought to be enforced is to be performed in such sister state. Missouri State Life Ins. Co. v. Lovelace, 1 Ga. App. 446, 58 S.E. 93 (1907).

Section applies if policy arises out of business transacted in state. — Where the policy sued on arises out of business transacted within this state, whether the contract of insurance be concluded here or elsewhere, this section applies. Travelers Ins. Co. v. Sheppard, 85 Ga. 751, 12 S.E. 18 (1890).

Application of Erie Doctrine. — In contractor's action against the subcontractor's insurer for damages the contractor paid to the clubhouse owner resulting from the subcontractor's defective installation of windows, the district court, sitting in diversity, held that O.C.G.A. § 33-4-6 was not applicable, as it was substantive for purposes of the Erie Doctrine, and the parties agreed that the policy was governed by Florida law. Pinkerton & Law, Inc. v. Royal Ins. Co., 227 F. Supp. 2d 1348 (N.D. Ga. 2002).

Preemption by federal law. — A state law that relates to insurance provided pursuant to an Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001-1461, plan but which is not part of the state insurance regulatory scheme is preempted by ERISA. Cockey v. Life Ins. Co. of N. Am., 804 F. Supp. 1571 (S.D. Ga. 1992).

Claims for bad faith damages and attorney's fees were preempted by federal law

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because the accidental death policy at issue was subject to Employee Retirement Income Security Act (ERISA). The bad faith claim was foreclosed, but attorney's fees could be recovered under ERISA itself. Cockey v. Life Ins. Co. of N. Am., 804 F. Supp. 1571 (S.D. Ga. 1992).

Section only applies between insureds and insurers. — The "bad faith" claims under this section are available only as between insureds and their insurers. Spicer v. American Home Assurance Co., 292 F. Supp. 27 (N.D. Ga. 1967), aff'd, 402 F.2d 988 (5th Cir. 1968), cert. denied, 394 U.S. 946, 89 S. Ct. 1275, 22 L. Ed. 2d 479 (1969), commented on in 6 Ga. St. B.J. 225 (1969).

This section applies only to an "insurer," defined by former Code 1933, § 56-103 (see O.C.G.A. § 33-1-2). McGhee v. Kroger Co., 150 Ga. App. 291, 257 S.E.2d 361 (1979).

The victim of an automobile accident lacked standing to bring an action against a liability insurer as assignee of the insured's claims against the insurer. Owens v. Allstate Ins. Co., 216 Ga. App. 650, 455 S.E.2d 368 (1995); Southern Gen. Ins. Co. v. Ross, 227 Ga. App. 191, 489 S.E.2d 53 (1997).

When an injured party sued the insurer of a motorist against whom the injured party obtained a judgment, both to collect on the judgment and to assert a claim, as assignee of the motorist, for bad faith failure to settle, while the motorist could not assign any claim the motorist might have against the insurer for a bad faith failure to settle under O.C.G.A. § 33-4-6, or any claim for punitive damages, the motorist could assign any tort claim the motorist might have had for bad faith for compensatory damages. Canal Indem. Co. v. Greene, 265 Ga. App. 67, 593 S.E.2d 41 (2003).

In an insured's suit asserting claims for bad faith breach of contract under O.C.G.A. § 33-4-6 in connection with an insurer's denial of the insured's claim for proceeds of a long-term disability insurance policy, the parent corporation of the insurer was not liable under an alter ego theory; because the insurer was not insolvent and had funds sufficient to satisfy any judgment for the insured, the insurer's corporate veil could not be pierced so as to hold the parent liable, even if the insurer and the parent failed to maintain separate corporate existences. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

In an insured's suit asserting claims for bad faith breach of contract under O.C.G.A. § 33-4-6 in connection with an insurer's denial of the insured's claim for proceeds of a long-term disability insurance policy, the insured's claim against the parent corporation of the insurer failed because § 33-4-6 does not provide for a separate claim against a policy administrator such as the parent. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

O.C.G.A. § 33-4-6 only provides for a claim against an insurer; it does not provide for a separate claim against the administrator of an insurance plan. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

In an insured's suit asserting claims for bad faith breach of contract under O.C.G.A. § 33-4-6 in connection with an insurer's denial of the insured's claim for proceeds of a long-term disability insurance policy, the parent corporation of the insurer, which administered the insurer's policies, was not liable under a joint venture theory because the insured's claims sounded in contract, not negligence. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

Section does not apply to employer. — When an employer was not an insurer as defined by former Code 1933, §§ 56-102, 56-103, 56-104, 56-105, 56-106, 56-107 (see O.C.G.A. § 33-1-2), it cannot be held liable for penalty and attorney fees provided for under statute covering workers' compensation insurer's initial failure to pay employee's indebtedness to a hospital. McGhee v. Kroger Co., 150 Ga. App. 291, 257 S.E.2d 361 (1979).

Section does not apply to fraternal benefit order. — Fraternal benefit orders are not liable for attorney's fees and damages imposed on "insurance companies of this state" (now "insurer") under terms of this section for refusal, in bad

faith, to pay losses. Brown v. Travelers' Protective Ass'n of Am., 45 Ga. App. 410, 165 S.E. 143 (1932).

Section applied broadly if contract is in essence insurance. — There is a tendency in the courts of Georgia to apply this section broadly where the relation of insured and the insurer exists, as in the case where the contract under consideration is in its essence a contract of insurance. Bankers' Health & Life Ins. Co. v. Knott, 41 Ga. App. 639, 154 S.E. 194 (1930).

Third party beneficiary clearly intended. — In an insurance dispute, the grant of summary judgment to the homeowner and house insurer was affirmed against the secondary insurer because the homeowner was specifically named on an endorsement as an additional insured on the secondary insurer's policy and that policy was a contract that clearly intended, on the contract's face, to benefit the homeowner as a third-party beneficiary. Southern Trust Insurance Company v. Cravey, 345 Ga. App. 697, 814 S.E.2d 802 (2018), cert. denied, No. S18C1319, 2018 Ga. LEXIS 820 (Ga. 2018).

Applies to fidelity insurance company. — This section is not restricted in its application to any particular class of insurance companies, but applies to fidelity insurance companies, and to policies insuring employers against the defalcations of their employees. Bankers' Health & Life Ins. Co. v. Knott, 41 Ga. App. 639, 154 S.E. 194 (1930).

Applies to fidelity bond. — This section is applicable to refusal to pay on a fidelity bond, because such a bond is a contract of fidelity insurance and is governed by insurance law. Bank of Acworth v. Firemen's Ins. Co., 339 F. Supp. 1229 (N.D. Ga. 1972).

Prisoner's wife is not "holder" of sheriff's official bond. — This section, allowing the "holder" of an insurance policy to recover, in addition to the sum named in the policy, reasonable attorney's fees, under certain conditions, was not applicable to a suit on a sheriff's official bond by wife of a prisoner beaten to death by sheriff and deputies. Hall v. National Sur. Corp., 72 Ga. App. 644, 34 S.E.2d 628 (1945).

Assignment of benefits by insured. — After an insured assigned the right to insurance benefits to a hospital, the hospital, in effect, became the holder of the policy for all purposes, including the right to demand payment of the assigned benefits, and not until the right to benefits was reassigned did the insured become entitled to demand payment under O.C.G.A. § 33-4-6. Blue Cross & Blue Shield v. Bennett, 223 Ga. App. 291, 477 S.E.2d 442 (1996).

Section does not apply to actions for breach of duty. — The penalty provisions of this section are inapplicable and provide no measure of recovery where the insured's suit is not upon the contract but rather in tort and naturally involves a duty and an alleged breach of that duty. United States Fid. & Guar. Co. v. Evans, 116 Ga. App. 93, 156 S.E.2d 809, aff'd, 223 Ga. 789, 158 S.E.2d 243 (1967).

Section does not apply to actions for fraud or return of premiums. — This section, as to the recovery of attorney's fees and damages in a suit on an insurance policy, contemplates a loss for which the insurer is liable under the terms of the policy and does not apply to a suit to recover premiums which the insured paid when they ought to have been waived under a clause providing for their waiver in case of disability. Metropolitan Life Ins. Co. v. Saul, 182 Ga. 284, 185 S.E. 266 (1936).

This section has reference to claims on policies of insurance and not to actions for fraud and for the return of premiums. Bankers Health & Life Ins. Co. v. Plumer, 67 Ga. App. 720, 21 S.E.2d 515 (1942).

Right to attorney's fees is not part of original claim. — The provision for attorney's fees is no part of the original demand against the insurance company and cannot apply until at least 60 days after any loss shall have occurred, and then only can apply when it is made to appear to the jury that the refusal was in bad faith; such fees cannot be awarded except when the matter is brought before a jury for its determination, and they are not a part of the claim sued on, but may be awarded as costs or smart money. National-Ben Franklin Fire Ins. Co. v. Darby, 48 Ga. App. 394, 172 S.E. 819 (1934).

General Consideration (Cont'd)

An insurance company is not liable for damages and attorney's fees for bad faith in refusing to settle under this section. Cotton States Mut. Ins. Co. v. Phillips, 110 Ga. App. 581, 139 S.E.2d 412 (1964), later appeal, 112 Ga. App. 600, 145 S.E.2d 643 (1965).

Bad faith attorney fees unavailable when insurer's reasons for denying coverage are not unreasonable. — Bad faith attorney fees were unavailable under O.C.G.A. § 33-4-6 based on a jury finding that an insurer wrongfully denied an insured's claim for roof damage to a commercial building caused by decayed roof trusses because the insurer's unsuccessful argument that the trusses were not "hidden from view" and that the damage could have been visually detected was not unreasonable. Johnston v. Companion Prop. & Cas. Ins. Co., 318 Fed. Appx. 861 (11th Cir. 2009) (Unpublished).

Liable only for failure to pay loss covered by policy. — This section does not provide for damages for a refusal to settle a claim, but only for failure to pay a loss covered by a policy. Cotton States Mut. Ins. Co. v. Phillips, 110 Ga. App. 581, 139 S.E.2d 412 (1964), later appeal, 112 Ga. App. 600, 145 S.E.2d 643 (1965).

Insurer may be liable for damages for bad faith refusal to settle. — If the insurance company in bad faith refused to settle the judgments, which exceeded the limits of the policy, for an amount within the limits of the policy plus an additional amount provided by the insured, the insurance company would be liable for the full amount of the judgments. Cotton States Mut. Ins. Co. v. Phillips, 110 Ga. App. 581, 139 S.E.2d 412 (1964), later appeal, 112 Ga. App. 660, 145 S.E.2d 643 (1965).

Insurer's obligation to pay settlement is not greater than obligation to pay judgment. — An insurer's obligation to pay on behalf of its insured an amount agreed upon in settlement is not any greater than its obligation to pay legally determined damages as embodied in a judgment. Tennessee Corp. v. Hartford Accident & Indem. Co., 326 F. Supp. 520 (N.D. Ga. 1971), aff'd, 463 F.2d 548 (5th Cir. 1972).

Payment of emergency medical expenses held loss incurred under policy. — Where the authority given by a policy of insurance does not only specifically authorize, but might reasonably be construed to require, the insured to safeguard the interests of the insurer by providing reasonable medical relief to persons to whom the insured is liable in all cases of emergency where it is not palpably clear and plain that the insured would not be liable for the injury, the liability assumed and paid by the insured as agent for the insurer amounts to a loss incurred by the insured under the terms of the policy within the meaning of this section. Employers' Liab. Assurance Corp. v. Manget Bros. Co., 45 Ga. App. 721, 165 S.E. 770 (1932).

Refusal to defend and pay costs held to make insurer liable for penalty. — Where the policy shows on its face that the defendant, if it should have defended another action against the plaintiff, would be liable for the costs of defense, including court costs and attorney fees, and the defendant's refusal to undertake this duty was in bad faith within the meaning of this section, it would be liable for the statutory penalty also. Hughes v. State Farm Mut. Auto. Ins. Co., 101 Ga. App. 443, 114 S.E.2d 61 (1960).

Insured held entitled to monthly benefit multiplied by ten. — When insurance policy describes the period of benefit payments in the very plainest of words as ten months, and not for up to ten months or during loss of employment or during disability, the insured is correct in the insured's contention that the insured is entitled to a payment equal to the stipulated monthly benefit multiplied by ten. Guarantee Trust Life Ins. Co. v. Davis, 244 Ga. 541, 261 S.E.2d 336 (1979).

Demand on recovery in excess of liability does not justify denial of any liability. — The fact that the plaintiff demanded only $432.00 benefits, recovered $580.80, and was entitled to recover only $360.00, does not justify the defendant's refusal to pay any amount of the claim or to tender the proper amount, where it based its refusal solely upon a denial of any liability whatever. Metropolitan Life Ins. Co. v. Lovett, 50 Ga. App.

763, 179 S.E. 253 (1935).

Penalty is not precluded although full claim is not recovered. — A failure on the part of the insured to recover the full amount claimed and sued for will not, after a denial of any liability whatsoever by the insurance company, preclude the insured from recovering against the insurance company penalty or attorney's fees under this section. Central Mfrs. Mut. Ins. Co. v. Graham, 24 Ga. App. 199, 99 S.E. 434 (1919); Hanover Ins. Co. v. Hallford, 127 Ga. App. 322, 193 S.E.2d 235 (1927); New York Life Ins. Co. v. Williamson, 53 Ga. App. 28, 184 S.E. 755 (1936).

Recovery of under this section is not prevented by failure to recover full amount of claim. Atlantic Mut. Fire Ins. Co. v. Laney, 38 Ga. App. 1, 142 S.E. 571, cert. denied, 38 Ga. App. 816 (1928).

Penalty not precluded unless recovery is substantially less than claim. — The evidence fails to show bad faith on the part of the defendant where the plaintiff claimed the full amount of the policy and the jury found the defendant was justified in resisting this claim, the amount found by them as due under the policy being considerably less than the amount claimed. Southern Mut. Ins. Co. v. Turnley, 100 Ga. 296, 27 S.E. 975 (1897).

Where the amount of the verdict is substantially less than the amount claimed in the proofs of loss and sued for, a verdict for attorney's fees and damages is unauthorized under this section. Queen Ins. Co. v. Peters, 10 Ga. App. 289, 73 S.E. 536 (1912); Love v. National Liberty Ins. Co., 157 Ga. 259, 121 S.E. 648 (1924); Firemen's Ins. Co. v. Larsen, 52 Ga. App. 140, 182 S.E. 677 (1935); Georgia Farm Bureau Mut. Ins. Co. v. Boney, 113 Ga. App. 459, 148 S.E.2d 457 (1966).

Recovery of attorney fees barred if underlying claims fail. — In an insured's suit asserting claims for breach of contract and bad faith breach of contract in connection with an insurer's denial of the insured's claim for proceeds of a disability insurance policy, the parent corporation of the insurer, which administered the insurer's policies, was not liable upon the insured's claim for attorney fees and expenses under O.C.G.A. § 33-4-6 because the insured had not succeeded on its underlying claims against the parent, which was determined not to be an alter ego of the insurer. Adams v. UNUM Life Ins. Co. of Am., 508 F. Supp. 2d 1302 (N.D. Ga. 2007).

No interest recoverable on unliquidated amount. — Interest from the date of the loss was not a recoverable item where the amount sought was not liquidated. Fidelity & Cas. Co. v. Mangum, 102 Ga. App. 311, 116 S.E.2d 326 (1960).

Penalty is based on loss without including attorney's fees. — Where the amount recovered is the amount sought including attorney's fees and interest, as well as the loss under the policies it was held that this section did not authorize the penalty of 25 percent to be based on the total amount recovered. Fidelity & Cas. Co. v. Mangum, 102 Ga. App. 311, 116 S.E.2d 326 (1960).

The amount recoverable for attorney's fees under this section should be regarded as "costs," and hence, where a reasonable amount for attorney's fees was necessary to bring the amount in controversy up to the minimum set by federal statute, the action, though between citizens of different states, was not within the jurisdiction of the federal court. Peters v. Queen Ins. Co. of Am., 182 F. 113 (S.D. Ga. 1910).

Attorney's fees recoverable only in accordance with section, not actual charges. — For refusal in bad faith to pay, the insurer is liable for "reasonable attorney's fees," the amount of which is to be determined in accordance with the standards set forth in this section and not by what the attorney actually charged the insured. Motors Ins. Corp. v. Roper, 136 Ga. App. 224, 221 S.E.2d 55 (1975).

Attorney's work to meet unfounded defense may be considered. — In the event bad faith is shown in the refusal to pay the claim by the insurance company, the additional work, time, and effort by the plaintiff's attorney to meet an unfounded affirmative defense by the defendant would be a proper element to consider in awarding reasonable attorney's fees for the prosecution of the case against the company. Reserve Life Ins. Co. v. Ayers, 101 Ga. App. 887, 115 S.E.2d 477 (1960).

General Consideration (Cont'd)

Merely pleading unfounded defense does not justify punitive damages and attorney's fees. — There is no provision of law which allows punitive damages and attorney's fees because the defendant pleads an unfounded defense. Reserve Life Ins. Co. v. Ayers, 101 Ga. App. 887, 115 S.E.2d 477 (1960).

A contingent fee may or may not be "reasonable." Old Equity Life Ins. Co. v. Barnard, 120 Ga. 596, 171 S.E.2d 636 (1969).

Contingent fee is limited to recovery, not amount sued for. — A contingent fee is by definition a proportionate part of a judgment recovered by the attorney for his client. It cannot, however, mean a proportionate amount of the sum sued for, whether recovered or not, because the amount sued for is not contingent; it is known from the time of inception of the suit. Old Equity Life Ins. Co. v. Barnard, 120 Ga. App. 596, 171 S.E.2d 636 (1969).

Insurer's default insufficient to establish liability. — That a title insurer defaulted by failing to answer the insureds' complaint did not require the trial court to award the insureds' attorney fees and penalties under O.C.G.A. § 33-4-6 because the complaint did not establish by well-pled facts, nor the fair inferences to be drawn therefrom, the insurer's liability for fees and penalties under § 33-4-6. Jimenez v. Chi. Title Ins. Co., 310 Ga. App. 9, 712 S.E.2d 531 (2011).

Failure to state claim. — Claims under O.C.G.A. § 33-4-6 for bad faith and derivative liability were properly dismissed because the plaintiff was not entitled to relief under any state of provable facts as allegations established that investigation into and adjustment of the claim was ongoing when the plaintiff demanded payment from the insurance company on January 16, 2015. Villa Sonoma at Perimeter Summit Condo. Ass'n v. Commercial Indus. Bldg. Owners Alliance, Inc., 349 Ga. App. 666, 824 S.E.2d 738 (2019).

Cited in South Carolina Ins. Co. v. Hunnicutt, 107 Ga. App. 366, 130 S.E.2d 239 (1963); GEICO v. Hardin, 108 Ga. App. 230, 132 S.E.2d 513 (1963); GEICO v. Hardin, 219 Ga. 474, 133 S.E.2d 873 (1963); Nationwide Mut. Ins. Co. v. Barnes, 108 Ga. App. 643, 134 S.E.2d 552 (1963); Newark Ins. Co. v. Smith, 108 Ga. App. 839, 135 S.E.2d 339 (1964); American Family Life Ins. Co. v. Glenn, 109 Ga. App. 122, 135 S.E.2d 442 (1964); Cotton States Mut. Ins. Co. v. Davis, 110 Ga. App. 601, 139 S.E.2d 427 (1964); Sun Ins. Co. v. League, 112 Ga. App. 625, 145 S.E.2d 768 (1965); Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966); Hartford Accident & Indem. Co. v. Grant, 113 Ga. App. 795, 149 S.E.2d 712 (1966); Starling v. Gulf Life Ins. Co., 382 F.2d 701 (5th Cir. 1967); Nationwide Mut. Fire Ins. Co. v. Jenkins, 389 F.2d 373 (5th Cir. 1967); Travelers Ins. Co. v. Page, 120 Ga. App. 72, 169 S.E.2d 682 (1969); Climatrol Indus., Inc. v. Home Indem. Co., 316 F. Supp. 314 (N.D. Ga. 1970); Ramsden v. GEICO, 123 Ga. App. 163, 179 S.E.2d 671 (1971); Harvey v. Travelers Ins. Co., 339 F. Supp. 262 (N.D. Ga. 1971); Cash v. Balboa Ins. Co., 130 Ga. App. 60, 202 S.E.2d 252 (1973); State Farm Mut. Ins. Co. v. Potts, 131 Ga. App. 26, 205 S.E.2d 43 (1974); Allstate Ins. Co. v. Harris, 133 Ga. App. 567, 211 S.E.2d 783 (1974); Roper v. Motors Ins. Corp., 139 Ga. App. 788, 229 S.E.2d 481 (1976); Piedmont Life Ins. Co. v. Lea, 140 Ga. App. 400, 231 S.E.2d 147 (1976); Interstate Life & Accident Ins. Co. v. Brown, 141 Ga. App. 195, 233 S.E.2d 44 (1977); Jones v. Associated Indem. Corp., 143 Ga. App. 139, 237 S.E.2d 651 (1977); United Ins. Co. of Am. v. Dixon, 143 Ga. App. 133, 237 S.E.2d 661 (1977); Bains v. Hartford Fire Ins. Co., 440 F. Supp. 15 (N.D. Ga. 1977); Lee v. Safeco Ins. Co., 144 Ga. App. 519, 241 S.E.2d 627 (1978); Georgia Farm Bureau Mut. Ins. Co. v. Washington, 145 Ga. App. 216, 243 S.E.2d 639 (1978); Kennesaw Life & Accident Ins. Co. v. Hall, 147 Ga. App. 221, 248 S.E.2d 524 (1978); Blue Cross of Georgia/Atlanta, Inc. v. Grenwald, 148 Ga. App. 486, 251 S.E.2d 585 (1978); Southern United Life Ins. Co. v. Nelson, 151 Ga. App. 798, 261 S.E.2d 742 (1979); Georgia-Carolina Brick & Tile Co. v. Brown, 153 Ga. App. 747, 266 S.E.2d 531 (1980); Ken-Mar Constr. Co. v. Bowen, 245 Ga. 676, 266 S.E.2d 796 (1980); Security Life Ins. Co. v. Blitch, 155 Ga. App.

167, 270 S.E.2d 349 (1980); Sentry Indem. Co. v. Sharif, 156 Ga. App. 828, 280 S.E.2d 354 (1980); Hutsell v. U.S. Life Title Ins. Co., 157 Ga. App. 845, 278 S.E.2d 730 (1981); Allstate Ins. Co. v. Ammons, 160 Ga. App. 257, 286 S.E.2d 765 (1981); Nationwide Mut. Fire Ins. Co. v. Rhee, 160 Ga. App. 468, 287 S.E.2d 257 (1981); Travelers Ins. Co. v. King, 160 Ga. App. 473, 287 S.E.2d 381 (1981); Davis v. Cincinnati Ins. Co., 160 Ga. App. 813, 288 S.E.2d 233 (1982); Hawkins v. Travelers Ins. Co., 162 Ga. App. 231, 290 S.E.2d 348 (1982); Allstate Ins. Co. v. Ammons, 163 Ga. App. 385, 294 S.E.2d 610 (1982); Shepherd v. Metropolitan Property & Liab. Ins. Co., 163 Ga. App. 650, 294 S.E.2d 638 (1982); Cummings v. Prudential Ins. Co. of Am., 542 F. Supp. 838 (S.D. Ga. 1982); Binns v. Metropolitan Atlanta Rapid Transit Auth., 168 Ga. App. 261, 308 S.E.2d 674 (1983); Southern Trust Ins. Co. v. First Fed. Sav. & Loan Ass'n, 168 Ga. App. 899, 310 S.E.2d 712 (1983); Bowers v. Continental Ins. Co., 753 F.2d 1574 (11th Cir. 1985); Consulting Eng'rs Group, Inc. v. Pace Constr., 613 F. Supp. 1192 (N.D. Ga. 1985); All Am. Assurance Co. v. Brown, 177 Ga. App. 402, 339 S.E.2d 611 (1985); Gibbs v. Jefferson-Pilot Fire & Cas. Ins. Co., 178 Ga. App. 544, 343 S.E.2d 758 (1986); Northern Assurance Co. of Am. v. Karp, 257 Ga. 40, 354 S.E.2d 129 (1987); Hall v. Time Ins. Co., 663 F. Supp. 599 (M.D. Ga. 1987); Liberty Nat'l Fire Ins. Co. v. F & M Bank & Trust Co., 189 Ga. App. 759, 377 S.E.2d 528 (1989); Vulcan Life Ins. Co. v. Davenport, 191 Ga. App. 79, 380 S.E.2d 751 (1989); Claussen v. Aetna Cas. & Sur. Co., 754 F. Supp. 1576 (S.D. Ga. 1990); Mimbs v. Commercial Life Ins. Co., 832 F. Supp. 354 (S.D. Ga. 1993); Blue Cross & Blue Shield of Ga., Inc. v. Sheehan, 215 Ga. App. 228, 450 S.E.2d 228 (1994); Department of Transp. v. Hardaway Co., 216 Ga. App. 262, 454 S.E.2d 167 (1995); Georgia Farm Bureau Mut. Ins. Co. v. Richardson, 217 Ga. App. 201, 457 S.E.2d 181 (1995); Southern Fire & Cas. Co. v. Freeman, 222 Ga. App. 308, 474 S.E.2d 195 (1996); Caribbean Lumber Co. v. Phoenix Assurance Co., 227 Ga. App. 236, 488 S.E.2d 718 (1997); Burt Co. v. Clarendon Nat'l Ins. Co., 385 Fed. Appx. 892 (11th Cir. 2010) (Unpublished); Auto Owners Ins. Co. v. Gay Constr. Co., 332 Ga. App. 757, 774 S.E.2d 798 (2015).

Demand for Payment

Demand for payment necessary for attorney's fees or penalty. — To render an insurance company liable for attorney's fees under the provisions of this section, a demand and a refusal to pay, 60 days before suit is brought, must be plainly averred, and the truth of such averment must be established on the trial. Lester v. Piedmont & Arlington Life Ins. Co., 55 Ga. 475 (1875); Ancient Order United Workmen v. Brown, 112 Ga. 545, 37 S.E. 890 (1901); Globe & Rutgers Fire Ins. Co. v. Jewell-Loudermilk Co., 36 Ga. App. 538, 137 S.E. 286, cert. denied, 36 Ga. App. 825, (1927).

The liability of an insurer for attorney's fees and damages cannot accrue until the lapse of 60 days from the date of a demand made when there was a right to demand. National Cas. Co. v. Borochoff, 45 Ga. App. 745, 165 S.E. 905 (1932).

Action on an insurance policy cannot be amended for the purpose of recovering damages and attorney's fees against the defendant, where at the time of the commencement of the suit there was not liability upon the part of the defendant therefor, in that it appears that there was no demand for payment of the amount due under the policy, and refusal to pay, more than 60 days before the commencement of the suit. Massachusetts Mut. Life Ins. Co. v. Montague, 63 Ga. App. 137, 10 S.E.2d 279 (1940).

To recover attorney's fees or penalty for bad faith, a demand for payment of the loss must be made more than 60 days prior to filing of the suit. Hanover Ins. Co. v. Hallford, 127 Ga. App. 322, 193 S.E.2d 235 (1972).

Where the plaintiffs sent their demand for payment to the defendant insurance company on the very day they filed suit, the insurance company was entitled to summary judgment on the plaintiffs' claims under the statute. Cagle v. State Farm Fire & Cas. Co., 236 Ga. App. 726, 512 S.E.2d 717 (1999).

Since insured did not make a demand for payment before filing suit, he was not entitled to maintain a claim for bad faith

Demand for Payment (Cont'd)

penalties and attorney fees against his insurer for nonpayment of an alleged loss under a policy. Stedman v. Cotton States Ins. Co., 254 Ga. App. 325, 562 S.E.2d 256 (2002).

Standing alone, a proof of loss is not a demand for payment thereof under this section. Guarantee Reserve Life Ins. Co. v. Norris, 219 Ga. 573, 134 S.E.2d 774 (1964).

Petition did not allege failure to pay loss. — In an action upon an insurance policy, when the only allegation as to a demand upon the insurance company for payment of the loss was contained in the allegation as to the filing of the proof of loss, which was filed prior to December 7, 1925, on which date the insurance company acknowledged receipt of proof of loss and denied liability and refused payment of loss, and when the action was filed on January 12, 1926, the petition did not allege a failure of the insurance company to pay the loss within 60 days after demand. Continental Life Ins. Co. v. Wilson, 36 Ga. App. 540, 137 S.E. 403 (1927).

Inadequate bad faith demand by insured. — Due to the inadequacies of an insured's bad faith demand, as its attempt to equate the submission of a claim with the demand for payment required by O.C.G.A. § 33-4-6 was directly contravened by case law, and the fact that the insurer met all its obligations under the policy the insurer issued to its insured, the trial court did not err in denying summary judgment to the insured and granting summary judgment on the insurer's cross-motion, authorizing the insurer to quitclaim the refinanced property to the insurer in full satisfaction of its duties and obligations under the policy. BayRock Mortg. Corp. v. Chi. Title Ins. Co., 286 Ga. App. 18, 648 S.E.2d 433 (2007), cert. denied, 2008 Ga. LEXIS 108 (Ga. 2008).

No particular language is necessary to constitute a demand under this section. Hanover Ins. Co. v. Hallford, 127 Ga. App. 322, 193 S.E.2d 235 (1972).

This section does not prescribe any particular form in which such demand shall be made, nor whether it shall be in writing or a verbal demand will suffice. Hull v. Alabama Gold Life Ins. Co., 79 Ga. 93, 3 S.E. 903 (1887).

Ample evidence of demand. — When proofs of death were promptly made out upon company forms, and repeated demands for payment were thereafter made by the agent of the beneficiary, who was recognized and treated as such by both parties, and after the time for payment fixed by the policy the beneficiary notified the company and sent a person to its principal office, who made a direct demand for payment, there was ample evidence of a demand made under this section. Hull v. Alabama Gold Life Ins. Co., 79 Ga. 93, 3 S.E. 903 (1887).

Transactions constituted demand and refusal to pay. — When the insured presented the insured's policies to the insurance company for payment; the insured also had prepared and sent in proofs of loss and was informed by the company that they had no liability as to the accidental death policy; the company again denied liability on the ground of accord and satisfaction in answer to a letter written by the insured's attorneys inquiring the reason for denial of the claim; and all of these acts took place at a time when the policy was due and payable, the transactions constituted a demand and refusal to pay within the purview of this section. Mutual Sav. Life Ins. Co. v. Hines, 96 Ga. App. 442, 100 S.E.2d 466 (1957).

No particular language is necessary to constitute a demand, and the insistence of the plaintiff that the plaintiff be paid even if it meant resorting to the courts after the adjuster informed the plaintiff that the insurer would not pay the plaintiff anything unless the plaintiff signed a "nonwaiver" agreement was a sufficient demand to comply with this section. Cotton States Mut. Ins. Co. v. Clark, 114 Ga. App. 439, 151 S.E.2d 780 (1966).

Pre-suit demand insufficient. — Trial court properly determined that the insured's pre-suit communications with the insurer as to the expenses incurred for tree and debris removal did not satisfy the pre-suit demand requirement because the threat of litigation pertained only to those items and did not cover other expenses sought by the insured. Thompson v. Homesite Insurance Company of Ga., 345

Ga. App. 183, 812 S.E.2d 541 (2018), cert. denied, No. S18C1044, 2018 Ga. LEXIS 738 (Ga. 2018).

Failure to name particular sum does not make demand insufficient. — The demand made by plaintiff's attorney more than 60 days prior to the action would be sufficient, and the failure to demand payment in any particular sum would not render the demand insufficient. Hanover Ins. Co. v. Hallford, 127 Ga. App. 322, 193 S.E.2d 235 (1927).

Failure to assert bad faith. — Beneficiary's telephone call demanding payment of life insurance proceeds two days after her husband's death, before the insurer received formal evidence of the loss, and not asserting a bad faith claim, was not a sufficient demand under O.C.G.A. § 33-4-6. Primerica Life Ins. Co. v. Humfleet, 217 Ga. App. 770, 458 S.E.2d 908 (1995).

Including unauthorized item in demand held not to bar penalty and attorney's fees. — The fact that the insured who was liable to an injured third party and had paid the party's medical expenses, when demanding payment from the insurer, might have included in the demand a specified amount disbursed by the insured for the burial expenses of the person injured, who had afterwards died, would not defeat the right to sue for and recover the penalty and attorney's fees authorized under this section, where the response to such a demand was failure to pay any amount and a statement that it appeared to the insurer that the insured had "paid these various charges not on account of the liability involved, but on account of the contracts you made with various parties for the treatment of this injured," and where there was no objection to the amount of the claim because it included the burial expenses of the injured person in addition to the itemized amounts paid for her medical treatment. Employers' Liab. Assurance Corp. v. Manget Bros. Co., 45 Ga. App. 721, 165 S.E. 770 (1932).

Demand made after counterclaim filed is improper. — When, in insurer's declaratory judgment action, insured's counterclaim seeking penalties for insurer's bad faith refusal to pay claim was filed before his demand for payment, the demand was not proper. Howell v. Southern Heritage Ins. Co., 214 Ga. App. 536, 448 S.E.2d 275 (1994).

Demand must be made when there is right to demand payment. — Under this section, the liability of the insurer for attorney's fees and damages cannot accrue until the lapse of 60 days from the date of a demand made when there is a right to demand payment. New Zealand Fire Ins. Co. v. Brewer, 29 Ga. App. 773, 116 S.E. 922 (1923); American Nat'l Ins. Co. v. Brantley, 38 Ga. App. 505, 144 S.E. 332 (1928); Life Ins. Co. v. Burke, 219 Ga. 214, 132 S.E.2d 737 (1963).

As a finding of bad faith in refusal to pay insurance benefits is dependent upon the demand being made at a time when the right to make demand exists, so also is a finding of bad faith in refusal to pay no-fault insurance benefits dependent upon the claim being made at a time when it is a valid claim. Doran v. Travelers Indem. Co., 254 Ga. 63, 326 S.E.2d 221 (1985).

Immediate payment is in order. — The penalties accrue by virtue of a demand, and the demand must be made at a time when a demand for immediate payment is in order. American Nat'l Ins. Co. v. Brantley, 38 Ga. App. 505, 144 S.E. 332 (1928); National Cas. Co. v. Borochoff, 45 Ga. App. 745, 165 S.E. 905 (1932); Napp v. American Cas. Co., 110 Ga. App. 673, 139 S.E.2d 425 (1964).

Demand is not in order if made when policy gives insurer time to investigate. — The demand for payment of the proceeds of an insurance policy must be made at a time when a demand for immediate payment is in order. It is not in order if the insurer, under the terms of the insurance policy, has additional time left in which to investigate or adjust the loss and therefore has no legal duty to pay at the time the demand is made. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Demand failed to include critical facts regarding insured's loss. — Based upon a lender's failure to notify the lender's title insurer of critical facts pertaining to the lender's loss in the lender's bad faith demand letter, including the

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actual amount of the lender's loss from the defect in title, the court could not hold the title insurer liable for bad faith under O.C.G.A. § 33-4-6. Doss & Assocs. v. First Am. Title Ins. Co., 325 Ga. App. 448, 754 S.E.2d 85 (2013).

Demand made before time set by policy for payment after proof of loss. — The liability of the insurer for attorney's fees and damages could not accrue until the lapse of 60 days from the date of a demand made when there was a right to demand; thus, where by the terms of the policy it was not payable until 60 days from the submission of proofs of loss and it appeared that the only demand for payment was made with the proof of loss, which was before the plaintiff had a right to make an absolute demand for payment, the evidence did not authorize a recovery of attorney's fees and damages. Philadelphia Fire & Marine Ins. Co. v. Burroughs, 176 Ga. 260, 168 S.E. 36 (1932).

Where it appears from the record and the admissions of counsel for the plaintiff that demand, if any, was made before or at the time proofs of loss were filed, which time was before the plaintiff had a right to make an absolute demand for payment, the recovery of damages and attorney's fees was not authorized by the evidence. Life Ins. Co. v. Burke, 219 Ga. 214, 132 S.E.2d 737 (1963).

Proof of loss filing waived. Whether a demand was good under former Code 1933, §§ 56-706 and 56-1206 depends on whether it was made at a time when immediate payment could be exacted, which in turn depends on whether the filing (not merely the time of filing) of proof of loss forms was waived under former Code 1933, § 56-2427 (see O.C.G.A. § 33-24-39). Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969); Britt v. Independent Fire Ins. Co., 184 Ga. App. 225, 361 S.E.2d 226 (1987).

Proof of loss filed after bad faith demand improper. — Bad faith claim brought by an insured against an insurer for failure to pay a claim for extra expenses incurred by the insured after the insured suffered a fire loss at one of the insured's bakeries failed because the insured made the insured's bad faith demand before the insured filed any proof of loss, and therefore, no right to demand immediate payment existed. Lavoi Corp. v. Nat'l Fire Ins. of Hartford, 293 Ga. App. 142, 666 S.E.2d 387 (2008).

Demand may accompany proof of loss where policy made payable then. — Where the policy became due and payable immediately upon proof of loss, a contemporaneous demand made at the time of the filing of the proof of loss meets the requirements of a demand when there was a right to demand. American Nat'l Ins. Co. v. Brantley, 38 Ga. App. 505, 144 S.E. 332 (1928).

There is no equitable exception to the 60-day rule for instances in which the lawsuit is filed shortly before the expiration of a limitations period. Cagle v. State Farm Fire & Cas. Co., 236 Ga. App. 726, 512 S.E.2d 717 (1999).

Submission of medical bill does not constitute demand. — The mere submission of medical bills does not necessarily constitute an actual demand for payment within the meaning of O.C.G.A. § 33-4-6. Blue Cross & Blue Shield of Georgia/Atlanta, Inc. v. Merrell, 170 Ga. App. 86, 316 S.E.2d 548 (1984).

An insurer's denial of a claim does not waive the 60-day statutory period, and the insured's filing suit within this period, without making a demand for payment, precludes the recovery of a statutory penalty and attorney's fees. Kilpatrick Marine Piling v. Fireman's Fund Ins. Co., 795 F.2d 940 (11th Cir. 1986).

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Exclusive remedy. — O.C.G.A. § 33-4-6 provided the exclusive remedy for an insurer's bad faith refusal to pay insurance proceeds. As a result, the insured had no independent claim for consequential damages, and summary judgment was granted to the insurance company on that claim. B.S.S.B., Inc. v. Owners Ins. Co., No. 7:08-CV-112 (HL), 2010 U.S. Dist. LEXIS 4106 (M.D. Ga. Jan. 20, 2010).

No recovery under section unless refusal to pay made in bad faith. — Where the evidence fails to authorize a

finding of bad faith, the jury is not authorized to find an amount against the company representing attorney's fees. New York Life Ins. Co. v. Ittner, 64 Ga. App. 806, 14 S.E.2d 203 (1941).

Where it is made to appear that the refusal of the company to pay the loss was in bad faith, attorney's fees may be authorized. American Fire & Cas. Co. v. Barfield, 81 Ga. App. 887, 60 S.E.2d 383 (1950).

Attorney's fees and the penalty provided for should never be permitted unless the defendant acts in bad faith — that is, that the defense is frivolous and unfounded. Continental Cas. Co. v. Owen, 90 Ga. App. 200, 82 S.E.2d 742 (1954).

Unless the jury finds the action to have been in bad faith, the penalty is not assessed. Reserve Life Ins. Co. v. Gay, 96 Ga. App. 601, 101 S.E.2d 158 (1957), rev'd on other grounds, 214 Ga. 2, 102 S.E.2d 492 (1958).

The insurance company is liable for attorney's fees and penalty only where the refusal to pay is in bad faith, frivolous, and unfounded. Mead Corp. v. Liberty Mut. Ins. Co., 107 Ga. App. 167, 129 S.E.2d 162 (1962), rev'd on other grounds, 219 Ga. 6, 131 S.E.2d 534 (1963).

Insured was not entitled to proceeds of a business buy out expense insurance policy, because the insured was not employed full-time prior to becoming disabled and the buy out was not accomplished through the practice and pursuant to a buy-sell agreement. Oak Rd. Family Dentistry, P.C. v. Provident Life & Accident Ins. Co., 370 F. Supp. 2d 1317 (N.D. Ga. Feb. 4, 2005).

Even assuming an administratrix's original complaint was deficient for not setting forth allegations that, if proven, would have established the notice requirements to recover extra-contractual damages against a life insurance company for bad faith in denying a claim for insurance death benefits under O.C.G.A. § 33-4-6, it was clear that the administratrix's proposed amended complaint cured any defects that might have existed; thus, the administratrix adequately pleaded a breach of contract claim, including a claim for extra-contractual damages and attorney fees. Garrett v. Unum Life Ins. Co. of Am., 427 F. Supp. 2d 1158 (M.D. Ga. 2005).

Summary judgment for an insurance company on a motorist's claim against it was proper since there was no evidence of bad faith; the insurance company did not settle the motorist's property damage claim because its adjuster believed that, at the motorist's request, the motorist's insurer was assuming responsibility for settling the claim; an adjuster with the motorist's insurer confirmed that the motorist's insurer had "handled" the motorist's claim, and, further, the motorist sent a demand letter to the motorist's insurer on the same day that the motorist sent a demand letter to the insurance company, indicating that the motorist was still looking to the motorist's own insurer for payment. King v. Atlanta Cas. Ins. Co., 279 Ga. App. 554, 631 S.E.2d 786 (2006).

Trial court erred in denying the insured's motion for summary judgment as to the insured's request for attorney's fees for bad-faith refusal to pay only as to the refusal to pay for the burglary damage and not the lost rent claim. Auto-Owners Ins. Co. v. Neisler, 334 Ga. App. 284, 779 S.E.2d 55 (2015).

Although the general contractor's new claim against the surety for surety bad faith, arguing that the surety stubbornly refused to meet the surety's obligations under the bonds despite clear and undisputed evidence of the surety's liability under the bond because there were genuine issues of material fact as to whether the general contractor was entitled to coverage under the payment and performance bonds, the surety had reasonable grounds to contest the general contractor's claims and bad-faith penalties were not warranted. Choate Constr. Co. v. Auto-Owners Ins. Co., 335 Ga. App. 331, 779 S.E.2d 465 (2015).

Absence of bad faith prevents punitive and attorney fees awards. — Because the trial court's ruling that neither the insurance agent or company had a contract of insurance with the tree service company owner in effect on the date of the accident, no bad faith claim could be asserted against either defendant for failure to pay a claim arising from the accident; thus, the claims for punitive damages and

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attorney fees also failed since those claims were derivative of the underlying claims. Popham v. Landmark Am. Ins. Co., 340 Ga. App. 603, 798 S.E.2d 257 (2017).

"Acting in bad faith" in breach of contract. — Refusal to pay in "bad faith" under former Code 1933, §§ 56-706 and 56-1206 (see O.C.G.A. § 33-4-6) was not the legal equivalent of "having acted in bad faith" under former Civil Code 1895, § 3796 (see O.C.G.A. § 13-6-11). Traders Ins. Co. v. Mann, 118 Ga. 381, 45 S.E. 426 (1903); New York Life Ins. Co. v. Bradford, 57 Ga. App. 657, 196 S.E. 92 (1938).

The "bad faith" referred to in former Code 1933, §§ 20-1404 56-706, and 56-1206 (see O.C.G.A. §§ 13-6-11 and 33-4-6) was not the same. Canal Ins. Co. v. Lawson, 123 Ga. App. 376, 181 S.E.2d 91 (1971).

Motion to dismiss a breach of contract claim against an insurer was denied because an insured could have brought a breach of contract case and a claim for bad faith refusal to pay under O.C.G.A. § 33-4-6 simultaneously. Estate of Thornton v. Unum Life Ins. Co. of Am., 445 F. Supp. 2d 1379 (N.D. Ga. 2006).

Claim not good under this section may be good under section on breach. — Although the plaintiff's allegations did not support the claim for attorney's fees under former Civil Code 1910, §§ 2549 and 4392 (see O.C.G.A. §§ 13-6-11 and 33-4-6), the allegations of bad faith on the part of the defendant relative to the transaction and dealings out of which the cause of action arose rendered the claim for attorney's fees good as against demurrer (now motion to dismiss). Glover v. Bankers' Health & Life Ins. Co., 30 Ga. App. 308, 117 S.E. 665 (1923).

"Bad faith" by officer justifying exemplary damages on bond. — The "bad faith" referred to in former Civil Code 1910, § 299 (see O.C.G.A. § 45-4-29) may be of a different character from that which under certain conditions will authorize a recovery under former Code 1933, §§ 56-706 and 56-1206 (see O.C.G.A. § 33-4-6). Copeland v. Dunehoo, 36 Ga. App. 817, 138 S.E. 267 (1927).

"Bad faith" under this section means frivolous and unfounded denial of liability. — Refusal of an insurance company "in bad faith" to pay means a frivolous and unfounded denial of liability. Albergotti v. Equitable Life Assurance Soc'y of United States, 48 F. Supp. 290 (S.D. Ga. 1942); Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E.2d 227 (1946); Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949) (For comment, see 12 Ga. B.J. 337 (1950)); North British & Mercantile Ins. Co. v. Mercer, 90 Ga. App. 143, 82 S.E.2d 41, aff'd, 211 Ga. 161, 84 S.E.2d 570 (1954); Gulf Life Ins. Co. v. Moore, 90 Ga. App. 791, 84 S.E.2d 696 (1954); Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962); Georgia Cas. & Sur. Co. v. Seaboard Sur. Co., 210 F. Supp. 644 (N.D. Ga. 1962), aff'd, 327 F.2d 666 (5th Cir. 1964); Belch v. Gulf Life Ins. Co., 219 Ga. 823, 136 S.E.2d 351 (1964); Lanier v. American Cas. Co., 226 F. Supp. 630 (N.D. Ga. 1964); Dorsey v. State Mut. Life Assurance Co., 238 F. Supp. 391 (N.D. Ga. 1964), aff'd, 357 F.2d 600 (5th Cir. 1966); American Cas. Co. v. Ten Tex Corp., 357 F.2d 269 (5th Cir. 1966); United States Fid. & Guar. Co. v. Woodward, 118 Ga. App. 591, 164 S.E.2d 878 (1968); Pioneer Nat'l Title Ins. Co. v. American Cas. Co., 459 F.2d 963 (5th Cir. 1972); Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205 (5th Cir. 1977); Canal Ins. Co. v. Savannah Bank & Trust Co., 181 Ga. App. 520, 352 S.E.2d 835 (1987).

To authorize imposition of the penalty and attorney's fees, it must appear that the basis of the insurance company's position as to the amount of liability was frivolous and unfounded. Georgia Farm Bureau Mut. Ins. Co. v. Boney, 113 Ga. App. 459, 148 S.E.2d 457 (1966).

"Bad faith" in refusing to pay claim. — "Bad faith" means a frivolous and unfounded refusal to pay a claim. Business Men's Assurance Co. of Am. v. Tilley, 109 Ga. App. 529, 136 S.E.2d 514 (1964); Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970); Public Sav. Life Ins. Co. v. Wilder, 123 Ga. App. 754, 182 S.E.2d 536 (1971); Dixie Constr. Prods. Inc. v. WMH, Inc., 179 Ga. App. 658, 347 S.E.2d 303 (1986).

Refusal to pay means a frivolous and unfounded failure to pay a valid claim. Phillips v. State Farm Mut. Auto. Ins. Co., 437 F.2d 365 (5th Cir. 1971).

"Bad faith" is shown by evidence that, under the terms of the policy upon which the demand is made and under the facts surrounding the response to that demand, the insurer had no "good cause" for resisting and delaying payment. Georgia Int'l Life Ins. Co. v. Harden, 158 Ga. App. 450, 280 S.E.2d 863 (1981).

Facts alleged by an administratrix in the complaint, alleging an improper denial of insurance death benefits, set forth a simple claim for a breach of contract; there was no suggestion that the parties had a special relationship; absent a special relationship between parties to a contract, Georgia law did not support a tort claim for negligent infliction of emotional distress and O.C.G.A. § 33-4-6 was the administratrix's exclusive remedy. Garrett v. Unum Life Ins. Co. of Am., 427 F. Supp. 2d 1158 (M.D. Ga. 2005).

There was evidence that an insurance company that denied a claim relating to a stolen bulldozer acted in bad faith; correspondence put the company on notice of the difficulty of construing its policy. Certain Underwriters at Lloyd's of London v. Rucker Constr., Inc., 285 Ga. App. 844, 648 S.E.2d 170 (2007).

In a case wherein mortgage lenders obtained title insurance policies from an insurer to guard against defects in title, where the policies required the insurer to pay or otherwise cure the title problem in the event of such defects, and such defects clearly existed, triggering the insurer's obligations under the policies, a judgment against the insurer was upheld on appeal as it was shown that the insurer failed to comply with its obligations until after it had named its policy holders as defendants in a protracted lawsuit; the trial court was authorized to find that the lawsuit was filed by the insurer to delay or avoid legitimate claims payment. Atl. Title Ins. Co. v. Aegis Funding Corp., 287 Ga. App. 392, 651 S.E.2d 507 (2007), cert. denied, No. S08C0137, 2008 Ga. LEXIS 107 (Ga. 2008).

Trial court did not err in granting summary judgment to an insured on the issue of liability for bad faith penalties and attorney fees under O.C.G.A. § 33-4-6 because a finding of bad faith as a matter of law was eminently justified when the insurer failed to set forth any defense to a determination of bad faith other than its meritless reliance on the business-risk clauses of the insured's comprehensive general liability policy; the insurer simply submitted no admissible evidence to defend itself on the insured's bad faith claims, and the insurer neglected even to protect itself by defending under a reservation of rights while filing a declaratory judgment action in order to determine the extent of coverage and its duty to defend. Transp. Ins. Co. v. Piedmont Constr. Group, LLC, 301 Ga. App. 17, 686 S.E.2d 824 (2009), cert. denied, No. S10C0507, 2010 Ga. LEXIS 312 (Ga. 2010).

No bad faith in insurer's reliance on contractual time limitation provision. — Dismissal of the complaint based on the contractual time-limitation provision in the insurance policy was proper because there was no evidence that the insurer waived enforcement of that provision, or that there was a jury question as once mediation ended and the parties failed to reach a settlement, the insured had approximately seven months in which to file suit before the two-year limitation period expired, but the insured failed to do so. Premier Eye Assocs. v. Mag Mut. Ins. Co., 844 S.E.2d 282, No. A20A0373, 2020 Ga. App. LEXIS 364 (2020).

"Bad faith" in refusing to pay loss after demand. — "Bad faith," within the meaning of this section, is any frivolous or unfounded refusal in law or in fact to pay a loss according to the insurance contract after legal demand. Cimarron Ins. Co. v. Pace, 212 Ga. 427, 93 S.E.2d 593 (1956); Millers Nat'l Ins. Co. v. Waters, 97 Ga. App. 103, 102 S.E.2d 193 (1958); Reserve Life Ins. Co. v. Ayers, 217 Ga. 206, 121 S.E.2d 649 (1961).

The term "bad faith," as used in this section, means any frivolous and unfounded refusal in law or in fact to comply with the demand of the policyholder to pay according to the terms of the policy. Royal Ins. Co. v. Cohen, 105 Ga. App. 746, 125 S.E.2d 709 (1962); Interstate Life & Accident Ins. Co. v. Williamson, 220 Ga.

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323, 138 S.E.2d 668, answer conformed to, 110 Ga. App. 557, 139 S.E.2d 429 (1964); United States Fid. & Guar. Co. v. Biddy Lumber Co., 114 Ga. App. 358, 151 S.E.2d 466 (1966); Interstate Life & Accident Ins. Co. v. Brown, 146 Ga. App. 622, 247 S.E.2d 205 (1978); Smith v. New York Life Ins. Co., 579 F.2d 1267 (5th Cir. 1978); Progressive Cas. Ins. Co. v. Avery, 165 Ga. App. 703, 302 S.E.2d 605 (1983).

"Bad faith" means any frivolous or unfounded refusal in law or in fact to comply with the terms of the contract under the conditions imposed by statute. Life Ins. Co. v. Burke, 219 Ga. 214, 132 S.E.2d 737 (1963); Lincoln Life Ins. Co. v. Anderson, 109 Ga. App. 238, 136 S.E.2d 1 (1964).

When damages and attorney fees are sought under this section, the term "bad faith" means any frivolous or unfounded refusal in law or in fact to comply with the demand of the policyholder to pay according to the terms of the policy and the conditions imposed by statute. Witt v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 117 Ga. App. 838, 162 S.E.2d 251 (1968).

Manufacturer's demand for payments pursuant to O.C.G.A. § 33-4-6 was valid because the manufacturer delivered a letter to the insurance company demanding reimbursement for payments the manufacturer had made on the warranty claims. The claims were denied because the claims had become too costly; as such, the insurance company's refusal to pay was not reasonable as a matter of law. Lloyd's Syndicate No. 5820 v. AGCO Corp., 319 Ga. App. 260, 734 S.E.2d 899 (2012).

Failure to completely investigate. — Trial court did not err in denying an insurer's motion for a directed verdict on whether the insurer denied the insured's claim in bad faith in the face of evidence that the claim was not completely investigated. United Servs. Auto. Ass'n v. Carroll, 226 Ga. App. 144, 486 S.E.2d 613 (1997).

Only one penalty recoverable from one accident. — When a trial court erroneously granted an insured statutory damages against an insurer, for bad faith, under O.C.G.A. § 33-4-6, for each of 26 medical bills arising from one automobile accident, this was a nonamendable defect which appeared on the face of the record, so the trial court could correct its judgment in the term of court after the term in which the judgment was entered by granting one statutory damages award for all claims arising from the accident. Byrd v. Regal Ins. Co., 275 Ga. App. 779, 621 S.E.2d 758 (2005).

"Bad faith" is not equivalent of fraud. — The term "bad faith" in this section is not the equivalent of actual fraud, but means any frivolous or unfounded refusal in law or in fact to comply with the requisition of the policyholder to pay according to the terms of his contract and the conditions imposed by statute. Cotton States Life Ins. Co. v. Edwards, 74 Ga. 220 (1884); Missouri State Life Ins. Co. v. Lovelace, 1 Ga. App. 446, 58 S.E. 93 (1907); Bankers' Health & Life Ins. Co. v. Brown, 49 Ga. App. 294, 175 S.E. 387 (1934); Sentinel Fire Ins. Co. v. McRoberts, 50 Ga. App. 732, 179 S.E. 256 (1934); Life & Cas. Ins. Co. v. Smith, 51 Ga. App. 122, 179 S.E. 744 (1935); Mutual Life Ins. Co. v. Barron, 70 Ga. App. 454, 28 S.E.2d 334 (1943); Southeastern Constr. Co. ex rel. Beckham v. Glens Falls Indem. Co., 81 Ga. App. 770, 59 S.E.2d 751, rev'd on other grounds, 207 Ga. 488, 62 S.E.2d 149 (1950).

"Bad faith," within the meaning of this section, is not the equivalent of actual fraud, but is any frivolous or unfounded refusal in law or in fact to pay according to the insurance contract, after a demand. Metropolitan Life Ins. Co. v. Lovett, 50 Ga. App. 763, 179 S.E. 253 (1935); American Cas. Co. v. Callaway, 75 Ga. App. 799, 44 S.E.2d 400 (1947).

Agent's bad faith held bad faith of insurer. — Where insurer refused payment of policy after loss occurred, relying on contentions which were admitted on the trial to be untrue and on further ground that its agent had never been paid for the policy, if in fact he was paid, his bad faith in making this denial became the bad faith of the company, for he was its agent with authority to act in the premises. Kansas City Life Ins. Co. v. Williams, 62 Ga. App. 707, 9 S.E.2d 680 (1940).

Insurer may have real issues of fact submitted to jury. — The test for the

payment of damages and attorney's fees, under this section, is whether the refusal is frivolous and unfounded, and the statute never intended to penalize insurance companies for desiring to have real issues of fact submitted to a jury. Life & Cas. Co. v. Jordan, 69 Ga. App. 287, 25 S.E.2d 103 (1943).

No waiver of contractual limitations period in policy. — Grant of summary judgment to an insurance company in a insured's suit for nonpayment of claims on an insurance policy was upheld because the two-year limitation period in the insurance policy was valid and enforceable, and the insured did not contest the general enforceability of that provision. Premier Eye Assocs. v. Mag Mut. Ins. Co., 844 S.E.2d 282, No. A20A0373, 2020 Ga. App. LEXIS 364 (2020).

Penalties for bad faith are not authorized where there is a disputed question of fact. United States Fid. & Guar. Co. v. Woodward, 118 Ga. App. 591, 164 S.E.2d 878 (1968).

Gross discrepancies between facts appearing in the plaintiff's signed application and those which investigation discloses after a claim is made on a policy gives an insurance company good reason to take issue with the policy owner. Public Sav. Life Ins. Co. v. Wilder, 123 Ga. App. 754, 182 S.E.2d 536 (1971).

Whether deceased insured was drunk. — As to double indemnity benefit, insurance company was within its rights in having a jury pass upon the question as to whether or not at the time the insured met his death he was under the influence of intoxicating liquors. Progressive Life Ins. Co. v. Smith, 71 Ga. App. 157, 30 S.E.2d 411 (1944).

Contesting payment where questions of law are intricate. — Where the questions of law involved in a case are intricate and difficult of solution, the insurer has the right to contest payment of the claim and is not guilty of bad faith in refusing to pay it. United States Fid. & Guar. Co. v. Woodward, 118 Ga. App. 591, 164 S.E.2d 878 (1968).

Insured's refusal to pay based on material misrepresentations in the application did not constitute bad faith where, even though it waived its defense that the policy was void, the question of waiver was complicated, and was not evidence of bad faith. Florida Int'l Indem. Co. v. Osgood, 233 Ga. App. 111, 503 S.E.2d 371 (1998).

Close questions of liability adjudicated without penalty. — There being no evidence of any frivolous or unfounded refusal by the defendant insurance company to pay the plaintiff and the question of liability being a close one under the law and facts, the defendant was reasonably entitled to have the matter adjudicated without being subject to the charge of bad faith, and the award of attorney's fees as a penalty under this section was therefore unauthorized. American Nat'l Ins. Co. v. Holbert, 50 Ga. App. 527, 179 S.E. 219 (1935); Bankers Health & Life Ins. Co. v. Hamilton, 56 Ga. App. 569, 193 S.E. 477 (1937).

Where the question of liability is close or the facts are in dispute, so that the insurer has reasonable grounds to contest the claim, no penalty should be permitted. Hartford Fire Ins. Co. v. Lewis, 112 Ga. App. 1, 143 S.E.2d 556 (1965).

The purpose of this section was not to penalize an insurer for appealing to the courts where there are questions concerning an insurance contract which are sufficiently doubtful to justify adjudication. Morris v. Mutual Benefit Life Ins. Co., 258 F. Supp. 186 (N.D. Ga. 1966).

When a bona fide dispute exists concerning liability, recovery of damages and attorney fees because of bad faith is not authorized. Norfolk & Dedham Mut. Fire Ins. Co. v. Cumbaa, 128 Ga. App. 196, 196 S.E.2d 167 (1973).

No "bad faith" exists where there is a doubtful question of law involved. — The evidence did not show bad faith on the part of the company in refusing to pay the loss, where the legal questions involved were sufficiently doubtful and important to justify the insurer in litigating the matter. Continental Life Ins. Co. v. Wells, 38 Ga. App. 99, 142 S.E. 900 (1928).

No "bad faith" exists where there is a doubtful question of law involved. Brown v. Seaboard Lumber & Supply Co., 221 Ga. 35, 142 S.E.2d 842 (1965); United States Fid. & Guar. Co. v. Woodward, 118 Ga. App. 591, 164 S.E.2d 878 (1968); Federal Ins. Co. v. National Distrib. Co., 203 Ga.

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App. 763, 417 S.E.2d 671 (1992), cert. denied, 203 Ga. App. 906, 417 S.E.2d 671 (1992).

Trial court erred in denying summary judgment to the insurer on the insured's bad faith claim because the insurer had a reasonable factual and legal basis for denying coverage such that bad faith penalties were not allowed as the question of whether the previous reservations of rights were still effective had not been squarely answered, and it may have appeared from a review of the insurer's records that the reservation of rights letters had been sent out once the insurer agreed to cover the litigation. American Safety Indemnity Co. v. Sto Corp., 342 Ga. App. 263, 802 S.E.2d 448 (2017).

Insurer may contest liability on undecided legal question. — The insurer has a right to contest liability depending on a legal question which has not heretofore been decided by the courts of this state. Reserve Life Ins. Co. v. Bearden, 96 Ga. App. 549, 101 S.E.2d 120 (1957), aff'd, 213 Ga. 904, 102 S.E.2d 494 (1958).

The questions of law as to the proper construction of the double indemnity provision of the policy of insurance not having been decided by the courts of Georgia, and having been decided contrary to the contentions of the plaintiff by other courts, the defendant insurance company was not subject to damages and attorney's fees on the ground of bad faith, since its defense was not frivolous or unfounded. Life Ins. Co. v. Burke, 219 Ga. 214, 132 S.E.2d 737 (1963).

An insurance company is not guilty of bad faith in seeking a judicial determination of an issue involving a question of law previously undecided in this state. Georgia Farm Bureau Mut. Ins. Co. v. Calhoun, 127 Ga. App. 213, 193 S.E.2d 35 (1972).

Where the issue raised in the case is one of first impression, and the Court of Appeals divided 6-3 on the issue, and the Supreme Court granted an application for a writ of certiorari to resolve the issue, the insurer was legally justified in litigating the issue and cannot, as a matter of law, be liable for the statutory penalty under this section. State Farm Mut. Auto. Ins. Co. v. Bass, 231 Ga. 269, 201 S.E.2d 444 (1973); Bass v. State Farm Mut. Auto. Ins. Co., 130 Ga. App. 393, 203 S.E.2d 379 (1973).

Work product documents discoverable for bad faith counterclaim. — Even though documents in an insurer's claim file were prepared in anticipation of litigation under the work product doctrine of Fed. R. Civ. P. 26(b)(3), an additional insured showed substantial need because the documents were the only reliable indication of the insurer's bad faith for the insurer's counterclaim under O.C.G.A. § 33-4-6, except that the insurer was entitled to redact information showing mental impressions. Underwriters Ins. Co. v. Atlanta Gas Light Co., 248 F.R.D. 663 (N.D. Ga. 2008).

Insurer could dispute applicability of clause. — Trial court properly entered summary judgment for the insurer in business's bad faith claim under O.C.G.A. § 33-4-6 since there was no evidence that the insurer acted in bad faith as there was a genuine dispute as to the applicability of the civil authority clause in a business insurance policy. Assurance Co. v. BBB Serv. Co., 259 Ga. App. 54, 576 S.E.2d 38 (2002).

Insurer may seek declaratory judgment. — Where an action is instituted by an insurance company in federal court seeking a declaratory judgment as to its ultimate liability under a policy, the insurance company is not liable for attorney's fees and expenses incurred by the insured in such a proceeding in the absence of policy provisions to the contrary, or in the absence of fraud, bad faith, and stubborn litigiousness. Maryland Cas. Co. v. Sammons, 63 Ga. App. 323, 11 S.E.2d 89 (1940).

Actions initiated before expiration of 60 days from demand. — Where the insurance company initiates a declaratory judgment action well before the expiration of 60 days from demand, the applicant has no action for attorney's fees for a bad faith refusal to pay under this section. Allstate Ins. Co. v. Anderson, 121 Ga. App. 582, 174 S.E.2d 591 (1970).

Declaratory judgment action must do more than ask determination of liability. — An insurer will not be ab-

solved of the bad faith penalty provided by this section merely by the fact that a declaratory judgment action is brought by it, where the action does no more than ask the court to determine whether the insurer is liable upon an insurance policy which it issued. State Farm Fire & Cas. Co. v. Gosdin, 147 Ga. App. 156, 248 S.E.2d 216 (1978).

Insurer's filing of a declaratory judgment action that disputed coverage under an insured's policy did not insulate the insurer from a counterclaim filed by the insured under O.C.G.A. § 33-4-6 for bad faith refusal to pay. Great Southwest Express Co. v. Great Am. Ins. Co., 292 Ga. App. 757, 665 S.E.2d 878, cert. denied, 293 Ga. App. 365, 667 S.E.2d 192 (2008).

Where there is a reasonable basis for so doing, an insurer is entitled to maintain and defend its position as to the amount of its liability without the imposition of penalty and attorney's fees, even if doing so results in considerable delay in bringing the matter to a conclusion. Any rule or principle which would deny to the company the right of full and free litigation on the question of its liability or of the amount thereof is wrong. Georgia Farm Bureau Mut. Ins. Co. v. Boney, 113 Ga. App. 459, 148 S.E.2d 457 (1966).

Delay in settlement does not justify penalty where insurer's offer is fair. — Where the insurer disagrees with the insured as to the amount of his damage, offering to pay a sum which, in the light of the facts available to it and of proposals from reputable people engaged in the repairing of automobiles, it deems to be fair and reasonable as damages for the loss sustained and the insured declines the offer, insisting upon the payment of a sum substantially in excess of the amount offered, the matter thus reaching a stalemate, a recovery of damages and attorney's fees because of delay in making settlement is not authorized. Georgia Farm Bureau Mut. Ins. Co. v. Boney, 113 Ga. App. 459, 148 S.E.2d 457 (1966).

Insurer need not proceed with appraisal if insured will not cooperate. — Where, after unsuccessful negotiations to settle the claim, the insurer requested the insured to appoint an appraiser and before any appraiser was appointed learned from the insured that he had disposed of the car, but the insured declined to inform the insurer as to whom he had sold the car or where it might be found for the purpose of having an appraisal made, the insurer was under no duty to proceed further with the proposed appraisal. Georgia Farm Bureau Mut. Ins. Co. v. Boney, 113 Ga. App. 459, 148 S.E.2d 457 (1966).

Use of 17(c) formula for motor vehicle claim not bad faith. — Trial court erred when the court denied the defense insurer's motion for partial summary judgment as to the plaintiffs' bad faith claim under O.C.G.A. § 33-4-7 because the insurer's proposed adjustment of the plaintiffs' diminished value claim was reasonable and provided the insurer with good cause as a matter of law for the insurer's refusal to pay the amount demanded by the plaintiffs since it was undisputed that the insurer's adjuster used the 17(c) formula as part of the subjective determination of the lost value of the car at issue. Amica Mut. Ins. Co. v. Sanders, 335 Ga. App. 245, 779 S.E.2d 459 (2015).

Bad faith will be implied from any frivolous and unfounded refusal to pay the benefits of an insurance policy within 60 days after demand. Independent Life & Accident Ins. Co. v. Thornton, 102 Ga. App. 285, 115 S.E.2d 835 (1960).

Defenses not showing reasonable and probable cause. — Any defense not manifesting reasonable and probable cause would expose the company to the imputation of bad faith and to the assessment of damages therefor. Travelers Ins. Co. v. Sheppard, 85 Ga. 751, 12 S.E. 18 (1890); New York Life Ins. Co. v. Ittner, 59 Ga. App. 89, 200 S.E. 522 (1938), later appeal, 62 Ga. App. 31, 8 S.E.2d 582 (1940); Reserve Life Ins. Co. v. Peavy, 98 Ga. App. 268, 105 S.E.2d 465 (1958); Interstate Life & Accident Ins. Co. v. Williamson, 110 Ga. App. 557, 139 S.E.2d 429 (1964); Colonial Life & Accident Ins. Co. v. McClain, 144 Ga. App. 201, 240 S.E.2d 759 (1977); Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745 (1979); Cincinnati Ins. Co. v. Kastner, 233 Ga. App. 594, 504 S.E.2d 496 (1998).

Probable cause negatives imputation of bad faith. — Probable cause for

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refusing payment will negative the imputation of bad faith, but without such probable cause, refusal will be at the company's peril. Life & Cas. Ins. Co. v. Smith, 51 Ga. App. 122, 179 S.E. 744 (1935); Reserve Life Ins. Co. v. Peavy, 98 Ga. App. 268, 105 S.E.2d 465 (1958); Interstate Life & Accident Ins. Co. v. Hopgood, 133 Ga. App. 6, 209 S.E.2d 703 (1974).

If there is any reasonable ground for contesting the claim, there is no bad faith. Albergotti v. Equitable Life Assurance Soc'y of United States, 48 F. Supp. 290 (S.D. Ga. 1942); Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E. 227 (1946); Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949), (for comment, see 12 Ga. B.J. 337 (1950)); Gulf Life Ins. Co. v. Moore, 90 Ga. App. 791, 84 S.E.2d 696 (1954); Georgia Cas. & Sur. Co. v. Seaboard Sur. Co., 210 F. Supp. 644 (N.D. Ga. 1962), aff'd, 327 F.2d 666 (5th Cir. 1964); Belch v. Gulf Life Ins. Co., 219 Ga. 823, 136 S.E.2d 351 (1964); Lanier v. American Cas. Co., 226 F. Supp. 630 (N.D. Ga. 1964); Dorsey v. State Mut. Life Assurance Co., 238 F. Supp. 391 (N.D. Ga. 1964), aff'd, 357 F.2d 600 (5th Cir. 1966); American Cas. Co. v. Ten Tex Corp., 357 F.2d 269 (5th Cir. 1966); Morris v. Mutual Benefit Life Ins. Co., 258 F. Supp. 186 (N.D. Ga. 1966); Witt v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 117 Ga. App. 838, 162 S.E.2d 251 (1968); United States Fid. & Guar. Co. v. Woodward, 118 Ga. App. 591, 164 S.E.2d 878 (1968); Home Indem. Co. v. Godley, 122 Ga. App. 356, 177 S.E.2d 105 (1970); Boston-Old Colony Ins. Co. v. Warr, 127 Ga. App. 364, 193 S.E.2d 624 (1972); Pioneer Nat'l Title Ins. Co. v. American Cas. Co., 459 F.2d 963 (5th Cir. 1972); Progressive Cas. Ins. Co. v. West, 135 Ga. App. 1, 217 S.E.2d 310 (1975); Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205 (5th Cir. 1977); Wright v. Hartford Accident & Indem. Co., 442 F. Supp. 155 (N.D. Ga. 1977); Smith v. New York Life Ins. Co., 579 F.2d 1267 (5th Cir. 1978); Grange Mut. Cas. Co. v. Law, 223 Ga. App. 748, 479 S.E.2d 357 (1996).

In an insurance coverage dispute, there was not sufficient grounds upon which a jury could find that the insurer acted in bad faith by failing to pay a claim because the insurer was not unreasonable in relying on its adjuster's findings, following inspection, that rainwater had entered the building through openings caused by unsecured roofing work. Mock v. Cent. Mut. Ins. Co., 158 F. Supp. 3d 1332 (S.D. Ga. Jan. 25, 2016).

Disputed questions of fact. — To support a cause of action under O.C.G.A. § 33-4-6, the insured bears the burden of proving that the refusal to pay the claim was made in bad faith. A defense going far enough to show reasonable and probable cause for making it would vindicate the good faith of the company as effectually as would a complete defense to the action. Penalties for bad faith are not authorized where the insurance company has any reasonable ground to contest the claim and where there is a disputed question of fact. Moon v. Mercury Ins. Co. of Ga., 253 Ga. App. 506, 559 S.E.2d 532 (2002).

As to the insured's claim for bad faith breach of an insurance contract under O.C.G.A. § 33-4-6, summary judgment was warranted in favor of defendants. The insurer utilized independent medical examiners (IMEs), the insurer's IMEs provided the medical bases for their conclusions; the insurer tested its IMEs' conclusions with the insured's information; and further, under Georgia law, the absence of bad faith was buttressed by the existence of a genuine issue of material fact whether defendants owed the insured coverage. Worsham v. Provident Cos., 249 F. Supp. 2d 1325 (N.D. Ga. 2003).

Trial court properly granted the title insurance company's motion for summary judgment as to the insured's allegation of bad faith refusal to pay under O.C.G.A. § 33-4-6 because genuine issues of material fact existed as to whether the bank was aware of Exhibit C addressing the environmental problems with the property prior to closing and, thus, whether the insured's claim was excluded under the insurance policy as an assumed title defect. Old Republic Nat'l Title Ins. Co. v. RM Kids, LLC, 337 Ga. App. 638, 788 S.E.2d 542 (2016), cert. denied, No. S16C1843, 2017 Ga. LEXIS 117 (Ga. 2017).

Defense showing reasonable and probable cause vindicates insurer's good faith. — A defense going far enough to show reasonable and probable cause for making it would vindicate the good faith of the company as effectually as would a complete defense to an action under this section. Travelers Ins. Co. v. Sheppard, 85 Ga. 751, 12 S.E. 18 (1890); New York Life Ins. Co. v. Ittner, 59 Ga. App. 89, 200 S.E. 522 (1938), later appeal, 62 Ga. App. 31, 8 S.E.2d 582 (1940); Reserve Life Ins. Co. v. Peavy, 98 Ga. App. 268, 105 S.E.2d 465 (1958); Interstate Life & Accident Ins. Co. v. Williamson, 110 Ga. App. 557, 139 S.E.2d 429 (1964); Whitlock v. Interstate Life & Accident Ins. Co., 112 Ga. App. 235, 144 S.E.2d 541 (1965); Georgia Farm Bureau Mut. Ins. Co. v. Calhoun, 127 Ga. App. 213, 193 S.E.2d 35 (1972); Colonial Life & Accident Ins. Co. v. McClain, 144 Ga. App. 201, 240 S.E.2d 759 (1977); Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745 (1979).

Refusal to pay medical benefits not unreasonable. — Insurer's refusal to pay medical benefits on the basis of an opinion by an independent medical provider that there was no causal connection between the treatment and the accident was not unreasonable. Jones v. State Farm Mut. Auto. Ins. Co., 228 Ga. App. 347, 491 S.E.2d 830 (1997); Shaffer v. State Farm Mut. Auto. Ins. Co., 246 Ga. App. 244, 540 S.E.2d 227 (2000).

Insurer's cancellation of insured's medical benefits on the basis of report from an independent medical examiner was not unreasonable where the insured failed to prove that the examiner's opinion was patently wrong. Lancaster v. USAA Cas. Ins. Co., 232 Ga. App. 805, 502 S.E.2d 752 (1998).

Suspension of payments of lost wage benefits not unreasonable. — Summary judgment on the question of plaintiff's claim for bad faith damages under subsection (a) of O.C.G.A. § 33-4-6 was proper where it was undisputed that the insurer suspended payment of plaintiff's lost wage benefits relying upon the opinion of a board certified orthopedic surgeon. Wallace v. State Farm Fire & Cas. Co., 247 Ga. App. 95, 539 S.E.2d 509 (2000).

Good faith shown by reasonable and probable cause is complete defense. — Should the insurance company show a reasonable and probable cause for refusing to pay, the company's good faith would be a complete defense to an action under this section. Independent Life & Accident Ins. Co. v. Thornton, 102 Ga. App. 285, 115 S.E.2d 835 (1960).

Breach of duty to defend. — Insurer breached the insurer's duty to defend under O.C.G.A. § 33-4-6(a) against a nightclub guest's personal injury complaint; the guest's claims at least arguably would have been covered by a provision in the nightclub's insurance policy that provided coverage for an assault or battery by an employee that was committed to protect persons or property. Landmark Am. Ins. Co. v. Khan, 307 Ga. App. 609, 705 S.E.2d 707 (2011).

Even though defense is not accepted. — The insurer's defense must be evaluated, because if there was reasonable and probable cause to make it, an award for damages and attorney fees for bad faith is not authorized. Not every defense bars a finding of bad faith. It is a defense which raises a reasonable question of law or a reasonable issue of fact even though not accepted by the trial court or jury. Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745 (1979).

If defense is rejected, jury may find it was not made in good faith. — Where insurance company gave as a reason for refusal to pay claim on a life insurance policy a contention that the first premium had never been paid or the policy delivered to the insured and the jury found against such contention, it was within their power to find from the evidence that such contention was not in good faith. Kansas City Life Ins. Co. v. Williams, 62 Ga. App. 707, 9 S.E.2d 680 (1940).

Refusal to pay justified at time of refusal shows no bad faith. — Where it appears from the evidence that the insurer's refusal to pay was justified on the basis of the facts appearing in the insurer at the time of the refusal, bad faith is now shown. Lincoln Life Ins. Co. v. Anderson, 109 Ga. App. 238, 136 S.E.2d 1 (1964);

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National-Ben Franklin Ins. Co. v. Prather, 109 Ga. App. 459, 136 S.E.2d 499 (1964); Old Colony Ins. Co. v. Dressel, 109 Ga. App. 465, 136 S.E.2d 525, aff'd, 220 Ga. 354, 138 S.E.2d 886 (1964).

Given an insurer's initial and prolonged payment of disability benefits to the insured during its investigation of the insured's claim, and its eventual termination of benefits only after the insured failed to respond to inquiries requesting an explanation of how the insured's disability prevented the insured from engaging in the insured's purported occupations, the decision to terminate the benefits could not be characterized as either frivolous or unreasonable. Giddens v. Equitable Life Assur. Soc'y of the United States, 356 F. Supp. 2d 1313 (N.D. Ga. 2004), aff'd in part and rev'd in part, 445 F.3d 1286, 2006 U.S. App. LEXIS 8970 (11th Cir. Ga. 2006).

Insurer's filing of a 28 U.S.C. § 1335 interpleader suit was done in good faith as was the insurer's denial of a trustee's claim for payment of a decedent's life insurance policies as the insurer was unable to determine, due to a myriad of events that occurred between the decedent's establishment of a revocable trust, whether the trust, the decedent's children with his first wife, or the decedent's second wife and any children they may have had together were entitled to the decedent's life insurance policy proceeds, and the parties were scattered through several different countries, making it more difficult for the insurer to determine who was entitled to the proceeds; that the children later averred that the proceeds belonged to the trust and the second wife disclaimed any interest in the proceeds did not mean that the insurer acted in bad faith under O.C.G.A. § 33-4-6 in denying payment of the trustee's claim. Nat'l Life Ins. Co. v. Alembik-Eisner, 582 F. Supp. 2d 1362 (N.D. Ga. 2008).

The test of bad faith within the meaning of this section is as of the time of trial, and not at the time of refusal to pay upon demand. Interstate Life & Accident Ins. Co. v. Williamson, 110 Ga. App. 557, 139 S.E.2d 429 (1964).

Whatever the facts are at the time of a refusal to pay, if at the trial there is a reasonable ground for the insurer to contest the claim, there can be no finding against the insurance company for bad faith and attorney's fees regardless of the outcome of the case. Interstate Life & Accident Ins. Co. v. Williamson, 110 Ga. App. 557, 139 S.E.2d 429 (1964).

The question of bad faith must be determined by the defense made at the time of trial. Phillips v. State Farm Mut. Auto. Ins. Co., 437 F.2d 365 (5th Cir. 1971).

Discovery of defense showing probable cause after refusal vindicates insurer. — Where, at the expiration of 60 days after a demand by an insured for the amount claimed to be due under an insurance policy, the insurance company knows of no good reason for refusing to pay the claim, a defense later discovered and made, on the trial of the case, going far enough to show probable cause of making such defense vindicates the insurer's refusal to pay the claim so as to preclude the insured from recovering attorney's fees and penalty provided in this section. Interstate Life & Accident Ins. Co. v. Williamson, 220 Ga. 323, 138 S.E.2d 668, answer conformed to, 110 Ga. App. 557, 139 S.E.2d 429 (1964).

Insurer need not pay claim prior to judgment being entered against uninsured motorist. Allstate Ins. Co. v. McCall, 166 Ga. App. 833, 305 S.E.2d 413 (1983), aff'd, 251 Ga. 869, 310 S.E.2d 513 (1984).

Insurer need not pay beyond limits of uninsured motorist policy. — The insurer is not guilty of bad faith in failing to pay the insured the full amount of the verdict, which is beyond the limits of an uninsured motorist policy of which she is the beneficiary, where the insurer tenders the limit of the policy to the insured after judgment is entered in the case. Allstate Ins. Co. v. McCall, 166 Ga. App. 833, 305 S.E.2d 413 (1983), aff'd, 251 Ga. 869, 310 S.E.2d 513 (1984).

A defense which would bar a finding of bad faith is one which raises a reasonable question of law or a reasonable issue of fact. Giles v. National Union Fire Ins. Co., 578 F. Supp. 376 (M.D. Ga. 1984).

After an insurer paid a borrower for

mortgaged equipment destroyed in a fire, without knowing that the insurer should have paid the predecessor bank, which was later closed by the FDIC, the record did not show evidence of unfounded reasons for nonpayment, so the bad faith claim failed. Ameris Bank v. Lexington Ins. Co., No. CV413-241, 2015 U.S. Dist. LEXIS 129431 (S.D. Ga. Sept. 25, 2015).

Defense reasonable where insurer not aware of change in medical opinion as to preexisting condition. — Where insured's coverage was expressly limited to loss resulting directly, independently, and exclusively from accidental injury, where insurer made disability payments until being informed by insured's own physician that insured's accident had aggravated a preexisting condition, and where there was no indication that insurer knew that insured's doctor had changed his opinion prior to the litigation, insurer's defense was reasonable and an award of attorney fees was in error. Colonial Life & Accident Ins. Co. v. Donaldson, 172 Ga. App. 211, 322 S.E.2d 510 (1984).

Where the court determines that the coverage is void ab initio under § 33-24-6(a) and there is no evidence of bad faith on behalf of the insurance company, a beneficiary is not entitled to recover under this section. Connecticut Gen. Life Ins. Co. v. Wood, 631 F. Supp. 9 (N.D. Ga. 1984), questions certified to Georgia Supreme Court and proceedings stayed upon appeal, 758 F.2d 1459 (11th Cir. 1985); Wood v. New York Life Ins. Co., 631 F. Supp. 3 (N.D. Ga. 1984).

Former rule. — Prior to 1964, it was held that the bad faith on the part of an insurance company necessary to support a claim for attorney fees had to occur at the time the company failed to pay the benefit provided for in a policy of full force and effect at the expiration of the 60-day period after proof of loss and demand for payment had been made, rather than at the time of the trial. Independent Life & Accident Ins. Co. v. Hopkins, 80 Ga. App. 348, 56 S.E.2d 177 (1949); North British & Mercantile Ins. Co. v. Mercer, 90 Ga. App. 143, 82 S.E.2d 41, aff'd, 211 Ga. 161, 84 S.E.2d 570 (1954); Life & Cas. Ins. Co. v. Brown, 95 Ga. App. 354, 98 S.E.2d 68, rev'd on other grounds, 213 Ga. 390, 99 S.E.2d 98 (1957); Reserve Life Ins. Co. v. Bearden, 96 Ga. App. 549, 101 S.E.2d 120 (1957), aff'd, 213 Ga. 904, 102 S.E.2d 494 (1958); Reserve Life Ins. Co. v. Ayers, 101 Ga. App. 887, 115 S.E.2d 477 (1960).

The question of bad faith was to be judged upon the facts that they appeared prior to the time of the trial as they bore upon the insurer's reason, or absence of reason, for refusing to pay the claim upon demand. Calvert Fire Ins. Co. v. Mack, 88 Ga. App. 617, 76 S.E.2d 829 (1953).

Liability for the penalty and attorney's fees attached at the time when the insurer in bad faith and within 60 days after demand for payment of the loss failed or refused to pay the fees; this was true regardless of whether at a later date there was reasonable cause to refuse the claim of loss. Reserve Life Ins. Co. v. Peavy, 98 Ga. App. 268, 105 S.E.2d 465 (1958).

Whether there was any reasonable grounds for contesting the claim was a matter which depended upon the circumstances existing when liability was declined or not admitted, not by the event of the ultimate determination. Georgia Cas. & Sur. Co. v. Seaboard Sur. Co., 210 F. Supp. 644 (N.D. Ga. 1962), aff'd, 327 F.2d 666 (5th Cir. 1964); Dorsey v. State Mut. Life Assurance Co., 238 F. Supp. 391 (N.D. Ga. 1964), aff'd, 357 F.2d 600 (5th Cir. 1966).

Case of first impression. — Where case was one of first impression in which fireman's fund presented a legal defense adopted by other courts, the trial court erred in failing to grant fireman's fund's motion for directed verdict on the issue of bad faith and attorney fees. Fireman's Fund Ins. Co. v. Dean, 212 Ga. App. 262, 441 S.E.2d 436 (1994).

No bad faith in refusal to pay on fire insurance policy. — In a dispute in a fire insurance case in which the insurer failed to pay for over seven months and denied coverage because the home was not the insured's primary residence, although an appellate court concluded that coverage was provided, the trial court did not err in granting summary judgment for the insurer on the issue of bad faith. Lee v. Mercury Ins. Co., 343 Ga. App. 729, 808 S.E.2d 116 (2017), cert. denied, No. S18C0518, 2018 Ga. LEXIS 491 (Ga. 2018).

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Insurance coverage demanded, but not provided. — The exclusive remedy for an insurance company's bad faith refusal to pay a claim was set forth in O.C.G.A. § 33-4-6 and penalties against the insurance company and agents were not available for their alleged bad faith as the fire insurance policy they issued to the insured did not provide the insurance coverage demanded. Anderson v. Ga. Farm Bureau Mut. Ins., 255 Ga. App. 734, 566 S.E.2d 342 (2002).

Closing protection letter not an insurance policy. — A trial court properly ruled that a mortgage lender was not entitled to statutory penalties authorized by O.C.G.A. § 33-4-6 in a suit asserting the bad faith denial on the part of a title insurance company in paying for a fraud claim as the closing protection letter relevant was not a policy of insurance so as to authorize imposition of the penalties. Lawyers Title Ins. Corp. v. New Freedom Mortg. Corp., 288 Ga. App. 642, 655 S.E.2d 269 (2007), cert. denied, 2008 Ga. LEXIS 384 (Ga. 2008).

Insured party excluded from coverage by terms of policy. — Because the driver was excluded from coverage under the insurance policy, the driver could not maintain an action for bad faith penalties and attorney fees under O.C.G.A. § 33-4-6. Progressive Ins. Co. v. Horde, 259 Ga. App. 769, 577 S.E.2d 835 (2003).

District court did not err when the court found that an insurance company was entitled to summary judgment on an insured's claims that the company committed breach of contract and was liable for bad faith penalties under O.C.G.A. § 33-4-6 because the court denied the insured's claim seeking compensation for damages that occurred to the insured's home and personal property when water, mud, and debris entered the home during a rainstorm; damages the insured sustained were caused by "surface water," as that term was defined under Georgia law, and a provision in the insured's homeowner's policy excluded coverage for damage to the insured's home and personal property that was caused by surface water. Williams v. State Farm Fire & Cas. Ins. Co., No. 14-11100, 2014 U.S. App. LEXIS 13681 (11th Cir. July 17, 2014) (Unpublished).

Insured precluded damage recovery by failure to provide records to insurer. — Where insured breached insurance contract by failing to fulfill conditions precedent to commencement of suit by failing to provide insurer with any records, insured was precluded from recovery and insurer had reasonable grounds to refuse payment of the claim; accordingly, damages under O.C.G.A. § 33-4-6 were not warranted. Hall v. Liberty Mut. Fire Ins. Co., No. CV4:06-218, 2008 U.S. Dist. LEXIS 22509 (S.D. Ga. Mar. 21, 2008), aff'd, No. 08-12051, 2009 U.S. App. LEXIS 2075 (11th Cir. Ga. 2009).

Summary judgment for insurer proper on bad faith claim. — Although a worker making a claim under a disability policy was able to perform light duties, whether the worker was wholly disabled from performing "material" duties within 180 days of the injury, as required by the policy, was a jury question, and summary judgment on this issue was improper; however, the worker was not entitled to bad faith penalties under O.C.G.A. § 33-4-6 because, in light of the policy language and the underlying facts, the insurer had reasonable grounds to contest coverage for total disability. Fountain v. Unum Life Ins. Co. of Am., 297 Ga. App. 458, 677 S.E.2d 334 (2009).

Because the master policy of insurance liability did not provide indemnification for the extended protection plan (EPP) claims for which the manufacturer was "legally liable," only claims for which it had been "held legally liable," the manufacturer's claim for indemnification did not, and would not, accrue until its legal liability for the EPP claims had been established by a court holding, and the insurer was entitled to summary judgment on the bad faith denial of insurance coverage claim. Lloyd's Syndicate No. 5820 v. AGCO Corp., 294 Ga. 805, 756 S.E.2d 520 (2014).

Insurer had reasonable grounds to contest homeowners' claims. — Insureds' bad faith claim under O.C.G.A. § 33-4-6 against an insurer that alleged

the insurer acted in bad faith in underpaying for tree damage and in refusing to pay for water damage failed under summary judgment because the insurer had reasonable grounds to contest the claims; the insureds' request for additional payment for the tree damage was based on estimates for repairs that exceeded the scope of the tree damages, and there was no indication that the insureds properly asserted a new claim for the water damage. Matthews v. State Farm Fire & Cas. Co., 500 Fed. Appx. 836 (11th Cir. 2012) (Unpublished).

Bad faith not found. — Because of an "impaired property" exclusion in a commercial general liability policy, an insurer did not breach its duty to indemnify or defend where an auto parts store filed a claim with the insurer after customers sued the store for its failure to deliver conforming goods (store allegedly filled its customers' orders for freon with a freon substitute and illegally imported freon); the court granted summary judgment in favor of the insurer on the issues of bad faith and failure to defend and indemnify. JLM Enters. v. Houston Gen. Ins. Co., 196 F. Supp. 2d 1299 (S.D. Ga. 2002).

Insured who tried to recover damages for injuries the insured sustained in a motor vehicle accident in Florida, but who alleged that the insured's claim was denied because she did not have the right to sue under Florida's no-fault statute, was entitled to collect uninsured motorist benefits from the insured's own insurance company, pursuant to O.C.G.A. § 33-7-11. However, the trial court, which heard the insured's action against the insurance company, erred when it denied the company's motion for summary judgment on the insured's claim seeking penalties and attorney fees, pursuant to O.C.G.A. § 33-4-6, because the case presented a unique issue of law and there was no evidence that the company acted in bad faith when it denied the insured's claim. Ga. Farm Bureau Mut. Ins. Co. v. Williams, 266 Ga. App. 540, 597 S.E.2d 430 (2004).

Award in favor of an insured was reversed as the insurer refused to pay the insured's claim based on an investigation which produced evidence that the insured's claim under the policy was fraudulent. As the insured denied the fraud claim, there was a genuine conflict over whether the claim was legitimate, and since the insurer's grounds for refusing to pay the claim were reasonable and not frivolous or unfounded, there was a lack of evidence to support the jury's verdict finding that the insurer refused to pay the claim in bad faith. Allstate Ins. Co. v. Smith, 266 Ga. App. 411, 597 S.E.2d 500 (2004).

Trial court properly granted summary judgment as to the successor in interest to an insurance company as to claims of bad faith pursuant to O.C.G.A. § 33-4-6, as the insurer reasonably based its denial of coverage on a decedent's failure to make the required premium payments. Guideone Life Ins. Co. v. Ward, 275 Ga. App. 1, 619 S.E.2d 723 (2005).

Where an insurer was found to have improperly rescinded a directors and officers insurance policy with its insured, the insured was not liable for bad faith damages because the insurer's decision to rescind the policy was reasonable; the insurer promptly initiated and conducted an investigation of the circumstances surrounding the issuance of the policy, which reasonably led it to conclude that the policy had been procured on the basis of material misrepresentations. Exec. Risk Indem. v. AFC Enters., 510 F. Supp. 2d 1308 (N.D. Ga. 2007), aff'd, 279 Fed. Appx. 793 (11th Cir. 2008).

Insurer was not liable for attorney fees based on bad faith failure to pay a corporate insured's claim for inspections and repairs to faulty industrial boilers because the business risk exclusions contained in the insured's general commercial liability policy exempted such matters from recovery. Gentry Mach. Works, Inc. v. Harleysville Mut. Ins. Co., 621 F. Supp. 2d 1288 (M.D. Ga. 2008).

Insured settled a claim without its insurer's consent, contrary to a provision in the parties' policy. As the insurer was liable under the policy to pay only those sums the insured was legally obligated to pay, and neither policy provision was illegal or contrary to public policy, the insured could not sue the insurer for bad faith failure to settle, O.C.G.A. § 33-4-6,

Bad Faith Refusal to Pay (Cont'd)

in the absence of an excess verdict or an agreed-upon settlement. Trinity Outdoor, LLC v. Cent. Mut. Ins. Co., 285 Ga. 583, 679 S.E.2d 10 (2009).

Insurance company presented evidence showing that the reason for the payment delay was because there was a dispute over how much was owed under the lost business income provision of the policy. From that evidence, the court granted the insurance company's motion for summary judgment on the insured's claim for bad faith under O.C.G.A. § 33-4-6. B.S.S.B., Inc. v. Owners Ins. Co., No. 7:08-CV-112 (HL), 2010 U.S. Dist. LEXIS 4106 (M.D. Ga. Jan. 20, 2010).

Trial court erred by denying an insurer's motion for summary judgment dismissing a mortgagee's claims for bad faith damages under O.C.G.A. § 33-4-6 in its action seeking payment of insurance proceeds because the insurer had good reason for delaying payment until the insurer acquired the necessary information about the foreclosure of the insured residence less than 60 days before suit was filed; the mortgagee ultimately showed that after foreclosing on and obtaining title to the residence, the mortgagee incurred a net loss that gave the mortgagee a right to the entire $103,000 of insurance proceeds, but the information necessary for the insurer to conclude that the mortgagee had a right to claim the entire $103,000 of insurance proceeds was provided to the insurer less than 60 days before suit was filed, and the mortgagee made no demand for payment of all the insurance proceeds after that information was provided. Balboa Life & Cas., LLC v. Home Builders Fin., 304 Ga. App. 478, 697 S.E.2d 240 (2010).

Homeowner could not prevail on a bad-faith claim based on an insurer's denial of coverage for water damage to a house, as the insurer reasonably denied the claim; the policy unambiguously contained a residency requirement, and the homeowner never resided there. Mahens v. Allstate Ins. Co., 447 Fed. Appx. 51 (11th Cir. 2011) (Unpublished).

Trial court did not err in granting an insurer summary judgment on a widow's claim for bad faith penalties and attorney fees under O.C.G.A. § 33-4-6 because the insurer's reasons for refusing to pay the insurance proceeds to the widow were erroneous but not frivolous or unreasonable. Flynt v. Life of the South Ins. Co., 312 Ga. App. 430, 718 S.E.2d 343 (2011), cert. denied, No. S12C0461, 2012 Ga. LEXIS 305 (Ga. 2012).

In an insurance dispute coverage claim, the homeowners' contention on appeal that the insurance company denied the homeowners' claim in bad faith, in violation of O.C.G.A. § 33-4-6, was not ruled on by the trial court; thus, the appellate court was presented with nothing to review on appeal, but stated that the homeowners failed to state the particular statutory or contractual provision the homeowners contended the insurance company intentionally omitted from the homeowner's policy. Bell v. Liberty Mut. Fire Ins. Co., 319 Ga. App. 302, 734 S.E.2d 894 (2012).

Trial court erred by denying a title company's motion for summary judgment on a lender's claim for coverage under the title insurance policy and for bad faith damages because the policy stated that the title company was liable for the lesser amount of the difference between the value of the insured estate and the value of the insured estate subject to the defect insured against, thus, since the lender received more in the foreclosure sale than the value, the title company was liable for zero. Doss & Assocs. v. First Am. Title Ins. Co., 325 Ga. App. 448, 754 S.E.2d 85 (2013).

Procedure

1. Generally

No damages absent allegations of fraud, special circumstances. — The plaintiff's request for both the 25 percent penalty and unspecified punitive damages was at least redundant, where he alleged only his entitlement to the disputed proceeds and the defendant's bad faith failure to pay them, no allegations of fraud or other special circumstances having been pleaded. Hall v. Travelers Ins. Co., 691 F. Supp. 1406 (N.D. Ga. 1988).

Allegation of "bad faith" sufficient, not mere conclusion. — In an action on

an insurance contract, if definite facts are well pleaded which in law make a case of liability against the insurer and disclose a duty to pay the damage and if it is further alleged that on timely demand by the insured the insurer within 60 days thereafter refused to compensate for the loss sustained, the pleader may allege that the refusal was in "bad faith," and that the defendant is therefore subject to a penalty provided by law, without subjecting this allegation to the complaint that it is a mere conclusion of the pleader. Rogers v. American Nat'l Ins. Co., 145 Ga. 570, 89 S.E. 700 (1916); North British & Mercantile Ins. Co. v. Parnell, 53 Ga. App. 178, 185 S.E. 122 (1936); Glens Falls Indem. Co. v. Gottlieb, 76 Ga. App. 70, 44 S.E.2d 706 (1947).

It is proper to allege liability for penalty as legal result. — The allegation following that of "bad faith," that "making the defendant liable for said penalty of 25 percent as (sic) attorney's fees," is an allegation of legal result which will be judicially recognized by the Court of Appeals as arising from the allegation of refusal in "bad faith," and, as such, is not objectionable. North British & Mercantile Ins. Co. v. Parnell, 53 Ga. App. 178, 185 S.E. 122 (1936).

Reason for refusal in "bad faith" need not be alleged. — Whether there is any reason given, or whether there are other insinuating facts in connection with the refusal of the insurer to compensate for loss sustained, is purely a matter of evidence tending to support the ultimate issue of fact as to "bad faith" and need not be pleaded. North British & Mercantile Ins. Co. v. Parnell, 53 Ga. App. 178, 185 S.E. 122 (1936).

The pleadings made a case for submission to a jury as to whether the defendant was liable for the damages and attorney's fees provided for under this section by its refusal to defend suit brought against plaintiff railroad in accordance with its contractual obligations. Liberty Mut. Ins. Co. v. Atlantic C.L.R.R., 66 Ga. App. 826, 19 S.E.2d 377 (1942).

Allegations held sufficient to authorize finding of no good faith. — Where from the allegations and admissions in the pleadings, which it was the duty of the jury to accept as true, the jury was authorized to find that at the time of the refusal to pay the claim after the expiration of the 60-day period, as well as at the time the suit was filed and the answer filed thereto, no investigation had been made by the defendant insurer to determine whether payment should have been made, the jury was authorized to find the defendant lacking in the exercise of good faith. Independent Life & Accident Ins. Co. v. Hopkins, 80 Ga. App. 348, 56 S.E.2d 177 (1949).

Demand at time payment due and refusal continuing 60 days must be alleged. — In order for the insured to recover under this section the demand ought to be averred as taking place at a time when the plaintiff had a right to exact present payment, and the plaintiff's pleading should show that refusal, in "bad faith," was made and persisted in for 60 days. Twin City Fire Ins. Co. v. Wright, 46 Ga. App. 537, 167 S.E. 891 (1933).

Violation of 60-day waiting period. — Where insurer sued to cancel contract within 60-day period following demand, the insured's compulsory counterclaim did not violate the 60-day waiting period so as to foreclose claim for damages and attorneys fees. Sawyer v. Citizens & S. Nat'l Bank, 164 Ga. App. 177, 296 S.E.2d 134 (1982).

Waiver of 60-day notice requirement. — Insurer waived the 60-day coverage demand requirement under this section in an action by the insured to recover judgments and the costs of defending a wrongful death action, where the insurer filed a declaratory judgment action to determine its duty to defend under the policy prior to the initiation of the suit by the insured. Leader Nat'l Ins. Co. v. Kemp & Son, 189 Ga. App. 115, 375 S.E.2d 231 (1988), aff'd, 259 Ga. 329, 380 S.E.2d 458 (1989).

Insurer's waiver of defenses. — Where the insurer sent notice of termination and nonrenewal after it learned of the insured's fraud, it waived its defense that the insured's misrepresentations in his application voided the policy ab initio; however, such waiver with regard to the insurer's liability under the policy did not waive its defense to a bad faith claim under this section. Florida Int'l Indem.

Procedure (Cont'd)
1. Generally (Cont'd)

Co. v. Osgood, 233 Ga. App. 111, 503 S.E.2d 371 (1998).

Allegations as to demand held sufficient. — Pleading showing that plaintiff made due proof of death of insured, that payment had been refused, and that upon being informed, only after she had fraudulently been induced to sign release, that the sum of $3.30 was all she was entitled to recover, she expressed her dissatisfaction, stated that she did not understand the transaction which she was fraudulently induced to enter into, and tendered back the amount she had received, making the offer a continuous one, set a cause of action for recovery of the amount of the policy, and of damages and attorney's fees under this section. Industrial Life & Health Ins. Co. v. Johnson, 62 Ga. App. 630, 9 S.E.2d 121 (1940).

Admission of liability and small offer held to justify penalty. — Where the defendant in its answer admitted that it was indebted to the plaintiff and since the amount offered the plaintiff was a small portion of the lowest estimate of the repairs necessary as a result of the incident out of which the claim under the policy arose, it cannot be said that the finding of the penalty and attorney's fees under this section was unauthorized. Fidelity & Cas. Co. v. Mangum, 102 Ga. App. 311, 116 S.E.2d 326 (1960).

Denial of defendant's motion for continuance held not abuse of discretion. — Where in view of history of the insurance case before it and the evidence on the hearing for a continuance, the trial court was authorized to determine that the defendant would not by a continuance be placed in any better position than it was at the trial to defend against the demand for the statutory penalty and attorney's fees, made in the plaintiff's amendment, the trial court did not abuse its discretion in overruling the motion for a continuance. National Life & Accident Ins. Co. v. Moore, 86 Ga. App. 618, 72 S.E.2d 141 (1952).

Amendment of complaint allowed. — Plaintiff insured was allowed to amend a second time to clarify a claim for a bad faith breach of an insurance contract under O.C.G.A. § 33-4-6, based on a refusal to pay disability benefits, because defendant insurers were on notice of the claim, and in fact, the parties had conducted discovery on its merits; however, the court granted the insurers leave to file a motion for summary judgment on the claim, if they chose, because briefing the issue was an efficient use of judicial resources. Worsham v. Provident Cos., 249 F. Supp. 2d 1325 (N.D. Ga. 2002).

Insured was allowed to amend the insured's complaint, which alleged that several insurers violated O.C.G.A. § 33-4-6 in the handling of the insured's claim under a homeowners' policy, so as to add claims for negligence in the handling of the insured's claim; Georgia law was ambiguous as to whether the insured could recover for negligent, as well as bad faith, failure to settle the insured's claim, and thus, the amendment was not futile. Cordell v. Pac. Indem., No. 4:05-CV-167-RLV, 2006 U.S. Dist. LEXIS 46859 (N.D. Ga. July 11, 2006).

Amount in controversy for jurisdiction. — Motion to remand was denied because the amount in controversy satisfied 28 U.S.C. § 1332 since an insurer proved by a preponderance of the evidence that the benefit payable under a life insurance policy was $51,000, which, when added with the statutory penalty of $25,500 under O.C.G.A. § 33-4-6, totaled $76,500. Estate of Thornton v. Unum Life Ins. Co. of Am., 445 F. Supp. 2d 1379 (N.D. Ga. 2006).

Bifurcation of claims proper. — Trial court was authorized to conclude, after extensive discussion with the parties, that bifurcation of an insured's breach of an insurance contract and bad faith failure to pay benefits claims were appropriate under O.C.G.A. § 9-11-42(b) because coverage turned on whether the insured's debilitating condition arose from an injury or sickness, and the discrete coverage issue had to be resolved first since bad faith was irrelevant absent coverage; even if a single action was required under O.C.G.A. § 33-4-6, nothing in the case violated the requirement because the insured brought the claims against the insurer in a single civil action, and the

claims were resolved in that action, albeit through a bifurcated proceeding. Saye v. Provident Life & Accident Ins. Co., 311 Ga. App. 74, 714 S.E.2d 614 (2011), cert. denied, No. S11C1857, 2011 Ga. LEXIS 984 (Ga. 2011).

2. Burden of Proof and Evidence

Proper demand must be shown by evidence. — Such a demand as required by this section in order for the insured to recover damages in addition to the loss not being shown by the evidence, the verdict for damages given by the section was unauthorized. The judgment overruling the defendant's motion for a new trial was affirmed on condition that such damages be written off. Alliance Ins. Co. v. Williamson, 36 Ga. App. 497, 137 S.E. 277, cert. denied, 36 Ga. App. 825, 138 S.E. 267 (1927).

Evidence held not to prove demand at proper time. — The plaintiff having failed to prove any demand for payment at a time when she had the absolute right to make such demand, a verdict for damages and attorney's fees was unauthorized by the evidence and the applicable rules of law. Life Ins. Co. v. Burke, 219 Ga. 214, 132 S.E.2d 737 (1963).

Prior to 1979 bad faith was held fact to be proved. — Bad faith in refusing to pay a claim within 60 days after demand was a fact to be proved in order to recover the penalty and attorney's fees provided by this section. Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E.2d 227 (1946); Glens Falls Indem. Co. v. Gottlieb, 76 Ga. App. 70, 44 S.E.2d 706 (1947).

Unless there was evidence of a frivolous and unfounded denial of liability, no recovery could be had under this section. Morris v. Mutual Benefit Life Ins. Co., 258 F. Supp. 186 (N.D. Ga. 1966).

Burden of showing bad faith was on the insured. Reserve Life Ins. Co. v. Bearden, 96 Ga. App. 549, 101 S.E.2d 120 (1957), aff'd, 213 Ga. 904, 102 S.E.2d 494 (1958); Whitlock v. Interstate Life & Accident Ins. Co., 112 Ga. App. 235, 144 S.E.2d 541 (1965); Georgia Farm Bureau Mut. Ins. Co. v. Calhoun, 127 Ga. App. 213, 193 S.E.2d 35 (1972).

To support a cause of action under O.C.G.A. § 33-4-6, the insured bears the burden of proving that the refusal to pay the claim was made in bad faith. Central Nat'l Ins. Co. v. Dixon, 188 Ga. App. 680, 373 S.E.2d 849 (1988); Massachusetts Bay Ins. Co. v. Hall, 196 Ga. App. 349, 395 S.E.2d 851, cert. denied, 196 Ga. App. 908, 395 S.E.2d 851 (1990).

In a policy holder's suit asserting breach of contract, bad faith refusal to advance defense costs, and declaratory judgment, the policy holder could not establish the first element of a bad faith claim because the underlying litigation, which alleged that the trustees breached the trustees' fiduciary duties, was not covered under the claims-made policy. Langdale Co. v. Nat'l Union Fire Ins. Co., 110 F. Supp. 3d 1285 (N.D. Ga. 2014).

Plaintiff must show bad faith. — In actions brought under this section the burden of showing bad faith on the part of the defendant was on the plaintiff. Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E.2d 227 (1946); Witt v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 117 Ga. App. 838, 162 S.E.2d 251 (1968).

The burden was on the plaintiff to show bad faith on the part of the defendant in refusing to pay the claim within 60 days after demand. Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949). For comment, see 12 Ga. B.J. 337 (1950).

The burden was on the plaintiff to show bad faith on the part of the defendant in refusing to pay a claim or in offering an amount in settlement of the claim which was less than the amount of the loss found by the jury. Security Ins. Co. v. Hudgins, 87 Ga. App. 711, 75 S.E.2d 267 (1953).

In an action to recover penalties and attorney's fees for the refusal of an insurer to pay a claim, it had to be shown that the refusal was in "bad faith," and the burden was on the insured to show that such refusal had been made in bad faith. Interstate Life & Accident Ins. Co. v. Williamson, 220 Ga. 323, 138 S.E.2d 668, answer conformed to, 110 Ga. App. 557, 139 S.E.2d 429 (1964); Interstate Life & Accident Ins. Co. v. Brown, 146 Ga. App. 622, 247 S.E.2d 205 (1978).

The burden of proof is on the insured to establish bad faith. Winningham v. Centennial Ins. Co., 708 F.2d 658 (11th Cir. 1983).

Procedure (Cont'd)
2. Burden of Proof and Evidence (Cont'd)

In an action to recover penalties and attorney fees for the refusal of an insurer to pay a claim it must be shown that the refusal was in "bad faith," and the burden is on the insured to show that such refusal was made in bad faith. Republic Ins. Co. v. Martin, 182 Ga. App. 390, 355 S.E.2d 694 (1987).

When insured fails to meet initial burden, no damage award. — When insured failed to meet the insured's initial burden of producing "any" evidence of insurer's "bad faith" refusal to pay the insured's demand, the award of damages pursuant to O.C.G.A. § 33-4-6 could not stand. Canal Ins. Co. v. Bryant, 173 Ga. App. 173, 325 S.E.2d 839 (1984).

Compliance with requirements as to demand. — The plaintiff having alleged bad faith in her petition, the burden was on her to prove bad faith under the applicable rules of law, and that she had complied with the law and decisions of the Supreme Court as to "demand" for payment. Life Ins. Co. v. Burke, 219 Ga. 214, 132 S.E.2d 737 (1963).

Failure to comply with demand did not shift burden as to bad faith. — The mere fact that an insurer did not comply with a demand was not evidence of bad faith nor was any burden thereby cast on the insurer to prove good faith. Interstate Life & Accident Ins. Co. v. Williamson, 220 Ga. 323, 138 S.E.2d 668, answer conformed to, 110 Ga. App. 557, 139 S.E.2d 429 (1964); Interstate Life & Accident Ins. Co. v. Brown, 146 Ga. App. 622, 247 S.E.2d 205 (1978).

Unless delay was unusual and unnecessary. — The burden of proof, where unusual and unnecessary delay is shown, should be upon the company to give reason for the delay. Missouri State Life Ins. Co. v. Lovelace, 1 Ga. App. 446, 58 S.E. 93 (1907); Piedmont S. Life Ins. Co. v. Gunter, 108 Ga. App. 236, 132 S.E.2d 527 (1963) ("burden of proof" used in sense of "risk of nonpersuasion").

Where unusual and apparently unnecessary delay in paying the claim is shown, the burden is upon the company to show that the refusal was made in good faith. Georgia Life Ins. Co. v. McCranie, 12 Ga. App. 855, 78 S.E. 1115 (1913).

Supreme Court held insurer must show good cause. — The intention of this section was to penalize insurers for resisting and delaying payment unless good cause was shown. Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745 (1979), answer conformed to, 150 Ga. App. 883, 258 S.E.2d 655 (1979).

Denying penalty because evidence would support verdict for insurer is incorrect. — The rule that a finding of bad faith is not authorized if the evidence would have supported a verdict in accordance with the contentions of the defendant is incorrect. Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745 (1979), answer conformed to, 150 Ga. App. 883, 258 S.E.2d 655 (1979).

Former rule. — Where the jury would have been authorized, under the evidence, to have found that the insured came to his death by reason of riding or operating a motorcycle, in which case his death would have been covered by the policy, or that the insured did not so come to his death, the plaintiff failed to prove bad faith on the part of the defendant in refusing to pay. Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949).

Prior to 1979 it was held that if the evidence could be said to have authorized a finding in accordance with the contentions of the defendant, a finding of bad faith was not authorized. Lincoln Life Ins. Co. v. Anderson, 109 Ga. App. 238, 136 S.E.2d 1 (1964); Old Colony Ins. Co. v. Dressel, 109 Ga. App. 465, 136 S.E.2d 525, aff'd, 220 Ga. 354, 138 S.E.2d 886 (1964); United States Fid. & Guar. Co. v. Woodward, 118 Ga. App. 591, 164 S.E.2d 878 (1968); Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970); Phillips v. State Farm Mut. Auto. Ins. Co., 437 F.2d 365 (5th Cir. 1971); Boston-Old Colony Ins. Co. v. Warr, 127 Ga. App. 364, 193 S.E.2d 624 (1972).

At the time of the trial the insurer has the right to show good faith in refusing to pay in reply to the plaintiff's charge and evidence that the refusal was in bad faith. Interstate Life & Accident

Ins. Co. v. Williamson, 220 Ga. 323, 138 S.E.2d 668, answer conformed to, 110 Ga. App. 557, 139 S.E.2d 429 (1964).

Insurer's judgment on former trial not evidence of good faith without record. — A verdict and judgment in the insurer's favor on a former trial, without the aid of the record of the trial in which the verdict was returned and the judgment entered, would constitute no proof that the defense interposed by the insurer on the former trial was upon probable cause or made in good faith. Reserve Life Ins. Co. v. Peavy, 98 Ga. App. 268, 105 S.E.2d 465 (1958).

The faith of an insurance company should not be judged by the preliminary proofs or other ex parte affidavits, but by the case made at the trial. Interstate Life & Accident Ins. Co. v. Williamson, 110 Ga. App. 557, 139 S.E.2d 429 (1964).

Questions can only be determined by admissible evidence. — The question of good or bad faith on the part of the insurance company in refusing to make payment to the beneficiary can only be determined from evidence that is relevant and admissible for a determination of the case on its merits. New York Life Ins. Co. v. Ittner, 59 Ga. App. 89, 200 S.E. 522 (1938), later appeal, 62 Ga. App. 31, 8 S.E.2d 582 (1940).

Evidence of cancellation of insurance held inadmissible. — Where, in an action on a policy of insurance for the loss, by fire, or an automobile insured thereunder, the plaintiff seeks to recover the value of the automobile, attorney's fees, and the statutory penalty for bad faith, under this section, it is such error as to require the grant of a new trial to permit the introduction of evidence, for the purpose of demonstrating bad faith, that some ten and one-half months after the loss and some five months after the commencement of action to recover for the loss of the automobile, the insurer, without denying liability for the loss of the automobile, canceled the insurance for the unexpired term. Calvert Fire Ins. Co. v. Mack, 88 Ga. App. 617, 76 S.E.2d 829 (1953).

Failure to prove any defense is evidence of bad faith. — The complete failure of the insurer to prove any defense to an action on the policy is evidence of the bad faith contemplated by this section and subjects the insurer to a verdict for the statutory penalty and attorney's fees. Reserve Life Ins. Co. v. Ayers, 217 Ga. 206, 121 S.E.2d 649 (1961); Hanover Ins. Co. v. Hallford, 127 Ga. App. 322, 193 S.E.2d 235 (1972); Key Life Ins. Co. v. Mitchell, 129 Ga. App. 192, 198 S.E.2d 919 (1973); Cincinnati Ins. Co. v. Gwinnett Furn. Mart, Inc., 138 Ga. App. 444, 226 S.E.2d 283 (1976).

When no evidence substantiates pled defense, bad faith may be found. — When the insurer introduced no evidence in explanation of its varied changes of position in its defenses to an action by the beneficiary, and the answers to such questions as to whether the policy had been issued, the application approved, and the premium paid, were certainly within its knowledge or easily ascertainable, and when the insurer had ample time to investigate and establish some basis, if basis there was, for its contention that the applicant insured had misrepresented his use of intoxicants on the application, but failed to do so, the jury was authorized to find that the insurer's refusal to pay the loss covered by the contract of insurance was in bad faith. National Life & Accident Ins. Co. v. Moore, 86 Ga. App. 618, 72 S.E.2d 141 (1952).

Where the insurance company pleaded that the policy was obtained by fraud on the part of the plaintiff and there was no evidence introduced on the trial of the case to substantiate this, the jury was authorized to find for the plaintiff on the issue raised by the pleadings that the insurance company's failure to pay the loss was in "bad faith." Guaranty Life Ins. Co. v. Brown, 92 Ga. App. 847, 90 S.E.2d 97 (1955).

Where the insured notified the insurer that he had not received a premium due notice after discovering that the insurer had cancelled his policy, and the insurer could produce nothing from its records showing that it had sent the notice and continued to refuse to pay the insured's claim, the jury was authorized to find bad faith on the part of the insurer. State Farm Mut. Auto. Ins. Co. v. Drury, 222 Ga. App. 196, 474 S.E.2d 64 (1996).

Procedure (Cont'd)
2. Burden of Proof and Evidence (Cont'd)

Refusal to adjust or pay any loss evidences bad faith. — Refusal upon the part of the insurance company to adjust or pay for any loss or damage claimed, after having received notice of loss and demand for payment, constitutes evidence of bad faith in an action based upon this section. Central Mfrs. Mut. Ins. Co. v. Graham, 24 Ga. App. 199, 99 S.E. 434 (1919).

A failure upon the part of the insurance company to investigate the alleged loss or damage and a denial upon the part of the company of any liability whatsoever upon the ground that such loss or damage was not recoverable under the policy, but arose from some cause not covered by the policy, may be considered as evidence of bad faith. Central Mfrs. Mut. Ins. Co. v. Graham, 24 Ga. App. 199, 99 S.E. 434 (1919).

Refusal to pay until other claimant is satisfied. — Where the agents of a life insurance company show active sympathy with one who claims the proceeds of a policy, against the legal representative of the insured, and refuse to pay any part of the proceeds until such claimant is satisfied, although such claim is for a portion only, it is evidence of bad faith, in the meaning of this section, and the company may be proceeded against for 25 percent damages and counsel fees. Mutual Life Ins. Co. v. Watson, 30 F. 653 (S.D. Ga. 1887).

Evidence that burglary charges were pending against the insured and that he had been released on bond at the time of the fires was admissible where presented in a noninflammatory manner by the insurance company which was defending against the insured's claim of bad-faith denial of coverage, such evidence being admissible to prove the insured's poor financial condition and therefore falling within a specific exception to the federal rule prohibition on use of evidence of other crimes. Aetna Cas. & Sur. Co. v. Gosdin, 803 F.2d 1153 (11th Cir. 1986).

Evidence held to show bad faith. — Where a policy of fire insurance contains a stipulation that "the assured is the sole and undisputed owner, absolutely in fee simple, of the land on which the insured buildings stand, unless it is otherwise expressed in writing hereon," and where in the same policy it is provided that "privilege is granted for any of the above-described buildings to stand on leased ground, or ground the property of others, or upon ground to which the title may be questioned," and where the evidence shows that, at the time application for insurance was made, the insurance company, through its solicitor or agent, knew that the applicant did not own the land on which the building sought to be insured was situated, the jury is authorized to find for the insured damages and attorney's fees. Globe & Rutgers Fire Ins. Co. v. Walker, 150 Ga. 163, 103 S.E. 407 (1920).

The insurer's denial of the existence of the policy, and denial of the payment of premiums thereon, up to and including the trial and until the premium receipt book was shown in court by the beneficiary, was sufficient basis for the trial judge to find that the insurer acted in "bad faith." Interstate Life & Accident Ins. Co. v. Hopgood, 133 Ga. App. 6, 209 S.E.2d 703 (1974).

Where the evidence supported a finding that the insurer alternately led the insured and his daughter, who inquired frequently about the status of their claim, to believe that the claim would be paid, and thus lulled them into forbearing suit to protect their interests, the jury was authorized to award plaintiffs bad faith penalties and attorney fees. Republic Ins. Co. v. Martin, 182 Ga. App. 390, 355 S.E.2d 694 (1987).

Even assuming that investigation of the insured's fire loss led to some delay, the insured was not notified of it nor of the insurer's desire to rebuild rather than pay under the policies' limits until seven months after the fire. This time lag and the extent of the insurer's offer were evidence supporting a bad faith finding. Southern Ins. Underwriters, Inc. v. Ray, 188 Ga. App. 469, 373 S.E.2d 236, cert. denied, 188 Ga. App. 912, 373 S.E.2d 236 (1988).

Evidence was sufficient to support a

finding of bad faith and an award of attorney's fees where the defendant insurer failed to follow industry procedures for contesting coverage and failed to maintain proper reserves to pay claims, the president of the defendant insurer admitted that he used the insurer's funds for himself, and the defendant insurer failed to investigate any of the plaintiff's medical bills for over 4 years and never attempted to verify some of them. American Ass'n of Cab Cos. v. Olukoya, 233 Ga. App. 731, 505 S.E.2d 761 (1998).

Evidence held not to show bad faith. — In an action to recover upon a fire insurance policy for damage to personal property such as a piano, caused by fire, where the defendant denies liability under the policy, and where it appears from the evidence that after the damage to the property the plaintiff contended that although the property was not totally destroyed it was nevertheless a total loss and that the property could not be restored by being repaired, and where the defendant contended that the property was not a total loss but could be repaired, and offered to repair the property in compliance with a provision of the policy that the defendant had an option to repair the property, the evidence is insufficient to authorize an inference that the defendant's refusal to pay the loss was in bad faith. National Fire Ins. Co. v. Shuman, 50 Ga. App. 846, 178 S.E. 758 (1935).

Where it appears that the defendant insurance company, prior to the commencement of the action, offered to pay the plaintiff the full amount to which the plaintiff was entitled under the provisions of the policy, and that the plaintiff refused to accept said sum, there was no evidence of bad faith on the part of the company, nor a refusal to pay the amount due under the provisions of the policy, and the judgment in favor of the plaintiff against the defendant for attorney's fees was unauthorized. Life & Cas. Ins. Co. v. McLeod, 70 Ga. App. 181, 27 S.E.2d 871 (1943).

As a title insurer did not deny coverage; hired an appraiser to evaluate the insureds' loss; and tendered the insureds a check based on that evaluation, which the insureds' rejected, the trial court was entitled to find that the insurer did not act in bad faith. Jimenez v. Chi. Title Ins. Co., 310 Ga. App. 9, 712 S.E.2d 531 (2011).

Evidence as to amount of attorney's fee. — The evidence of what amount of counsel fee would be reasonable should be confined to a certain fee, and inquiry should not extend to a conditional fee, in the particular case. Nor can any estimate be made to cover future litigation by motion for a new trial, writ of error, etc., there being no certainty that such future litigation will occur. If witnesses estimate fees on a basis which is too comprehensive, or on a misconception as to what the nature of the case involves, they should be requested on cross-examination to eliminate the superfluous elements and correct their estimates accordingly. Travelers Ins. Co. v. Sheppard, 85 Ga. 751, 12 S.E. 18 (1890).

Similar transaction evidence on failure to pay. — Trial court did not abuse the court's discretion in ruling that a widow could not introduce evidence of an insurer's conduct towards insureds in two prior cases in which the court refused to honor incontestability clauses to demonstrate bad faith because the trial court was entitled to find that the prior cases were materially dissimilar from the widow's case, given that neither of those cases involved coverage under the group policy at issue and the revisions to the certificate of insurance forms made that year. Flynt v. Life of the South Ins. Co., 312 Ga. App. 430, 718 S.E.2d 343 (2011), cert. denied, No. S12C0461, 2012 Ga. LEXIS 305 (Ga. 2012).

3. Questions for Jury or Court

Jury decides if insurer has given proper consideration to insured's interest in settlement. — In deciding whether to accept an offer of settlement within policy coverage the insurer must accord the interest of its insured the same faithful consideration it gives its own interest, and it is for the jury to decide whether the insurer has or has not so acted. Great Am. Ins. Co. v. Exum, 123 Ga. App. 515, 181 S.E.2d 704 (1971).

Bad faith is usually a jury question. Liberty Mut. Ins. Co. v. Atlantic C.L.R.R., 66 Ga. App. 826, 19 S.E.2d 377 (1942); American Cas. Co. v. Callaway, 75 Ga.

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3. Questions for Jury or Court (Cont'd)

App. 799, 44 S.E.2d 400 (1947); Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949), for comment, see 12 Ga. B.J. 337 (1950); Life & Cas. Ins. Co. v. Brown, 95 Ga. App. 354, 98 S.E.2d 68, rev'd on other grounds, 213 Ga. 390, 99 S.E.2d 98 (1957); Jackson v. Motors Ins. Corp., 97 Ga. App. 658, 104 S.E.2d 253 (1958); American Family Life Assurance Co. v. United States Fire Co., 885 F.2d 826 (11th Cir. 1989).

Jury should determine bad faith. — Whether there was such bad faith as would authorize the recovery of attorney's fees, was, under the facts of this case, a question for the jury. Continental Aid Ass'n v. Hand, 22 Ga. App. 726, 97 S.E. 206 (1918).

Where plaintiff submitted proof of disability and defendant insurance company waited six months and then refused payment, it was a question for the jury to determine whether the refusal to pay was in bad faith or not and whether the plaintiff was entitled to recover damages and attorney's fees. Liner v. Travelers Ins. Co., 50 Ga. App. 643, 180 S.E. 383 (1935).

It is usually a question for the jury whether an insurance company, in refusing to pay, acted in bad faith and thereby subjected itself to the penalty and attorney's fees as provided by this section. New York Life Ins. Co. v. Williamson, 53 Ga. App. 28, 184 S.E. 755 (1936); Glens Falls Indem. Co. v. Gottlieb, 76 Ga. App. 70, 44 S.E.2d 706 (1947); Guaranty Life Ins. Co. v. Brown, 92 Ga. App. 847, 90 S.E.2d 97 (1955); Millers Nat'l Ins. Co. v. Waters, 97 Ga. App. 103, 102 S.E.2d 193 (1958).

Whether or not the defendant acted in bad faith in stopping disability payments and in refusing to continue them was for the jury. New York Life Ins. Co. v. Bradford, 57 Ga. App. 657, 196 S.E. 92 (1938).

Ordinarily, questions of an insurer's bad faith in refusing to pay a claim for the jury. Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E.2d 227 (1946).

Bad faith is a question for the jury to pass on, and it may arise from the facts and circumstances of the case, that is, from the whole complexion of the case as presented to the jury. North British & Mercantile Ins. Co. v. Mercer, 90 Ga. App. 143, 82 S.E.2d 41, aff'd, 211 Ga. 161, 84 S.E.2d 570 (1954).

In an action to recover benefits for total disability under the provisions of an insurance policy where the insurer presents no evidence and relies in defense solely on the undisputed facts as brought out by the insured and his witnesses on direct and cross-examination as the basis of its refusal to make total disability payments, and such facts, upon application of long-standing decisions of the Supreme Court, seemingly afford no substantial basis for regarding the insured as other than totally disabled, it is not error to submit the issue of bad faith and attorney's fees to the jury, and a verdict for attorney's fees is not unauthorized as a matter of law. Travelers Ins. Co. v. Stanley, 117 Ga. App. 445, 160 S.E.2d 876 (1968).

If, at trial, the plaintiff presents evidence showing the insurance company's bad faith and the company's defense meets the "reasonable and probable cause" standard, the question of bad faith must be submitted to the jury for final resolution. Colonial Life & Accident Ins. Co. v. McClain, 144 Ga. App. 201, 240 S.E.2d 759 (1977); Colonial Life & Accident Ins. Co. v. McClain, 150 Ga. App. 883, 258 S.E.2d 655 (1979).

The question of bad faith is for the jury unless it can be said that as a matter of law there was a reasonable defense which vindicates the insurer's good faith. St. Paul Fire & Marine Ins. Co. v. Snitzer, 183 Ga. App. 395, 358 S.E.2d 925 (1987).

Trial court did not err in denying the insured's motion for summary judgment on the issue of whether the insured was entitled to bad faith penalties under O.C.G.A. § 33-4-6 for the insurer's refusal to pay its vandalism claim because there were disputed questions of fact as to whether the insured sufficiently cooperated with the investigation of the vandalism claim, and thus whether the insured breached the insurance policy and was barred from recovery on that basis. R&G Invs. & Holdings, LLC v. Am. Family Ins. Co., 337 Ga. App. 588, 787 S.E.2d 765 (2016), cert. denied, No. S16C1830, 2017

Ga. LEXIS 144 (Ga. 2017).

Bad faith not a question of law. — The question of bad faith is a question for the jury and not a question of law. National Cas. Co. v. Tanner, 100 Ga. App. 618, 112 S.E.2d 232 (1959).

Bad faith issue not subject to motion for directed verdict. — The existence of bad faith is a jury question and not subject to a motion for a directed verdict. Atlantic Am. Life Ins. Co. v. Morris, 144 Ga. App. 577, 241 S.E.2d 463 (1978).

Unless no evidence of bad faith is introduced. — If there is no evidence of a frivolous or unfounded refusal to pay, the court, for the furtherance of justice, should see to it that a verdict which illegally carries a penalty for bad faith is not allowed to stand. Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E.2d 227 (1946); Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949). For comment, see 12 Ga. B.J. 337 (1950).

Where no evidence of bad faith is introduced, the issue should not be presented to the jury, and an award under this section is unjustified. Interstate Life & Accident Ins. Co. v. Brown, 146 Ga. App. 622, 247 S.E.2d 205 (1978).

Prior to 1979 defense authorizing verdict for insurer made bad faith question for court. — Where the defense presented by the defendant insurance company, if believed, would authorize a verdict for it, the issue of "bad faith" in refusing to pay the claim should not be submitted to the jury. Hermitage Health & Life Ins. Co. v. Baggs, 115 Ga. App. 138, 154 S.E.2d 270 (1967).

Where the evidence adduced showed a reasonable and probable cause for denial of a claim, it was error to submit the issue of bad faith to the jury. Witt v. Pennsylvania Nat'l Mut. Cas. Ins. Co., 117 Ga. App. 838, 162 S.E.2d 251 (1968).

If question of liability close. — If the question of liability was a close one, the court had to see to it that a verdict illegally carrying a penalty for bad faith was not allowed to stand. Pearl Assurance Co. v. Nichols, 73 Ga. App. 452, 37 S.E.2d 227 (1946); Life & Cas. Ins. Co. v. Freemon, 80 Ga. App. 443, 56 S.E.2d 303 (1949), for comment, see 12 Ga. B.J. 337 (1950).

Justiciable controversy was presented. — Where the evidence adduced presented a justiciable controversy, the trial judge was authorized to conclude that there was a reasonable ground for contesting the claim so as to remove the issue from the jury and direct a verdict for the insurer. Ware v. Nationwide Mut. Ins. Co., 140 Ga. App. 660, 231 S.E.2d 556 (1976); Smith v. New York Life Ins. Co., 579 F.2d 1267 (5th Cir. 1978).

Former rule was held incorrect by Supreme Court in 1979. — The rule that a finding of bad faith is not authorized if the evidence would have supported a verdict in accordance with the contentions of the defendant is incorrect. Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745, answer conformed to, 150 Ga. App. 883, 258 S.E.2d 655 (1979).

In any case, jury is not required if not demanded. — It was not error for the judge, sitting without a jury, to render judgment for damages and attorney's fees under this section as well as for the amount stated in the face of the insurance policy, the case being in default, and no jury having been demanded. Great E. Cas. Co. v. Haynie, 147 Ga. 119, 92 S.E. 939 (1917).

Bad faith to be judged by case made at trial. — The trial court erred in awarding summary judgment to an insurance company as to liability for bad-faith damages and attorney fees, as the issue of bad faith should be judged by the case made at trial, not by preliminary proofs or other ex parte affidavits. Stegall v. Guardian Life Ins. Co. of Am., 171 Ga. App. 576, 320 S.E.2d 575 (1984).

The issue of bad faith should be judged by the case made at trial, not by the preliminary proofs or other ex parte affidavits. Blue Ridge Ins. Co. v. Maddox, 185 Ga. App. 153, 363 S.E.2d 595, cert. denied, 185 Ga. App. 909, 363 S.E.2d 595 (1987).

Summary judgment held improper. — When the evidence of record did not establish as a matter of law that the insurer acted reasonably in refusing to honor the insured's claim, the trial court erred in granting the insurer summary judgment on a claim for a bad-faith penalty and attorney fees. Travillian v. Geor-

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3. Questions for Jury or Court (Cont'd)

gia Farm Bureau Mut. Ins. Co., 182 Ga. App. 241, 355 S.E.2d 677 (1987).

Insurer's summary judgment motion denied even though reasonable factual dispute. — Insurer's motion for summary judgment on plaintiff's claim of bad faith penalties and attorney's fees was denied even though a reasonable dispute existed as to whether arson destroyed plaintiff's property since the faith of the company should not be judged by the preliminary proofs or other ex parte affidavits but at the case made at trial. Forbus v. Allstate Ins. Co., 603 F. Supp. 113 (N.D. Ga. 1984).

Summary judgment to insurer proper following theft by computer virus. — As an insurance coverage dispute arose from a theft of the insured's account by a key-logger virus, summary judgment was properly granted to the insurer on the insured's breach of contract and bad faith claims because the loss was within the policy's malicious-code exclusion. Metro Brokers, Inc. v. Transp. Ins. Co., No. 14-12969, 2015 U.S. App. LEXIS 3473 (11th Cir. Mar. 5, 2015) (Unpublished).

Amount of penalties and attorney fees a jury question. — Trial court erred in determining the amount of bad faith penalties and attorney fees against an insured under O.C.G.A. § 33-4-6 because it was premature in determining the amount of the penalty without first submitting it to a jury as required by § 33-4-6(a). Transp. Ins. Co. v. Piedmont Constr. Group, LLC, 301 Ga. App. 17, 686 S.E.2d 824 (2009), cert. denied, No. S10C0507, 2010 Ga. LEXIS 312 (Ga. 2010).

Jury trial on attorney fees and expenses not error. — Although O.C.G.A. § 33-4-6 sets forth the exclusive remedy for bad faith denial of insurance benefits so that litigation expenses under O.C.G.A. § 13-6-11 are not recoverable, a trial court did not commit any reversible error by ordering a jury trial on issues relating only to attorney fees and not other litigation expenses. Atl. Title Ins. Co. v. Aegis Funding Corp., 287 Ga. App. 392, 651 S.E.2d 507 (2007), cert. denied, No. S08C0137, 2008 Ga. LEXIS 107 (Ga. 2008).

4. Instructions

Charge on bad faith required when in issue. — Where the issue of bad faith is raised by the pleadings and supported by the evidence, it is the duty of the court to charge the jury the law relative to such issue. Templeton v. Kennesaw Life & Accident Ins. Co., 216 Ga. 770, 119 S.E.2d 549 (1961).

Request for charge is necessary. — In the absence of a timely written request, it was not error for a trial court to charge this section without defining the term "bad faith" as applied to insurance companies. Hanover Fire Ins. Co. v. Elrod, 91 Ga. App. 403, 85 S.E.2d 821 (1955).

Charge is properly given where insurer made low offer. — Where the defendant had offered the plaintiff less than 75 cents on the dollar of the lowest estimate proved on the trial of the case and this estimate did not include certain repairs claimed to be necessary by the plaintiff and which the witness making the estimate did not include because he did not know whether they were necessary or not, it cannot be said that a charge complained of, authorizing the jury to award attorney's fees and damages as provided in this section, was error when the complaint was based on there being no evidence of bad faith. Fidelity & Cas. Co. v. Mangum, 102 Ga. App. 311, 116 S.E.2d 326 (1960).

The court errs in charging that the plaintiff would be entitled to recover the penalty merely on proof of refusal and regardless of whether bad faith had been proved to the satisfaction of the jury. Reserve Life Ins. Co. v. Gay, 96 Ga. App. 601, 101 S.E.2d 158 (1957), rev'd on other grounds, 214 Ga. 2, 102 S.E.2d 492 (1958).

Charge on section improper where insurer had reasonable ground to deny liability. — Where the defenses relied on by the insurance company cannot justly be said to be frivolous or obviously without merit, the court is not authorized to give in charge to the jury any instructions whatsoever with regard to

the assessment of damages and attorney's fees against the company. Morris v. Imperial Ins. Co., 106 Ga. 461, 32 S.E. 595 (1899).

Where the defendant insurer had reasonable ground for denying liability, charge relative to attorney fees was error. Gulf Life Ins. Co. v. Moore, 90 Ga. App. 791, 84 S.E.2d 696 (1954).

If there is any reasonable ground for the insurer to contest the claim, there is no bad faith, and it is error for the trial court to charge the jury under this section that they may return a verdict for penalties and attorney's fees. Dependable Ins. Co. v. Gibbs, 218 Ga. 305, 127 S.E.2d 454 (1962); Pioneer Nat'l Title Ins. Co. v. American Cas. Co., 459 F.2d 963 (5th Cir. 1972).

Charge on section held of proper scope. — Where the court charged this section and defined the meaning of the term "bad faith" as used in the section, and then clearly instructed the jury that they would have to find by a preponderance of the evidence that the failure and refusal to make payment was on account of bad faith on the part of the insurance company before it would be liable for damages or attorney's fees, and that if the company did not act in bad faith, the insured could not recover either damages or attorney's fees, the charge was not error. Palatine Ins. Co. v. Gilleland, 79 Ga. App. 18, 52 S.E.2d 537 (1949).

Charge as to waiving proof of loss harmless if liability admitted. — Where the defendant's answer admitted liability in a lesser amount than the plaintiff claimed, a charge with reference to waiving a proof of loss was, if error, harmless, for the admission of some liability waived the technical requirements of a proof of loss. Fidelity & Cas. Co. v. Mangum, 102 Ga. App. 311, 116 S.E.2d 326 (1960).

Jury bound to observe restrictive instructions on considering evidence. — Where instructions are given to consider certain exhibits in regard to the question of bad faith, the jury is bound to consider such evidence solely for that restricted purpose. Hermitage Health & Life Ins. Co. v. Baggs, 115 Ga. App. 138, 154 S.E.2d 270 (1967).

5. Verdict and Judgment

An assessment of penalties is not a condition precedent to an award of attorney fees. Hardin v. Fireman's Fund Ins. Co., 150 Ga. App. 277, 257 S.E.2d 300 (1979).

Award of attorney's fees. — That the jury awarded fees without also awarding damages of 25 percent or less, as provided for in this section, is no ground for setting aside their finding as to the attorney's fees. Continental Aid Ass'n v. Hand, 22 Ga. App. 726, 97 S.E. 206 (1918).

Since this section does not require that penalty damages be paid, but merely limits the amount of liability, such an award is not a condition precedent to the award of reasonable attorney's fees. American Reliable Ins. Co. v. Woodward, 143 Ga. App. 652, 239 S.E.2d 543 (1977).

Verdict denying damages for bad faith bars award of attorney's fees. — The language used in a verdict, that "we, the jury, do not award any damages to the plaintiff for bad faith on the part of the defendant," nullifies that part of the jury's verdict awarding attorney's fees. Union Cent. Life Ins. Co. v. Cofer, 103 Ga. App. 355, 119 S.E.2d 281 (1961).

The award of attorney's fees is not authorized where the verdict states, "we, the jury, do not award any damages to the plaintiff for bad faith on the part of the defendant." Hardin v. Fireman's Fund Ins. Co., 150 Ga. App. 277, 257 S.E.2d 300 (1979).

Award of damages in absence of finding of bad faith was error. — In a widow's suit against an insurer for failing to pay benefits under a life insurance policy, because the jury found the insurer was not guilty of bad faith in its refusal to pay these benefits but awarded the widow additional damages, the additional damages award was not authorized under O.C.G.A. § 33-4-6(a) because a finding of the insurer's bad faith was a condition precedent to such an award and there was no other authority for awarding additional damages for an insurer's failure to pay. Cherokee Nat'l Life Ins. Co. v. Eason, 276 Ga. App. 183, 622 S.E.2d 883 (2005).

Part of verdict awarding penalty and attorney's fees properly written off if without evidence. — Where the

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5. Verdict and Judgment (Cont'd)

evidence demands a finding that the insurance company did not act in bad faith in refusing to pay the claim, it is proper to write off that part of the verdict awarding a penalty and attorney's fees, where the verdict is otherwise supported by the evidence. Jackson v. Motors Ins. Corp., 97 Ga. App. 658, 104 S.E.2d 253 (1958).

Pleadings not amended after judgment to allow claims for statutory damages. — After obtaining a judgment in its favor against uninsured motorist, the motorist could not amend pleadings to add claims for statutory damages, through O.C.G.A. §§ 33-4-6 and 33-7-11, even though the judgment in the action in the motorist's favor held that the penalties and fees sought must be sought in an action against an uninsured motorist, because the trial court determined the court lacked authority to reopen the case after the judgment to allow amendment of the complaint. McCall v. Wyman, 173 Ga. App. 131, 325 S.E.2d 629 (1984).

Modification of order denying attorney's fees not authorized. — When the trial court determined as a matter of law that there was no claim under an insurance policy, there could be no recovery of attorney's fees under O.C.G.A. § 33-4-6, and the court was without power to modify the court's order denying an attorney's fees award to plaintiff after the term of court expired in which that order was made. State Farm Mut. Auto. Ins. Co. v. Johnson, 242 Ga. App. 591, 530 S.E.2d 492 (2000).

6. Appeal

Damages and attorney's fees part of amount involved for appeal from justice of peace. — In an action in a justice of the peace court, where the plaintiff, as a beneficiary in a life insurance policy, brought suit against the insurer to recover in the sum of $30.00, representing the amount due the plaintiff under the terms of the policy, $7.50 representing 25 percent of the amount sued for as damages, and $50.00 representing reasonable attorney's fees as provided in this section, which authorizes a recovery for damages and attorney's fees where the insurer has acted in bad faith in failing to pay the amount due under a policy within the required time, the amount sued for and claimed in the suit was in excess of $50.00, for purposes of appeal. Tate v. Industrial Life & Health Ins. Co., 58 Ga. App. 305, 198 S.E. 303 (1938).

Only damages counted in appeal from Civil Court of Fulton County. — The penalty allowable under this section where sued for is considered as part of the amount involved in the action in determining if appeal lies from Civil Court of Fulton County to Court of Appeals. General Assurance Corp. v. Roberts, 92 Ga. App. 834, 90 S.E.2d 70 (1955).

Attorney's fees excluded from amount involved. — The attorney's fees allowable under this section are not part of the "amount involved" in an action in the Civil Court of Fulton County. General Assurance Corp. v. Roberts, 92 Ga. App. 834, 90 S.E.2d 70 (1955).

Insured's verdict not disturbed if any evidence supports it. — The question as to whether or not an insurance company acted in bad faith in refusing to pay a loss, where the evidence was conflicting but sufficient to support either a verdict for or against the insurer, was a question solely for the jury, and the Court of Appeals cannot say as a matter of law that its finding of bad faith was not authorized. Hanover Fire Ins. Co. v. Elrod, 91 Ga. App. 403, 85 S.E.2d 821 (1955).

In reviewing the determination of the issue of whether an insurer's refusal to pay is frivolous and unfounded, if there is some evidence to support the verdict of the trial court in favor of the insured, it will not be disturbed. National-Ben Franklin Ins. Co. v. Prather, 109 Ga. App. 459, 136 S.E.2d 499 (1964).

Proper rule is that a judgment for "bad faith" penalties and attorney's fees should be affirmed if there is any evidence to support it unless it can be said as a matter of law that there was a reasonable defense which vindicates the good faith of the insurer. Progressive Cas. Ins. Co. v. Avery, 165 Ga. App. 703, 302 S.E.2d 605 (1983); Republic Ins. Co. v. Martin, 182 Ga. App. 390, 355 S.E.2d 694 (1987); First Fin. Ins. Co. v. American Sandblast-

ing Co., 223 Ga. App. 232, 477 S.E.2d 390 (1996).

Unless as matter of law reasonable defense vindicates good faith of insurer. — Judgment for the insured should be affirmed if there is any evidence to support it, unless it can be said as a matter of law that there was a reasonable defense which vindicates the good faith of the insurer. Colonial Life & Accident Ins. Co. v. McClain, 243 Ga. 263, 253 S.E.2d 745, answer conformed to, 150 Ga. App. 883, 258 S.E.2d 655 (1979); State Farm Fire & Cas. Co. v. Mills Plumbing Co., 152 Ga. App. 531, 263 S.E.2d 270 (1979); State Farm Mut. Auto. Ins. Co. v. Chadwick, 154 Ga. App. 394, 268 S.E.2d 436 (1980); Canal Ins. Co. v. Bryant, 166 Ga. App. 483, 304 S.E.2d 565 (1983).

Judgment to be affirmed absent defense indicating good faith of insurer. — The judgment should be affirmed if there is any evidence to support it unless it can be said as a matter of law that there was a reasonable defense which vindicates the good faith of the insurer. Georgia Int'l Life Ins. Co. v. Harden, 158 Ga. App. 450, 280 S.E.2d 863 (1981).

Award of attorney's fees not disturbed if within range of evidence as to value. — Where loss is covered by the insurance policy and the insurer has refused to pay within 60 days after a demand has been made, an award of attorney's fees is not unauthorized as a matter of law; and an appellate court will not disturb the findings and judgment thereon when the award is within the range of evidence as to the reasonable value thereof. American Reliable Ins. Co. v. Woodward, 143 Ga. App. 652, 239 S.E.2d 543 (1977).

Penalty part of verdict will be written off if defendant acquitted of bad faith. — Where the questions of law made in a case were of such character as to acquit the defendant of bad faith in refusing to pay the loss within the time limited by law, the Supreme Court will direct that, upon or before the entering of the remittitur, the plaintiff shall write off the items allowed for attorney's fees and damages in the finding of the jury and that the verdict thereupon will stand affirmed. Phenix Ins. Co. v. Clay, 101 Ga. 331, 28 S.E. 853, 65 Am. St. R. 307 (1897).

Defendant having judgment modified is entitled to cost of appeal. — Where there was no evidence to authorize a verdict for attorney's fees under this section, this will not require a reversal, but direction will be given to write off the attorney's fees, and the defendant, having obtained a material modification of the judgment of the court below, is entitled to the cost of bringing the case to the Supreme Court. Empire Life Ins. Co. v. Allen, 141 Ga. 413, 81 S.E. 120 (1914).

Modification of penalty award when refusal not unfounded as to one claim. — In action to recover double indemnity benefits for alleged accidental death of insured, where jury found in favor of the plaintiff and awarded penalty and attorney's fees against the insurer, the appellate court would divide the penalty and attorney's fees as between the death benefit claim and the double indemnity claim, and direct a write-off of one-half this amount, where the refusal of the insurer to pay the double indemnity benefit did not appear to be frivolous or unfounded. Progressive Life Ins. Co. v. Smith, 71 Ga. App. 157, 30 S.E.2d 411 (1944).

Finding evidence insufficient to show bad faith does not necessarily modify judgment. — A finding by the appellate court that the evidence was insufficient to show bad faith is not necessarily a modification of the original judgment. National-Ben Franklin Fire Ins. Co. v. Darby, 48 Ga. App. 394, 172 S.E. 819 (1934).

Modifying award of fees set in notes modifies original judgment. — Attorney's fees in notes are fees which arise by contract, and a modification of a judgment awarding such fees is a modification of the judgment on the original contract. National-Ben Franklin Fire Ins. Co. v. Darby, 48 Ga. App. 394, 172 S.E. 819 (1934).

Judgment on appeal reversed where not supported by record. — Where the Court of Appeals ruled that there was support in the record for determining that the insurer has followed a strained interpretation of its contract by always paying only the lesser amount, but

Procedure (Cont'd)
6. Appeal (Cont'd)

nothing in the record supports the ruling of the Court of Appeals that the insurance company has followed any particular practice with reference to the payment of the claims of other persons under the policy, the resulting judgment of the Court of Appeals as to penalties and attorney's fees will be reversed. Guarantee Trust Life Ins. Co. v. Davis, 244 Ga. 541, 261 S.E.2d 336 (1979).

Reversal on "bad faith" penalties and attorney's fees does not affect underlying award. — When the only error in the case is the award of "bad faith" penalties and attorney's fees, the judgment will be affirmed with direction that the portion thereof awarding such penalties and attorney's fees be written off. Progressive Cas. Ins. Co. v. Avery, 165 Ga. App. 703, 302 S.E.2d 605 (1983).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, §§ 107, 108.

Am. Jur. Trials. — Actions Against Insurer for Bad Faith Failure to Settle Claim, 21 Am. Jur. Trials 229.

C.J.S. — 46A C.J.S., Insurance, §§ 2166 et seq., 2169 et seq.

ALR. — Validity of statutory provision for attorneys' fees, 90 A.L.R. 530.

Remedy and measure of recovery where insurer breaches its contract to pay indemnity periodically, 99 A.L.R. 1171.

Validity, construction, and effect of statutory or policy provisions which give injured or damaged person right of action against insurer in respect of indemnity or liability insurance voluntarily carried, 106 A.L.R. 516.

What persons or corporations, contracts or policies, are within statutory provisions allowing recovery of attorney's fee penalty against insurance companies or against companies dealing in specified kinds of insurance, 126 A.L.R. 1439.

Refusal of automobile liability or indemnity insurer to assume defense of action against insured upon ground that claim upon which action is based is not within coverage, 133 A.L.R. 1516; 49 A.L.R.2d 694; 50 A.L.R.2d 458.

Effect of insurer's wrongful rejection of insured's claim under disability clause of life policy, 140 A.L.R. 781.

Compromise by insured as affecting right to recover against liability or indemnity insurer, either where claim exceeds limit of liability under policy, or where insurer denies liability on policy, refuses to defend, or otherwise delays taking action, 142 A.L.R. 809.

Necessity and sufficiency, or waiver, of demand as a condition of statutory liability of insurer for failure to pay delay in paying loss, 145 A.L.R. 343.

Liability of insurer based upon its act of withdrawal after assumption of defense, 167 A.L.R. 243.

Remedies of insured other than direct action on policy where fire or other property insurer refuses to comply with policy provisions for appointment of appraisers to determine amount of loss, 44 A.L.R.2d 850.

Consequences of liability insurer's refusal to assume defense of action against insured upon ground that claim upon which action is based is not within coverage of policy, 49 A.L.R.2d 694; 50 A.L.R.2d 458.

Insurer's liability under accident policy which terminated after accidental injury but prior to completion of medical treatment, hospitalization, and the like, 75 A.L.R.2d 876.

Liability insurer's liability for interest and costs on excess of judgment over policy limit, 76 A.L.R.2d 983.

Insurer's liability as affected by refusal of public authorities to permit reconstruction or repair after fire, 90 A.L.R.2d 790.

What constitutes "trial," "final trial," or "final hearing" under statute authorizing allowance of attorneys' fees as costs on such proceeding, 100 A.L.R.2d 397.

Beneficiary's ignorance of existence of life or accident policy as excusing failure to give notice, make proofs of loss, or bring action within time limited by policy or statute, 28 A.L.R.3d 292.

Insurer's failure to pay amount of admitted liability as precluding reliance on statute of limitations, 41 A.L.R.3d 1111.

Insurer's liability for consequential or punitive damages for wrongful delay or refusal to make payments due under contracts, 47 A.L.R.3d 314.

Amount of attorney's compensation, 57 A.L.R.3d 475; 57 A.L.R.3d 550; 57 A.L.R.3d 584; 58 A.L.R.3d 201; 58 A.L.R.3d 235; 58 A.L.R.3d 317; 17 A.L.R.5th 366; 23 A.L.R.5th 241.

Insured's payment of excess judgment, or portion thereof, as prerequisite of recovery against liability insurer for wrongful failure to settle claim against insured, 63 A.L.R.3d 627.

Right of injured person recovering excess judgment against insured to maintain action against liability insurer for wrongful failure to settle claim, 63 A.L.R.3d 677.

Construction and application of state statute or rule subjecting party making untrue allegations or denials to payment of costs or attorney's fees, 68 A.L.R.3d 209.

Validity of statute allowing attorney's fee to successful claimant but not to defendant, or vice-versa, 73 A.L.R.3d 515.

Recoverability of punitive damages in action by insured against liability insurer for failure to settle claim against insured, 85 A.L.R.3d 1211.

Insured's right to recover attorney's fees incurred in declaratory judgment action to determine existence of coverage under liability policy, 87 A.L.R.3d 429.

Allocation of defense costs between primary and excess insurance carriers, 19 A.L.R.4th 107.

Modern status of rules requiring liability insurer to show prejudice to escape liability because of insured's failure or delay in giving notice of accident or claim, or in forwarding suit papers, 32 A.L.R.4th 141.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim, 33 A.L.R.4th 579.

Excess carrier's right of action against primary carrier for improper or inadequate defense of claim, 49 A.L.R.4th 304.

Liability of independent or public insurance adjuster to insured for conduct in adjusting claim, 50 A.L.R.4th 900.

Duty of insurer to pay for independent counsel when conflict of interest exists between insured and insurer, 50 A.L.R.4th 932.

Credit life insurer's punitive damage liability for refusing payment, 55 A.L.R.4th 246.

Emotional or mental distress as element of damages for liability insurer's wrongful refusal to settle, 57 A.L.R.4th 801.

Liability insurance: third party's right of action for insurer's bad-faith tactics designed to delay payment of claim, 62 A.L.R.4th 1113.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

Computation of net "loss" for which fidelity insurer is liable, 5 A.L.R.5th 132.

Liability of insurer, or insurance agent or adjuster, for infliction of emotional distress, 6 A.L.R.5th 297.

Admissibility of polygraph or similar lie detector test results, or willingness to submit to test, on issues of coverage under insurance policy, or insurer's good-faith belief that claim was not covered, 7 A.L.R.5th 143.

Excessiveness or adequacy of attorneys' fees in matters involving real estate — modern cases, 10 A.L.R.5th 448.

What constitutes mental illness or disorder, insanity, or the like, within provision limiting or excluding coverage under health or disability policy, 19 A.L.R.5th 533.

Liability of insurer for prejudgment interest in excess of policy limits for covered loss, 23 A.L.R.5th 75.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer, 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy, 116 A.L.R.5th 247.

Calculations of attorneys' fees under Federal Tort Claims Act—28 USCS sec. 2678, 86 A.L.R. Fed. 866.

Pre-emption by Federal Longshore and Harbor Workers' Compensation Act of state law claims for bad-faith dealing by insurer or agent of insurer, 90 A.L.R. Fed. 723.

Construction and application of Longshore and Harbor Workers' Compensation Act (LHWCA) — Supreme Court cases, 72 A.L.R. Fed. 2d 1.

Federal Common Law and Preemption Under National Flood Insurance Act 42 U.S.C.A. §§ 4001 et seq., 36 A.L.R. Fed. 3d Art. 6.

Nature and Limitation of Insurance Coverage Under National Flood Insurance Act, 42 U.S.C.A. § 4013, 37 A.L.R. Fed. 3d Art. 5.

Employee as Entitled to Title VII Protections Despite Being Citizen of Foreign Country, 37 A.L.R. Fed. 3d Art. 8.

33-4-7. Affirmative duty to fairly and promptly adjust in incidents covered by motor vehicle liability policies; actions for bad faith; notice to Commissioner and consumers' insurance advocate.

(a) In the event of a loss because of injury to or destruction of property covered by a motor vehicle liability insurance policy, the insurer issuing such policy has an affirmative duty to adjust that loss fairly and promptly, to make a reasonable effort to investigate and evaluate the claim, and, where liability is reasonably clear, to make a good faith effort to settle with the claimant potentially entitled to recover against the insured under such policy. Any insurer who breaches this duty may be liable to pay the claimant, in addition to the loss, not more than 50 percent of the liability of the insured for the loss or $5,000.00, whichever is greater, and all reasonable attorney's fees for the prosecution of the action.

(b) An insurer breaches the duty of subsection (a) of this Code section when, after investigation of the claim, liability has become reasonably clear and the insurer in bad faith offers less than the amount reasonably owed under all the circumstances of which the insurer is aware.

(c) A claimant shall be entitled to recover under subsection (a) of this Code section if the claimant or the claimant's attorney has delivered to the insurer a demand letter, by statutory overnight delivery or certified mail, return receipt requested, offering to settle for an amount certain; the insurer has refused or declined to do so within 60 days of receipt of such demand, thereby compelling the claimant to institute or continue suit to recover; and the claimant ultimately recovers an amount equal to or in excess of the claimant's demand.

(d) At the expiration of the 60 days set forth in subsection (c) of this Code section, the claimant may serve the insurer issuing such policy by service of the complaint in accordance with law. The insurer shall be an unnamed party, not disclosed to the jury, until there has been a verdict resulting in recovery equal to or in excess of the claimant's demand. If

that occurs, the trial shall be recommenced in order for the trier of fact to receive evidence to make a determination as to whether bad faith existed in the handling or adjustment of the attempted settlement of the claim or action in question.

(e) The action for bad faith shall not be abated by payment after the 60 day period nor shall the testimony or opinion of an expert witness be the sole basis for a summary judgment or directed verdict on the issue of bad faith.

(f) The amount of recovery, including reasonable attorney's fees, if any, shall be determined by the trier of fact and included in a separate judgment against the insurer rendered in the action; provided, however, that the attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services based on the time spent and legal and factual issues involved in accordance with prevailing fees in the locality where the action is pending; provided, further, that the trial court shall have the discretion, if it finds the jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend the portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his or her attorney for the services of the attorney.

(g) In any action brought pursuant to subsection (b) of this Code section, and within 20 days of bringing such action, the plaintiff shall, in addition to service of process in accordance with Code Section 9-11-4, mail to the Commissioner a copy of the demand and complaint by first-class mail. Failure to comply with this subsection may be cured by delivering same.

History. — Code 1981, § 33-4-7, enacted by Ga. L. 2001, p. 784, § 1; Ga. L. 2015, p. 1088, § 22/SB 148; Ga. L. 2016, p. 864, § 33/HB 737; Ga. L. 2019, p. 337, § 1-22/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" in the first sentence of subsection (g).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, a semicolon was substituted for a comma twice in subsection (c), "of this Code section" was inserted following "subsection (c)" in subsection (d), and "first-class mail" was substituted for "first class mail" in subsection (g).

Law reviews. — For article, "Bad Faith in Insurance Claim Handling in Georgia: An Overview and Update," see 9 Ga. St. B.J. 10 (2003). For annual survey on insurance, see 65 Mercer L. Rev. 135 (2013). For annual survey on insurance law, see 68 Mercer L. Rev. 133 (2016).

For note on the 2001 enactment of this Code section, see 18 Ga. St. U.L. Rev. 167 (2001).

JUDICIAL DECISIONS

Construction with § 33-4-6. — Because a party mischaracterized O.C.G.A. § 33-4-7 as a "companion" to O.C.G.A. § 33-4-6 and erroneously contended that the General Assembly intended to extend the same rights to a third party, or a party other than the policy holder, and thus, the appellate court should therefore read § 33-4-7 as applying, like § 33-4-6, in the event of any covered loss, those arguments were rejected as specious. Mills v. Allstate Ins. Co., 288 Ga. App. 257, 653 S.E.2d 850 (2007).

Use of 17(c) formula. — Trial court erred when the court denied the defense insurer's motion for partial summary judgment as to the plaintiffs' bad faith claim under O.C.G.A. § 33-4-7 because the insurer's proposed adjustment of the plaintiffs' diminished value claim was reasonable and provided it with good cause as a matter of law for the insurer's refusal to pay the amount demanded by the plaintiffs since it was undisputed that the insurer's adjuster used the 17(c) formula as part of the subjective determination of the lost value of the car at issue. Amica Mut. Ins. Co. v. Sanders, 335 Ga. App. 245, 779 S.E.2d 459 (2015).

Proposed adjustment of diminished value claim is reasonable and provides good cause as a matter of law for the insurer's refusal to pay the amount demanded when it is undisputed that the adjuster used the 17(c) formula as part of the subjective determination of the lost value of the car at issue. Amica Mut. Ins. Co. v. Sanders, 335 Ga. App. 245, 779 S.E.2d 459 (2015).

Bad faith not shown. — Summary judgment for an insurance company on a motorist's claim against it was proper since there was no evidence of bad faith; the insurance company did not settle the motorist's property damage claim because its adjuster believed that, at the motorist's request, the motorist's insurer was assuming responsibility for settling the claim; an adjuster with the motorist's insurer confirmed that the motorist's insurer had "handled" the motorist's claim, and, further, the motorist sent a demand letter to the motorist's insurer on the same day that the motorist sent a demand letter to the insurance company, indicating that the motorist was still looking to the motorist's own insurer for payment. King v. Atlanta Cas. Ins. Co., 279 Ga. App. 554, 631 S.E.2d 786 (2006).

Statute applied to property, not personal injury, claims. — Because O.C.G.A. § 33-4-7 applied only to an insurer's bad faith in responding to claims for property damage, an insurer was properly granted a judgment on the pleadings as a complaint asserting that it acted in bad faith in responding to a claimant's claims for personal injury failed to state a claim upon which relief under the statute could be granted. Mills v. Allstate Ins. Co., 288 Ga. App. 257, 653 S.E.2d 850 (2007).

Statute did not apply. — Because the damage claimed by the company was subject to a cargo liability policy that the underwriters had issued to the insured, and not a motor vehicle liability insurance policy, O.C.G.A. § 33-4-7 provided no authority for the imposition of any penalty for the underwriters' alleged bad faith in connection with the claim. Equipco Int'l, LLC v. Certain Underwriters at Lloyd's, 320 Ga. App. 345, 739 S.E.2d 797 (2013).

RESEARCH REFERENCES

Am. Jur. 2d. — 7A Am. Jur. 2d, Automobile Insurance, § 367 et seq.

CHAPTER 5

REGULATION OF UNAUTHORIZED INSURERS

Article 1

General Provisions

Sec.

33-5-1. Representation of unauthorized insurers prohibited.
33-5-2. Validity of contracts effectuated by unauthorized insurers; dissemination of advertising for or on behalf of unauthorized insurers.
33-5-3. Penalty for violations of chapter.

Article 2

Surplus Line Insurance

Part 1

General Provisions

33-5-20. Short title.
33-5-20.1. Definitions.
33-5-20.2. Criteria for domestic surplus lines insurer; construction with federal provisions; eligibility to write insurance; taxes; protection; financial and solvency requirements; exemption from statutory requirements.
33-5-21. Authorization of procurement of surplus line insurance; conditions; procuring or placing nonadmitted insurance for exempt commercial purchaser.
33-5-21.1. Application of Chapter 9 or Code Section 33-24-9.
33-5-22. Licensing of surplus line brokers generally.
33-5-23. Revocation or suspension of broker's license.
33-5-24. Acceptance and placement of business by surplus line brokers generally.
33-5-25. Broker to ascertain financial condition of unauthorized insurer prior to placement of insurance therewith; placement of insurance with foreign or alien insurers.
33-5-26. Endorsement of insurance contract by broker.
33-5-27. Issuance to insured by broker of evidence of insurance; issuance of substitute certificate or endorsement; delivery of policy to insured; penalties.
33-5-28. Maintenance by broker of records of policies written or renewed.
33-5-29. Filing of quarterly affidavits by surplus line brokers; filing of reports of affairs and operations by brokers.
33-5-30. Validity and enforceability of contracts procured as surplus line insurance.
33-5-31. Payment by broker of tax for privilege of doing business; computation and allocation of tax.
33-5-32. Penalty for failure to file quarterly affidavit or remit tax within time prescribed by law; collection and disposition of penalty.
33-5-33. Filing of report by persons procuring insurance with unauthorized insurers; levy, collection, and disposition of tax by persons procuring such insurance.
33-5-34. Venue of actions against unauthorized insurers issuing surplus line policies; service of process; filing of pleading by insurer.
33-5-35. Applicability of article.

Part 2

Interstate Cooperation for Collection and Disbursement of Premium Taxes

33-5-40. Legislative findings.
33-5-41. Governor authorized to enter into cooperative agreement, compact, or reciprocal agreement for collection of insurance premium taxes.
33-5-42. Agreement to substantially fol-

Sec.
low form of model Surplus Lines Insurance Multi-State Compliance Compact.
33-5-43. Governor to select agreement providing best financial advantage.
33-5-44. Notice; report.

Article 3

Unauthorized Insurers Process Act

33-5-50. Short title; construction.
33-5-51. Purpose of article.
33-5-52. Acts by insurer which constitute appointment of Commissioner as agent for service.
33-5-53. Service of action and process upon Commissioner; sending of notice of service to defendant; applicability.
33-5-54. Service of process upon solicitor, collector, or other agent of insurer.
33-5-55. Mode of service prescribed by article cumulative.
33-5-56. Right of plaintiff or complainant to default judgment or judgment with leave to prove damages.
33-5-57. Conditions precedent to filing of pleadings by insurer generally; granting of postponements; filing by insurer of motion to quash writ or set aside service.
33-5-58. Recovery of penalty and attorney's fees by plaintiff; effect of failure of insurer to defend action.
33-5-59. Applicability of article.

RESEARCH REFERENCES

ALR. — Constitutionality of statutes relating to insurance contracts made and to be performed out of state, upon property or life within state, 32 A.L.R. 636.

Full faith and credit provision as affecting insurance contracts, 41 A.L.R. 1386; 114 A.L.R. 250; 119 A.L.R. 483; 173 A.L.R. 1138.

Collateral business activities incident to, or in aid of, interstate transportation, as related to interstate commerce, 152 A.L.R. 1078.

Decision of United States Supreme Court that insurance is interstate commerce as affecting state statutes relating to foreign insurance companies, 164 A.L.R. 500.

ARTICLE 1

GENERAL PROVISIONS

33-5-1. Representation of unauthorized insurers prohibited.

(a) No person in this state shall:

(1) Represent an insurer who is not at the time duly authorized to transact insurance in this state in the solicitation, negotiation, or effectuation of insurance, inspection of risks, fixing of rates, investigation or adjustment of losses, collection of premiums, or in any other manner in the transaction of insurance with respect to subjects of insurance, resident, located, or to be performed in this state; or

(2) Represent any person in the procuring of insurance with an unauthorized insurer upon or with relation to any subject of insurance.

(b) This Code section shall not apply to:

(1) Surplus line insurance which is authorized by this chapter and transactions as to which a certificate of authority is not required of an insurer under Code Section 33-3-2;

(2) Reinsurance as authorized by Code Section 33-7-14;

(3) The services of an adjuster with respect to claims under policies lawfully solicited, issued, and delivered outside of Georgia;

(4) Acceptance of service by the Commissioner pursuant to this title;

(5) The professional services of an attorney; or

(6) Any insurance company or underwriter issuing contracts of insurance to nuclear insureds, nor to any contract of insurance issued to any one or more nuclear insureds, provided that such nuclear insured under a contract procured from an unauthorized insurer shall pay to the Commissioner before March 1 of the succeeding calendar year following the year in which the insurance was so effectuated, continued, or renewed, a premium receipts tax of 4 percent of the gross premiums charged for such insurance. For the purposes of this paragraph, a "nuclear insured" is an insured purchasing policies of insurance on risks on its own nuclear generating plants and other facilities at such plants in this state.

History. — Code 1933, § 56-601, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 476, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2019, p. 337, § 1-23/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" in the first sentence of paragraph (b)(6).

Cross references. — Liability of persons making contracts for unauthorized insurers, § 33-23-42.

JUDICIAL DECISIONS

Preservation of right to raise untimely notice objection. — Surplus insurers were authorized to file a declaratory judgment action to preserve their right to raise untimely notice of an occurrence as a defense to coverage even without a certificate of authority to conduct business in the State of Georgia. Kay-Lex Co. v. Essex Ins. Co., 286 Ga. App. 484, 649 S.E.2d 602 (2007).

Cited in American Sur. Co. v. Smallon, 54 Ga. App. 45, 186 S.E. 892 (1936); National Sur. Corp. v. Boney, 215 Ga. 271, 110 S.E.2d 406 (1959); Service Cas. Co. v. Carr, 101 Ga. App. 70, 113 S.E.2d 175 (1960); Gordy Tire Co. v. Dayton Rubber Co., 216 Ga. 83, 114 S.E.2d 529 (1960); Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 43.

ALR. — Personal liability of agents or brokers in respect of policies of foreign insurance companies not authorized to do business in the state, 131 A.L.R. 1079.

33-5-2. Validity of contracts effectuated by unauthorized insurers; dissemination of advertising for or on behalf of unauthorized insurers.

(a) A contract of insurance effectuated by an unauthorized insurer in violation of this title shall be voidable except at the instance of the insurer unless during the life of such contract the insurer is authorized to transact the class or classes of insurance involved.

(b) No publication published in this state or radio or television broadcast or any other agency or means for the dissemination of information operated or located in this state shall publish, broadcast, or otherwise disseminate within this state advertising for or on behalf of any insurer not then authorized to transact insurance in this state; provided, however, that this subsection shall not apply as to publications published in this state principally for circulation in other states, wherein advertising by or on behalf of such unauthorized insurers is not expressly directed toward residents or subjects of insurance in this state.

History. — Code 1933, § 56-602, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2019, p. 337, § 1-24/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "television broadcast" for "television broadcaster" near the beginning of subsection (b).

JUDICIAL DECISIONS

Cited in Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971); American Druggist Ins. Co. v. Georgia Power Co., 145 Ga. App. 104, 243 S.E.2d 319 (1978).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 80.

ALR. — Constitutionality of statutes relating to insurance contracts made and to be performed out of state, upon property life within state, 32 A.L.R. 636.

Full faith and credit provision as affecting insurance contracts, 41 A.L.R. 1386; 114 A.L.R. 250; 119 A.L.R. 483; 173 A.L.R. 1138.

33-5-3. Penalty for violations of chapter.

Any person, firm, or corporation violating any of the provisions of this chapter shall be guilty of a misdemeanor.

History. — Code 1933, § 56-9915, enacted by Ga. L. 1960, p. 289, § 1.

ARTICLE 2

SURPLUS LINE INSURANCE

JUDICIAL DECISIONS

Coverage issued under article accords with provisions regulating unauthorized insurers. — Surplus line coverage issued in accordance with this article is issued in accordance with this chapter, while insurance written in a manner which authorizes service on the insurer under the Unauthorized Insurers Process Act (see O.C.G.A. § 33-5-50 et seq.) is written in violation of and not in accordance with this chapter. Reeves v. South Am. Managers, Inc., 110 Ga. App. 49, 137 S.E.2d 700 (1964), aff'd, 220 Ga. 493, 140 S.E.2d 201 (1965).

Cited in Kelley v. Montgomery, 108 Ga. App. 271, 132 S.E.2d 857 (1963); Insurance Co. v. Dills, 145 Ga. App. 183, 243 S.E.2d 549 (1978).

OPINIONS OF THE ATTORNEY GENERAL

This article does not transform an unauthorized insurer into an authorized insurer. 1969 Op. Att'y Gen. No. 69-498.

PART 1

GENERAL PROVISIONS

Editor's notes. — Ga. L. 2011, p. 449, § 8/HB 413, effective July 1, 2011, designated Code Sections 33-5-20 through 33-5-35 as Part 1 of Article 2.

33-5-20. Short title.

This article shall be known and may be cited as "The Surplus Line Insurance Law."

History. — Code 1933, § 56-613, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2020, p. 493, § 33/SB 429.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "shall be known and may be cited as" for "shall constitute and may be referred to as" in this Code section.

OPINIONS OF THE ATTORNEY GENERAL

Surplus line insurance unacceptable as used car dealer licensure. — The State Board of Registration of Used Car Dealers may not accept surplus line insurance in lieu of the surety bond required by O.C.G.A. § 43-47-8(h) for proper licensure. 1994 Op. Att'y Gen. No. 94-5.

33-5-20.1. Definitions.

As used in this article, the term:

(1) "Domestic surplus lines insurer" means a nonadmitted insurer that is domiciled in this state with which a surplus lines broker may place surplus lines insurance;

(1.1) "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(A) The person employs or retains a qualified risk manager to negotiate insurance coverage;

(B) The person has paid aggregate nation-wide commercial property and casualty insurance premiums in excess of $100,000.00 in the immediately preceding 12 months; and

(C)(i) The person meets at least one of the following criteria:

(I) The person possesses a net worth in excess of $20 million as such amount is adjusted pursuant to division (ii) of this subparagraph;

(II) The person generates annual revenues in excess of $50 million as such amount is adjusted pursuant to division (ii) of this subparagraph;

(III) The person employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;

(IV) The person is a not for profit organization or public entity generating annual budgeted expenditures of at least $30 million as such amount is adjusted pursuant to division (ii) of this subparagraph; or

(V) The person is a municipality with a population in excess of 50,000.

(ii) Effective on January 1, 2016, and every five years on January 1 thereafter, the amounts in subdivisions (I), (II), and (IV) of division (i) of this subparagraph shall be adjusted to reflect the percentage change for such five-year period in the Consumer Price Index for All Urban Consumers as reported by the Bureau of Labor Statistics of the United States Department of Labor.

(2) "Home state" means:

(A) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(B) If 100 percent of the insured risk is located outside the state referred to in subparagraph (A) of this paragraph, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

If more than one insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined according to subparagraph (A) of this paragraph, of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(3) "Nonadmitted insurance" means any property and casualty insurance permitted in a state to be placed directly or through a surplus line broker with a nonadmitted insurer eligible to accept such insurance.

(4) "Principal place of business" means the state where the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business's activities.

(5) "Principal residence" means the state where the individual resides for the greatest number of days during a calendar year.

(6) "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets all of the following requirements:

(A) The person is an employee of, or third-party consultant retained by, the commercial policyholder;

(B) The person provides skilled services in purchase of insurance and in loss prevention, loss reduction, or risk and insurance coverage analysis;

(C) The person has a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management and:

(i) Has three years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance;

(ii) Has a designation as a chartered property and casualty underwriter issued by the American Institute for CPCU/Insurance Institute of America;

(iii) Has a designation as an associate in risk management issued by the American Institute for CPCU/Insurance Institute of America;

(iv) Has a designation as certified risk manager issued by the National Alliance for Insurance Education & Research;

(v) Has a designation as a RIMS Fellow issued by the Global Risk Management Institute; or

(vi) Has any other designation, certification, or license determined by the Commissioner to demonstrate minimum competency in risk management; and

(D) The person has:

(i) At least seven years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance;

(ii) Any one of the designations specified in subparagraph (C) of this paragraph; or

(iii) A graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management.

(7) "Surplus line insurance" means any property and casualty insurance permitted in a state to be placed through a surplus line broker with a nonadmitted insurer eligible to accept such insurance.

(8) "Surplus line broker" or "broker" means an individual who is licensed in this state to sell, solicit, or negotiate insurance on properties, risks, or exposures located or to be performed in this state with nonadmitted insurers.

History. — Code 1981, § 33-5-20.1, enacted by Ga. L. 2011, p. 449, § 1/HB 413; Ga. L. 2018, p. 744, § 1/SB 381; Ga. L. 2019, p. 337, § 1-25/SB 132; Ga. L. 2019, p. 1056, § 33/SB 52.

The 2018 amendment, effective July 1, 2018, added paragraph (1); and redesignated former paragraph (1) as present paragraph (1.1)

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, added "or" at the end of division (6)(D)(ii); deleted former division (6)(D)(iii), which read: "At least ten years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or"; and redesignated former division (6)(D)(iv) as present division (6)(D)(iii). The second 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, deleted "or" following "subparagraph;" at the end of subdivisions (1.1)(C)(i)(I) and (1.1)(C)(i)(II).

33-5-20.2. Criteria for domestic surplus lines insurer; construction with federal provisions; eligibility to write insurance; taxes; protection; financial and solvency requirements; exemption from statutory requirements.

(a) A nonadmitted insurer that is domiciled in this state shall be deemed a domestic surplus lines insurer if all of the following criteria are satisfied:

(1) The insurer shall possess a policyholder surplus of at least $15 million;

(2) The insurer is an eligible surplus lines insurer in at least one jurisdiction other than this state;

(3) The board of directors of the insurer has passed a resolution seeking to be a domestic surplus lines insurer in this state; and

(4) The Commissioner has issued a certificate of authority or otherwise provided written approval for the insurer to be a domestic surplus lines insurer.

(b) For the purposes of the federal Nonadmitted and Reinsurance Reform Act of 2010, 15 U.S.C Section 8201, et seq, a domestic surplus lines insurer shall be considered a nonadmitted insurer with respect to risks insured in this state.

(c) A domestic surplus lines insurer shall be deemed an eligible surplus lines insurer and authorized to write any kind of insurance that a nonadmitted insurer not domiciled in this state is eligible to write.

(d) Notwithstanding any other statute, the policies issued in this state by a domestic surplus lines insurer shall be subject to taxes assessed upon surplus lines policies issued by nonadmitted insurers, including the surplus lines premium tax, but will not be subject to other taxes levied upon admitted insurers, whether domestic or foreign.

(e) Policies issued by a domestic surplus lines insurer are not subject to the protections or other provisions of the Georgia Insurers Insolvency Pool created by Chapter 36 of this title or the Georgia Life and Health Insurance Guaranty Association created by Chapter 38 of this title.

(f) All financial and solvency requirements imposed by this state's laws upon domestic admitted insurers shall apply to domestic surplus lines insurers unless domestic surplus lines insurers are otherwise specifically exempted.

(g) Policies issued by a domestic surplus lines insurer shall be exempt from all statutory requirements relating to insurance rating plans, policy forms, premiums charged to insureds, and other statutory

requirements in the same manner and to the same extent as a nonadmitted insurer domiciled in another state.

History. — Code 1981, § 33-5-20.2, enacted by Ga. L. 2018, p. 744, § 2/SB 381. **Effective date.** — This Code section became effective July 1, 2018.

33-5-21. Authorization of procurement of surplus line insurance; conditions; procuring or placing nonadmitted insurance for exempt commercial purchaser.

(a) Surplus line insurance may be procured from unauthorized insurers subject to the following conditions:

(1) The insurance must be procured through a licensed surplus line broker;

(2) The insurance may only be procured from insurers which meet the financial condition requirements of Code Section 33-5-25;

(3) The insured or the insured's agent has made an effort to procure the desired insurance coverage or benefits from authorized insurers, but such effort has been unsuccessful in obtaining insurance coverage or benefits which are satisfactory to the insured except as provided under subsection (b) of this Code section; and

(4) The insurance shall not be procured under this chapter for personal private passenger motor vehicle coverage or residential dwelling property coverage unless such insurance cannot be obtained from an authorized insurer.

(b) The broker shall not be required to make a due diligence search to determine whether the full amount or type of insurance can be obtained from authorized insurers when the surplus line broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser, provided:

(1) The broker procuring or placing the surplus line insurance has disclosed to the exempt commercial purchaser that such insurance may be available from the admitted market that may provide greater protection with more regulatory oversight; and

(2) The exempt commercial purchaser has subsequently requested in writing for the broker to procure or place such insurance from a nonadmitted insurer.

History. — Code 1933, § 56-614, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1995, p. 1165, § 1; Ga. L. 2011, p. 449, § 2/HB 413; Ga. L. 2019, p. 337, § 1-26/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "private" in paragraph (a)(4).

JUDICIAL DECISIONS

Preservation of right to raise untimely notice objection. — Surplus insurers were authorized to file a declaratory judgment action to preserve their right to raise untimely notice of an occurrence as a defense to coverage even without a certificate of authority to conduct business in the State of Georgia. Kay-Lex Co. v. Essex Ins. Co., 286 Ga. App. 484, 649 S.E.2d 602 (2007).

33-5-21.1. Application of Chapter 9 or Code Section 33-24-9.

Insurance placed in accordance with this article shall not be subject to the provisions of Chapter 9 of this title or Code Section 33-24-9.

History. — Code 1981, § 33-5-21.1, enacted by Ga. L. 1997, p. 1581, § 1; Ga. L. 1997, p. 683, § 1.

Editor's notes. — Ga. L. 1997, p. 1581, § 1 and Ga. L. 1997, p. 683, § 1 both enacted a Code section designated 33-5-21.1 and containing identical provisions.

33-5-22. Licensing of surplus line brokers generally.

A surplus lines broker shall be licensed in accordance with Code Section 33-23-37.

History. — Code 1933, § 56-618, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1965, p. 248, § 1; Ga. L. 1973, p. 499, § 1; Ga. L. 1985, p. 1239, § 1; Ga. L. 1988, p. 1519, § 1; Ga. L. 1992, p. 2725, § 9; Ga. L. 1997, p. 683, § 1; Ga. L. 2001, p. 925, § 2.

Editor's notes. — Ga. L. 1985, p. 1239, § 3, provided that that Act would apply to insurance policies issued, delivered, issued for delivery, or renewed on and after July 1, 1985.

OPINIONS OF THE ATTORNEY GENERAL

Those seeking renewal of their licenses need not submit to examination; an individual is considered an applicant only when he makes his initial application for a license, so only those individuals seeking a license for a first time must submit to a personal examination. 1973 Op. Att'y Gen. No. 73-90.

RESEARCH REFERENCES

ALR. — Right to enjoin business competitor from unlicensed or otherwise illegal acts or practices, 90 A.L.R.2d 7.

33-5-23. Revocation or suspension of broker's license.

(a) The Commissioner shall revoke any surplus line broker's license:

(1) If the broker fails to file his quarterly affidavit or to remit the tax as required by law;

(2) If the broker fails to maintain an office in this state, or to keep records, or to allow the Commissioner to examine his records as required by law; or

(3) For any of the causes for which an agent's license may be revoked.

(b) The Commissioner may revoke or suspend any or all such licenses whenever he deems such suspension or revocation to be in the best interests of the people of this state.

(c) The procedures provided in Article 1 of Chapter 23 of this title for the suspension or revocation of agents' licenses shall be applicable to suspension or revocation of a surplus line broker's license.

(d) No broker whose license has been so revoked shall again be so licensed within five years thereafter nor until any penalties or delinquent taxes owing by him or her have been paid.

History. — Code 1933, § 56-625, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1220, § 5; Ga. L. 1982, p. 3, § 33; Ga. L. 1993, p. 91, § 33; Ga. L. 2019, p. 337, § 1-27/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (d), substituted "within five years" for "within two years" and inserted "or her".

33-5-24. Acceptance and placement of business by surplus line brokers generally.

A licensed surplus line broker may accept and place surplus line business for any insurance agent or broker licensed in this state for the kind of insurance involved and may compensate such agent or broker for the surplus line business.

History. — Code 1933, § 56-619, enacted by Ga. L. 1960, p. 289, § 1.

33-5-25. Broker to ascertain financial condition of unauthorized insurer prior to placement of insurance therewith; placement of insurance with foreign or alien insurers.

(a) The broker shall ascertain the financial condition of the unauthorized insurer before placing insurance with the unauthorized insurer and shall not place surplus line insurance with any insurer who does not meet, according to current available reliable financial information, the requirements provided in subsection (b) of this Code section.

(b)(1) The broker shall so insure only:

(A) With an insurance company domiciled in a United States jurisdiction that is authorized to write the type of insurance in its

domiciliary jurisdiction and has a capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(i) The minimum capital and surplus requirements of this title; or

(ii) Fifteen million dollars;

The requirements of this subparagraph may be satisfied by an insurer that possesses less than the minimum capital and surplus upon an affirmative finding of acceptability by the Commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. In no event shall the Commissioner make an affirmative finding of acceptability when the unauthorized insurer's capital and surplus is less than $4.5 million;

(B) With any group of foreign individual underwriters licensed and domiciled in a state or United States territory if such group maintains a trust or security fund of at least $10 million as security to the full amount thereof for all policyholders and creditors in the United States of each member of the group. If the group includes incorporated and unincorporated underwriters, the incorporated members shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the level of solvency regulation and control by the group's domiciliary regulatory agency as are the unincorporated members; or

(C) With an alien insurer or group of underwriters domiciled outside of the United States, including, but not limited to, any Lloyd's group, that is listed in the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners.

(2) An insurer or group of foreign individual underwriters described in subparagraph (A) or (B) of paragraph (1) of this subsection shall annually furnish to the broker a copy of its current annual financial statement and, in the case of a group of foreign individual underwriters, evidence of compliance with required trust or security fund deposits.

(c) For any violation of this Code section, a broker's license may be suspended or revoked as provided in Code Section 33-5-23.

History. — Code 1933, § 56-620, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1969, p. 609, § 1; Ga. L. 1985, p. 1239, § 2; Ga. L. 1989, p. 672, § 1; Ga. L. 1992,

p. 6, § 33; Ga. L. 1995, p. 1165, § 2; Ga. L. 2002, p. 8, § 1; Ga. L. 2011, p. 449, § 3/HB 413; Ga. L. 2012, p. 775, § 33/HB 942.

Editor's notes. — Ga. L. 1985, p. 1239, § 3, provided that that Act would apply to insurance policies issued, delivered, issued for delivery, or renewed on and after July 1, 1985.

33-5-26. Endorsement of insurance contract by broker.

(a) Every insurance contract procured and delivered as a surplus line coverage shall be initialed by or bear the name of the surplus line broker who procured it and shall have printed or stamped upon it the following: "This contract is registered and delivered as a surplus line coverage under the Surplus Line Insurance Law, O.C.G.A. Chapter 33-5."

(b) No surplus lines policy or certificate in which the policy premium is $5,000.00 per annum or less shall be delivered in this state unless a standard disclosure form or brochure explaining surplus lines insurance is attached to or made a part of the policy or certificate. The Commissioner shall prescribe by rule or regulation the format and contents of such form or brochure.

History. — Code 1933, § 56-616, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2002, p. 8, § 2; Ga. L. 2019, p. 337, § 1-28/SB 132.

The 2019 amendment, effective July 1, 2019, deleted former subsection (c), which read: "Pursuant to Code Section 33-2-9, the Commissioner may promulgate rules and regulations which are necessary to implement the provisions of this article."

JUDICIAL DECISIONS

Cited in Tyson v. Scottsdale Indemnity Co., 343 Ga. App. 370, 805 S.E.2d 138 (2017).

33-5-27. Issuance to insured by broker of evidence of insurance; issuance of substitute certificate or endorsement; delivery of policy to insured; penalties.

(a) Upon placing a surplus line coverage, the broker shall promptly issue and deliver to the insured evidence of the insurance consisting either of the policy as issued by the insurer or, if the policy is not then available, the surplus line broker's certificate. The certificate shall be executed by the broker and shall show the description and location of the subject of the insurance, a general statement of the kind and type of insurance purchased, and the term of the insurance, the premium and date charged, taxes collected from the insured, and the name and address of the insured and the insurer. If the direct risk is assumed by more than one insurer, the certificate or the policy, when delivered, shall state the name and address and proportion of the entire direct risk assumed by each insurer.

(b) No broker shall issue any certificate or any cover note or purport to insure or represent that insurance will be or has been granted by any unauthorized insurer unless he has prior written authority from the insurer for the insurance or has received information from the insurer in the regular course of business that the insurance has been granted or an insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

(c) If, after the issuance and delivery of any certificate, there is any change as to the identity of the insurers or the proportion of the direct risk assumed by the insurer as stated in the broker's original certificate or in any other material respect as to the insurance coverage evidenced by the certificate, the broker shall promptly issue and deliver to the insured a substitute certificate or endorsement accurately showing the current status of the coverage and the insurers responsible thereunder.

(d) If a policy issued by the insurer is not available upon placement of the insurance and the broker has issued and delivered his certificate as provided in subsection (a) of this Code section, upon request therefor by the insured, the broker shall as soon as reasonably possible procure from the insurer its policy evidencing the insurance and deliver the policy to the insured in replacement of the broker's certificate theretofore issued.

(e) Any surplus line broker who knowingly or negligently issues a false certificate of insurance or who fails promptly to notify the insured of any material change with respect to such insurance by delivery to the insured of a substitute certificate or endorsement as provided in subsection (c) of this Code section shall be subject to the penalties provided by Code Section 33-5-32 or to any greater applicable penalty provided by law.

History. — Code 1933, § 56-621, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1995, p. 1165, § 3.

JUDICIAL DECISIONS

Cited in Tyson v. Scottsdale Indemnity Co., 343 Ga. App. 370, 805 S.E.2d 138 (2017).

33-5-28. Maintenance by broker of records of policies written or renewed.

Each licensed surplus line broker shall keep in his office a separate account of each policy written or renewed showing the exact amount of insurance placed, the name and post office address of the insured, the name and home address of the insurer, the location of the insured

property, the gross premium charged therefor, the amount of premium tax paid thereon, the nature of the risk, the number, date, and term of the policy, and any other information as the Commissioner may require. The record shall at all times be open to examination by the Commissioner.

History. — Code 1933, § 56-622, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1220, § 2.

33-5-29. Filing of quarterly affidavits by surplus line brokers; filing of reports of affairs and operations by brokers.

(a) Each surplus line broker shall file with the Commissioner, on a quarterly basis, an affidavit executed by the surplus line broker setting forth the facts referred to in Code Section 33-5-21. Such affidavit shall furnish certificate or cover note number, name of insured, the amount of the premium, the tax paid thereon, and any other information as the Commissioner may require for all surplus line transactions in which premiums were paid to the surplus line broker during the previous quarter. The quarterly affidavit shall be filed with the Commissioner on or before the fifteenth day of April, July, October, and January. Each surplus line broker shall remit a 4 percent tax on direct premiums written, as described in Code Section 33-5-31. The tax shall be remitted with the surplus line broker's quarterly affidavit.

(b) In addition to the information required on the quarterly affidavit, each surplus line broker shall provide the Commissioner with such reports of its affairs and operations regarding insurance covering insured persons, resident or located in this state, for such periods of time as the Commissioner may require. The Commissioner may require from surplus line brokers who are the custodians of relevant records of surplus line insurers reports containing such information as the Commissioner may by regulation or by order prescribe which, as to product liability insurers, may include but shall not be required to be limited to the following information:

(1) The total number of product liability claims, broken down by:

(A) The type or category of claims; and

(B) Whether the claims were:

(i) Reported during a prior period and closed during the reporting period;

(ii) Reported and closed during the reporting period; or

(iii) Reported and not closed during the reporting period;

(2) The total amount paid in settlement or discharge of the claims for each type or category of claims;

(3) The total amount of reserves available to pay those product liability claims which were reported for the last preceding year; provided, however, the information on reserves shall be required to be maintained by the Commissioner in confidence, except that summaries of the combined totals of such reserves shall be subject to inspection by members of the General Assembly upon request;

(4) The total amount of premiums received from insured persons, resident or located in this state, which is attributable to product liability insurance and which must be classified separately with respect to manufacturers, wholesalers or distributors, and retailers;

(5) The total number of insured persons, resident or located in this state, for which the product liability insurance has been provided which must be classified separately with respect to manufacturers, wholesalers or distributors, and retailers;

(6) The total number of insured persons, resident or located in this state, whose product liability insurance coverage the insurer, with which the surplus line broker placed the coverage, canceled or refused to renew and the reasons therefor which must be classified separately with respect to manufacturers, wholesalers or distributors, and retailers; and

(7) The total number of insured persons, resident or located in this state, who failed to renew their product liability insurance policies during the reporting period which information must be classified separately with respect to manufacturers, wholesalers or distributors, and retailers.

History. — Code 1933, § 56-615, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1220, § 1; Ga. L. 1974, p. 465, § 2; Ga. L. 1978, p. 2025, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1995, p. 1165, § 4; Ga. L. 2019, p. 337, § 1-29/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "as described in" for "as defined in" near the end of the fourth sentence of subsection (a).

33-5-30. Validity and enforceability of contracts procured as surplus line insurance.

Insurance contracts procured as surplus line coverage from unauthorized insurers in accordance with this chapter shall be fully valid and enforceable as to all parties and shall be given recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

History. — Code 1933, § 56-617, enacted by Ga. L. 1960, p. 289, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Surplus line insurance unacceptable as used car dealer licensure. — Although O.C.G.A. § 33-5-30 gives validity to surplus line insurance, it does not transform an unauthorized insurer into an authorized insurer by rendering surplus line insurance acceptable for licensure as a used car dealer. 1994 Op. Att'y Gen. No. 94-5.

33-5-31. Payment by broker of tax for privilege of doing business; computation and allocation of tax.

(a) The surplus line broker shall remit to the Commissioner, on or before the fifteenth day of April, July, October, and January, at the time his or her quarterly affidavit is submitted, as a tax imposed for the privilege of doing business as a surplus line broker in this state, a tax of 4 percent on all premiums paid to the surplus line broker during the preceding quarter, less return premiums and exclusive of sums collected to cover state or federal taxes, on surplus line insurance subject to tax transacted by him or her during the preceding quarter as shown by his or her affidavit filed with the Commissioner.

(b) If this state participates in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44 and a surplus line policy covers risks or exposures located or to be performed both in and out of this state, the sum payable shall be computed based on an amount equal to 4 percent of that portion of the gross premiums allocated to this state plus an amount equal to the portion of premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed outside this state.

History. — Code 1933, § 56-623, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1220, § 3; Ga. L. 1974, p. 465, § 3; Ga. L. 1995, p. 1165, § 5; Ga. L. 2011, p. 449, § 4/HB 413; Ga. L. 2012, p. 1117, § 2/SB 385.

OPINIONS OF THE ATTORNEY GENERAL

No exemption of coverage for Metropolitan Atlanta Rapid Transit Authority. — Insurance companies and surplus line brokers who provide insurance coverage for the Metropolitan Atlanta Rapid Transit Authority are not exempt from paying tax on the premiums collected for such coverage. 1975 Op. Att'y Gen. No. 75-54.

Credit, not refund, may be granted when policy is cancelled "flat." — The Insurance Commissioner may not make a lump-sum refund of taxes paid, but he may grant a credit against future taxes due in the event that a surplus line broker has paid the required tax during a preceding quarter and the underlying policy, for which the taxes are due, is subsequently cancelled "flat" as of the date of its inception by mutual agreement of the parties. 1975 Op. Att'y Gen. No. 75-116.

33-5-32. Penalty for failure to file quarterly affidavit or remit tax within time prescribed by law; collection and disposition of penalty.

If any surplus line broker fails to file his or her quarterly affidavit or fails to remit the tax as provided by law within 30 days after the tax is due, he or she shall be liable for a penalty of either $25.00 for each day of delinquency commencing after the expiration of the 30 day period or an amount equal to 100 percent of the tax, whichever is less, except that for good cause shown, the Commissioner may grant a reasonable extension of time within which the affidavit may be filed and the tax may be paid. The tax may be recovered by distraint and the penalty and tax may be recovered by an action instituted by the Commissioner in any court of competent jurisdiction. The Commissioner shall pay to the Office of the State Treasurer any penalty so collected.

History. — Code 1933, § 56-624, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1220, § 4; Ga. L. 1982, p. 3, § 33; Ga. L. 1993, p. 1402, § 18; Ga. L. 2010, p. 863, § 2/SB 296; Ga. L. 2011, p. 449, § 5/HB 413.

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990).

33-5-33. Filing of report by persons procuring insurance with unauthorized insurers; levy, collection, and disposition of tax by persons procuring such insurance.

(a) Every insured who in this state procures or causes to be procured or continues or renews insurance with an unauthorized insurer upon a subject of insurance resident, located, or to be performed both within and outside this state, other than insurance procured through a surplus line broker pursuant to this article or exempted from this article under Code Section 33-5-35, shall within 30 days after the date such insurance was so procured, continued, or renewed file a report of the same with the Commissioner in writing and upon forms designated by the Commissioner and furnished to such an insured upon request. The report shall state the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently paid thereon, and such additional information as reasonably requested by the Commissioner.

(b) If this state participates in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44, then for the general support of the government of this state, there is levied and there shall be collected from every such insured in this state for the privilege of so insuring his property or interests, a tax covering risks or exposures located or to be performed

both in and out of this state, after deduction of return premiums, if any. The sum payable shall be computed based upon an amount equal to 4 percent of that portion of the gross premiums allocated to this state plus an amount equal to the portion of premiums allocated to other states or territories on the basis of the tax rates and fees applicable to properties, risks, or exposures located or to be performed outside this state. Such tax shall be paid to the Commissioner coincidentally with the filing of the report provided for in subsection (a) of this Code section.

(b.1) If this state does not participate in a cooperative agreement, compact, or reciprocal agreement with other states pursuant to Code Sections 33-5-40 through 33-5-44, then for the general support of the government of this state, there is levied and there shall be collected from every such insured in this state for the privilege of so insuring his or her property or interests both in and out of this state, a tax at the rate of 4 percent of the gross premium paid for any such insurance, after deduction of return premiums, if any. Such tax shall be paid to the Commissioner coincidently with the filing of the report provided for in subsection (a) of this Code section.

(c) The tax imposed under subsection (b) of this Code section, if delinquent, shall bear interest at the rate of 6 percent per annum, compounded annually.

(d) Such tax shall be collectable by civil action brought by the Commissioner or by distraint and, if with respect to insurance of real property, the tax shall constitute a lien upon such real property while owned by the insured, enforceable in the same manner and through the same procedures as govern the collection of other taxes upon such real property under the laws of this state.

(e) This Code section shall not apply to life or accident and sickness insurance.

History. — Code 1933, § 56-628, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2011, p. 449, § 6/HB 413; Ga. L. 2012, p. 1117, § 3/SB 385; Ga. L. 2019, p. 337, § 1-30/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "sickness insurance" for "sickness insurances" at the end of subsection (e).

RESEARCH REFERENCES

ALR. — Constitutionality of statutes relating to insurance contracts made and to be performed out of state, upon property life within state, 32 A.L.R. 636.

33-5-34. Venue of actions against unauthorized insurers issuing surplus line policies; service of process; filing of pleading by insurer.

(a) An action shall be brought against any unauthorized insurer under any contract issued by it as a surplus line contract pursuant to this chapter in the superior court of the county in which the cause of action arose.

(b) Every unauthorized insurer issuing or delivering a surplus line policy through a surplus line broker in this state shall be deemed thereby to have appointed the Commissioner as its attorney for acceptance of service of all legal process issued in this state in any action or proceeding arising out of the policy, and service of process upon the Commissioner shall be lawful personal service upon the insurer.

(c) Each surplus line policy shall contain a provision stating the substance of subsection (b) of this Code section and designating the person to whom the Commissioner shall mail process as provided in subsection (d) of this Code section.

(d) Duplicate copies of legal process against the insurers shall be served upon the Commissioner and at time of service the plaintiff shall pay a fee in an amount as provided in Code Section 33-8-1, taxable as costs in the action. The Commissioner shall immediately mail one copy of the process so served to the person designated by the insurer in the policy for the purpose, by registered or certified mail or statutory overnight delivery with return receipt requested.

(e) The insurer shall have 30 days after the date of mailing within which to plead, answer, or otherwise defend the action.

History. — Code 1933, § 56-626, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1985, p. 1399, § 2; Ga. L. 1992, p. 2725, § 10; Ga. L. 2000, p. 1589, § 3.

Cross references. — Venue generally, Ga. Const. 1983, Art. VI, Sec. II and § 9-10-30 et seq. Venue of actions against insurance companies generally, § 33-4-1.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

Law reviews. — For comment on McGee v. International Life Ins. Co., 355 U.S. 220, 78 S. Ct. 199, 2 L. Ed. 2d 223 (1957), holding that for a state to assert jurisdiction over a foreign insurance company it is sufficient for due process purposes if the contract on which the case is based has a substantial connection with that state, see 21 Ga. B.J. 113 (1958).

JUDICIAL DECISIONS

Inapplicable to domestic primary insurers. — O.C.G.A. § 33-5-4 does not apply to a domestic primary insurer and further does not provide, even in that situation, for an "alternative manner" of service by certified mail, only an "alterna-

tive recipient." Lewis v. Southern Gen. Ins. Co., 209 Ga. App. 232, 433 S.E.2d 80 (1993).

This section applies only to surplus line contracts. Smith v. Lloyd's of London, 568 F.2d 1115 (5th Cir. 1978).

Formal service upon Commissioner required. — Since subsection (a) of O.C.G.A. § 33-5-34 provides only for an alternative recipient of service and does not include a provision for an alternative manner of service, it follows that the plaintiff must have effected formal service upon the Insurance Commissioner in order to be subject to the jurisdiction of the trial court. If the record reveals neither a viable acknowledgment of service nor a return of service, there is no basis for a finding that process was legally served upon the Commissioner. Cheshire Bridge Enters., Inc. v. Lexington Ins. Co., 183 Ga. App. 672, 359 S.E.2d 702, cert. denied, 183 Ga. App. 905, 359 S.E.2d 702 (1987).

Subsection (a) does not apply if surplus line insurer is only garnishee. — Where an alien surplus line insurance company is merely named as a garnishee in case against others and the action is not on a cause of action arising under a contract, the superior court where the cause of action arose is not the sole court having jurisdiction of the company under subsection (a) of this section. Lloyd's of London, Inc. v. Goldkist, Inc., 145 Ga. App. 478, 243 S.E.2d 726 (1978).

Garnishee may be served by serving Commissioner. — Under subsection (b) of this section, an alien surplus line insurance company named as garnishee is properly served by process served on the Insurance Commissioner, the action being "a proceeding arising out of such policy." Lloyd's of London, Inc. v. Goldkist, Inc., 145 Ga. App. 478, 243 S.E.2d 726 (1978).

Defendant normally has 30 days from mailing of process to answer. — In the normal litigations with which this section is concerned, the defendant has 30 days, commencing with the date on which the process is mailed by the Insurance Commissioner. Lloyd's of London, Inc. v. Goldkist, Inc., 145 Ga. App. 478, 243 S.E.2d 726 (1978).

Time for answering in garnishment proceeding is different. — In all garnishment proceedings there is a different statutory directive than subsection (e) of this section: the garnishee may not answer before 30 days, and he must answer by the forty-fifth day. Lloyd's of London, Inc. v. Goldkist, Inc., 145 Ga. App. 478, 243 S.E.2d 726 (1978).

Cited in Insurance Co. v. Dills, 145 Ga. App. 183, 243 S.E.2d 549 (1978).

33-5-35. Applicability of article.

This article controlling the placing of insurance with unauthorized insurers shall not apply to reinsurance or to the following insurance when so placed by licensed agents or brokers of this state:

(1) Insurance on property or operation of railroads engaged in interstate commerce; or

(2) Insurance of aircraft owned or operated by manufacturers of aircraft or operated in scheduled interstate flight, or cargo of the aircraft, or against liability, other than workers' compensation and employer's liability, arising out of the ownership, maintenance, or use of the aircraft.

History. — Code 1933, § 56-627, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1977, p. 1281, § 2; Ga. L. 2011, p. 449, § 7/HB 413; Ga. L. 2019, p. 337, § 1-31/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "following insurance" for "following insurances" in the introductory language of this Code section.

PART 2

INTERSTATE COOPERATION FOR COLLECTION AND DISBURSEMENT OF PREMIUM TAXES

33-5-40. Legislative findings.

The General Assembly finds the federal Nonadmitted and Reinsurance Reform Act of 2010, which was incorporated into the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, P.L. 111-203, provides that only an insured's home state may require premium tax payment for nonadmitted insurance and authorizes states to enter into a compact or otherwise establish procedures to allocate among the states the nonadmitted insurance premium taxes. The General Assembly further finds that as the states are still in flux as to which proposed plan is best for them to enter, or if any agreement should be entered into by the state, the Commissioner is in a unique position to weigh these options and to determine what is in the best interest of the state financially. Therefore, the General Assembly acknowledges that some flexibility is necessary to determine that the best financial interests of the state are met.

History. — Code 1981, § 33-5-40, enacted by Ga. L. 2011, p. 449, § 8/HB 413; Ga. L. 2019, p. 337, § 1-32/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" in the second sentence of this Code section.

U.S. Code. — The Dodd-Frank Wall Street Reform and Consumer Protection Act, referred to in this Code section, is codified at 12 U.S.C. § 5381 et seq.

33-5-41. Governor authorized to enter into cooperative agreement, compact, or reciprocal agreement for collection of insurance premium taxes.

The Governor, on behalf of the state, advised by and in consultation with the Commissioner, is authorized to enter into a cooperative agreement, compact, or reciprocal agreement with another state or states for the purpose of the collection of insurance premium taxes imposed by Code Sections 33-5-31 and 33-5-33.

History. — Code 1981, § 33-5-41, enacted by Ga. L. 2011, p. 449, § 8/HB 413; Ga. L. 2012, p. 1117, § 4/SB 385; Ga. L. 2019, p. 337, § 1-33/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" near the beginning of this Code section.

33-5-42. Agreement to substantially follow form of model Surplus Lines Insurance Multi-State Compliance Compact.

The cooperative agreement, compact, or reciprocal agreement for the purpose of the collection of insurance premiums imposed by Code Section 33-5-31 shall substantially follow the form of the model Surplus Lines Insurance Multi-State Compliance Compact, also known as SLIMPACT-lite, created by the National Conference of Insurance Legislators or the model Nonadmitted Insurance Multi-State Agreement, also known as NIMA, created by the National Association of Insurance Commissioners, as such documents exist on July 1, 2011.

History. — Code 1981, § 33-5-42, enacted by Ga. L. 2011, p. 449, § 8/HB 413.

33-5-43. Governor to select agreement providing best financial advantage.

The Governor with the consultation and advice of the Commissioner shall select the agreement, if any, that provides the best financial advantage to the state. In determining which agreement, if any, provides the best financial advantage to the state, the Governor with the consultation and advice of the Commissioner shall consider the impact on the state's gross receipt of premium tax, the potential additional administrative burden to the state and surplus line brokers procuring or placing surplus line insurance under this chapter, and such other criteria as determined by the Governor with the consultation and advice of the Commissioner.

History. — Code 1981, § 33-5-43, enacted by Ga. L. 2011, p. 449, § 8/HB 413.

33-5-44. Notice; report.

In the event the Governor enters into a cooperative agreement, compact, or reciprocal agreement with another state or states as authorized under this part, notice of such action shall be communicated to the chairperson of the House Committee on Insurance and the chairperson of the Senate Insurance and Labor Committee. The Commissioner shall thereafter annually issue a report to such committees that assesses whether, in his or her opinion, the agreement continues to be in the best financial interest of the state.

History. — Code 1981, § 33-5-44, enacted by Ga. L. 2011, p. 449, § 8/HB 413.

ARTICLE 3

UNAUTHORIZED INSURERS PROCESS ACT

Cross references. — Service of process on alien or foreign insurers, § 33-4-3 et seq. Venue of actions against and service of process upon unauthorized insurers issuing surplus line policies, § 33-5-34.

Law reviews. — For comment on McGee v. International Life Ins. Co., 355 U.S. 220, 78 S. Ct. 199, 2 L. Ed. 2d 223 (1957), holding that for a state to assert jurisdiction over a foreign insurance company it is sufficient for due process purposes if the contract on which the case is based has a substantial connection with that state, see 21 Ga. B.J. 113 (1958).

JUDICIAL DECISIONS

Purpose. — This article is not punitive in nature but is intended, among other purposes, to protect residents of Georgia from the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights. Retail Union Health & Welfare Fund v. Seabrum, 240 Ga. 695, 242 S.E.2d 18 (1978).

This article provides a method of suing in this state unauthorized insurers who write insurance on property having a situs in this state. Reeves v. South Am. Managers, Inc., 110 Ga. App. 49, 137 S.E.2d 700 (1964), aff'd, 220 Ga. 493, 140 S.E.2d 201 (1965).

This article does not purport to deal with the question of venue of suits against insurance companies, but only with the mode of service of process upon unauthorized insurers. Liberty Bell Mut. Fire Ins. Co. v. Exum, 209 Ga. 548, 74 S.E.2d 738 (1953).

Insurance authorizing service under article is written in violation of chapter. — Surplus line coverage in accordance with the provisions of the Surplus Line Insurance Law (see O.C.G.A. § 33-5-20 et seq.) is issued in accordance with this chapter, while insurance written in a manner which authorizes service under this article is written in violation of and not in accordance with this chapter. Reeves v. South Am. Managers, Inc., 110 Ga. App. 49, 137 S.E.2d 700 (1964), aff'd, 220 Ga. 493, 140 S.E.2d 201 (1965).

Cited in Gordy Tire Co. v. Dayton Rubber Co., 216 Ga. 83, 114 S.E.2d 529 (1960); Rossville Crushed Stone, Inc. v. Massey, 219 Ga. 467, 133 S.E.2d 874 (1963).

RESEARCH REFERENCES

ALR. — Collateral business activities incident to, or in aid of, interstate transportation, as related to interstate commerce, 152 A.L.R. 1078.

33-5-50. Short title; construction.

(a) This article constitutes and may be cited as the "Unauthorized Insurers Process Act."

(b) This article shall be so interpreted as to effectuate its general purpose to make uniform the law of those states which enact it.

History. — Code 1933, § 56-603, enacted by Ga. L. 1960, p. 289, § 1.

33-5-51. Purpose of article.

The purpose of this article is to subject certain insurers to the jurisdiction of the courts of this state in actions by or on behalf of insureds or beneficiaries under insurance contracts. The General Assembly declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under those policies. In furtherance of the state interest, the General Assembly herein provides a method of substituted service of process upon the insurers and declares that in so doing it exercises its power to protect its residents and to define, for the purpose of this article, what constitutes doing business in this state and also exercises power and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Sess., S. 340, which declares that the business of insurance and every person engaged in the business of insurance shall be subject to the laws of the several states.

History. — Code 1933, § 56-604, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Service of process generally, § 9-11-4.

U.S. Code. — Public Law 15, 79th Congress of the United States, Chapter 20, 1st Sess., S. 340, referred to in this Code section, is codified as 15 U.S.C. § 1011.

JUDICIAL DECISIONS

Acts held to constitute doing business and render insurer subject to suit in state. — A life insurance company not authorized to transact business in Georgia because of failure to obtain a certificate of authority from the Insurance Commissioner is nevertheless doing business, although illegally, in the state by accepting an application for insurance from a resident of the state, delivering the application to the resident by mail, and mailing premium notices to or accepting premiums from the resident during the life of the policy, so as to render it subject to suit and judgment in this state. Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966).

Cited in Retail Union Health & Welfare Fund v. Seabrum, 240 Ga. 695, 242 S.E.2d 18 (1978).

33-5-52. Acts by insurer which constitute appointment of Commissioner as agent for service.

Any of the following acts in this state effected, by mail or otherwise, by an unauthorized foreign or alien insurer:

(1) The issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business in this state;

(2) The solicitation of applications for said contracts;

(3) The collection of premiums, membership fees, assessments, or other considerations for the contracts; or

(4) Any other transaction of business

is equivalent to and shall constitute an appointment by the insurer of the Commissioner and his successors in office as its attorney upon whom may be served all lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of the contracts of insurance; and any such act shall be a signification of this agreement that the service of process is of the same legal force and validity as personal service of process in this state upon the insurer.

History. — Code 1933, § 56-605, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Acts held to constitute doing business and render insurer subject to suit in state. — A life insurance company not authorized to transact business in Georgia because of failure to obtain a certificate of authority from the insurance commissioner is nevertheless doing business, although illegally, in the state by accepting an application for insurance from a resident of the state, delivering the application to the resident by mail, and mailing premium notices to or accepting premiums from the resident during the life of the policy, so as to render it subject to suit and judgment in this state. Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966).

Cited in Bishopsgate Ins. Co. v. Cactus Club, Inc., 176 Ga. App. 354, 335 S.E.2d 685 (1985).

RESEARCH REFERENCES

ALR. — Constitutionality of statutes relating to insurance contracts made and to be performed out of state, upon property life within state, 32 A.L.R. 636.

33-5-53. Service of action and process upon Commissioner; sending of notice of service to defendant; applicability.

(a) Service shall be made by delivery to and leaving with the Commissioner or some person in apparent charge of his office two copies of the action and process.

(b) At the time of such service, the plaintiff shall pay the Commissioner the sum of $15.00, which shall be taxable as cost. The Commissioner shall immediately mail by registered or certified mail or statutory overnight delivery one of the copies of such action and process to the defendant at his last known principal place of business and shall keep a record of all process so served upon him. Such service is sufficient, provided that notice of the service and a copy of the action and process are sent within 15 days thereafter by registered or certified mail or statutory overnight delivery by plaintiff or plaintiff's attorney to the defendant at his last known principal place of business; and the

defendant's receipt, or receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed and the affidavit of the plaintiff or plaintiff's attorney showing a compliance with service as provided in this Code section are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear or within such further time as the court may allow.

(c) Service upon the Commissioner pursuant to this Code section shall only be made when service pursuant to the manner provided in Code Section 33-5-54 cannot be effectuated.

History. — Code 1933, § 56-606, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1985, p. 1399, § 3; Ga. L. 1991, p. 1090, § 1; Ga. L. 2000, p. 1589, § 3.

Cross references. — Service of process generally, § 9-11-4.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

33-5-54. Service of process upon solicitor, collector, or other agent of insurer.

Service of process in any action or proceeding shall be valid if served upon any person within this state who, in this state on behalf of the insurer, is:

(1) Soliciting insurance;

(2) Making, issuing, or delivering any contract of insurance; or

(3) Collecting or receiving any premium, membership fee, assessment, or other consideration for insurance

and a copy of the process is sent within ten days thereafter by registered or certified mail or statutory overnight delivery by the plaintiff or plaintiff's attorney to the defendant at the last known principal place of business of the defendant; and the defendant's receipt, or the receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed and the affidavit of the plaintiff or plaintiff's attorney showing a compliance with the requirements of this Code section are filed with the clerk of the court in which the action is pending on or before the date the defendant is required to appear or within such further time as the court may allow.

History. — Code 1933, § 56-607, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1991, p. 1090, § 2; Ga. L. 2000, p. 1589, § 3.

Cross references. — Service of process generally, § 9-11-4.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assem-

bly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

JUDICIAL DECISIONS

Cited in Congress Re-Insurance Corp. v. Archer-Western Contractors, 226 Ga. App. 829, 487 S.E.2d 679 (1997).

33-5-55. Mode of service prescribed by article cumulative.

Nothing in this article shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner now or hereafter permitted by law.

History. — Code 1933, § 56-609, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Service of process generally, § 9-11-4.

33-5-56. Right of plaintiff or complainant to default judgment or judgment with leave to prove damages.

No plaintiff or complainant shall be entitled to a judgment by default or to a judgment with leave to prove damages under this Code section until the expiration of 30 days from date of the filing of the affidavit of compliance.

History. — Code 1933, § 56-608, enacted by Ga. L. 1960, p. 289, § 1.

33-5-57. Conditions precedent to filing of pleadings by insurer generally; granting of postponements; filing by insurer of motion to quash writ or set aside service.

(a) Before any unauthorized insurer shall file or cause to be filed any pleadings in any action or proceeding instituted against it, such unauthorized insurer shall either:

(1) Deposit with the clerk of the court in which such action or proceeding is pending cash or securities or file with the clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in the action; provided, however, the court may in its discretion make an order dispensing with the deposit or bond where the insurer makes a showing satisfactory to the court that it maintains in a state of the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in the action or proceeding; or

(2) Procure a certificate of authority to transact the business of insurance in this state.

(b) The court in any action or proceeding in which service is made in the manner provided in Code Section 33-5-53 or 33-5-54, in its discretion, may order any postponement as may be necessary to afford the defendant reasonable opportunity to comply with subsection (a) of this Code section and to defend the action.

(c) Nothing in subsection (a) of this Code section is to be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service of such writ made in the manner provided in Code Section 33-5-53 or 33-5-54 on one or more of the following grounds:

(1) That such unauthorized insurer has not done any of the acts enumerated in Code Section 33-5-52;

(2) That the person on whom service was made pursuant to Code Section 33-5-54 was not doing any of the acts therein enumerated; or

(3) That it is otherwise not properly subject to the jurisdiction of court pursuant to this article.

History. — Code 1933, § 56-610, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

JUDICIAL DECISIONS

The purpose of this section is to provide assurance that any judgment rendered against the insurer may be collected by the insured or beneficiary. This purpose is found in the terms of the section (cash, securities, bond, etc.) and is made particularly clear by the provision allowing the trial court to dispense with cash deposit and bond upon a showing by the insurer of sufficient available liquid assets to satisfy such judgment as may be rendered against it. Retail Union Health & Welfare Fund v. Seabrum, 240 Ga. 695, 242 S.E.2d 18 (1978).

Conditions precedent apply to unauthorized foreign or alien insurers when sued. — The conditions precedent to filing defenses set forth by this section apply to unauthorized foreign or alien insurers when they have been sued. Underwriters at Lloyd's, London v. Strickland, 99 Ga. App. 89, 107 S.E.2d 860 (1959).

Procuring certificate of authority is alternative act but not required. — It is not the purpose of this section to require an unauthorized insurer to procure a certificate of authority to transact business in this state, as that is merely one of the acts an unauthorized insurer is permitted to take so as to be entitled to defend a suit instituted against it. Retail Union Health & Welfare Fund v. Seabrum, 240 Ga. 695, 242 S.E.2d 18 (1978).

Section assumes deposit or bond will be filed when defensive pleadings filed. — Former Code 1933, § 56-610(1) (see subsection (a) of this Code section) assumed that an unauthorized insurer will file the required cash, securities, or bond at the time of filing defensive pleadings. Retail Union Health & Welfare Fund v. Seabrum, 240 Ga. 695, 242 S.E.2d 18 (1978).

Compliance with subsection (a) within reasonable time suffices. — When an unauthorized insurer timely files defensive pleadings and then fully complies with the requirements of former Code 1933, § 56-610(1) (see subsection (a)

of O.C.G.A. § 33-5-7) within a reasonable time following notice that this section is applicable, then this section does not command a forfeiture of the right to litigate the merits of the dispute. Retail Union Health & Welfare Fund v. Seabrum, 240 Ga. 695, 242 S.E.2d 18 (1978).

33-5-58. Recovery of penalty and attorney's fees by plaintiff; effect of failure of insurer to defend action.

In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state or to a resident of this state or to a corporation authorized to do business in this state, if the insurer has failed for 30 days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears that such refusal was vexatious and without reasonable cause, the said insurer shall be subject to a penalty of not more than 25 percent of the liability of the insurer for the loss and an allowance for reasonable attorney's fees. The attorney's fees shall be determined by the trial court and shall be included in any judgment which is rendered in the action. Failure of an insurer to defend the action shall be deemed prima-facie evidence that its failure to make payment was vexatious and without reasonable cause. The limitations contained in this Code section in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his attorney for the services of the attorney in the action against the unauthorized insurer.

History. — Code 1933, § 56-611, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Liability of authorized insurer refusing in bad faith to pay claim, § 33-4-6.

Law reviews. — For article discussing Georgia provisions concerning damages for insurer's failure to pay first-party claims, see 14 Ga. L. Rev. 497 (1980).

JUDICIAL DECISIONS

If the question of liability is a close one, the insurer cannot be guilty of bad faith. Allen v. National Liberty Life Ins. Co., 153 Ga. App. 579, 266 S.E.2d 269 (1980).

Evidence admissible on question of reasonable cause though unknown when claim denied. — Although it does not appear that a doctor's opinion was known by the insurer at the time it decided to deny the decedent's claim for benefits, such testimony is nonetheless admissible for the purpose of disproving appellant's allegation that the denial of benefits was "vexatious and without reasonable cause." Allen v. National Liberty Life Ins. Co., 153 Ga. App. 579, 266 S.E.2d 269 (1980).

Ordinarily, the question of good or bad faith of the insurer is for the jury. Allen v. National Liberty Life Ins. Co., 153 Ga. App. 579, 266 S.E.2d 269 (1980).

Summary judgment for insurer is proper if evidence shows substantial defense. — Where under the evidence submitted on the insurer's motion, it is clear that genuine issues of material fact exist on the question of what caused the decedent's loss, but it is also clear that the insurer has evidence on which a substantial defense to liability under the policy can be based, since the denial of benefits

was based upon "reasonable cause" and was not "vexatious," the trial court did not err in granting the insurer motion for partial summary judgment on the insured's claim under this section. Allen v. National Liberty Life Ins. Co., 153 Ga. App. 579, 266 S.E.2d 269 (1980).

Cited in Cotton States Mut. Ins. Co. v. McFather, 251 Ga. 739, 309 S.E.2d 799 (1983).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 46 et seq.

C.J.S. — 44 C.J.S., Insurance, § 153 et seq.

ALR. — Validity of statutory provision for attorneys' fees, 90 A.L.R. 530.

What persons or corporations, contracts or policies, are within statutory provisions allowing recovery of attorney's fee penalty against insurance companies or against companies dealing in specified kinds of insurance, 126 A.L.R. 1439.

Consequences of liability insurer's refusal to assume defense of action against insured upon ground that claim upon which action is based is not within coverage of policy, 49 A.L.R.2d 694.

What constitutes "trial," "final trial," or "final hearing" under statute authorizing allowance of attorneys' fees as costs on such proceeding, 100 A.L.R.2d 397.

Validity of statute allowing attorney's fee to successful claimant but not to defendant, or vice-versa, 73 A.L.R.3d 515.

Recoverability of punitive damages in action by insured against liability insurer for failure to settle claim against insurer, 85 A.L.R.3d 1211.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

33-5-59. Applicability of article.

This article shall not apply to any action or proceeding against any unauthorized insurer arising out of any contract of:

(1) Reinsurance effectuated in accordance with the laws of Georgia;

(2) Surplus line insurance authorized by this chapter;

(3) Insurance on property or operations of carriers engaged in interstate commerce;

(4) Insurance against legal liability arising out of the ownership, operation, or maintenance of any property having a permanent situs outside of this state; or

(5) Insurance against loss of or damage to any property having a permanent situs outside of this state where the contract contains a provision designating the Commissioner or a bona fide resident of the State of Georgia to be its true and lawful attorney upon whom may be served all lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of the contract or where the insurer enters a general appearance in any such action or proceeding.

History. — Code 1933, § 56-612, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Cheshire Bridge Enters., Inc. v. Lexington Ins. Co., 183 Ga. App. 672, 359 S.E.2d 702 (1987).

CHAPTER 6

UNFAIR TRADE PRACTICES

Article 1

General Provisions

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33-6-2. "Person" defined.
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33-6-5. Other unfair methods of competition and unfair and deceptive acts or practices.
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33-6-14. Construction of article.

Article 2

Unfair Claims Settlement Practices

33-6-30. Short title.
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33-6-32. Definitions.
33-6-33. When claims settlement practice improper.
33-6-34. (For effective date, see note.) Unfair claims settlement practices.
33-6-35. Notice of hearing; hearing procedures; cease and desist orders; penalties; judicial review; intervenors.
33-6-36. Rules and regulations.
33-6-37. Private cause of action not created or implied.

Cross references. — Deceptive trade practices generally, § 10-1-370 et seq.

Administrative rules and regulations. — Unfair trade and claims settlement practices, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-20.

JUDICIAL DECISIONS

Cited in Hubbard v. Stewart, 651 F. Supp. 294 (M.D. Ga. 1987).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 19 et seq.

C.J.S. — 44 C.J.S., Insurance, § 75 et seq.

ALR. — Right to enjoin business competitor from unlicensed or otherwise illegal acts or practices, 90 A.L.R.2d 7.

Provisions of insurance company's contract with independent insurance agent restricting competitive placements by agent as illegal restraint of trade under state law, 42 A.L.R.4th 1072.

Constitutional right to jury trial in cause of action under state unfair or deceptive trade practices law, 54 A.L.R.5th 631.

ARTICLE 1

GENERAL PROVISIONS

Editor's notes. — Ga. L. 1992, p. 3048, § 9, effective July 1, 1992, designated Code Sections 33-6-1 through 33-6-14 as Article 1.

33-6-1. Purpose of article.

The purpose of this article is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining or providing for the determination of all practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

History. — Code 1933, § 56-701, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 3048, § 1.

U.S. Code. — The Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), referred to in this Code section, is codified as 15 U.S.C. § 1011.

JUDICIAL DECISIONS

Unfair insurance practices not subject to Georgia's Uniform Deceptive Trade Practices Act. — Pursuant to O.C.G.A. § 10-1-374(a)(1), insurance transactions are exempt from Georgia's Uniform Deceptive Trade Practices Act (UDTPA), O.C.G.A. § 10-1-370 et seq. Claims of unfair trade practices in insurance transactions are instead governed by the Georgia Insurance Code. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

Cited in Fairfax MK, Inc. v. City of Clarkston, 274 Ga. 520, 555 S.E.2d 722 (2001).

33-6-2. "Person" defined.

As used in this article, the term "person" means an individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including but not limited to agents, brokers, counselors, and adjusters.

History. — Code 1933, § 56-702, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 3048, § 2.

OPINIONS OF THE ATTORNEY GENERAL

This section includes as "person" any legal entity engaged in the business of insurance. 1963-65 Op. Att'y Gen. 435.

33-6-3. Unfair methods of competition or unfair and deceptive acts or practices prohibited.

No person shall engage in this state in any trade practice which is defined in this article as or determined pursuant to this article to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

History. — Code 1933, § 56-703, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 3048, § 3.

JUDICIAL DECISIONS

Violation found. — A claims adjuster, even absent a fiduciary relationship, may not induce a claimant by trick, artifice or misrepresentation to sign a general release while the claimant is under a disability which deprives the claimant of the capacity to read, reason or investigate personally. Cravey v. Johnson, 229 Ga. App. 130, 493 S.E.2d 536 (1997).

33-6-4. Enumeration of unfair methods of competition and unfair or deceptive acts or practices; penalty.

(a) As used in this Code section, the term:

(1) "Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.

(2) "Policy" means any insuring bond issued by an insurer.

(3) "Store gift card" shall have the same meaning as provided in Code Section 10-1-393.

(b) The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Making, publishing, disseminating, circulating, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular,

pamphlet, letter, or poster, or over any radio station or in any other way an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;

(2) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph;

(3) Making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance;

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

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

(6) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully

appointed to examine into its condition or into any of its affairs or any public official to whom such insurer is required by law to report or who has authority by law to examine into its condition or into any of its affairs or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of the insurer;

(7) Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, benefit certificates or shares in any common-law corporation, securities, or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance;

(8)(A)(i) Making or permitting any unfair discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(ii) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or sickness insurance, in the benefits payable thereunder, in any of the terms or conditions of the contract, or in any other manner whatever.

(iii) Making or permitting any unfair discrimination in the issuance, renewal, or cancellation of any policy or contract of insurance against direct loss to residential property and the contents thereof, in the amount of premium, policy fees, or rates charged for the policies or contracts when the discrimination is based solely upon the age or geographical location of the property within a rated fire district without regard to objective loss experience relating thereto.

(iv)(I) Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such discrimination which were previously enacted and currently exist, or

which may be enacted subsequently, and shall not be a limitation on such other provisions of law.

(II) A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney's fees and costs of litigation. A violation of this division shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided in this division are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.

(B) Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan, or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

(C) Nothing in subparagraphs (A) and (B) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

(ii) In the case of life or accident and sickness insurance policies issued on the industrial debit or weekly premium plan,

making allowance in an amount which fairly represents the saving in collection expense to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer;

(iii) Making a readjustment of the rate of premium for a policy based on the loss or expense experienced at the end of the first or any subsequent policy year of insurance thereunder, which adjustment may be made retroactive only for the policy year;

(iv) Issuing life or accident and sickness insurance policies covering bona fide employees of the insurer at a rate less than the rate charged other persons in the same class;

(v) Issuing life or accident and sickness policies on a salary-saving, payroll deduction, preauthorized, postdated, automatic check, or draft plan at a reduced rate commensurate with the savings made by the use of such plan;

(vi) Paying commissions or other compensation to duly licensed agents or brokers or allowing or returning dividends, savings, or unabsorbed premium deposits to participating policyholders, members, or subscribers;

(vii) Paying by an insurance agent of part or all of the commissions on public insurance to a nonprofit association of insurance agents which is affiliated with a recognized state or national insurance agents' association, which commissions are to be used in whole or in part for one or more civic enterprises;

(viii) Paying for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during group sales presentations and group seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars;

(ix) Paying for business meals and entertainment by an insurer or an agent, broker, or employee of an insurer, agent, or broker for current or prospective clients; or

(x) Advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy;

(9) Failing to instruct and require properly that agents shall, in the solicitation of insurance and the filling out of applications of insurance on behalf of policyholders, incorporate therein all material facts relevant to the risk being written, which facts are known to the agent or could have been known by proper diligence;

(10) Encouraging agents to accept applications which contain material misrepresentations or conceal material information which, if stated in the application, would prevent issuance of the policy or which would void a policy from its inception according to its terms even though premiums had been paid on the policy;

(11) Any insurer or agent of same becoming a party to requiring or imposing as a condition to the sale of real or personal property or to the financing of real or personal property, as a condition to the granting of or an extension of a loan which is to be secured by the title to or a lien of any kind on real or personal property, or as a condition to the performance of any other act in connection with the sale, financing, or lending, whether the person thus acts for himself or for anyone else, that the insurance or any renewal thereof to be issued on said property as collateral to said sale or loan shall be written through any particular insurance company or agent, provided that this paragraph shall not apply to a policy purchased by the seller, financier, or lender from his or its own funds and not charged to the purchaser or borrower in the sale price of the property or the amount of the loan or required to be paid for out of his personal funds; provided, further, that such seller, financier, or lender may disapprove for reasons affecting solvency or other sensible and sufficient reasons, the insurance company selected by the buyer or borrower. This paragraph shall not apply to title insurance;

(12)(A) Representing that any insurer or agent is employed by or otherwise associated with any medicare program as defined in Code Section 33-43-1 or the United States Social Security Administration or that any insurance policy sold or offered for sale has been endorsed or sponsored by the federal or state government.

(B) Knowingly selling or offering to sell medicare supplement insurance coverage as defined in Code Section 33-43-1 which is not in compliance with the provisions of Chapter 43 of this title, relating to medicare supplement insurance, or the rules and regulations promulgated by the Commissioner pursuant to Chapter 43 of this title.

(C) Representing that any individual policy is a group policy or that the insurer, agent, or policy is endorsed, sponsored by, or associated with any group, association, or other organization unless such is, in fact, the case.

(D) Knowingly selling to Medicaid recipients substantially unnecessary coverage which duplicates benefits provided under the Medicaid program without disclosing to the prospective buyer that it may not be to the buyer's benefit or that it might actually be to the buyer's detriment to purchase the additional coverage;

(13)(A) Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group life insurance policy in which computation of the death benefit is of such a technical nature that such death benefit cannot reasonably be properly presented in the advertisement and understood by a member of the insuring public. Policies, other than variable life or other interest sensitive policies, which provide for multiple changes in death benefits, combinations of increasing and nonuniformly decreasing term insurance, or increasing life insurance benefits equal to or slightly greater than the premiums paid during the early years of the coverage combined with accidental death benefits are types of contracts within the purview of this subparagraph. Additionally, any life insurance policy which cannot be truthfully, completely, clearly, and accurately disclosed in an advertisement falls within this subparagraph.

(B) Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy which is misleading in fact or by implication that the coverage is "guaranteed issue" when there are conditions to be met by those persons to be insured, such as limited medical questions or other underwriting guidelines of the insurer.

(C) Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy where such advertisement has not been approved for use in this state by the Commissioner;

(14) Failing to disclose in printed advertising material that medical benefits are calculated on the basis of usual, customary, and reasonable charges;

(14.1) Engaging in dishonest, unfair, or deceptive insurance practices in marketing or sales of insurance to service members of the armed forces of the United States and, notwithstanding any other provision of this title, the Commissioner may promulgate such rules and regulations as necessary to define dishonest, unfair, or deceptive military marketing and sales practices;

(14.2) Failing to submit all claims data to the Georgia All-Payer Claims Database as required in Article 3 of Chapter 53 of Title 31; or

(15)(A) As used in this paragraph, the term:

(i) "Confidential abuse information" means information about acts of family violence or sexual assault, the status of a victim of family violence or sexual assault, an individual's medical condition that the insurer knows or has reason to know is related to family violence or sexual assault, or the home and work addresses and telephone numbers of a subject of family violence or sexual assault.

(ii) "Family violence" means family violence as defined in Code Sections 19-13-1 and 19-13-20 and as limited by Code Section 19-13-1.

(iii) "Sexual assault" means rape, sodomy, aggravated sodomy, sexual battery, and aggravated sexual battery as those terms are defined in Chapter 6 of Title 16.

(B) No person shall deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or sexual assault or that such person knows or has reason to know the applicant or insured may be a victim of family violence or sexual assault; nor shall any person take or fail to take any of the aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence or sexual assault.

(C) No person shall request, directly or indirectly, any information the person knows or reasonably should know relates to acts of family violence or sexual assault or an applicant's or insured's status as a victim of family violence or sexual assault or make use of such information however obtained, except for the limited purpose of complying with legal obligations, verifying an individual's claim to be a subject of family violence or sexual assault, cooperating with a victim of family violence or sexual assault in seeking protection from family violence or sexual assault, or facilitating the treatment of a family violence or sexual assault related medical condition. When a person has information in their possession that clearly indicates that the insured or applicant is a subject of family violence or sexual assault, the disclosure or transfer of the information by a person to any person, entity, or individual is a violation of this Code section, except:

(i) To the subject of family violence or sexual assault or an individual specifically designated in writing by the subject of family violence or sexual assault;

(ii) To a health care provider for the direct provision of health care services;

(iii) To a licensed physician identified and designated by the subject of family violence or sexual assault;

(iv) When ordered by the Commissioner or a court of competent jurisdiction or otherwise required by law;

(v) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed pursuant to this division only to the following persons or entities, all of whom shall be bound by this subparagraph:

(I) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of family violence or sexual assault and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(II) A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the person;

(III) Medical or claims personnel contracting with the person, only where necessary to process an application or perform the person's duties under the policy or to protect the safety or privacy of a subject of family violence or sexual assault; or

(IV) With respect to address and telephone number, to entities with whom the person transacts business when the business cannot be transacted without the address and telephone number;

(vi) To an attorney who needs the information to represent the person effectively, provided the person notifies the attorney of its obligations under this paragraph and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the person;

(vii) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about family violence or sexual assault status; or

(viii) To any other entities deemed appropriate by the Commissioner.

(D) It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued

in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator's coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 and may obtain continuation and conversion of such coverages notwithstanding the act or omission of the perpetrator. A person may request and receive confidential abuse information to implement the continuation and conversion of coverages under this subparagraph.

(E) Subparagraph (C) of this paragraph shall not preclude a subject of family violence or sexual assault from obtaining his or her insurance records. Subparagraph (C) of this paragraph shall not prohibit a person from asking about a medical condition or a claims history or from using medical information or a claims history to underwrite or to carry out its duties under the policy to the extent otherwise permitted under this paragraph and other applicable law.

(F) No person shall take action that adversely affects an applicant or insured on the basis of a medical condition, claim, or other underwriting information that the person knows or has reason to know is family violence or sexual assault related and which:

(i) Has the purpose or effect of treating family violence or sexual assault status as a medical condition or underwriting criterion;

(ii) Is based upon correlation between a medical condition and family violence or sexual assault;

(iii) Is not otherwise permissible by law and does not apply in the same manner and to the same extent to all applicants and insureds similarly situated without regard to whether the condition or claim is family violence or sexual assault related; or

(iv) Except for claim actions, is not based on a determination, made in conformance with sound actuarial and underwriting principles and guidelines generally applied in the insurance industry and supported by reasonable statistical evidence, that there is a correlation between the applicant's or insured's circumstances and a material increase in insurance risk.

(G) No person shall fail to pay losses arising out of family violence or sexual assault against an innocent first-party claimant to the extent of such claimant's legal interest in the covered property, if the loss is caused by the intentional act of an insured

against whom a family violence or sexual assault complaint is brought for the act causing this loss.

(H) No person shall use other exclusions or limitations on coverage which the Commissioner has determined through the policy filing and approval process to unreasonably restrict the ability of victims of family violence or sexual assault to be indemnified for such losses.

(I) Any person issuing, delivering, or renewing a policy of insurance in this state at any time shall include with such policy or renewal certificate a notice attached thereto containing the following language:

"NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence."

(c) Any person violating this Code section by making unlawful, false representations as to the policy sold shall be guilty of a misdemeanor.

History. — Code 1933, §§ 56-704, 56-9906, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1978, p. 2016, § 1; Ga. L. 1980, p. 1266, § 2; Ga. L. 1989, p. 888, § 1; Ga. L. 1989, p. 1276, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1992, p. 996, §§ 1-3; Ga. L. 2000, p. 236, § 1; Ga. L. 2001, p. 4, § 33; Ga. L. 2002, p. 441, § 2; Ga. L. 2005, p. 563, § 2/HB 407; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2006, p. 433, § 1/HB 425; Ga. L. 2007, p. 500, § 1/SB 84; Ga. L. 2016, p. 381, § 1/HB 784; Ga. L. 2019, p. 337, § 1-34/SB 132; Ga. L. 2019, p. 866, § 1/HB 227; Ga. L. 2020, p. 743, § 2/SB 482.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" at the end of subparagraph (b)(13)(C) and deleted "within a period of 24 months after July 1, 2000," following "at any time" in subparagraph (b)(15)(I). The second 2019 amendment, effective July 1, 2019, substituted "family violence or sexual assault" for "family violence" throughout paragraph (b)(15); added ", the term" at the end of the introductory language of subparagraph (b)(15)(A); substituted "Confidential abuse information" for "Confidential family violence information" near the beginning of division (b)(15)(A)(i); added division (b)(15)(A)(iii); substituted "family violence or sexual assault" for "abuse" throughout subparagraph (b)(15)(C); substituted "confidential abuse information" for "family violence information" in the first sentence of division (b)(15)(C)(v) and in the last sentence of subparagraph (b)(15)(D); and substituted "Confidential abuse" for "Family violence" at the beginning of the second sentence in division (b)(15)(C)(v).

The 2020 amendment, effective August 5, 2020, added paragraph (b)(14.2).

Cross references. — False advertising generally, § 10-1-420 et seq. Provision that contracts in general restraint of trade contravene public policy, § 13-8-2. Punishment for misdemeanors generally, § 17-10-3.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, in subdivision (b)(8)(A)(iv)(II), "this division" was substituted for "this Code section" in the second sentence and "in this division" was substituted for "herein" in the last sentence.

Pursuant to Code Section 28-9-5, in 2020, "or" was deleted at the end of paragraph (b)(14.1) and "; or" was substituted for a period at the end of paragraph (b)(14.2).

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of Chapter 20A of this title.

Law reviews. — For note on 1989 amendment to this Code section, see 6 Ga. St. U.L. Rev. 261 (1989). For note on 2000 amendment of this Code section, see 17 Ga. St. U.L. Rev. 220 (2000). For note on the 2002 amendment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Ga. L. 1912, p. 119, § 20, are included in the annotations for this Code section.

Contract held prohibited as discriminatory. — Where a mutual life insurance company prepared a form of contract for sale by its agent to certain persons taking insurance which named the insured as "local inspector," stated that he agreed, upon written request, to furnish information on certain subjects which he might be able to obtain without expense to himself, and recited that, in consideration thereof, the company agreed to create a fund based on insurance in force, to be divided into 1,000 equal shares, and that each "local inspector" who should pay to the company the annual premium on $5,000 of insurance and perform the other duties required by the contract would be entitled to one share therein, this was a special discriminatory contract, prohibited by Ga. L. 1912, p. 119, § 20. Leonard v. American Life & Annuity Co., 139 Ga. 274, 77 S.E. 41 (1913) (decided under former Ga. L. 1912, p. 119, § 20).

Note for premium held void because of agreement for rebate. — Where an agent by parol contract agreed to insure a person's life and agreed to rebate a part of the first premium, and took a note for the amount of the premium less the amount of the rebate, the agreement to rebate was an integral part of the contract, and the agreement to rebate being void, the note given in furtherance of the contract was itself illegal and void. Jones v. Crawford, 21 Ga. App. 29, 93 S.E. 515 (1917) (decided under former Ga. L. 1912, p. 119, § 20).

Cited in Nat'l Viatical, Inc. v. State, 258 Ga. App. 408, 574 S.E.2d 337 (2002); Fortis Ins. Co. v. Kahn, 299 Ga. App. 319, 683 S.E.2d 4 (2009).

OPINIONS OF THE ATTORNEY GENERAL

Soliciting mortgage customers for insurance business not unfair competition. — A corporation engaged in the mortgage servicing and insurance business cannot be said to be guilty of unfair competition by merely soliciting the mortgagors, whose mortgages they service, to obtain their insurance business. 1965-66

Op. Att'y Gen. No. 66-213.

Unfair discrimination in premiums for life insurance, accident insurance, or sickness insurance is prohibited. 1974 Op. Att'y Gen. No. 74-81.

Rates for different group policies may be different. — For there to be unfair discrimination in premiums the insurance companies must not be offering the same amount of insurance for the same amount of premium to policyholders with the same risk rating; also, the number of employees under the group plan could legitimately affect the rates; consequently, for different group policies the rates charged by the insurance company may be different and at the same time may also be legal. 1974 Op. Att'y Gen. No. 74-81.

Validity of sales promotions. — An insurer who offers a gift to a prospective insured in exchange for the opportunity to compare the insured's current policy violates subparagraph (b)(8)(B) of this section and § 33-9-36(b), but an insurer who makes a charitable contribution based on a portion of the total sales of a particular policy for a specified period of time violates neither code provision. 1984 Op. Att'y Gen. No. 84-78.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 21, 41, 44.

C.J.S. — 44 C.J.S., Insurance, §§ 75, 76.

ALR. — Extension of time for payment of premium or assessment as within statute prohibiting discrimination by insurance companies, 53 A.L.R. 1537.

Wrongful termination of policy by insurer, or false information to insured in that regard, as excusing further tender and payment of premiums or assessments, 122 A.L.R. 385; 160 A.L.R. 629.

Insurance: illustrations concerning accumulations, dividends, surplus, etc., 127 A.L.R. 1464.

Grounds for cancelation or rescission of annuity agreement, or for recovery back of property conveyed, or money paid, thereunder, 131 A.L.R. 424.

Duty of life insurer, or its agents, to inform or explain to insured his rights under policy before accepting his surrender of the same, 131 A.L.R. 1299.

Insurance agent's misrepresentations to applicant, insured, or beneficiary, as basis of action by them, other than on policy itself, or as defense to action against them, 136 A.L.R. 5.

Insurer's demand for additional or corrected proof of loss as waiver or estoppel as to right to assert contractual limitation provision, or as suspending running thereof, 15 A.L.R.2d 955.

Construction and effect of state statute forbidding unfair trade practice or competition by discriminatory allowances of rebates, commissions, discounts, or the like, 54 A.L.R.2d 1187.

Liability of insurance broker or agent to insured for failure to procure insurance, 64 A.L.R.3d 398.

Wrongful cancellation of medical malpractice insurance, 99 A.L.R.3d 469.

Propriety of automobile insurer's policy of refusing insurance, or requiring advanced rates, because of age, sex, residence, or handicap, 33 A.L.R.4th 523.

Validity, construction, and application of state statute forbidding unfair trade practice or competition by discriminatory allowance of rebates, commissions, discounts, or the like, 41 A.L.R.4th 675.

State regulation of insurer's right to classify insureds for premium or other underwriting purposes by occupation, 57 A.L.R.4th 625.

Liability of insurance agent or broker on ground of inadequacy of liability insurance coverage procured, 60 A.L.R.5th 165.

33-6-5. Other unfair methods of competition and unfair and deceptive acts or practices.

In addition to Code Section 33-6-4, violations of the following provisions also are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) No insurance company shall issue or cause to be issued any policy of insurance of any type or description upon life or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail such property, real or personal; and no other person shall advertise, offer, or give free insurance or insurance without cost or for less than the approved or customary rate in connection with the sale or bailment of real or personal property, except as provided in Chapter 27 of this title;

(2) No person who is not an insurer shall assume or use any name which deceptively implies or suggests that he or she is an insurer;

(3) Where the premium or charge for insurance of or involving real or personal property or merchandise is included in the overall purchase price or financing of the purchase of merchandise or property, the vendor or lender shall separately state and identify the amount charged and to be paid for the insurance and the classifications, if any, upon which based; and the inclusion or exclusion of the cost of insurance in such purchase price or financing shall not increase, reduce, or otherwise affect any other factor involved in the cost of the merchandise or property or financing as to the purchaser or borrower. A vendor or lender shall not be prohibited from charging the purchaser or borrower a finance charge otherwise permitted by law on any premium or charge for insurance included in the cost of the merchandise or property or financing. This paragraph shall not apply to credit life or credit accident and sickness insurance which is in compliance with Code Section 33-31-7;

(4)(A) No insurer shall make, offer to make, or permit any preference or distinction in property, marine, casualty, or surety insurance as to form of policy, certificate, premium, rate, or conditions of insurance based upon membership, nonmembership, or employment of any person or persons by or in any particular group, association, corporation, or organization, making the foregoing preference or distinction available in any event based upon any fictitious grouping of persons.

(B) As used in this paragraph, the term "fictitious grouping" means any grouping by way of membership, nonmembership, license, franchise, employment contract, agreement, or any other method or means resulting in unfair discrimination.

(C) The restrictions and limitations of this paragraph shall not extend to life or accident and sickness insurance; nor shall they apply to any bona fide association group which is composed of members engaged in a common trade, business, or profession and which has had group insurance of the same type continuously in existence for at least five years;

(5) No insurer or agent thereof shall hypothecate, sell, or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to acceptance of the risk by the insurer;

(6)(A) No person shall knowingly collect any sum as premium or charge for insurance, which insurance is not then provided or not in due course to be provided subject to acceptance of the risk by the insurer by an insurance policy issued by an insurer as permitted by this title.

(B) No person shall knowingly collect as premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, which sum is specified in the policy in accordance with the applicable classifications and rates as filed with and approved by the Commissioner. In cases where classifications, premiums, or rates are not required by this title to be filed and approved:

(i) The premiums and charges for insurance, except insurance written in accordance with Chapter 5 of this title, shall not be in excess of or less than those specified in the policy and as fixed by the insurer; and

(ii) The premiums and charges for insurance written in accordance with Chapter 5 of this title shall not be in excess of or less than those specified in the policy.

This subparagraph shall not be deemed to prohibit surplus lines brokers licensed under Chapter 5 of this title from charging and collecting the amount of applicable state and federal taxes in addition to the premium required by the insurer; nor shall it be deemed to prohibit a life or accident and sickness insurer from charging and collecting amounts actually to be expended for medical examination of an applicant for life or accident and sickness insurance or for reinstatement of a life or accident and sickness insurance policy.

(C) Notwithstanding this paragraph or any other law limiting or regulating interest rates or other charges, any insurance agent or agency, as defined in Code Section 33-23-1, shall be authorized but not required to charge, receive, and collect on any unpaid premium

account with a balance owing for 30 days or more a service charge which shall not exceed 15¢ per $10.00 per month computed on all amounts unpaid on the premium from month to month which need not be a calendar month or other regular period; provided, however, that, if the amount of service charge so computed shall be less than $1.00 for the month, a service charge of $1.00 for the month may be charged, received, and collected. Nothing contained in this subparagraph shall be construed to prevent an agent, agency, or broker from canceling a policy in accordance with the laws of this state;

(7)(A) Any insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this title or unless, by reason thereof, the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.

(B) Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create a monopoly;

(8) No insurance company shall cancel, modify coverage, refuse to issue, or refuse to renew any property or casualty insurance policy solely because the applicant or insured or any employee of either is mentally or physically impaired, provided that this paragraph shall not apply to accident and sickness insurance policies sold by a casualty insurer; provided, further, that this paragraph shall not be interpreted to modify any other provision of this title relating to the cancellation, modification, issuance, or renewal of any insurance policy or contract;

(9) No insurance company, when selling salvage motor vehicles, major component parts, or parts, shall sell directly to a used motor vehicle parts dealer, motor vehicle dismantler, motor vehicle rebuilder, salvage pool dealer, or salvage dealer who is not licensed under Chapter 47 of Title 43; provided, however, this paragraph shall not prevent an insurance company from selling salvage motor vehicles, major component parts, or parts to any person, firm, or corporation when the sale is made through a used motor vehicle parts dealer, motor vehicle dismantler, motor vehicle rebuilder, salvage pool dealer, or salvage dealer who is licensed under Chapter 47 of Title 43;

(10) No insurer shall refuse to insure an individual, refuse to continue to insure an individual, limit the amount, extent, or kind of

coverage available to an individual, or charge an individual a different rate for coverage solely because the individual is blind or partially blind;

(11) Each insurer which acquires a salvage motor vehicle, as defined in Code Section 40-3-2, shall, within 30 days of acquisition, apply for a salvage certificate of title, and no insurer shall sell, convey, or transfer any such salvage motor vehicle without first applying for and obtaining a salvage certificate of title;

(12)(A) No insurer shall cancel, nonrenew, or otherwise terminate all or substantially all of an entire line or class of business for the purpose of withdrawing from the market in this state unless:

(i) The insurer has notified the Commissioner in writing of the action, including the reasons for such action, at least one year before the completion of the withdrawal, provided that this paragraph shall not be construed to prevent such insurer from canceling, nonrenewing, or terminating policies where the insurer, by contract, statute, or otherwise, has the right to do so; or

(ii) The insurer has filed a plan of action for the orderly cessation of the insurer's business within a period of time shorter than one year and such plan of action has been approved by the Commissioner.

(B) At a minimum, in order to provide for orderly cessation and withdrawal, an insurer shall provide a general notice to each insured at least 90 days prior to the termination of any policy followed by a subsequent notice which meets the applicable statutory notice requirements for canceling, nonrenewing, or terminating insurance under this title.

(C) An insurer's rates, rules, and forms filed pursuant to Code Sections 33-9-21 and 33-24-9 shall be considered no longer on file for use with any new business in the market affected by the insurer's withdrawal plan on and after the withdrawal plan goes into effect;

(12.1) No insurer or managed care entity subject to licensing by the Commissioner shall violate any provision of Chapter 20A of this title;

(13)(A) As used in this paragraph, the term:

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

(ii) "Insurer" includes an insurance company and any person authorized to represent the insurer with respect to a claim and who is acting within the scope of the person's authority.

(iii) "Nonoriginal equipment manufacturer aftermarket crash part" means an aftermarket crash part made by any manufacturer other than the original vehicle manufacturer or his or her supplier.

(iv) "Repair facility" means a motor vehicle dealer, garage, body shop, or other commercial entity which undertakes the repair or replacement of those parts that generally constitute the exterior of a motor vehicle.

(B) Any aftermarket crash part manufactured or supplied for use in this state on or after January 1, 1990, shall have affixed thereto or inscribed thereon the logo, identification number, or name of its manufacturer. Such manufacturer's logo, identification number, or name shall be visible after installation whenever practicable.

(C) In all instances where nonoriginal equipment manufacturer aftermarket crash parts are used in preparing an estimate for repairs the written estimate prepared by the insurance adjuster and repair facility shall clearly identify each such part. A disclosure document attached to the estimate shall contain the following information in no smaller than ten-point type:

"THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AFTERMARKET CRASH PARTS SUPPLIED BY A SOURCE OTHER THAN THE MANUFACTURER OF YOUR MOTOR VEHICLE. THE AFTERMARKET CRASH PARTS USED IN THE PREPARATION OF THIS ESTIMATE ARE WARRANTED BY THE MANUFACTURER OR DISTRIBUTOR OF SUCH PARTS RATHER THAN THE MANUFACTURER OF YOUR VEHICLE."; and

(14) On and after July 1, 1992, no insurer, as defined in Code Section 33-1-2, shall issue, cause to be issued, renew, or provide coverage under any major medical insurance policy or plan containing a calendar year deductible or similar plan benefit period deductible which does not provide for a carry-over of the application of such deductible as provided in this paragraph. If all or any portion of an insured's or member's cash deductible for a calendar year or similar plan benefit period is applied against covered expenses incurred by the insured or member during the last three months of the deductible accumulation period, the insured's or member's cash deductible for the next ensuing calendar year or similar benefit plan period shall be reduced by the amount so applied. The provisions of this paragraph

shall apply to major medical insurance policies or plans which have a benefit plan period of less than 24 months, except policies or plans designed and issued to be compatible with a health savings account as set out in 26 U.S.C. Section 223 or a spending account as defined in Chapter 30B of this title.

History. — Code 1933, § 56-713, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1971, p. 887, § 1; Code 1933, § 56-712, as redesignated by Ga. L. 1972, p. 1261, § 7; Ga. L. 1980, p. 1011, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 699, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 464, § 1; Ga. L. 1985, p. 1227, § 3; Ga. L. 1986, p. 695, § 3; Ga. L. 1989, p. 1396, § 1; Ga. L. 1992, p. 996, § 4; Ga. L. 1995, p. 1165, § 6; Ga. L. 1996, p. 6, § 33; Ga. L. 2000, p. 136, § 33; Ga. L. 2002, p. 441, § 3; Ga. L. 2002, p. 786, § 1; Ga. L. 2005, p. 481, § 1/HB 291; Ga. L. 2019, p. 337, § 1-35/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "immediately preceding March 8, 1960" following "five years" at the end of subparagraph (4)(C); and deleted "paragraph (4) of" preceding "Code Section 33-1-2" near the beginning of the first sentence of paragraph (14).

Cross references. — Provision that contracts in general restraint of trade contravene public policy, § 13-8-2.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1985, the paragraph (10) added by Ga. L. 1985, p. 1227, § 3 was redesignated as paragraph (11).

Pursuant to Code Section 28-9-5, in 2002, in paragraph (12), "canceling" was substituted for "cancelling" in division (A)(i) and subparagraph (B) and "Chapter 20A of this title" was substituted for "Chapter 20A of Title 33" in paragraph (12.1).

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of Chapter 20A of this title.

Law reviews. — For note on the 2002 amendment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

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Legislative intent. — Legislature's decision to restrict only mass cancellations and not mass renewals was not absurd or unjust, if the legislature had intended to restrict both, then it would have said so, as it did elsewhere in the unfair trade practices chapter. Ins. Dep't of Ga. v. St. Paul Fire & Cas. Ins. Co., 253 Ga. App. 551, 559 S.E.2d 754 (2002).

Under O.C.G.A. § 33-6-5(12), "cancel" did not mean "nonrenew"; interpreting cancel in that manner would be contrary to the strict letter of the statute. By its plain terms, the statute limits the power of an insurer to cancel an entire line or class of business, thereby effectuating an immediate, widespread interruption of insurance coverage. Ins. Dep't of

Ga. v. St. Paul Fire & Cas. Ins. Co., 253 Ga. App. 551, 559 S.E.2d 754 (2002).

Cited in Nat'l Viatical, Inc. v. State, 258 Ga. App. 408, 574 S.E.2d 337 (2002).

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Section prohibits requiring minimum purchases to maintain insurance. — A credit card insurance plan which requires that a cardholder must purchase during each billing period at least $10.00 worth of the goods and services merchandised by the credit card company and its affiliates in order to acquire and maintain the insurance coverage falls squarely within the prohibition of paragraph (1) of this section. 1972 Op. Att'y Gen. No. 72-66.

Efforts to stimulate business by free insurance. — The use of the words "in connection with" in paragraph (1) of this section extends to and prohibits every commercial effort to stimulate business by gifts of free insurance. 1963-65 Op. Att'y Gen. p. 435.

Offer of group rate valid when offered under statutory standards. — A filing which purports to offer insurance rates on a group basis does not violate paragraph (4) of O.C.G.A. § 33-6-5 when the rates are derived on the basis of rate-making considerations and standards set forth in O.C.G.A. § 33-9-4. 1984 Op. Att'y Gen. No. 84-88.

Fact that title insurance is sold at different prices to different purchasers would not constitute a violation of subparagraph (6)(B) of O.C.G.A. § 33-6-5. 1983 Op. Att'y Gen. No. 83-31.

Practice of title insurance companies bidding below their published rates in an attempt to obtain orders on large commercial accounts while charging their residential customers the published amount without bidding against each other would not violate subparagraph (6)(B) of O.C.G.A. § 33-6-5 unless they are charging either the large commercial or residential customers amounts either above or below the rates fixed by the insurance company and specified in the policies issued to such persons. 1983 Op. Att'y Gen. No. 83-31.

Paragraph (9) of O.C.G.A. § 33-6-5 does not limit the class of purchasers to those mentioned; however, if an insurance company chooses to sell salvage parts and vehicles to anyone in the class of purchasers enumerated, the purchaser must be licensed. 1984 Op. Att'y Gen. No. 84-28.

RESEARCH REFERENCES

ALR. — Legality of combinations or agreements between insurance companies or insurance agents, 21 A.L.R. 543.

When payment of insurance premiums or assessments deemed involuntary so as to permit their recovery back, 86 A.L.R. 388.

Wrongful cancellation of medical malpractice insurance, 99 A.L.R.3d 469.

33-6-6. Power of Commissioner as to investigation of unfair or deceptive acts or practices generally.

(a) The Commissioner shall have the power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this chapter.

(b) In addition to any other authority granted to the Commissioner by this title and in addition to those reports required by Code Section 33-3-21, the Commissioner may require persons engaged in the busi-

ness of insurance in this state to file reports by postal ZIP Code, where appropriate, or in any other format to enable the Commissioner to determine readily if such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this article.

History. — Code 1933, § 56-705, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1978, p. 2016, § 2; Ga. L. 1992, p. 3048, § 4.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 20 et seq.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-6-7. Conduct of hearings by Commissioner; rights of person being investigated; powers of Commissioner; service of process.

(a) Whenever the Commissioner shall have reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice, whether or not defined in Code Sections 33-6-4 and 33-6-5, and have reason to believe that a proceeding by the Commissioner in respect to such unfair method of competition or such unfair or deceptive act or practice would be in the public interest, he shall issue and serve upon the person a statement of the charges in that respect and a notice of a hearing on the charges to be held at a time and place fixed in the notice, which time shall not be less than 15 days after the date of the service of the notice.

(b) At the time and place fixed for the hearing, the person shall have an opportunity to be heard and to show cause why an order requiring the person to cease and to desist from the acts, methods, or practices so complained of should not be made by the Commissioner. Upon good cause shown, the Commissioner shall permit any person to intervene, appear, and be heard at the hearing by counsel or in person.

(c) Nothing contained in this article shall require the observance at the hearing of formal rules of pleading or evidence.

(d) The Commissioner at the hearing may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, subpoena and compel the attendance of witnesses, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The Commissioner at the hearing may and, upon request of any party, shall cause to be made a record of all the evidence and all the proceedings had at the hearing. In case of a refusal of any person to comply with any subpoena issued under this Code section or to testify with respect to any matter

concerning which he may be lawfully interrogated, the Superior Court of Fulton County or the superior court of the county where the party resides, on application of the Commissioner, may issue an order requiring the person to comply with the subpoena and to testify; and any failure to obey any order of the court may be punished by the court as a contempt thereof.

(e) Statements of charges, notices, orders, and other processes of the Commissioner under this article may be served by anyone duly authorized by the Commissioner either in the manner provided by law for service of process in civil actions or by registering or certifying and mailing a copy of the statement, notice, order, or other process to the person affected by it at the person's residence or principal office or place of business. The verified return by the person so serving the statement, notice, order, or other process, which return sets forth the manner of the service, shall be proof of the same; and the return post card receipt for the statement, notice, order, or other process, which receipt is registered or certified and mailed as provided in this Code section, shall be proof of the service of the same.

History. — Code 1933, § 56-706, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1261, § 1; Ga. L. 1992, p. 3048, § 5.

Cross references. — Conduct of hearings by Commissioner generally, § 33-2-16 et seq. Administrative procedure generally, T. 50, C. 13.

Law reviews. — For comment on Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952) see 14 Ga. B.J. 468 (1952).

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Editor's notes. — In light of the similarity of the statutory provisions, a decision under former Ga. L. 1950, p. 326, is included in the annotations for this Code section.

Section blueprints procedure to be followed. — The investigative powers of the Commissioner as set forth in this section constitute a legislative "blueprint" of the procedure that he must employ. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Insurance company has no duty to copy records for Commissioner. — There is nothing in the law placing upon the insurance company a duty to copy its records and mail them to the Commissioner, and when the Commissioner has fully performed the duties and employed the powers given the Commissioner by law, the Commissioner will have all the information that the Commissioner could obtain by requiring copies of the company's records to be mailed to the Commissioner. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Commissioner may not refuse license renewal for failure to copy records. — Having the power and duty to investigate an insurance company, to inspect its original records, and to take the sworn testimony of its agents, the Commissioner has a duty to do so and is unauthorized to impose upon the company a duty to copy its records and refuse a renewal of its license upon its failure in that respect. Bankers Life & Cas. Co. v. Cravey, 208 Ga. 682, 69 S.E.2d 87 (1952), commented on in 14 Ga. B.J. 468 (1952).

Cited in Georgia-Carolina Brick & Tile Co. v. Brown, 153 Ga. App. 747, 266 S.E.2d 531 (1980).

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Commissioner may challenge any method of competition as unfair. — This section apparently gives the Commissioner the right to challenge any method of competition as being unfair, and therefore the Commissioner would want to bear this in mind in passing upon the approval of a program involving gifts of life insurance. 1963-65 Op. Att'y Gen. p. 435.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 27 et seq.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-6-8. Issuance of cease and desist orders; issuance of orders providing for other relief; change in orders; date on which orders appealable.

(a) If, after the hearing provided for in Code Section 33-6-7, the Commissioner shall determine that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring such person to cease and desist from engaging in the method of competition, act, or practice; and, if the act or practice is a violation of Code Sections 33-6-4 and 33-6-5, the Commissioner may at his discretion order any one or more of the following:

(1) Payment of a monetary penalty of not more than $1,000.00 for each and every act or violation, unless the person knew or reasonably should have known he was in violation of this article, in which case the penalty shall be not more than $5,000.00 for each and every act or violation;

(2) Suspension or revocation of the person's license, if he knew or reasonably should have known he was in violation of this article; or

(3) Any other relief as is reasonable and appropriate.

(b) The Commissioner may at any time before the serving of notice of appeal upon him, as provided for in Code Section 33-6-11, or after the expiration of the time allowed by law for the serving of the notice, if no notice has been thus served, amend or set aside in whole or in part any order issued by him under this Code section whenever in his opinion the facts and circumstances surrounding the case have so changed as to require the action or if the public interest shall so require. No change of an order in a manner unfavorable to the person charged or to the parties at interest shall be made except after notice and opportunity for hearing. The date of the Commissioner's last order shall be the point of time from which it may be reviewed by appeal.

History. — Code 1933, § 56-707, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1261, §§ 2, 3; Ga. L. 1992, p. 3048, § 6.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 22 et seq.

ALR. — Recovery of cumulative statutory penalties, 71 A.L.R.2d 986.

33-6-9. Penalties for violations of cease and desist orders.

After notice and hearing and upon order of the Commissioner, any person who violates a cease and desist order under Code Section 33-6-8, while the order is in effect may, at the discretion of the Commissioner, be subject to any one or more of the following:

(1) A monetary penalty of not more than $10,000.00 for each and every act or violation;

(2) Suspension or revocation of such person's license; or

(3) Any other relief as is reasonable and appropriate.

History. — Code 1933, § 56-711, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1261, § 6; Code 1933, § 56-710, as redesignated by Ga. L. 1972, p. 1261, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 22 et seq.

C.J.S. — 44 C.J.S., Insurance, § 67 et seq.

33-6-10. Orders of Commissioner and judicial review.

(a) Any order, decision, or the imposition of any penalty by the Commissioner shall be subject to review by petition for review as provided in Chapter 2 of this title. The Commissioner's finding upon questions of fact shall be final if sustained by substantial evidence.

(b) To the extent that the order of the Commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the Commissioner.

(c) An order issued by the Commissioner under Code Section 33-6-8 shall become final:

(1) Upon the expiration of the time allowed by law for the filing of a petition for review, if no petition has been filed within that time, except that the Commissioner may thereafter modify or set aside his order to the extent provided in subsection (b) of Code Section 33-6-8; or

(2) Upon the final decision of the court, if the court directs that the order of the Commissioner be affirmed or the appeal dismissed.

History. — Code 1933, § 56-709, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1261, § 5; Code 1933, § 56-708, as redesignated by Ga. L. 1972, p. 1261, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 32.

C.J.S. — 44 C.J.S., Insurance, § 70 et seq.

33-6-11. Intervenor appeal for judicial review.

If the report of the Commissioner does not charge a violation of this article, any intervenor in the proceedings may cause a review of such decision by appeal to the Superior Court of Fulton County as provided for in Chapter 2 of this title. Upon that review, the court shall have authority to issue appropriate orders and decrees in connection with such review, including, if the court finds that it is in the public interest, orders enjoining and restraining the continuance of any method of competition, act, or practice which it finds constitutes a violation of this article notwithstanding the report of the Commissioner.

History. — Code 1933, § 56-710, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-709, as redesignated by Ga. L. 1972, p. 1261, § 7; Ga. L. 1992, p. 3048, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 32.

C.J.S. — 44 C.J.S., Insurance, § 70 et seq.

33-6-12. Promulgation of rules and regulations by Commissioner.

The Commissioner after notice and hearing may promulgate reasonable rules and regulations as are necessary or proper to identify specific methods of competition or acts or practice which are prohibited by Code Sections 33-6-4 and 33-6-5; but the rules and regulations shall not enlarge upon or extend the provisions of Code Sections 33-6-4 and 33-6-5. The rules and regulations shall be subject to Code Section 33-2-9.

History. — Code 1933, § 56-713, enacted by Ga. L. 1972, p. 1261, § 8.

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Soliciting mortgage customers for insurance business not unfair competition. — A corporation engaged in the mortgage servicing and insurance business cannot be said to be guilty of unfair competition by merely soliciting the mort-

gagors, whose mortgages they service, to obtain their insurance business. 1965-66 Op. Att'y Gen. No. 66-213.

33-6-13. Unlawful contracts, understandings, and combinations; powers of Commissioner as to enforcement of Code section.

(a) No person shall either within or outside of this state enter into any contract, understanding, or combination with any other person to do jointly or severally any act or engage in any practice for the purpose of or that has a tendency to or the effect of:

(1) Controlling the rates to be charged for insuring any risk or any class of risks in this state;

(2) Unfairly discriminating against any person in this state by reason of his plan or method of transacting insurance or by reason of his affiliation or nonaffiliation with any insurance organization; or

(3) Establishing or perpetuating any condition in this state detrimental to free competition in the business of insurance or injurious to the insuring public.

(b) This Code section shall not apply to ocean marine and foreign trade insurance.

(c) This Code section shall not be deemed to prohibit the doings of things permitted to be done in accordance with Chapter 9 of this title.

(d) Whenever the Commissioner has knowledge of any violation of this Code section, he shall immediately order the offending person to discontinue such practice immediately or to show cause to the satisfaction of the Commissioner why the order should not be complied with. If the offender is an insurer or a licensee under this title and fails to comply with such order within 30 days after receipt of such order, the Commissioner may immediately revoke the offender's certificate of authority or licenses.

History. — Code 1933, § 56-712, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-711, as redesignated by Ga. L. 1972, p. 1261, § 7.

Cross references. — Provision that contracts in general restraint of trade contravene public policy, § 13-8-2.

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Practice of title insurance companies paying up to 70 percent of premiums collected to agents in order to obtain business controlled by those agents does not violate paragraph (a)(3) of O.C.G.A. § 33-6-13. 1983 Op. Att'y Gen. No. 83-31.

RESEARCH REFERENCES

ALR. — Illegality as basis for denying remedy of specific performance for breach of contract, 58 A.L.R.5th 387.

33-6-14. Construction of article.

(a) The powers vested in the Commissioner by this article shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law with respect to the methods, acts, and practices declared to be unfair or deceptive by this article.

(b) Nothing contained in this article shall be construed as repealing or amending the power of the Commissioner to revoke the license of any insurer or agent of such insurer when he is commanded or authorized to do so by existing laws or on account of a violation of this article.

History. — Code 1933, § 56-714, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 3048, § 8.

ARTICLE 2

UNFAIR CLAIMS SETTLEMENT PRACTICES

33-6-30. Short title.

This article shall be known and may be cited as the "Unfair Claims Settlement Practices Act."

History. — Code 1981, § 33-6-30, enacted by Ga. L. 1992, p. 3048, § 9.

33-6-31. Purpose.

The purpose of this article is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of Georgia. It is not intended to cover claims involving workers' compensation, fidelity, or surety insurance.

History. — Code 1981, § 33-6-31, enacted by Ga. L. 1992, p. 3048, § 9.

33-6-32. Definitions.

As used in this article, the term:

(1) "Insured" means the party named on a policy or certificate or as defined in the contract as the person with legal rights to the benefits provided by such policy or certificate.

(2) "Person" means an individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including but not limited to agents, brokers, counselors, and adjusters.

(3) "Policy" or "certificate" means any contract of insurance; indemnity; medical, health, or hospital service; or annuity issued by an insurer. "Policy" or "certificate" shall not mean contracts for workers' compensation, fidelity, or surety insurance.

History. — Code 1981, § 33-6-32, enacted by Ga. L. 1992, p. 3048, § 9.

33-6-33. When claims settlement practice improper.

It is an improper claims settlement practice for any domestic, foreign, or alien insurer transacting business in Georgia to commit any act provided in Code Section 33-6-34 if such act:

(1) Is committed flagrantly and in conscious disregard of this title or any rule or regulation promulgated pursuant to this title; or

(2) Has been committed with such frequency so as to indicate a general business practice to engage in such conduct.

History. — Code 1981, § 33-6-33, enacted by Ga. L. 1992, p. 3048, § 9.

33-6-34. (For effective date, see note.) Unfair claims settlement practices.

Any of the following acts of an insurer when committed as provided in Code Section 33-6-33 shall constitute an unfair claims settlement practice:

(1) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement procedures for the prompt investigation and settlement of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;

(5) Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) Refusing to pay claims without conducting a reasonable investigation;

(7) When requested by the insured in writing, failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

(8) When requested by the insured in writing, making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

(9) Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form; provided, however, this paragraph shall not preclude an insurer from obtaining sworn statements if permitted under the policy;

(10) When requested by the insured in writing, failing in the case of claims denial or offers of compromise settlement to provide promptly a reasonable and accurate explanation of the basis for such actions. In the case of claims denials, such denials shall be in writing;

(11) Failing to provide forms necessary to file claims within 15 calendar days of a request with reasonable explanations regarding their use;

(12) Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by the insurer are performed in a workmanlike manner;

(13) **(For effective date, see note.)** Indicating to a first-party claimant on a payment, draft check, or accompanying letter that said payment is final or a release of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract;

(14) **(For effective date, see note.)** Issuing checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which releases the insurer or its insured from its total liability; and

(15) **(For effective date, see note.)** Failure to comply with any insurer requirement in Chapter 20E of Title 33, the "Surprise Billing Consumer Protection Act," including the failure to pay a resolution organization as required under Code Section 33-20E-16.

History. — Code 1981, § 33-6-34, enacted by Ga. L. 1992, p. 3048, § 9; Ga. L. 2020, p. 210, § 2/HB 888.

Delayed effective date. — Paragraphs (13), (14), and (15), as set out above, become effective January 1, 2021. For versions of paragraphs (13) and (14), in effect until January 1, 2021, see the 2020 amendment note. Until January 1, 2021, there is no paragraph (15).

The 2020 amendment, effective January 1, 2021, deleted "and" at the end of paragraph (13), substituted "; and" for the period at the end of paragraph (14), and added paragraph (15).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "first-party" was substituted for "first party" in two places in paragraph (13).

RESEARCH REFERENCES

ALR. — What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular conduct of insurer, 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim — Particular grounds for denial of claim: matters relating to policy, 116 A.L.R.5th 247.

33-6-35. Notice of hearing; hearing procedures; cease and desist orders; penalties; judicial review; intervenors.

(a) Whenever the Commissioner has reason to believe that any person has engaged or is engaging in this state in any unfair claims settlement practice and has reason to believe that a proceeding with respect to such unfair claims settlement practice would be in the public interest, the Commissioner shall serve upon such person a statement of the charges in that respect and a notice of hearing in the same manner as provided in Code Section 33-6-7.

(b) The provisions of Code Sections 33-6-7 through 33-6-11, relating to hearings, cease and desist orders, penalties, judicial review, intervenors, and other matters in connection with violations of Article 1 of this chapter shall be applicable to violations of this article.

History. — Code 1981, § 33-6-35, enacted by Ga. L. 1992, p. 3048, § 9.

33-6-36. Rules and regulations.

The Commissioner may, in accordance with the procedures set forth in Code Section 33-2-9, promulgate rules and regulations necessary to implement and enforce the provisions of this article. If the Commissioner should find that extraordinary circumstances exist and that it would be in the best interests of the citizens of this state, the Commissioner may suspend temporarily the applicability of any rule or regulation promulgated pursuant to this article.

History. — Code 1981, § 33-6-36, enacted by Ga. L. 1992, p. 3048, § 9.

JUDICIAL DECISIONS

Cited in White v. State Farm Fire & Casualty Co., 291 Ga. 306, 728 S.E.2d 685 (2012).

33-6-37. Private cause of action not created or implied.

Nothing contained in this article shall be construed to create or imply a private cause of action for a violation of this article.

History. — Code 1981, § 33-6-37, enacted by Ga. L. 1992, p. 3048, § 9.

CHAPTER 7

KINDS OF INSURANCE; LIMITS OF RISKS; REINSURANCE

Sec.
33-7-1. Definitions of insurance not deemed mutually exclusive.
33-7-2. Accident and sickness insurance.
33-7-2.1. Direct primary care agreements; no special certificate or license; requirements for agreement and discontinuation of services; refunding.
33-7-3. Casualty insurance.
33-7-3.1. Credit insurance.
33-7-4. Life insurance.
33-7-5. Marine and transportation insurance.
33-7-6. Property insurance; contract requirements; rules and regulations; exemptions.
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33-7-8. Title insurance.
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33-7-9. Vehicle insurance.
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33-7-11. Uninsured motorist coverage under motor vehicle liability policies.
33-7-11.1. Commencement of liability of insurer to pay benefits to third party on behalf of insured; applicability of Code section.
33-7-12. Effect of policy provision permitting insurer to settle or compromise claims of third persons against insured; release of claims by third persons.
33-7-13. Limitation of risks.
33-7-14. Reinsurance of risks.
33-7-15. Cooperation by insured with insurer in defense of action or threatened action under policy.

Cross references. — Designation of classes of insurance, § 33-3-5. Insurance by employer of payment of workers' compensation benefits to employees, § 34-9-120 et seq.

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 7 et seq.

ALR. — Criminal conviction as rendering conduct for which insured convicted within provision of liability insurance policy expressly excluding coverage for damage or injury intended or expected by insured, 35 A.L.R.4th 1063.

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, §§ 691 et seq., 704 et seq.

33-7-1. Definitions of insurance not deemed mutually exclusive.

It is intended that certain coverages may come within the definitions of two or more kinds of insurance as set forth in this chapter, and the fact that the coverage is included within one definition shall not exclude

the coverage as to any other kind of insurance within the definition of which the coverage likewise reasonably is includable.

History. — Code 1933, § 56-401, enacted by Ga. L. 1960, p. 289, § 1.

33-7-2. Accident and sickness insurance.

Accident and sickness insurance is insurance against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness and every insurance appertaining thereto.

History. — Code 1933, § 56-404, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Offering of accident, sickness, and disability insurance by fraternal benefit societies, § 33-15-60. Health care plans, T. 33, C. 20. Health maintenance organizations, T. 33, C. 21. Assignment of policy which permits change of beneficiary upon request of policy owner, § 33-24-17. Provisions of accident, sickness, and other insurance policies generally, §§ 33-24-20 through 33-24-31. Individual accident and sickness insurance, T. 33, C. 29. Group or blanket accident and sickness insurance, T. 33, C. 30. Credit accident and sickness insurance, T. 33, C. 31.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 540 et seq.

C.J.S. — 44 C.J.S., Insurance, § 11 et seq.

ALR. — Health insurance: provisions excluding or limiting liability in case of chronic diseases, 4 A.L.R. 875; 15 A.L.R. 1239.

Accident insurance: provisions regarding voluntary exposure to danger as applicable to dangers incident to automobiling, 4 A.L.R. 1244.

Accident insurance: injury by insect, 9 A.L.R. 529.

Accident insurance: taxicab as a public conveyance provided by a common carrier within provision for double or increased indemnity, 9 A.L.R. 1555.

Conflict between provision in accident insurance policy defining risks covered and provision limiting liability in case of loss from certain cause, 14 A.L.R. 1333.

Accident insurance: aiding peace officer as voluntary exposure to unnecessary danger, 17 A.L.R. 191.

Accident insurance: infection through a wound previously received, 18 A.L.R. 113.

Accident insurance: when insured deemed to be totally and continuously unable to transact all business duties, 24 A.L.R. 203; 41 A.L.R. 1376; 51 A.L.R. 1048; 79 A.L.R. 857; 98 A.L.R. 788; 39 A.L.R.3d 1026.

Infection through boil, or similar condition, as an accident or accidental means within accident policy, 24 A.L.R. 730.

Accident insurance: provision for reduced indemnity for injury while doing act pertaining to more hazardous occupation, 26 A.L.R. 123.

Insurance: applicability of provisions as to injuries intentionally inflicted, where insured is injured because of mistake of identity, 26 A.L.R. 129.

Criterion of health for purposes of warranty or condition in insurance contract, 40 A.L.R. 662; 100 A.L.R. 362.

Insurance: death or injury resulting from insured's voluntary act as caused by accident or accidental means, 42 A.L.R. 243; 45 A.L.R. 1528; 71 A.L.R. 1437; 111 A.L.R. 628.

Provision in accident insurance policy in relation to train wreck, 51 A.L.R. 1331.

"More hazardous" provision of accident policy as applied to one who without aban-

doning the occupation named also engages in a more hazardous occupation, 55 A.L.R. 1057.

What amounts to medical or surgical attendance or consultation within contemplation of contract of life or accident insurance, 63 A.L.R. 846.

"Permanent disability" within insurance policy as confined to disability lasting until death, 97 A.L.R. 126.

What constitutes bodily injury within policy of accident insurance or accident feature of life policy, 117 A.L.R. 739.

Construction and application of provisions of liability or indemnity policy regarding injury or death incident to construction, repairs, alterations, demolition, or wrecking of structure, or installation of elevators or other equipment, 130 A.L.R. 239.

Construction and application of specific provision of accident policy as to death or injury while standing in or on public street or highway, 130 A.L.R. 1155.

Burn as an accident or caused by accidental means within coverage of life or accident insurance policy, 138 A.L.R. 1514.

Burden of proof, in accident policy or accident feature of life policy, as regards conditions which, by terms of the policy, limit or exclude coverage, 142 A.L.R. 742.

Policy of group insurance as covering death or injury after termination of employment but within period allowed by policy for application for new or continued insurance, or within period of grace provided for payment of premiums, 145 A.L.R. 951.

Loss or impairment of vision as within meaning of total disability clause, 1 A.L.R.2d 756.

Loss of hearing as within meaning of total disability clause, 1 A.L.R.2d 952.

Proof of death or injury from external and violent means as supporting presumption or inference of death by accidental means within policy of insurance, 12 A.L.R.2d 1264.

Rupture of blood vessel following exertion or exercise as within terms of accident provision of insurance policy, 35 A.L.R.2d 1105.

Validity, construction, and effect of provisions of life or accident policy in relation to military service, 36 A.L.R.2d 1018.

Scope of provision in group health or accident insurance policy excluding from coverage sickness or accidents arising out of, or in the course of, employment, 47 A.L.R.2d 1240.

Repeated absorption of poisonous substance as "accident" within coverage clause of comprehensive general liability policy, 49 A.L.R.2d 1263.

Scope and application of provisions of accident policy, or accident feature of life policy, relating to accident in connection with automobile or other motor vehicle, 78 A.L.R.2d 1044.

Liability under accident policy, or accident feature of life policy, for injury or death from freezing or exposure to cold, 4 A.L.R.3d 1177.

When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 10 A.L.R.3d 468.

Right of tortfeasor or liability insurer to credit for amounts already disbursed to injured party under medical payments or funeral expenses clause in liability policy, 11 A.L.R.3d 1115.

What constitutes total or permanent disability within the meaning of insurance policy issued to physician or dentist, 21 A.L.R.3d 677.

Insurance: "total disability" or the like as referring to inability to work in usual occupation or in other occupations, 21 A.L.R.3d 1155.

Heart or vascular condition as constituting total or permanent disability within insurance coverage, 21 A.L.R.3d 1383.

What constitutes total or permanent disability within coverage of disability insurance issued to former or agricultural worker, 26 A.L.R.3d 714.

Beneficiary's ignorance of existence of life or accident policy as excusing failure to give notice make proofs of loss, or bring action within time limited by policy or statute, 28 A.L.R.3d 292.

What constitutes permanent or total disability within coverage of insurance policy issued to physical laborer or workman, 32 A.L.R.3d 922.

Validity and construction of accident insurance policy provision making bene-

fits conditional on disability occurring immediately, or at once, or within specified time of accident, 39 A.L.R.3d 1026.

Who is "fare-paying passenger" within coverage of life or accident insurance policy, 60 A.L.R.3d 1273.

Medical care insurance: right of insured under individual policy to coverage afforded by group policy from which he directly transferred on termination of his employment, 66 A.L.R.3d 1192.

Elimination of particular coverage, or termination, health, hospitalization, or medical insurance policy, as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illness, 66 A.L.R.3d 1205.

Liability insurance: assault as an "accident," or injuries therefrom as "accidentally" sustained, within coverage clause, 72 A.L.R.3d 1090; 31 A.L.R.4th 957; 33 A.L.R.4th 983; 34 A.L.R.4th 761; 35 A.L.R.4th 1063.

Admissibility of opinion evidence as to employability on issue of disability in health and accident insurance and workers' compensation cases, 89 A.L.R.3d 783.

Heart attack following exertion or exercise as within terms, 1 A.L.R.4th 1319.

Accident insurance: what is "loss" of body member, 51 A.L.R.4th 156.

Accident or life insurance: death by autoerotic asphyxiation as accidental, 62 A.L.R.4th 823.

What constitutes single accident or occurrence within liability policy limiting insurer's liability to a specified amount per accident or occurrence, 64 A.L.R.4th 668.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance, 75 A.L.R.4th 763.

When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 65 A.L.R.5th 649.

33-7-2.1. Direct primary care agreements; no special certificate or license; requirements for agreement and discontinuation of services; refunding.

(a) As used in this Code section, the term:

(1) "Direct primary care agreement" means a contract between a physician and an individual patient or his or her legal representative in which the physician or the physician's medical practice agrees to provide health care services to the individual patient for an agreed-upon fee and period of time.

(2) "Direct primary care practice" means a physician or physician's medical practice that charges a periodic fee for services, does not bill any third parties on a fee for service basis, and whose per visit charge is less than the monthly equivalent of the periodic fee.

(3) "Physician" means a person licensed to practice medicine pursuant to Article 2 of Chapter 34 of Title 43.

(b) A direct primary care agreement is not insurance, shall not be deemed an insurance arrangement nor agreement, and is not subject to state insurance laws.

(c) A physician offering, marketing, selling, or entering into a direct primary care agreement shall not be required to obtain a certificate of authority or license other than to maintain a current license to practice medicine with the State of Georgia.

(d) To be considered a direct primary care agreement for the purposes of this Code section, such agreement shall:

(1) Be in writing;

(2) Be signed by a physician or agent of the physician and the individual patient or his or her legal representative;

(3) Allow either party to terminate such agreement upon written notice; provided, however, that a physician shall be required to give a patient adequate notice of at least 30 days to allow a patient a reasonable amount of time to find another health care provider, and a patient shall be required to give a physician notice of no more than 30 days;

(4) Describe the scope of health care services that are covered by the periodic fee;

(5) Specify the periodic fee and any additional fees outside of the periodic fee for ongoing care;

(6) Specify the duration of such agreement and any automatic renewal periods and require that no more than 12 months of the periodic fee be paid in advance; and

(7) Prominently state in writing that such agreement is not health insurance.

(e) A physician providing health care services under a direct primary care agreement may decline to accept a patient if, in the physician's opinion, such patient's medical condition is such that the provider is unable to provide the appropriate level and type of health care services such patient requires. The physician may discontinue care for patients under the direct primary care agreement if:

(1) The patient fails to pay the periodic fee or any additional fees specified by the agreement;

(2) The patient has performed an act of fraud;

(3) The patient repeatedly fails to adhere to the recommended treatment plan;

(4) The patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct primary care practice; or

(5) The physician or the physician's medical practice discontinues operation as a direct primary care practice.

(f) In the event that either party terminates an agreement pursuant to this Code section, any unearned portion of any fees paid pursuant to

such agreement shall be refunded by the physician to the patient within 30 days of termination.

History. — Code 1981, § 33-7-2.1, enacted by Ga. L. 2019, p. 217, § 2/SB 18.

Effective date. — This Code section became effective July 1, 2019.

Editor's notes. — Ga. L. 2019, p. 217, § 1/SB 18, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Direct Primary Care Act.'"

Law reviews. — For article on the 2019 enactment of this Code section, see 36 Ga. St. U.L. Rev. 135 (2019).

RESEARCH REFERENCES

Am. Jur. 2d. — 61 Am. Jur. 2d, Physicians, Surgeons, and Other Healers, § 114 et seq.

33-7-3. Casualty insurance.

Casualty insurance includes vehicle insurance as defined in Code Section 33-7-9 and accident and sickness insurance as defined in Code Section 33-7-2 and in addition includes:

(1) Liability insurance, which is insurance against legal liability for the death, injury, or disability of any human being, or for damage to property, and which provides medical, hospital, surgical, and disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance;

(2) Workers' compensation and employers' liability insurance, which is insurance of the obligations accepted by, imposed upon, or assumed by employers for death, disablement, or injury of employees;

(3) Burglary and theft insurance, which is insurance against loss or damage by burglary, theft, larceny, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, wrongful conversion, disposal, concealment, mysterious disappearance, destruction of money or securities, or from any attempt at any of the foregoing, including supplemental coverages for medical, hospital, surgical, and funeral expenses incurred by the named insured or other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; also insurance against loss of or damage to moneys, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers and documents resulting from any cause;

(4) Personal property floater insurance, which is insurance upon personal effects against loss or damage from any cause;

(5) Glass insurance, which is insurance against loss or damage to glass, including its lettering, ornamentation, and fittings;

(6) Boiler and machinery insurance, which is insurance against any liability and loss or damage to property or interest resulting from accidents to or explosion of boilers, pipes, pressure containers, machinery, or apparatus, and inspection of, and issuing certificates of inspection upon, boilers, machinery, and apparatus of any kind, whether or not insured;

(7) Leakage and fire extinguishing equipment insurance, which is insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus, water pipes and containers, or by water entering through leaks or openings in buildings, and insurance against loss or damage to such sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus;

(8) Malpractice insurance, which is insurance against legal liability of the insured and against loss, damage, or expense incidental to a claim of such liability, including medical, hospital, surgical, and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury, or disablement of any person, or arising out of damage to the economic interest of any person as the result of negligence in rendering expert, fiduciary, or professional services;

(9) Entertainments insurance, which is insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation of such event or exhibition due to death, accidental injury, or sickness of performers, participants, directors, or other principals; and

(10) Miscellaneous insurance, which is insurance against any other kind of loss, damage, or liability properly a subject of insurance and not within any other kind of insurance as defined in this title, if the insurance is not disapproved by the Commissioner as being contrary to law or public policy.

History. — Code 1933, § 56-408, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1995, p. 437, § 1; Ga. L. 1996, p. 912, § 1.

Cross references. — Apportionment of casualty insurance among admitted insurers, §§ 33-9-7, 33-9-8. Offering of accident, sickness, and disability insurance by fraternal benefit societies, § 33-15-60. Provisions of accident, sickness, and other insurance policies generally, § 33-24-20 et seq. Accident and sickness insurance, T. 33, C. 29, C. 30, and C. 31. Workers' compensation generally, T. 34, C. 9.

JUDICIAL DECISIONS

This section conforms to the general policy that the freedom to contract should not be curtailed on public policy grounds unless the case is free from doubt. Greenwood Cem. v. Travelers Indem. Co., 238 Ga. 313, 232 S.E.2d 910 (1977).

Insurance against punitive damages is authorized. — Punitive damages are a legal liability, and accordingly insurance against such damages is expressly authorized by paragraph (1) of this section. This conclusion is fortified by paragraph (11) of this section. Greenwood Cem. v. Travelers Indem. Co., 238 Ga. 313, 232 S.E.2d 910 (1977).

Insurance coverage for punitive damages is not against public policy. Federal Ins. Co. v. National Distrib. Co., 203 Ga. App. 763, 417 S.E.2d 671, cert. denied, 203 Ga. App. 906, 417 S.E.2d 671 (1992).

Without some specific statutory authorization, action cannot proceed directly against liability insurance carrier until a judgment is obtained against the tortfeasor or his liability is otherwise fixed. Smith v. Commercial Union Assurance Co., 246 Ga. 50, 268 S.E.2d 632 (1980).

OPINIONS OF THE ATTORNEY GENERAL

"Casualty insurance," as used in the Georgia Code, is somewhat of a catch-all category that may include various types of coverage that are not included in life, health and accident, fire and allied lines, or worker's compensation. 1957 Op. Att'y Gen. p. 167.

"Security transaction insurance" would properly fall in what is designated as "miscellaneous casualty." 1957 Op. Att'y Gen. p. 167.

It is proper to treat "legal services insurance" as either "property insurance" or "casualty insurance." 1974 Op. Att'y Gen. No. 74-48.

Policy covering school officials against student injury claims was a liability policy. — Insurance policy which covered school officials and employees against injuries a student might receive while participating in an extracurricular activity was a liability policy under this section since the nonliability coverage, which only became effective if the injured party waived the right to make a legal liability claim against the named insureds, was clearly supplemental to the liability coverage. 1984 Op. Att'y Gen. No. 84-66.

When foreign insurer may write radioactive contamination and nuclear facility insurance. — A foreign language company licensed in this state to write fire and allied lines of insurance (property insurance) and miscellaneous casualty insurance may write insurance "against the perils of radioactive contamination and all other perils causing physical loss to nuclear energy installations and facilities, including consequential loss," provided the company is authorized to write such coverage by the laws of the state of its domicile. 1958-59 Op. Att'y Gen. p. 199.

When foreign insurer may underwrite homeowners' warranties. — An insurance company that has not met the requirements imposed upon risk retention groups by the state in which it is chartered as an insurance company may not underwrite homeowners' warranties in Georgia without a certificate of authority authorizing the transaction of insurance in Georgia. 1982 Op. Att'y Gen. No. 82-104.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1172.

Am. Jur. Proof of Facts. — Formaldehyde Fumes Emitted by Building Materials, 3 POF3d 225.

Avoiding the "Business Pursuits" Exclu-

sion — Insured's Activity as Not Business Pursuit, 15 POF3d 515.

Avoiding the "Business Pursuits" Exclusion — Insured's Activity as Ordinarily Incident to Nonbusiness Pursuits, 16 POF3d 355.

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 466.

ALR. — Insurance: validity of statute avoiding provision in casualty or indemnity policy making satisfaction by insured a condition of liability, 1 A.L.R. 1381.

Insurance: applicability of provisions as to injuries intentionally inflicted, where insured is injured because of mistake of identity, 26 A.L.R. 129.

Validity and construction of contract indemnifying against loss due to confiscation of property by public authorities, 36 A.L.R. 1499.

Provision making actual payment of judgment a condition of indemnity insurer's liability ("no action clause"), as affected by insurer defending action against insured, 37 A.L.R. 637.

Insurance against injuring property or person of third person as liability or indemnity insurance, 37 A.L.R. 644; 83 A.L.R. 677; 117 A.L.R. 239.

Criterion of health for purposes of warranty or condition in insurance contract, 40 A.L.R. 662; 100 A.L.R. 362.

Burglary, larceny, theft, or robbery within policy of insurance, 41 A.L.R. 846; 44 A.L.R. 471.

Losses covered by insurance against strikes, lockouts, or other labor disputes, 52 A.L.R. 162.

Insurance of banks against forgeries, 52 A.L.R. 1379.

Liability insurance: construction and operation of clause in liability or indemnity policies prohibiting assured from assuming liability, incurring expense, settling claims, or interfering with insurer's conduct of defense or settlement, 71 A.L.R. 1467.

Liability insurance: right of insurer, as against the assured and without his consent, in case of a claim or proceeding against him, to make a settlement or permit a consent judgment prejudicial to him, 79 A.L.R. 1118.

War risk life and disability insurance, 81 A.L.R. 933.

"Permanent disability" within insurance policy as confined to disability lasting until death, 97 A.L.R. 126.

Liability insurance: clause requiring assured's cooperation, aid, and (or) assistance, 98 A.L.R. 1465; 139 A.L.R. 771.

Act of insured while mentally incompetent in causing loss otherwise within coverage of property or liability insurance policy as defense or ground of setoff or counterclaim, 110 A.L.R. 1060.

Occupational disease as within coverage of policy of employers' liability or indemnity insurance not specifically including or excluding it, 112 A.L.R. 158.

Conflict of laws as regards statutory or contractual provisions relating to right of injured person to maintain action against tortfeasor's insurer, 120 A.L.R. 855.

Construction and application of provisions of liability or indemnity policy regarding injury or death incident to construction, repairs, alterations, demolition, or wrecking of structure, or installation of elevators or other equipment, 130 A.L.R. 239.

Construction and application of sprinkler leakage policy, or provisions of that nature in fire policy, as regards hazards or causes of loss, 130 A.L.R. 710.

Conditional sale as affecting provision in insurance policy against change of title, interest, or possession, 133 A.L.R. 785.

Judgment in favor of tortfeasor's insurer in an action by an injured person as res judicata in similar action by another person injured in same accident, 137 A.L.R. 1016.

Liability insurance: clause requiring assured's cooperation, aid, and (or) assistance, 139 A.L.R. 771.

Compromise by insured as affecting right to recover against liability or indemnity insurer, either where claim exceeds limit of liability under policy, or where insurer denies liability on policy, refuses to defend, or otherwise delays taking action, 142 A.L.R. 809.

Coverage, as regards causes of injury or damage, of policy insuring owner, occupier, or operator of premises against liability for injury to person or property, 148 A.L.R. 609.

Risks covered by contractor's liability policy, 156 A.L.R. 1285.

Automobile liability insurance of garages, repair shops, sales agencies, and the like, 165 A.L.R. 1471; 93 A.L.R.2d 1047.

Right of indemnitor of one joint tortfeasor to contribution by or indemnity against other joint tortfeasor or indemnitor of the latter, 171 A.L.R. 271.

Loss or impairment of vision as within meaning of total disability clause, 1 A.L.R.2d 756.

Loss of hearing as within meaning of total disability clause, 1 A.L.R.2d 952.

Act or default of additional insured in respect of giving notice of suit or delivery of suit papers to insured, as affecting rights of named insured against insurer, 6 A.L.R.2d 661.

Construction and application of provision of insurance policy excepting from coverage loss or damage caused by dishonesty of employee, 12 A.L.R.2d 236.

Rent loss insurance, 17 A.L.R.2d 1226.

Insurance: waiver of, or estoppel to assert, iron safe clause, 33 A.L.R.2d 615.

Robbery insurance: risks and losses covered, 37 A.L.R.2d 1081.

Refusal of liability insurer to defend action against insured involving both claims within coverage of policy and claims not covered, 41 A.L.R.2d 434.

Construction and effect of clause in burglary insurance policy requiring alarm system, 42 A.L.R.2d 733.

Coverage, construction, and effect of medical payments and funeral expense clauses of liability policy, 42 A.L.R.2d 983.

Repeated absorption of poisonous substance as "accident" within coverage clause of comphrehensive general liability policy, 49 A.L.R.2d 1263.

Allegations in third person's action against insured as determining liability insurer's duty to defend, 50 A.L.R.2d 458.

What are "forgeries" within coverage of forgery bond or insurance, 52 A.L.R.2d 207.

Clause excluding "products liability" from coverage of liability insurance policy, 54 A.L.R.2d 518; 58 A.L.R.3d 12.

Scope and effect of clause in liability policy excluding from coverage liability assumed by insured under contract not defined in policy, such as one of indemnity, 63 A.L.R.2d 1122.

Liability insurance: insured's submission to service of process as breach of cooperation clause, 66 A.L.R.2d 1238.

Basis and manner of distribution among multiple claimants of proceeds of liability insurance policy inadequate to pay all claims in full, 70 A.L.R.2d 416.

Coverage and exceptions in beauty shop liability policy, 77 A.L.R.2d 1258.

Construction of terms "in transit," "transportation," and the like, within coverage or exclusion clauses of insurance policy, 80 A.L.R.2d 445.

Failure of liability insurer, after notification, to defend suit against insured, as warranting opening default against insured on ground of inadvertence or excusable neglect, 87 A.L.R.2d 870.

Coverage and exclusions in insurance brokers' and agents' errors and omissions policy, 89 A.L.R.2d 1192.

Liability insurance of garages, motor vehicle repair shops and sales agencies, and the like, 93 A.L.R.2d 1047.

Builder's risk insurance policies, 94 A.L.R.2d 221; 97 A.L.R.3d 1270; 22 A.L.R.4th 701.

Injury from nuisance maintained by insured as within coverage of public liability policy, 98 A.L.R.2d 1047.

Liability insurance policy as covering insured's obligation to indemnify, or make contributions to, cotortfeasor, 4 A.L.R.3d 620.

When is medical expense "incurred" under policy providing for payment of medical expenses within fixed period of time from date of injury, 10 A.L.R.3d 468.

Right of tortfeasor or liability insurer to credit for amounts already disbursed to injured party under medical payments or funeral expense clause in liability policy, 11 A.L.R.3d 1115.

Provisions of burglary or theft policy as to effect of disappearance of property, 12 A.L.R.3d 865.

What constitutes total or permanent disability within the meaning of insurance policy issued to physician or dentist, 21 A.L.R.3d 677.

Insurance: "total disability" or the like as referring to work in usual occupation or in other occupations, 21 A.L.R.3d 1155.

Heart or vascular condition as constituting total or permanent disability

within insurance coverage, 21 A.L.R.3d 1383.

Provisions of burglary or theft policy requiring losses evidenced by "physical damage to premises," 22 A.L.R.3d 1305.

What constitutes total or permanent disability within the coverage of disability insurance coverage issued to farmer or agricultural worker, 26 A.L.R.3d 714.

Liability insurer's duty to defend action against an insured after insurer's full performance of its payment obligations under policy, 27 A.L.R.3d 1057.

What constitutes permanent or total disability within coverage of insurance policy issued to physical laborer or workman, 32 A.L.R.3d 922.

Aviation: helicopter accidents, 35 A.L.R.3d 707.

Theft insurance: coverage of expense of reward offered by insured, or other expenses incurred in recovering stolen property, 46 A.L.R.3d 403.

Insured's ratification, after loss, of policy procured without his authority, knowledge, or consent, 52 A.L.R.3d 235.

Premises liability insurance: coverage as extending to liability for injuries or damage caused by product sold or rented by the insured and occurring away from the insured premises, 62 A.L.R.3d 889.

Insured's payment of excess judgment, or portion thereof, as prerequisite of recovery against liability insurer for wrongful failure to settle claim against insured, 63 A.L.R.3d 627.

Right of injured person recovering excess judgment against insured to maintain action against liability insurer for wrongful failure to settle claim, 63 A.L.R.3d 677.

Coverage and exclusions under hospital professional liability or indemnity policy, 65 A.L.R.3d 969.

Medical care insurance: right of insured under individual policy to coverage afforded by group policy from which he directly transferred on termination of his employment, 66 A.L.R.3d 1192.

Elimination of particular coverage, or termination, of health, hospitalization, or medical care insurance policy as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illnesses, 66 A.L.R.3d 1205.

What constitutes "money" within coverage or exclusion of theft or other crime policy, 68 A.L.R.3d 1179.

Liability insurance: assault as an "accident," or injuries therefrom as "accidentally" sustained, within coverage clause, 72 A.L.R.3d 1090; 31 A.L.R.4th 957; 33 A.L.R.4th 983; 34 A.L.R.4th 761; 35 A.L.R.4th 1063.

Construction and application of liability or indemnity policy on civil engineer, architect, or the like, 83 A.L.R.3d 539; 14 A.L.R.5th 695.

Lawyers' professional liability insurance, 84 A.L.R.3d 187.

Loss through payment of extortion demand at place other than insured's premises as within coverage insuring against losses incurred on premises, 85 A.L.R.3d 1103.

Risks and causes of loss covered or excluded by aviation liability policy, 86 A.L.R.3d 118.

Admissibility of opinion evidence as to employability on issue of disability in health and accident insurance and workers compensation cases, 89 A.L.R.3d 783.

Exchange of labor by farmers as creating employment relationship for liability insurance purposes, 89 A.L.R.3d 834.

Performance by one insurer of its duty to defend as excusing failure of other insurers equally obligated to defend, 90 A.L.R.3d 1199.

Products liability insurance coverage as extending only to product-caused injury to person or other property, as distinguished from mere product failure, 91 A.L.R.3d 921.

Who is "resident" or "member" of same "household" or "family" as named insured, within liability insurance provision defining additional insureds, 93 A.L.R.3d 420.

Farmowner's liability insurance risks and coverage, 93 A.L.R.3d 472; 31 A.L.R.4th 957; 33 A.L.R.4th 983; 34 A.L.R.4th 761; 35 A.L.R.4th 1063.

Personal injuries inflicted by animal as within homeowner's or personal liability policy, 96 A.L.R.3d 891.

Coverage under builder's risk insurance policy, 97 A.L.R.3d 1270.

Wrongful cancellation of medical malpractice insurance, 99 A.L.R.3d 469.

Propriety of hospital's conditioning phy-

sician's staff privileges on his carrying professional liability or malpractice insurance, 7 A.L.R.4th 1238.

Scope of clause excluding from contractor's or similar liability policy damage to property in care, custody, or control of insured, 8 A.L.R.4th 563.

Liability insurance: failure or refusal of an insured to attend trial or to testify as breach of cooperation clause, 9 A.L.R.4th 218.

Construction, application, and effect of clause that liability insurance policy may be canceled by insured by mailing to insurer written notice stating when thereafter such cancellation shall be effective, 11 A.L.R.4th 456.

Construction and effect of provision of homeowner's, premises, or personal liability insurance policy covering or excluding watercraft, 26 A.L.R.4th 967.

Construction and application of provision of liability insurance policy expressly excluding injuries intended or expected by insured, 31 A.L.R.4th 957.

Coverage and exclusions of liability or indemnity policy on physicians, surgeons, and other healers, 33 A.L.R.4th 14; 14 A.L.R.5th 695.

Liability insurance: intoxication or other mental incapacity avoiding application of clause in liability policy specifically exempting coverage of injury or damage caused intentionally by or at direction of insured, 33 A.L.R.4th 983.

Acts in self-defense as within provision of liability insurance policy expressly excluding coverage for damage or injury intended or expected by insured, 34 A.L.R.4th 761.

Criminal conviction as rendering conduct for which insured convicted within provision of liability insurance policy expressly excluding coverage for damage or injury intended or expected by insured, 35 A.L.R.4th 1063.

Self-insurance against liability as other insurance within meaning of liability insurance policy, 46 A.L.R.4th 707.

Livestock or animal insurance; risks and losses, 47 A.L.R.4th 772.

Liability insurance: when is vehicle in "dead storage," 48 A.L.R.4th 591.

Liability insurance: excess carrier's right of action against primary carrier for improper or inadequate defense of claim, 49 A.L.R.4th 304.

Boiler and machinery insurance: risks and losses covered by policy or provision expressly covering boilers and machinery, 49 A.L.R.4th 336.

Health provider's agreement as to patient's copayment liability after award by professional service insurer as unfair trade practice under state law, 49 A.L.R.4th 1240.

Duty of insurer to pay for independent counsel when conflict of interest exists between insured and insurer, 50 A.L.R.4th 932.

Liability insurance: what is "claim" under deductibility-per-claim clause, 60 A.L.R.4th 983.

What constitutes single accident or occurrence within liability policy limiting insurer's liability to a specified amount per accident or occurrence, 64 A.L.R.4th 668.

Theft and vandalism insurance: coinsured's misconduct as barring innocent coinsured's right to recover on policy, 64 A.L.R.4th 714.

What constitutes theft within automobile theft insurance policy — modern cases, 67 A.L.R.4th 82.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

Construction and effect of "rain insurance" policies insuring against rainfall on the date of concert, exhibition, game, or the like, 70 A.L.R.4th 1010.

Homeowner's liability insurance coverage of injury from formaldehyde insulation in insured premises, 85 A.L.R.4th 956.

Loss of information stored in computer system or on computer disk cartridge, computer tape, or similar computer storage media as within coverage of liability policy, 85 A.L.R.4th 1102.

Liability insurance coverage for violations of antipollution laws, 87 A.L.R.4th 444.

Homeowner's liability insurance coverage of emotional distress allegedly inflicted on third party by insured, 8 A.L.R.5th 254.

Liability policy coverage for insured's injury to third party's investments, antic-

ipated profits, goodwill, or the like, unaccompanied by physical property damage, 18 A.L.R.5th 187.

Coverage under all-risk insurance, 30 A.L.R.5th 170.

Scope of provision in liability policy issued to municipal corporation or similar governmental body limiting coverage to injuries arising out of construction, maintenance, or repair work, 30 A.L.R.5th 699.

Construction and application of "business pursuits" exclusion provision in general liability policy, 35 A.L.R.5th 375.

Business interruption insurance, 37 A.L.R.5th 41.

Validity, construction, and effect of assault and battery exclusion in liability insurance policy at issue, 44 A.L.R.5th 91.

What constitutes "vacant land" within meaning of liability or property insurance policy provisions, 47 A.L.R.5th 535.

What constitutes "suit" triggering insurer's duty to defend environmental claims — state cases, 48 A.L.R.5th 355.

Duty of liability insurer to initiate settlement negotiations, 51 A.L.R.5th 701.

Insurance agents' and brokers' professional liability insurance, 55 A.L.R.5th 681.

What constitutes "vandalism" or "malicious mischief" within meaning of insurance policy specifically extending coverage to losses from such causes, 56 A.L.R.5th 407.

When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 65 A.L.R.5th 649.

33-7-3.1. Credit insurance.

(a) As used in this Code section, the term:

(1) "Credit insurance" means any insurance which is recognized by this title as being applicable or appropriate for use in connection with any loan, retail installment transaction, or any other credit transaction made pursuant to any law of this state. Such insurance includes, but is not limited to, the following:

(A) Credit life insurance;

(B) Credit accident and sickness insurance;

(C) Credit unemployment insurance;

(D) Credit casualty insurance;

(E) Credit property insurance;

(F) Nonrecording insurance or nonfiling insurance which is property insurance utilized in connection with credit transactions in lieu of the actual recording, filing, or releasing of a security instrument or financing statement. The premium charge for this insurance may not exceed the actual official fees which would be payable to file, record, or release a security instrument or financing statement. This insurance provides coverage for any loss or potential loss caused by any means whereby the creditor is prevented from obtaining possession of the covered property, enforcing its rights under a security agreement, or obtaining the proceeds to which it is entitled under the agreement. Nothing shall prohibit nonrecording insurance or nonfiling insurance from being incorpo-

rated, by endorsement or rider, into a vendor's single interest policy or a similar type of policy;

(G) Vendors' single interest insurance, which is property insurance securing the interest of a creditor as respects potential loss relative to tangible property used as collateral on credit transactions. Such insurance may include but is not limited to the following coverages: vandalism and malicious mischief, flood, collapse, alteration, skip, conversion, concealment, nonrecording insurance, misrepresentation, and embezzlement; and

(H) Any other lines or sublines of insurance which may become accepted as credit insurance by the insurance and lending industries unless otherwise disapproved by the Commissioner.

(2) "Credit loss insurance" means a form of casualty insurance against loss resulting from failure of debtors to pay their obligations to the insured creditor. Such term includes but is not limited to mortgage guaranty insurance, holder-in-due-course insurance, and repossession insurance. Credit loss insurance specifically does not include any of the coverages enumerated in subparagraphs (a)(1)(A) through (a)(1)(H) of this Code section.

(3) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction. Creditor also means any successor to the right, title, or interest of any such lender, vendor, or lessor and an affiliate, associate, or subsidiary of any of them or any director, officer, or employee of any of them or any other person in any way associated with any of them.

(4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction.

(b) Notwithstanding any law which may be construed to the contrary, neither the premium nor cost for any credit insurance which is written by or through a creditor nor any commission, dividend, or other gain payable by an insurer to a creditor for the sale or provision of credit insurance shall be deemed as interest, time price differential, finance charge, or other charge or amount in excess of permitted charges, in connection with any loan, retail installment transaction, or other credit transaction made pursuant to the laws of this state.

(c) Forms and rates for all lines or sublines of credit insurance shall be filed separately with the Commissioner. Unless disapproved by the Commissioner, pursuant to the authority to disapprove forms or rates under Chapter 9, 24, or 31 of this title, the utilization of such forms and rates shall be deemed in compliance with this title and the premiums

developed from such rates shall be deemed reasonable and in compliance with this title.

History. — Code 1981, § 33-7-3.1, enacted by Ga. L. 1996, p. 912, § 2.

RESEARCH REFERENCES

ALR. — What constitutes "vandalism" or "malicious mischief" within meaning of insurance policy specifically extending coverage to losses from such causes, 56 A.L.R.5th 407.

33-7-4. Life insurance.

Life insurance is insurance on human lives and insurance appertaining to or connected with human lives. The transacting of life insurance includes the granting of endowment benefits, additional benefits in the event of death or dismemberment by accident or accidental means, additional benefits in the event of the disability of the insured, and optional modes of settlement of proceeds of life insurance. An insurer authorized to transact life insurance may also grant annuities.

History. — Code 1933, § 56-402, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Cross references. — Persons deemed subject to laws regulating life insurance companies, § 33-7-10. Offering of life insurance by fraternal benefit societies, § 33-15-60. Life insurance generally, T. 33, C. 25. Industrial life insurance, T. 33, C. 26. Group or blanket life insurance, T. 33, C. 27. Annuity and pure endowment contracts, T. 33, C. 28. Credit life insurance, T. 33, C. 31.

JUDICIAL DECISIONS

Cited in Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 523 et seq.

C.J.S. — 44 C.J.S., Insurance, § 23 et seq.

ALR. — Refusal of original beneficiary to surrender policy as affecting attempted change of beneficiary, 36 A.L.R. 771.

War risk life and disability insurance, 81 A.L.R. 933.

"Permanent disability" within insurance policy as confined to disability lasting until death, 97 A.L.R. 126.

Death or injury resulting from insured's voluntary act as caused by accident or accidental means, 111 A.L.R. 628.

What constitutes bodily injury within policy of accident insurance or accident feature of life policy, 117 A.L.R. 739.

Construction and application of specific provision of accident policy as to death or injury while standing in or on public street or highway, 130 A.L.R. 1155.

Burn as an accident or caused by accidental means within coverage of life or accident insurance policy, 138 A.L.R. 1514.

Loss or impairment of vision as within meaning of total disability clause, 1 A.L.R.2d 756.

Loss of hearing as within meaning of total disability clause, 1 A.L.R.2d 952.

Scope and application of provisions of accident policy, or accident feature of life policy, relating to accident in connection with automobile or other motor vehicle, 78 A.L.R.2d 1044.

What constitutes total or permanent disability within the meaning of insurance policy issued to physician or dentist, 21 A.L.R.3d 677.

Insurance: "total disability" or the like as referring to inability to work in usual occupation or in other occupations, 21 A.L.R.3d 1155.

Heart or vascular condition as constituting total or permanent disability within insurance coverage, 21 A.L.R.3d 1383.

What constitutes total or permanent disability within the coverage of disability insurance coverage issued to farmer or agricultural worker, 26 A.L.R.3d 714.

What constitutes permanent or total disability within coverage of insurance policy issued to physical laborer or workman, 32 A.L.R.3d 922.

Who is "fare-paying passenger" within coverage of life or accident insurance policy, 60 A.L.R.3d 1273.

Accident or life insurance: death by autoerotic asphyxiation as accidental, 62 A.L.R.4th 823.

Construction and effect of contracts or insurance policies providing preneed coverage of burial expense or services, 67 A.L.R.4th 36.

Am. Jur. Trials. — Actions on Life Insurance Policies, 12 Am. Jur. Trials 549.

33-7-5. Marine and transportation insurance.

Marine and transportation insurance includes:

(1) Insurance against any and all kinds of loss or damage to vessels, craft, aircraft, cars, automobiles, and vehicles of every kind, as well as all goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidence of debt, valuable papers, bottomry and respondentia interests, and all other kinds of property and interests therein in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, or while awaiting the same, or during any delays, storage, transshipment, or reshipment incident thereto, including marine builders' risks and all personal property floater risks;

(2) Insurance against any and all kinds of loss or damage to person or to property in connection with or appertaining to a marine, inland marine, transit, or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance, or use of the subject matter of such insurance but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance, or use of automobiles;

(3) Insurance against any and all kinds of loss or damage to precious stones, jewels, jewelry, gold, silver, and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise;

(4) Insurance against any and all kinds of loss or damage to bridges, tunnels, and other instrumentalities of transportation and communication, excluding buildings, their furniture and furnishings, fixed contents, and supplies held in storage unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, or civil commotion, or any or all of them are the only hazards to be covered;

(5) Insurance against any and all kinds of loss or damage to piers, wharves, docks, and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, and civil commotion, and each of them;

(6) Insurance against any and all kinds of loss or damage to other aids to navigation and transportation, including dry docks and marine railways, dams, and appurtenant facilities for the control of waterways; and

(7) Marine protection and indemnity insurance, which is insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for loss of or damage to the property of another person.

History. — Code 1933, § 56-406, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Property insurance generally, § 33-7-6 and T. 33, C. 32. Motor vehicle accident insurance, T. 33, C. 34.

JUDICIAL DECISIONS

Contract of indemnity. — By Civil Code 1890, § 2120, a contract of marine insurance was in terms classed as a contract of indemnity. Exchange Bank v. Loh, 104 Ga. 446, 31 S.E. 459, 44 L.R.A. 372 (1898).

Perils of navigation include rain damage. — In a marine risk, when navigation is partly by fresh water and partly by salt water and involves transshipment, proof of damage by water of any kind is prima facie proof of damage by the perils of navigation, even if the wetting is caused by rains and whether the rains fell on board or on the usual transshipping wharf while the goods were upon the wharf in the ordinary course of transit. Underwriters' Agency v. Sutherlin, 55 Ga. 266 (1875).

Damage by water from improper stowage. — Damage from water in consequence of improper stowage, unless such improper stowage was occasioned or acquiesced in by the insured or his agent, is damage from the perils of navigation. Underwriters' Agency v. Sutherlin, 55 Ga. 266 (1875).

Waves from an ocean-going vessel do not constitute a peril of the sea. Kilpatrick Marine Piling v. Fireman's Fund Ins. Co., 795 F.2d 940 (11th Cir. 1986).

Misrepresentation invalidating policy. — Misrepresentation of any fact material to risk invalidates a marine hull insurance policy. Kilpatrick Marine Piling v. Fireman's Fund Ins. Co., 795 F.2d 940 (11th Cir. 1986).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 637 et seq.

C.J.S. — 2 C.J.S., Admiralty, § 42.

44 C.J.S., Insurance, §§ 20, 395 et seq., 403 et seq., 441, 450 et seq.; 45 C.J.S., Insurance, §§ 627 et seq., 1124 et seq.; 46 C.J.S., Insurance, §§ 1442 et seq., 1461 et seq., 1713 et seq., 1734 et seq.; 46A C.J.S., Insurance, §§ 1998, 1999, 2048 et seq.

ALR. — Inherent defect in vessel as affecting question whether loss is due to "perils of the sea" within policy of marine insurance, 9 A.L.R. 1314.

Right of owner to sue on fire or marine policy taken out by warehouseman, bailee, or carrier, 61 A.L.R. 720.

Losses beyond insured's own route or line as within coverage of carrier's insurance, 99 A.L.R. 283.

Construction and application of sprinkler leakage policy, or provisions of that nature in fire policy, as regards hazards or causes of loss, 130 A.L.R. 710.

Coverage of policy insuring motor carrier against liability for loss of or damage to shipped property, 36 A.L.R.2d 506.

Construction of terms "in transit," "transportation," and the like, within coverage or exclusion clauses of insurance policy, 80 A.L.R.2d 445.

Construction and effect of clause of marine policy warranting that insured's vessel will be laid up or out of commission during a specified time period, 83 A.L.R.2d 1455.

Damage to moored vessel by striking against hard bottom or hard or sharp object as loss due to peril of sea within marine policy coverage, 85 A.L.R.2d 446.

Marine insurance: losses covered by "latent defects" provision of "Inchmaree clause," 91 A.L.R.2d 1295.

What constitutes want of due diligence by insured or owner so as to bar recovery under Inchmaree clause of marine policy, 98 A.L.R.2d 952.

Risks covered by marine insurance policy against theft, 19 A.L.R.3d 1150.

Aviators: helicopter accidents, 35 A.L.R.3d 707.

What is "conveyance," "passenger conveyance," or "public conveyance" within coverage of accident policy, 60 A.L.R.3d 858.

Coverage under all-risks yacht policy, 75 A.L.R.3d 410.

Risks and causes of loss covered or excluded by aviation liability policy, 86 A.L.R.3d 118.

Airport operations liability insurance, 92 A.L.R.3d 1267.

Construction and effect of provision of homeowner's, premises, or personal liability insurance policy covering or excluding watercraft, 26 A.L.R.4th 967.

Aviation insurance: causal link between breach of policy provisions and accident as requisite to avoid insurer's liability, 48 A.L.R.4th 778.

33-7-6. Property insurance; contract requirements; rules and regulations; exemptions.

(a) Property insurance is insurance on real or personal property of every kind and interest therein against loss or damage from any or all hazards or causes and against loss consequential upon such loss or damage other than noncontractual legal liability for any such loss or damage. Property insurance shall also include miscellaneous insurance as defined in paragraph (10) of Code Section 33-7-3, except as to any noncontractual liability coverage includable therein.

(b) Property insurance also includes:

(1) Any contract, agreement, or instrument whereby a person assumes the risk of and the expense or portion thereof for:

(A) The mechanical breakdown or mechanical failure of a motor vehicle; or

(B) The repair of certain reasonable motor vehicle wear and tear sustained in ordinary use, such as:

(i) The removal of dents, dings, or creases in a motor vehicle without affecting the existing paint finish using paintless dent repair techniques;

(ii) The removal of small windshield chips and cracks without replacement of the entire windshield;

(iii) The repair of rips, burns, tears, holes, and punctures to interior fabric or carpet;

(iv) Cosmetic repair of minor scuffs, scratches, scrapes, or rash on exterior plastic surfaces, including, but not limited to, bumpers;

(v) Cosmetic repair to aluminum or painted wheels when the normal appearance of the wheel is altered with minor curb scuffs, scratches, scrapes, or rash; or

(vi) Exterior reconditioning of foggy or yellowed headlights to restore clarity and luster,

and shall include those agreements commonly known as vehicle service agreements or extended warranty agreements, if made by a person other than the motor vehicle manufacturer in exchange for a separately stated charge or the cost of the contract or contracts is included on a nonidentifiable basis in the cost of a motor vehicle sold in conjunction therewith, except that this provision shall not apply to an agreement underwritten by an insurer licensed to transact insurance in this state, either directly or through a reinsurance contract or, without regard to the requirement that the insurance cannot be obtained from an insurer authorized to do business in this state as required by Code Section 33-5-21, to an agreement underwritten by a surplus lines insurer which has not been rejected by the Commissioner for such purpose;

(2) Any contract, agreement, or instrument whereby a person assumes the risk of and the expense or portion of such expense for the structural or mechanical breakdown, loss of, or damage to a one-family or two-family residential building structure or any part thereof from any cause, including loss of or damage to or loss of use of the building structure or major components thereof which are attached to and become a part of said structure, if made by a person

other than the constructing contractor or manufacturer of the building structure or part thereof in exchange for a separately stated charge or the cost of the contract or contracts is included on a nonidentifiable basis in the cost of such building structure sold in conjunction therewith, except that this provision shall not apply to an agreement underwritten by an insurer licensed to transact insurance in this state, either directly or through a reinsurance contract or underwritten by a surplus line insurer approved by the Commissioner nor shall this provision apply to an agreement: (A) the performance of which is guaranteed by a surety bond executed by an authorized corporate surety insurer in favor of and approved by the Commissioner in an amount of not less than $1.5 million; provided further that a surety bond of an additional $100,000.00 shall be required for every additional $500,000.00 in written premium above $2 million in written premium. Any company relying upon one or more bonds pursuant to this subsection shall keep such bonds or equivalent coverage in place until the expiration of the contract, agreement, or instrument contemplated in this paragraph; or (B) notwithstanding with a duration of 13 months or less covering damage to or loss of use of the major appliances located in an existing or resold home where the performance of any covered repair is guaranteed by a surety bond executed by a corporate surety insurer authorized to offer surety insurance in this state in favor of the Commissioner and in an amount which in the discretion of the Commissioner will provide adequate protection to all the residents of this state who are covered by such agreements, provided that such amount shall not be less than $100,000.00; or

(3) Any contract, agreement, or instrument, other than an agreement, contract, or instrument covered by paragraphs (1) and (2) of this subsection, whereby a person assumes the risk of and the expense or portion thereof for the cost of repair or replacement of a product if such contract, agreement, or instrument is made by a person other than the manufacturer in exchange for a separately stated charge or the cost of the contract or contracts is included on a nonidentifiable basis in the cost of the product sold in conjunction therewith, except that this provision shall not apply to:

(A) An agreement underwritten by an insurer licensed to transact insurance in this state, either directly or through a reinsurance contract;

(B) Any contract, agreement, or instrument relating to similar services furnished by any air carrier that provides interstate air transportation;

(C) Any tire replacement contract, agreement, or instrument;

(D) A contract, agreement, or instrument whereby a retailer in the business of selling consumer products or a wholly owned

subsidiary of such retailer assumes the risk of and the expense or portion thereof for the cost of repair or replacement of consumer products where such contract, agreement, or instrument is guaranteed by a surety bond executed by a corporate surety insurer authorized to offer surety insurance in this state in favor of and approved by the Commissioner in an amount of not less than $100,000.00; or

(E) Any contract, agreement, or instrument whereby any person assumes the risk of and the expense or portion of such expense for the breakdown, service, repair, or replacement due to normal wear and tear or structural or inherent defect to the major appliances, utility systems, and roofing system of any one-family or two-family residential building structure in exchange for a separately stated consideration and does not otherwise provide direct or consequential coverage under a property contract defined in paragraph (1) or (2) of this subsection or the introductory language of this paragraph and such contract, agreement, or instrument is guaranteed by a surety bond executed by a corporate surety insurer authorized to offer surety insurance in this state in favor of and approved by the Commissioner in an amount of not less than $100,000.00.

(c)(1) Any contract, agreement, or instrument, as regulated under paragraphs (1), (2), and (3) of subsection (b) of this Code section, shall state clearly and conspicuously in the contract the name and address of the insurer or surety which has guaranteed or underwritten the contract, agreement, or instrument, either directly or through a reinsurance contract.

(2) In the event a regulated contract, agreement, or instrument is issued by a party other than an insurer so that the holder thereof, in the first instance, must make a claim or request for refund pursuant to paragraph (3) of this subsection against a party other than the insurer, the contract, agreement, or instrument shall provide that the holder shall be entitled to make a direct claim against the insurer upon the failure of the issuer to pay any claim or to refund the consideration paid by the holder for the contract, agreement, or instrument within 60 days after proof of loss has been filed with the issuer.

(3) The regulated contract, agreement, or instrument shall be noncancelable by the issuer except for fraud, material misrepresentation, or failure to pay the consideration due therefor. The cancellation shall be in writing and shall conform to the requirements of Code Section 33-24-44. The holder may cancel at any time upon demand and surrender of the contract, agreement, or instrument whereupon the issuer shall refund the excess of the consideration paid for the contract, agreement, or instrument above the customary short rate for the expired term of the contract, agreement, or instrument.

(4) Any contract, agreement, or instrument exempt under subparagraph (b)(3)(D) or (b)(3)(E) of this Code section shall state clearly and conspicuously substantially the following: "This is not a contract of insurance."

(d) The Commissioner shall promulgate rules and regulations regarding vehicle service agreements or extended warranty agreements as described in paragraph (1) of subsection (b) of this Code section. Such rules and regulations shall include filing requirements, disclosures for the benefit of the agreement holder, record keeping, and procedures for public complaints. Such rules and regulations shall also include the conditions under which surplus lines insurers may be rejected for the purpose of underwriting vehicle service agreements and extended warranty agreements.

(e)(1) As used in this subsection, the term "heavy equipment dealer" means a person, firm, or corporation which is primarily engaged in the business of selling, renting, leasing, and servicing heavy equipment, engines, power generation equipment, and parts and attachments to such heavy equipment which is primarily used for construction, industrial, maritime, mining, agriculture, or similar purposes and who is not required to be licensed.

(2) The provisions of this Code section shall not apply to heavy equipment dealers.

(f) Property insurance does not include those agreements commonly known as vehicle service agreements or extended warranty agreements which are issued, sold, or offered for sale by a retail installment seller, as defined in Code Section 10-1-31 in connection with the sale of a motor vehicle by such retail installment seller, provided that such retail installment seller:

(1) Maintains, or has a parent company maintain, a net worth or stockholders' equity of at least $50 million, provided the parent company guarantees the obligations of the retail installment seller arising from vehicle service agreements or extended warranty agreements underwritten pursuant to this paragraph;

(2) Complies with the registration requirement prescribed by the Commissioner through regulation;

(3) Files with the Commissioner a true and correct copy of the vehicle service agreement or extended warranty agreement that has a term of and is no longer than nine months in a form that is consistent with the terms prescribed by the Commissioner through regulation;

(4) Files a copy of its Form 10-K or Form 20-F disclosure statements, or if it does not file such statements with the United States

Securities and Exchange Commission, a copy of its audited financial statements reported on a GAAP basis. If the retail installment seller's financial statements are consolidated with those of its parent company, then the retail installment seller may comply with this provision by filing the statements of its parent company. The statement shall be filed with the Commissioner 30 days prior to the retail installment seller's initial offering or delivering of a service agreement or extended warranty agreement, and thereafter, the statement shall be filed with the Commissioner annually; and

(5) Upon the request of the Commissioner, posts a security deposit or surety bond in an amount not to exceed $250,000.00 and in the manner prescribed by the Commissioner through regulation.

History. — Code 1933, § 56-405, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1979, p. 804, § 1; Ga. L. 1980, p. 760, § 1; Ga. L. 1983, p. 864, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1986, p. 1237, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1988, p. 1467, §§ 1, 2; Ga. L. 1989, p. 680, § 1; Ga. L. 1992, p. 2389, §§ 1.1, 1.2; Ga. L. 1996, p. 912, § 3; Ga. L. 2000, p. 423, § 1; Ga. L. 2000, p. 859, § 1; Ga. L. 2002, p. 1037, § 1; Ga. L. 2005, p. 953, § 1/HB 428; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2008, p. 1021, § 1/SB 518; Ga. L. 2012, p. 1350, § 10/HB 1067; Ga. L. 2013, p. 679, § 1/SB 140; Ga. L. 2019, p. 337, § 1-36/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "have the power and authority to" preceding "promulgate rules" in the first sentence of subsection (d); and substituted "this paragraph" for "this subparagraph" at the end of paragraph (f)(1).

Cross references. — Insurable interest in relation to property insurance, § 33-24-4. Fire and other property insurance generally, T. 33, C. 32. Fair access to property insurance, T. 33, C. 33. Motor vehicle accident insurance, T. 33, C. 34.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2000, "$100,000.00" was substituted for "$100,000" at the end of paragraph (2) of subsection (b).

Editor's notes. — Ga. L. 1992, p. 2389, § 2, effective April 20, 1992, not codified by the General Assembly, provides: "Notwithstanding any provision of this chapter to the contrary, a group policyholder may require an employee contribution or an additional contribution for spousal coverage where the spouse so covered is eligible to receive coverage under another group accident and sickness policy but declines such coverage." However, the reference to "this chapter" in this uncodified section is unclear since Ga. L. 1992, p. 2389 amended Code sections in both chapter 7 and chapter 11 of Title 33.

Administrative rules and regulations. — Vehicle and automobile club service contracts, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-47.

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979). For annual survey of construction law, see 57 Mercer L. Rev. 79 (2005).

For note on 1989 amendment to this Code section, see 6 Ga. St. U.L. Rev. 278 (1989).

JUDICIAL DECISIONS

Made whole doctrine not applicable to property insurance. — Appellate court properly held that the made whole doctrine did not require an insurer to demonstrate that the insured had been fully compensated prior to exercising the insurer's subrogation rights under the insurance policy because no made whole

provision existed in O.C.G.A. § 33-7-6, which details the requirements of property insurance contracts. Woodcraft by MacDonald, Inc. v. Ga. Cas. & Sur. Co., 293 Ga. 9, 743 S.E.2d 373 (2013).

Georgia legislature has specifically declined to include a made whole provision in O.C.G.A. § 33-7-6, which details the requirements for real or personal property insurance contracts. Woodcraft by MacDonald, Inc. v. Ga. Cas. & Sur. Co., 293 Ga. 9, 743 S.E.2d 373 (2013).

Cited in Columbus Dodge, Inc. v. Parker, 163 Ga. App. 77, 293 S.E.2d 732 (1982).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions rendered under former Code 1933, § 56-804 are included in the annotations for this Code section.

Right to write radioactive contamination and nuclear plant insurance. — A foreign insurance company licensed in this state to write fire and allied lines of insurance (property insurance) and miscellaneous casualty insurance may write insurance "against the perils of radioactive contamination and all other perils causing physical loss to nuclear energy installations and facilities, including consequential loss," provided the company is authorized to write such coverage by the laws of the state of its domicile. 1958-59 Op. Att'y Gen. p. 199 (rendered under former Code 1933, § 56-804, repealed by Ga. L. 1960, p. 289).

It is proper to treat legal services insurance as either property insurance or casualty insurance. 1974 Op. Att'y Gen. No. 74-48.

Foreign insurer's ability to underwrite homeowners' warranties. — An insurance company that has not met the requirements imposed upon risk retention groups by the state in which it is chartered as an insurance company may not underwrite homeowners' warranties in Georgia without a certificate of authority authorizing the transaction of insurance in Georgia. 1982 Op. Att'y Gen. No. 82-104.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 77 et seq.

ALR. — Livestock or animal insurance: risks and losses, 47 A.L.R.4th 772.

Property damage insurance: what constitutes "contamination" within policy clause excluding coverage, 72 A.L.R.4th 633.

What is "flood" within exclusionary clause of property damage policy, 78 A.L.R.4th 817.

Construction and effect of provisional or monthly reporting inventory insurance, 81 A.L.R.4th 9.

Requirement under property insurance policy that insured submit to examination under oath as to loss, 16 A.L.R.5th 412.

33-7-7. Surety insurance.

Surety insurance includes:

(1) Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust;

(2) Insurance guaranteeing the performance of contracts other than insurance policies and guaranteeing and executing bonds, undertakings, and contracts of suretyship; and

(3) Insurance indemnifying banks, bankers, brokers, or financial or moneyed corporations or associations against loss resulting from

any cause of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts or other valuable papers, documents, money, precious metals and articles made from such metals, jewelry, watches, necklaces, bracelets, gems, precious and semiprecious stones, including any loss while the same are being transported in armored motor vehicles or by messenger but not including any other risks of transportation or navigation; also insurance against loss or damage to such an insured's premises or to his furnishings, fixtures, equipment, safes, and vaults in such an insured's premises caused by burglary, robbery, theft, vandalism, or malicious mischief or any attempt at burglary, robbery, theft, vandalism, or malicious mischief.

History. — Code 1933, § 56-409, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Cross references. — Suretyship, T. 10, C. 7.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1910, §§ 2550, 3538 are included in the annotations for this Code section.

Distinction between suretyship and fidelity insurance. — There is a well-recognized difference between a contract of suretyship and one of fidelity insurance as defined in this section. John Church Co. v. Aetna Indem. Co., 13 Ga. App. 826, 80 S.E. 1093 (1913) (decided under former Civil Code 1910, §§ 2550, 3538).

"Surety insurance" does not include reinsurance. — The phrase "other than insurance policies" as used in paragraph (2) of this section means that "surety insurance" is defined as insurance guaranteeing the performance of contracts, except insurance contracts. In other words, a contract for "reinsurance" is not included within the definition of "surety insurance." Climatrol Indus., Inc. v. Home Indem. Co., 316 F. Supp. 314 (N.D. Ga. 1970).

Cited in Houston Gen. Ins. Co. v. Brock Constr. Co., 241 Ga. 460, 246 S.E.2d 316 (1978); Congress Re-Insurance Corp. v. Archer-Western Contractors, 226 Ga. App. 829, 487 S.E.2d 679 (1997).

OPINIONS OF THE ATTORNEY GENERAL

Foreign insurer's ability to underwrite homeowners' warranties. — An insurance company that has not met the requirements imposed upon risk retention groups by the state in which it is chartered as an insurance company may not underwrite homeowners' warranties in Georgia without a certificate of authority authorizing the transaction of insurance in Georgia. 1982 Op. Att'y Gen. No. 82-104.

RESEARCH REFERENCES

Am. Jur. 2d. — 35 Am. Jur. 2d, Fidelity Bonds and Insurance, § 1.

C.J.S. — 44 C.J.S., Insurance, §§ 384, 385.

ALR. — Liability of surety company as distinguished from that of gratuitous surety, 12 A.L.R. 382; 94 A.L.R. 876.

Insurance against injuring property or

person of third person as liability or indemnity insurance, 37 A.L.R. 644; 83 A.L.R. 677; 117 A.L.R. 239.

Burglary, larceny, theft, or robbery within policy of insurance, 41 A.L.R. 846; 44 A.L.R. 471.

Losses covered by insurance against strikes, lockouts, or other labor disputes, 52 A.L.R. 162.

Insurance of banks against forgeries, 52 A.L.R. 1379.

Automobile conversion or embezzlement insurance, 55 A.L.R. 827.

Construction and effect of provisions of fidelity bond or fidelity insurance limiting amount of liability, 88 A.L.R. 455.

Act or default of officer or employee covered by fidelity bond or insurance, 98 A.L.R. 1264.

Rights and obligations arising out of bid for municipal bond issue, 139 A.L.R. 1047.

Who is an employee within fidelity bond or insurance, 140 A.L.R. 699.

Fidelity bond or policy as covering default of corporate officer or employee occurring while corporation is in hands of receiver, or after termination of receivership, 153 A.L.R. 1148.

Right of one covered by a fidelity bond to intervene in action by obligee against obligor, 157 A.L.R. 159.

Extent of liability on fidelity bond renewed from year to year, 7 A.L.R.2d 946.

Insurance of bank against larceny and false pretenses, 15 A.L.R.2d 1006.

Insurance: waiver of, or estoppel to assert, iron safe clause, 33 A.L.R.2d 615.

Construction and effect of provision in employee's fidelity bond requiring employer-insured to file "itemized" proof of claim or proof of loss with particulars, 37 A.L.R.2d 900.

Robbery insurance: risks and losses covered, 37 A.L.R.2d 1081.

Construction and effect of clause in burglary policy requiring alarm system, 42 A.L.R.2d 733.

Provisions of burglary or theft policy as to effect of disappearance of property, 12 A.L.R.3d 865.

Provisions of burglary or theft policy requiring losses evidenced by "physical damage to premises," 22 A.L.R.3d 1305.

Theft insurance: coverage of expense of reward offered by insured, or other expense incurred in recovering stolen property, 46 A.L.R.3d 403.

What constitutes "money" within coverage or exclusion of theft or other crime policy, 68 A.L.R.3d 1179.

Loss through payment of extortion demand at place other than insured's premises as within coverage of theft policy insuring against losses incurred on premises, 85 A.L.R.3d 1103.

Construction and effect of clause, infidelity bond, or insurance policy excluding from coverage losses proved by "inventory computation" or "profit and loss computation," 45 A.L.R.4th 1049.

What constitutes "vandalism" or "malicious mischief" within meaning of insurance policy specifically extending coverage to losses from such causes, 56 A.L.R.5th 407.

33-7-8. Title insurance.

Title insurance is insurance of owners of real or personal property or others having an interest in such real or personal property, or liens or encumbrances on such real or personal property, against loss by encumbrance, defective titles, invalidity, adverse claim to title, or unmarketability of title by reason of encumbrance or defects not excepted in the insurance contract, which contract shall be written only upon evidence or opinion of title obtained and preserved by the insurer.

History. — Code 1933, § 56-410, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 901, § 1/SB 202.

The 2019 amendment, effective July 1, 2019, inserted "or personal" in three places in this Code section.

Cross references. — Effect on title insurance companies of laws relating to

regulation of practice of law, §§ 15-19-52, 15-19-53. Recordation and registration of deeds and other instruments, T. 44, C. 2.

JUDICIAL DECISIONS

Defects of survey as covered by title insurance. — Defects of survey such as shortage of area may be sufficiently related to the standard notions of title defect or encumbrance so as to be a risk allowed coverage by title insurance. U.S. Life Title Ins. Co. v. Hutsell, 164 Ga. App. 443, 296 S.E.2d 760 (1982).

Cited in White v. Lawyers Title Ins. Corp., 197 Ga. App. 780, 399 S.E.2d 526 (1990).

OPINIONS OF THE ATTORNEY GENERAL

Mobile homes as real property. — Mobile homes deemed by parties to sales transaction to be a part of real property upon which they are located may be the subjects of title insurance. 1982 Op. Att'y Gen. No. 82-52.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 518.

Am. Jur. Proof of Facts. — Proof of Title Insurance Claims, 38 POF3d 389.

C.J.S. — 46 C.J.S., Insurance, § 1742 et seq.

ALR. — Measure, extent, or amount of recovery on policy of title insurance, 60 A.L.R.2d 972; 19 A.L.R.5th 786.

Title insurance: exclusion of liability for defects, liens, or encumbrances created, suffered, assumed, or agreed to by the insured, 87 A.L.R.3d 515.

What constitutes a charge, encumbrance, or lien within contemplation of title insurance policy, 87 A.L.R.3d 764.

Construction of clause in title insurance policy excepting defects resulting from the rights of parties in possession, 94 A.L.R.3d 1188.

Defect in, or condition of, adjacent land or way as within coverage of title insurance policy, 8 A.L.R.4th 1246.

Defects affecting marketability of title within meaning of title insurance policy, 18 A.L.R.4th 1311.

Title insurer's negligent failure to discover and disclose defect as basis for liability in tort, 19 A.L.R.5th 786.

Am. Jur. Trials. — Handling Title Insurance Claims, 15 Am. Jur. Trials 467.

33-7-8.1. Closing protection letters; definitions; premiums regarding such letters; maintenance of adequate reserves; rules and regulations.

(a) As used in this Code section, the term:

(1) "Closing protection letter" means insurance that indemnifies a buyer, lender, or seller in transactions where title to real estate is being conveyed solely against losses not to exceed the amount of the settlement funds only because of the following acts of the person responsible for the disbursement of settlement funds:

(A) Acts of fraud, theft, dishonesty, or negligence in handling settlement funds or documents in connection with a closing, but

only to the extent that the acts affect status or priority of title in the real estate insured by the title insurance; and

(B) Failure to comply with written closing instructions by a proposed insured when agreed to by the title agency or title agent relating to title insurance coverage, but only to the extent that the acts affect status or priority of title in real estate insured by the title insurance.

(2) "Settlement funds" means the total funds paid by the buyer, lender, or seller as consideration for the conveyance of real estate.

(b) A title insurer may issue closing protection letters only for real estate transactions where its title insurance policies are issued and where its issuing agent or agency is also responsible for the disbursement of settlement funds.

(c) The premium charged by the title insurer for closing protection letters shall be filed with and approved by the Commissioner in accordance with Chapter 9 of this title and shall not be subject to any agreement requiring a division of the premium collected on behalf of the title insurer.

(d) Companies issuing closing protection letters shall maintain adequate reserves for those closing protection letters pursuant to Chapter 10 of this title.

(e) The Commissioner shall promulgate rules and regulations necessary to implement this Code section, which shall include, but shall not be limited to, prescribing standard closing protection letter policy forms.

History. — Code 1981, § 33-7-8.1, enacted by Ga. L. 2012, p. 1077, § 2/SB 331; Ga. L. 2019, p. 337, § 1-37/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "be authorized to" preceding "promulgate rules" in subsection (e).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 518 et seq.

33-7-9. Vehicle insurance.

Vehicle insurance is insurance against loss of or damage to any land vehicle or aircraft, any draft or riding animal, or to property while contained therein or thereon or being loaded or unloaded therein or therefrom from any hazard or cause, and against any loss, liability, or expense resulting from or incident to ownership, maintenance, or use of any such vehicle, aircraft, or animal, together with insurance against accidental death or accidental injury to individuals, including the named insured, while in, entering, alighting from, adjusting, repairing,

cranking, or caused by being struck by a vehicle, aircraft, or draft or riding animal, if such insurance is issued as a part of insurance on the vehicle, aircraft, or draft or riding animal; and provisions of medical, hospital, surgical, and disability benefits to injured persons, funeral and death benefits to dependents, beneficiaries or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance.

History. — Code 1933, § 56-407, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Motor vehicle accident insurance, T. 33, C. 34.

Law reviews. — For article, "Uninsured Motorist Coverage in Georgia," see 4 Ga. St. B.J. 329 (1968). For annual survey of insurance law, see 42 Mercer L. Rev. 259 (1990).

JUDICIAL DECISIONS

Cited in United Servs. Auto. Ass'n v. Carroll, 226 Ga. App. 144, 486 S.E.2d 613 (1997).

RESEARCH REFERENCES

Am. Jur. 2d. — 7 Am. Jur. 2d, Automobile Insurance, § 1 et seq. 44 Am. Jur. 2d, Insurance, §§ 1421, 1434, 1435.

C.J.S. — 44 C.J.S., Insurance, § 21; 45 C.J.S., Insurance, § 625; 46 C.J.S., Insurance, § 1461 et seq.

ALR. — Automobile liability insurance, 6 A.L.R. 376; 13 A.L.R. 135; 19 A.L.R. 879; 23 A.L.R. 1472; 28 A.L.R. 1301; 41 A.L.R. 507.

Insurance covering damage to automobile by accident or collision, 14 A.L.R. 188; 26 A.L.R. 429; 30 A.L.R. 806; 35 A.L.R. 1031; 40 A.L.R. 999; 42 A.L.R. 1130; 54 A.L.R. 1445; 105 A.L.R. 1426.

Insurance against damage to automobile by fire, 14 A.L.R. 199; 35 A.L.R. 1471.

Insurance against theft of automobile, 14 A.L.R. 215; 19 A.L.R. 171; 24 A.L.R. 740; 30 A.L.R. 662.

Admissibility of evidence as to insurance on issue of negligence in operation or care of automobile, 28 A.L.R. 516.

Validity and construction of contract indemnifying against loss due to confiscation of property by public authorities, 36 A.L.R. 1499.

Automobile conversion or embezzlement insurance, 55 A.L.R. 827.

Construction and effect of provisions in automobile insurance policies as to location or place of keeping, 61 A.L.R. 312.

Automobile insurance: pleading and proof as to value, 64 A.L.R. 172.

Automobile liability or indemnity insurance: "omnibus" coverage clause, 72 A.L.R. 1375; 106 A.L.R. 1251; 126 A.L.R. 544.

Automobile theft insurance: rights and duties of parties as regards the finding, recovery, and (or) return of car, 75 A.L.R. 1420.

Scope and application of exception as regard carrying passengers in policies of automobile insurance, 95 A.L.R. 150; 118 A.L.R. 393; 147 A.L.R. 632.

Injury to or death of person whose relationship to named or additional insured was such as to negative latter's liability as within coverage of automobile liability or indemnity policy, 110 A.L.R. 87.

Constitutionality, construction, and application of statute for determination by executive or administrative board of questions in relation to motor vehicle accidents, 110 A.L.R. 826.

What amounts to accident within policy of automobile liability or indemnity insurance, 117 A.L.R. 1175.

Validity and application of provision of

automobile loss or damage or theft policy excluding liability for loss or damage by confiscation, or while car is being used for unlawful purpose, 122 A.L.R. 926.

Conditional sale as affecting provision in insurance policy against change of title, interest, or possession, 133 A.L.R. 785.

Refusal of automobile liability or indemnity insurer to assume defense of action against insured upon ground that claim upon which action is based is not within coverage of policy, 133 A.L.R. 1516; 49 A.L.R.2d 694; 50 A.L.R.2d 458.

Statute regarding automobile liability or indemnity insurance of state where injury occurred as applicable to policy of another state, 137 A.L.R. 656.

Coverage of liability policy on "commercial" vehicle, 144 A.L.R. 537.

"Business," within automobile liability insurance policy covering automobile when used for pleasure and business, as including business of insured's employer, 146 A.L.R. 1189.

Misstatement in description of automobile as affecting automobile policy, 149 A.L.R. 531.

Coverage of policy insuring automobile against particular risk, to the exclusion of others, where risk insured operates to subject it to risk not insured, 160 A.L.R. 947.

Fire loss or damage as within coverage of automobile, 171 A.L.R. 501.

Insurance as covering automobile while being used for illegal purpose, 4 A.L.R.2d 134.

Automobile liability insurance: permission or consent to employee's use of car within meaning of omnibus coverage clause, 5 A.L.R.2d 600.

Act or default of additional insured in respect of giving notice of suit or delivery of suit papers to insurer, as affecting rights of named insured against insurer, 6 A.L.R.2d 661.

Damage to vehicle resulting from wind or other phenomenon of nature as within coverage of automobile insurance policy insuring against collision or upset, 14 A.L.R.2d 812.

Recovery under automobile property damage policy expressly including or excluding collision damage, where vehicle strikes embankment, abutment, roadbed, or other part of highway, 23 A.L.R.2d 389.

Vehicles and operations covered by automobile dealer's collision insurance policy, 23 A.L.R.2d 796.

Construction and effect of clause in liability policy voiding policy while insured vehicles are being used more than a specified distance from principal garage, 29 A.L.R.2d 514.

Liability of insurer, under compulsory statutory vehicle liability policy, to injured third persons, notwithstanding insured's failure to comply with policy conditions, as measured by policy limits or by limits of Financial Responsibility Act, 29 A.L.R.2d 817.

Construction and effect of exclusionary clause in automobile liability policy making policy inapplicable while vehicle is used as a "public or livery conveyance," 30 A.L.R.2d 273.

Effect of provision of liability policy covering hired automobiles but excluding from definition of "insured" the owner of such vehicle or his employee, 32 A.L.R.2d 572.

Misrepresentation by applicant for automobile liability insurance as to ownership of vehicle as material to risk, 33 A.L.R.2d 948.

Automobile liability insurance: conditional vendee of insured as within coverage of omnibus clause, 36 A.L.R.2d 673.

What is an "automobile" or a "car" within coverage of accident policy, 38 A.L.R.2d 867.

Collision insurance: insured's release of tortfeasor before settlement by insurer as releasing insurer from liability, 38 A.L.R.2d 1095.

Scope of clause of insurance policy covering injuries sustained while "in or on" "in or upon" motor vehicle, 39 A.L.R.2d 952.

Measure of recovery by insured under automobile collision insurance policy, 43 A.L.R.2d 327.

Rights in proceeds of vehicle collision policy, under "loss-payable" clause, of conditional seller, chattel mortgagee, or the like, of vehicle where there has been improper repossession or foreclosure after the damage, 46 A.L.R.2d 992.

Automobile insurance: omnibus clause exception relating to public garages, sales agencies, service stations, and the like, 47 A.L.R.2d 556; 93 A.L.R.2d 1047.

Requirement of accident policy or clause that there be some external or visible evidence of collision or accident on the motor vehicle in which insured was riding, 47 A.L.R.2d 1248.

Consequences of liability insurer's refusal to assume defense of action against insured upon ground that claim upon which action is based is not within coverage of policy, 49 A.L.R.2d 694.

Liability insurance of garages, motor vehicle repair shops and sales agencies, and the like, 50 A.L.R.2d 458.

Meaning of "operate" or "being operated" within clause of automobile liability policy limiting its coverage, 51 A.L.R.2d 924.

What constitutes "managing employee" of insured within inclusionary or coverage provision of vehicle liability policy, 57 A.L.R.2d 931.

What loss of or damage to vehicle is accidental within coverage of collision policy, 57 A.L.R.2d 1229.

Motor vehicle theft policy: clause with respect to notice of loss, 66 A.L.R.2d 1280.

Automobile property insurance: sole, unconditional, or absolute ownership clause, 71 A.L.R.2d 223.

Automobile liability insurance: sole, unconditional, or absolute ownership clause, 71 A.L.R.2d 267.

What is an "automobile" or a "car" within coverage of automobile liability policy, 74 A.L.R.2d 1264.

Apportionment of liability between automobile liability insurers where one of the policies has an "excess insurance" clause and the other a "proportionate" or "prorata" clause, 76 A.L.R.2d 502.

What is a "nonowned" automobile within the meaning of the coverage clause or an automobile liability policy, 83 A.L.R.2d 926; 8 A.L.R.4th 387.

Motor vehicle insurance: exclusionary provision relating to age of operator, 83 A.L.R.2d 1236.

Construction of provision excluding automobile used in insured's "business or occupation" from nonowned automobile coverage of automobile liability policy, 85 A.L.R.2d 502.

Automobile liability insurance: operator's policies, 88 A.L.R.2d 995.

Risks within "loading and unloading" clause of motor vehicle liability insurance policy, 95 A.L.R.2d 1122.

Reformation of automobile liability insurance policy by adding to or substituting for the named insured the person intended to be insured, 1 A.L.R.3d 885.

Coverage of insurance policy against theft of property from motor vehicle, 2 A.L.R.3d 809.

Omnibus clause of automobile liability policy as covering accidents caused by third person who is using car with consent of permittee of named insured, 4 A.L.R.3d 10; 21 A.L.R.4th 1146.

Scope of provision of automobile liability insurance policy excluding liability for damage to property in charge of insured, or variation of such provision, 10 A.L.R.3d 515.

Subrogation rights of insurer under medical payments provision of automobile insurance policy, 19 A.L.R.3d 1054.

Automobile insurance: coverage as extending beyond death of named insured, 30 A.L.R.3d 1047.

Automobile insurance: construction of medical payments insurance provision covering injuries incurred when "struck by" automobile, 33 A.L.R.3d 962.

Recoverability, under property insurance or insurance against liability for property damage, of insured's expenses to prevent or mitigate damages, 33 A.L.R.3d 1262.

Collision automobile property insurance as covering collision with bodies of water, 34 A.L.R.3d 992.

Aviation: helicopter accidents, 35 A.L.R.3d 707.

Limitation of amount of coverage under automobile liability policy as affected by fact that policy covers more than one vehicle, 37 A.L.R.3d 1263.

Automobile insurance: when is a person "occupying" an automobile within meaning of medical payments provision, 42 A.L.R.3d 501.

Motor scooter as within policy provisions relating to automobiles as motorcycles, 43 A.L.R.3d 1400.

Validity, construction, and application of provision of automobile liability policy excluding from coverage injury or death of member of family or household of insured, 46 A.L.R.3d 1024; 52 A.L.R.4th 18.

Validity, construction, and application of provision of automobile liability policy excluding from coverage injury or death of insured, 46 A.L.R.3d 1061.

What is "conveyance," "passenger conveyance," or "public conveyance" within coverage of accident policy, 60 A.L.R.3d 858.

What constitutes "trailer" within coverage or exclusion provision of automobile liability policy, 65 A.L.R.3d 804.

"Vehicle" or "land vehicle" within meaning of insurance policy provision defining risks covered or excepted, 65 A.L.R.3d 824.

What constitutes "commercial automobile" within exclusion from death or disability benefit provided by automobile policy, 66 A.L.R.3d 424.

Motorcycle as within automobile liability policy provision covering temporary or infrequent use of other automobiles, 66 A.L.R.3d 451.

Liability of automobile collision insurer undertaking to repair damaged vehicle for negligence or delay in making repairs, 68 A.L.R.3d 1196.

Liability insurance: assault as an "accident," or injuries therefrom as "accidentally" sustained, within coverage clause, 72 A.L.R.3d 1090; 31 A.L.R.4th 957; 33 A.L.R.4th 983; 34 A.L.R.4th 761; 35 A.L.R.4th 1063.

Coverage under collision insurance policy for insured's cost of renting vehicle pending collision repairs, 80 A.L.R.3d 1180.

Extraterritorial application of statute permitting injured person to maintain direct action against tortfeasor's automobile liability insurer, 83 A.L.R.3d 338.

Risks and causes of loss covered or excluded by aviation liability policy, 86 A.L.R.3d 118.

Who is "named insured" within meaning of automobile insurance coverage, 91 A.L.R.3d 1280.

Who is "resident" or "member" of same "household" or "family" as named insured, within liability insurance provision defining additional insureds, 93 A.L.R.3d 420.

Risks within "loading and unloading" clause of motor vehicle liability insurance policy, 6 A.L.R.4th 686.

Automobile liability insurance: what are accidents or injuries "arising out of ownership, maintenance, or use" of insured vehicle, 15 A.L.R.4th 10.

Conflict of laws in determination of coverage under automobile liability insurance policy, 20 A.L.R.4th 738.

Combining or "stacking" medical payment provisions of automobile liability policy or policies issued by one or more insurers to one insured, 29 A.L.R.4th 49.

Liability insurer's waiver of right, or estoppel, to set up breach of co-operation clause, 30 A.L.R.4th 620.

What is "aircraft" or the like within meaning of exclusion or exception clause of insurance policy, 39 A.L.R.4th 214.

Construction and application of "automatic insurance" or "newly acquired vehicle" clause ("replacement," and "blanket," or "fleet" provisions) contained in automobile liability policy, 39 A.L.R.4th 229.

Construction and application of substitution provision of automobile liability policy, 42 A.L.R.4th 1145.

Aviation insurance: causal link between breach of policy provisions and accident as requisite to avoid insurer's liability, 48 A.L.R.4th 778.

What constitutes use of vehicle "in the automobile business" within exclusionary clause of liability policy, 56 A.L.R.4th 300.

What constitutes "entering" or "alighting from" vehicle within meaning of insurance policy, or statute mandating insurance coverage, 59 A.L.R.4th 149.

What constitutes single accident or occurrence within liability policy limiting insurer's liability to a specified amount per accident or occurrence, 64 A.L.R.4th 668.

What constitutes theft within automobile theft insurance policy—modern cases, 67 A.L.R.4th 82.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

Validity, construction, and application of provision in automobile liability policy excluding from coverage injury to, or death of, employee of insured, 43 A.L.R.5th 149.

What constitutes use of automobile "to carry persons or property for fee" within exclusion of automobile insurance policy, 57 A.L.R.5th 591.

Validity, construction, and application of exclusion of government vehicles from uninsured motorist provision, 58 A.L.R.5th 511.

Automobile insurance: what constitutes "occupying" under owned-vehicle exclusion on uninsured or underinsured motorist coverage of automobile insurance policy, 59 A.L.R.5th 191.

33-7-10. Persons deemed subject to laws regulating life insurance companies.

Every person writing or issuing contracts of life insurance as described in Code Section 33-7-4 or as defined in Code Section 33-25-1 shall be deemed to be engaged in the business of life insurance and shall be subject to all of the provisions of the laws of Georgia regulating life insurance companies.

History. — Code 1933, § 56-403, enacted by Ga. L. 1960, p. 289, § 1.

33-7-11. Uninsured motorist coverage under motor vehicle liability policies.

(a)(1) No automobile liability policy or motor vehicle liability policy shall be issued or delivered in this state to the owner of such vehicle or shall be issued or delivered by any insurer licensed in this state upon any motor vehicle then principally garaged or principally used in this state unless it contains an endorsement or provisions undertaking to pay the insured damages for bodily injury, loss of consortium or death of an insured, or for injury to or destruction of property of an insured under the named insured's policy sustained from the owner or operator of an uninsured motor vehicle, within limits exclusive of interests and costs which at the option of the insured shall be:

(A) Not less than $25,000.00 because of bodily injury to or death of one person in any one accident, and, subject to such limit for one person, $50,000.00 because of bodily injury to or death of two or more persons in any one accident, and $25,000.00 because of injury to or destruction of property; or

(B) Equal to the limits of liability because of bodily injury to or death of one person in any one accident and of two or more persons in any one accident, and because of injury to or destruction of property of the insured which is contained in the insured's personal coverage in the automobile liability policy or motor vehicle liability policy issued by the insurer to the insured if those limits of liability exceed the limits of liability set forth in subparagraph (A) of this paragraph. In any event, the insured may affirmatively choose uninsured motorist limits in an amount less than the limits of liability.

(2) The coverages for bodily injury or death or for injury to or destruction of property of an insured person, as provided in paragraph (1) of this subsection, may be subject to deductible amounts as follows:

(A) For bodily injury or death, deductibles of $250.00, $500.00, or $1,000.00, at the option of any named insured in the policy. Deductibles above $1,000.00 may be offered, subject to approval of the Commissioner;

(B) For injury to or destruction of property of the insured, deductibles of $250.00, $500.00, or $1,000.00, at the option of any named insured in the policy. Deductibles above $1,000.00 may be offered, subject to the approval of the Commissioner;

(C) Deductible amounts shown in subparagraphs (A) and (B) of this paragraph may not be reduced below $250.00;

(D) Deductible amounts shown in subparagraphs (A) and (B) of this paragraph shall be made available at a reduced premium; and

(E) Where an insurer has combined into one single limit the coverages required under paragraph (1) of this subsection, any deductible selected under subparagraphs (A) and (B) of this paragraph shall be combined, and the resultant total shall be construed to be a single aggregate deductible.

(3) The coverage required under paragraph (1) of this subsection shall not be applicable where any insured named in the policy shall reject the coverage in writing. The coverage required under paragraph (1) of this subsection excludes umbrella or excess liability policies unless affirmatively provided for in such policies or in a policy endorsement. The coverage need not be provided in or supplemental to a renewal policy where the named insured had rejected the coverage in connection with a policy previously issued to said insured by the same insurer. The amount of coverage need not be increased from the amounts shown on the declarations page on renewal once coverage is issued.

(4) The filing of a petition for relief in bankruptcy under a chapter of Title 11 of the United States Code by an uninsured motorist as described in this Code section, or the appointment of a trustee in bankruptcy for an uninsured motorist as described in this Code section, or the discharge in bankruptcy of an uninsured motorist as described in this Code section shall not affect the legal liability of an uninsured motorist as the term 'legal liability' is used in this Code section, and such filing of a petition for relief in voluntary or involuntary bankruptcy, the appointment of a trustee in bankruptcy, or the discharge in bankruptcy of such an uninsured motorist shall

not be pleaded by the insurance carrier providing uninsured motorist protection in bar of any claim of an insured as defined in this Code section so as to defeat payment for damages sustained by any insured by the insurance company providing uninsured motorist protection and coverage under the terms of this chapter; but the insurance company or companies shall have the right to defend any such action in its own name or in the name of the uninsured motorist and shall make payment of any judgment up to the limits of the applicable uninsured motorist insurance protection afforded by its policy. In those cases, the uninsured motorist upon being discharged in bankruptcy may plead the discharge in bankruptcy against any subrogation claim of any uninsured motorist carrier making payment of a claim or judgment in favor of an uninsured person, and the uninsured motorist may plead said motorist's discharge in bankruptcy in bar of all amounts of an insured person's claim in excess of uninsured motorist protection available to the insured person.

(b)(1) As used in this Code section, the term:

(A) "Bodily injury" shall include death resulting from bodily injury.

(B) "Insured" means the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies; a guest in such motor vehicle to which the policy applies; or the personal representatives of any such persons. The term "insured" shall also mean a foster child or ward residing in the household of the named insured pursuant to a court order, guardianship, or placement by the department of family and children services or other department or agency of the state, while in a motor vehicle or otherwise.

(C) "Property of the insured" as used in subsection (a) of this Code section means the insured motor vehicle and includes the personal property owned by the insured and contained in the insured motor vehicle.

(D) "Uninsured motor vehicle" means a motor vehicle, other than a motor vehicle owned by or furnished for the regular use of the named insured, the spouse of the named insured, and, while residents of the same household, the relative of either, as to which there is:

(i) No bodily injury liability insurance and property damage liability insurance;

(ii) Bodily injury liability insurance and property damage liability insurance and the insured has uninsured motorist

coverage provided under the insured's motor vehicle insurance policy; the motor vehicle shall be considered uninsured, and the amount of available coverages shall be as follows:

(I) Such motor vehicle shall be considered uninsured to the full extent of the limits of the uninsured motorist coverage provided under the insured's motor vehicle insurance policies, and such coverages shall apply to the insured's losses in addition to the amounts payable under any available bodily injury liability and property damage liability insurance coverages. The insured's uninsured motorist coverage shall not be used to duplicate payments made under any available bodily injury liability insurance and property damage liability insurance coverages but instead shall be available as additional insurance coverage in excess of any available bodily injury liability insurance and property damage liability insurance coverages; provided, however, that the insured's combined recovery from the insured's uninsured motorist coverages and the available coverages under the bodily injury liability insurance and property damage liability insurance on such uninsured motor vehicle shall not exceed the sum of all economic and noneconomic losses sustained by the insured. For purposes of this subdivision, available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle shall be the limits of coverage less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of other claims or otherwise, been reduced below the limits of coverage;

(II) Provided, however, that an insured may reject the coverage referenced in subdivision (I) of this division and select in writing coverage for the occurrence of sustaining losses from the owner or operator of an uninsured motor vehicle that considers such motor vehicle to be uninsured only for the amount of the difference between the available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle and the limits of the uninsured motorist coverages provided under the insured's motor vehicle insurance policies; and, for purposes of this subdivision, available coverages under the bodily injury liability insurance and property damage liability insurance coverages on such motor vehicle shall be the limits of coverage less any amounts by which the maximum amounts payable under such limits of coverage have, by reason of payment of other claims or otherwise, been reduced below the limits of coverage; and

(III) Neither coverage under subdivision (I) nor (II) of this division shall be applicable if the insured rejects such coverages as provided in paragraph (3) of subsection (a) of this Code section. The coverage set forth in subdivision (I) of this division need not be provided in or supplemental to a renewal policy where the named insured has rejected the coverage set forth in subdivision (I) of this division and selected the coverage set forth in subdivision (II) of this division in connection with a policy previously issued to said insured by the same insurer;

(iii) Bodily injury liability insurance and property damage liability insurance in existence but the insurance company writing the insurance has legally denied coverage under its policy;

(iv) Bodily injury liability and property damage liability insurance in existence but the insurance company writing the insurance is unable, because of being insolvent, to make either full or partial payment with respect to the legal liability of its insured, provided that in the event that a partial payment is made by or on behalf of the insolvent insurer with respect to the legal liability of its insured, then the motor vehicle shall only be considered to be uninsured for the amount of the difference between the partial payment and the limits of the uninsured motorist coverage provided under the insured's motor vehicle insurance policy; or

(v) No bond or deposit of cash or securities in lieu of bodily injury and property damage liability insurance.

(2) A motor vehicle shall be deemed to be uninsured if the owner or operator of the motor vehicle is unknown. In those cases, recovery under the endorsement or provisions shall be subject to the conditions set forth in subsections (c) through (j) of this Code section, and, in order for the insured to recover under the endorsement where the owner or operator of any motor vehicle which causes bodily injury or property damage to the insured is unknown, actual physical contact shall have occurred between the motor vehicle owned or operated by the unknown person and the person or property of the insured. Such physical contact shall not be required if the description by the claimant of how the occurrence occurred is corroborated by an eyewitness to the occurrence other than the claimant.

(c) If the owner or operator of any motor vehicle which causes bodily injury or property damage to the insured is unknown, the insured, or someone on his behalf, or in the event of a death claim someone on behalf of the party having the claim, in order for the insured to recover under the endorsement, shall report the accident as required by Code Section 40-6-273.

(d) In cases where the owner or operator of any vehicle causing injury or damages is known, and either or both are named as defendants in any action for such injury or damages, and a reasonable belief exists that the vehicle is an uninsured motor vehicle under subparagraph (b)(1)(D) of this Code section, a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant. If facts arise after an action has been commenced which create a reasonable belief that a vehicle is an uninsured motor vehicle under subparagraph (b)(1)(D) of this Code section and no such reasonable belief existed prior to the commencement of the action against the defendant, and the complaint was timely served on the defendant, the insurance company issuing the policy shall be served within either the remainder of the time allowed for valid service on the defendant or 90 days after the date on which the party seeking relief discovered, or in the exercise of due diligence should have discovered, that the vehicle was uninsured or underinsured, whichever period is greater. The uninsured motorist carrier may conduct discovery as a matter of right for a period of not less than 120 days after service prior to any hearing on the merits of the action. If either the owner or operator of any vehicle causing injury or damages is unknown, an action may be instituted against the unknown defendant as "John Doe," and a copy of the action and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company were actually named as a party defendant; and the insurance company shall have the right to file pleadings and take other action allowable by law in the name of "John Doe" or itself. In any case arising under this Code section where service upon an insurance company is prescribed, the clerk of the court in which the action is brought shall have such service accomplished by issuing a duplicate original copy for the sheriff or marshal to place his or her return of service in the same form and manner as prescribed by law for a party defendant. The return of service upon the insurance company shall in no case appear upon the original pleadings in such case. In the case of a known owner or operator of such vehicle, either or both of whom are named as a defendant in such action, the insurance company issuing the policy shall have the right to file pleadings and take other action allowable by law in the name of either the known owner or operator or both or itself.

(1) In cases where the owner or operator of a vehicle causing injury or damages is unknown and an action is instituted against the unknown defendant as "John Doe," the residence of such "John Doe" defendant shall be presumed to be in the county in which the accident causing injury or damages occurred, or in the county of residence of the plaintiff, at the election of the plaintiff in the action.

(2) A motor vehicle shall not be deemed to be an uninsured motor vehicle within the meaning of this Code section when the owner or operator of such motor vehicle has deposited security, pursuant to Code Section 40-9-32, in the amounts specified in subparagraph (a)(1)(A) of this Code section.

(e) In cases where the owner or operator of any vehicle causing injury or damage is known and either or both are named as defendants in any action for such injury or damages but the person resides out of the state, has departed from the state, cannot after due diligence be found within the state, or conceals himself to avoid the service of summons, and this fact shall appear by affidavit to the satisfaction of the judge of the court, and it shall appear either by affidavit or by a verified complaint on file that a claim exists against the owner or driver in respect to whom service is to be made and that he is a necessary or proper party to the action, the judge may grant an order that the service be made on the owner or driver by the publication of summons. A copy of any action filed and all pleadings thereto shall be served as prescribed by law upon the insurance company issuing the policy as though the insurance company issuing the policy were actually named as a party defendant. Subsection (d) of this Code section shall govern the rights of the insurance company, the duties of the clerk of court concerning duplicate original copies of the pleadings, and the return of service. Following service on the owner or driver by the publication of the summons as provided in this subsection and service as prescribed by law upon the insurance company issuing the policy, the plaintiff shall have a continuing duty to exercise diligence in attempting to locate the owner or driver against whom the claim exists, but such obligation of diligence shall not extend beyond a period of 12 months following service upon the owner or driver by publication of the summons. However, regardless of such time limitations, should the plaintiff learn of the location of the owner or driver against whom the claim exists, the plaintiff shall exercise due diligence to effect service of process upon that owner or driver within a reasonable time period after receiving such information.

(f) An insurer paying a claim under the endorsement or provisions required by subsection (a) of this Code section shall be subrogated to the rights of the insured to whom the claim was paid against the person causing such injury, death, or damage to the extent that payment was made, including the proceeds recoverable from the assets of the insolvent insurer, provided that the bringing of an action against the unknown owner or operator as "John Doe" or the conclusion of such an action shall not constitute a bar to the insured, if the identity of the owner or operator who caused the injury or damages complained of becomes known, bringing an action against the owner or operator theretofore proceeded against as "John Doe"; provided, further, that any recovery against such owner or operator shall be paid to the

insurance company to the extent that the insurance company paid the named insured in the action brought against the owner or operator as "John Doe," except that the insurance company shall pay its proportionate part of any reasonable costs and expense incurred in connection therewith, including reasonable attorney's fees. Nothing in an endorsement or provisions made under this Code section nor any other provision of law shall operate to prevent the joining in an action against "John Doe" or the owner or operator of the motor vehicle causing such injury as a party defendant, and joinder is specifically authorized.

(g) No endorsement or provisions shall contain a provision requiring arbitration of any claim arising under any endorsement or provisions, nor may anything be required of the insured, subject to the other provisions of the policy or contract, except the establishment of legal liability; nor shall the insured be restricted or prevented, in any manner, from employing legal counsel or instituting legal proceedings.

(h) Before a motor vehicle shall be deemed to be uninsured because of the insolvency of an insurance company under division (b)(1)(D)(iv) of this Code section, an insurer under the uninsured motorists endorsement provisions of subsection (a) of this Code section must be given notice within a reasonable time by its insured of the pendency of any legal proceeding against such insurance company of which he may have knowledge, and before the insured enters into any negotiation or arrangement with the insurance company, and before the insurer is prejudiced by any action or nonaction of the insured with respect to the determinations of the insolvency of the insurance company.

(i) In addition to any offsets or reductions contained in the provisions of division (b)(1)(D)(ii) of this Code section, an endorsement or the provisions of the policy providing the coverage required by this Code section may contain provisions which exclude any liability of the insurer for injury to or destruction of property of the insured for which such insured has been compensated by other property or physical damage insurance and may contain provisions which exclude any liability of the insurer for personal or bodily injury or death for which the insured has been compensated pursuant to "medical payments coverage," as such term is defined in paragraph (1) of Code Section 33-34-2, or compensated pursuant to workers' compensation laws.

(j) If the insurer shall refuse to pay any insured any loss covered by this Code section within 60 days after a demand has been made by the insured and a finding has been made that such refusal was made in bad faith, the insurer shall be liable to the insured in addition to any recovery under this Code section for not more than 25 percent of the recovery and all reasonable attorney's fees for the prosecution of the case under this Code section. The question of bad faith, the amount of the penalty, if any, and the reasonable attorney's fees, if any, shall be

determined in a separate action filed by the insured against the insurer after a judgment has been rendered against the uninsured motorist in the original tort action. The attorney's fees shall be fixed on the basis of competent expert evidence as to the reasonable value of the services, based on the time spent and legal and factual issues involved, in accordance with prevailing fees in the locality where the action is pending. The trial court shall have the discretion, if it finds such jury verdict fixing attorney's fees to be greatly excessive or inadequate, to review and amend such portion of the verdict fixing attorney's fees without the necessity of disapproving the entire verdict. The limitations contained in this subsection in reference to the amount of attorney's fees are not controlling as to the fees which may be agreed upon by the plaintiff and his attorney for the services of the attorney in the action against the insurer.

History. — Code 1933, § 56-407A, enacted by Ga. L. 1963, p. 588, § 1; Ga. L. 1964, p. 306, § 1; Ga. L. 1967, p. 463, § 1; Ga. L. 1968, p. 1089, §§ 1, 2; Ga. L. 1968, p. 1415, § 1; Ga. L. 1971, p. 926, §§ 1, 2; Ga. L. 1972, p. 882, § 1; Ga. L. 1973, p. 487, § 1; Ga. L. 1975, p. 1221, § 1; Ga. L. 1976, p. 1195, § 1; Ga. L. 1978, p. 1895, § 1; Ga. L. 1980, p. 1428, § 1; Ga. L. 1983, p. 938, § 1; Ga. L. 1984, p. 839, §§ 1-3; Ga. L. 1985, p. 149, § 33; Ga. L. 1986, p. 394, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1991, p. 1608, § 1.4; Ga. L. 1994, p. 97, § 33; Ga. L. 1998, p. 1064, § 3; Ga. L. 2000, p. 1516, § 1; Ga. L. 2001, p. 1228, §§ 1, 2; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2006, p. 815, §§ 1-3/SB 531; Ga. L. 2008, p. 1192, §§ 1, 2/SB 276; Ga. L. 2019, p. 337, § 1-38/SB 132.

The 2019 amendment, effective July 1, 2019, deleted the former fourth sentence of paragraph (a)(3), which read: "The amount of coverage need not be increased in a renewal policy from the amount shown on the declarations page for coverage existing prior to July 1, 2001."; in paragraph (a)(4), in the first sentence, substituted "as described in" for "as defined in" in three places, deleted "person" following "insured" in two places, and deleted "as now or hereafter amended" following "terms of this chapter"; substituted "representatives of any such persons. The term 'insured'" for "representatives of any of the above. For policies issued or renewed on or after July 1, 2006, the term 'insured'" and "department of family and children services" for "Department of Family and Children Services" in subparagraph (b)(1)(B); and deleted the former second and third sentences of subdivision (b)(1)(D)(ii)(III), which read: "For private passenger motor vehicle insurance policies in effect on January 1, 2009, insurers shall send to their insureds who have not rejected coverage pursuant to paragraph (3) of subsection (a) of this Code section a notice at least 45 days before the first renewal of such policies advising of the coverage options set forth in this division. Such notice shall not be required for any subsequent renewals for policies in effect on January 1, 2009, or for any renewals for policies issued after January 1, 2009."

Cross references. — Liability for failing or refusing in bad faith to pay claim generally, § 33-4-6. Apportionment of casualty insurance among admitted insurers, §§ 33-9-7, 33-9-8. Motor vehicle accident insurance generally, T. 33, C. 34. Motor carrier bond or insurance, § 40-1-112. Insurance requirements for operation of motor vehicles generally, § 40-6-10. Motor vehicle accident financial responsibility, T. 40, C. 9.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, "subparagraph (A) of this paragraph" was substituted for "subparagraph (a)(1)(A)" in subparagraph (a)(1)(B).

Editor's notes. — Ga. L. 1984, p. 839, § 4 not codified by the General Assembly, provided that that Act would apply to all

motor vehicle liability insurance policies issued, delivered, or renewed in Georgia on or after January 1, 1985, except for the subsection (j) amendment, which would take effect upon the date of the Governor's approval (March 28, 1984).

Ga. L. 1986, p. 394, § 2, not codified by the General Assembly, provided: "This Act shall become effective January 1, 1987, and shall apply to motor vehicle liability insurance policies issued, delivered, or renewed in Georgia on or after January 1, 1987."

Ga. L. 1991, p. 1608, § 3.1, not codified by the General Assembly, provides that this Code section shall become effective on October 1, 1991, and shall apply to policies of motor vehicle insurance issued, issued for delivery, delivered, or renewed on and after October 1, 1991.

Ga. L. 2001, p. 1228, § 3, not codified by the General Assembly, provides that: "Sections 1 and 2 of this Act shall only apply to policies issued or renewed on or after January 1, 2002."

Ga. L. 2006, p. 815, § 4, not codified by the General Assembly, provides that: "Section 1 of this Act shall apply to all policies issued, delivered, or issued for delivery in this state on and after such date."

Ga. L. 2008, p. 1192, § 5, not codified by the General Assembly, provides that the amendment to this Code section shall apply to all policies issued, delivered, issued for delivery, or renewed in this state on and after January 1, 2009.

Law reviews. — For article, "Uninsured Motorist Coverage in Georgia," see 4 Ga. St. B.J. 329 (1968). For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979). For article surveying Georgia cases in the area of insurance from June 1979 through May 1980, see 32 Mercer L. Rev. 79 (1980). For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981). For annual survey of insurance law, see 35 Mercer L. Rev. 177 (1983). For annual survey of law of insurance, see 38 Mercer L. Rev. 247 (1986). For annual survey of recent developments in insurance law, see 38 Mercer L. Rev. 473 (1986). For article, "Duty to Settle and Insurance Defense Counsel's Ethical Dilemmas," see 26 Ga. St. B.J. 68 (1989). For annual survey of insurance law, see 42 Mercer L. Rev. 259 (1990). For annual survey on trial practice and procedure, see 42 Mercer L. Rev. 469 (1990). For annual survey article on insurance law, see 45 Mercer Law Rev. 253 (1993). For review of 1998 legislation relating to insurance, see 15 Ga. St. U.L. Rev. 153 (1998). For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999). For annual survey article on evidence law, see 52 Mercer L. Rev. 303 (2000). For annual survey article discussing trial practice and procedure, see 52 Mercer L. Rev. 447 (2000). For article, "Insurance," see 53 Mercer L. Rev. 281 (2001). For survey article on insurance law for the period from June 1, 2002 through May 31, 2003, see 55 Mercer L. Rev. 277 (2003). For survey article on trial practice and procedure for the period from June 1, 2002 to May 31, 2003, see 55 Mercer L. Rev. 439 (2003). For article, "Bad Faith in Insurance Claim Handling in Georgia: An Overview and Update," see 9 Ga. St. B.J. 10 (2003). For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004). For annual survey of insurance law, see 57 Mercer L. Rev. 221 (2005). For annual survey of trial practice and procedure, see 57 Mercer L. Rev. 381 (2005). For annual survey of insurance law, see 58 Mercer L. Rev. 181 (2006). For survey article on evidence law, see 59 Mercer L. Rev. 157 (2007). For survey article on trial practice and procedure, see 59 Mercer L. Rev. 423 (2007). For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008). For survey article on trial practice and procedure, see 60 Mercer L. Rev. 397 (2008). For annual survey on insurance, see 61 Mercer L. Rev. 179 (2009). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010). For annual survey of law on trial practice and procedure, see 62 Mercer L. Rev. 339 (2010). For annual survey on insurance law, see 64 Mercer L. Rev. 151 (2012). For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014). For annual survey of insurance law, see 67 Mercer L. Rev. 73 (2015). For article, "Uninsured Motorist Benefits in Light of Thurman v. State

Farm," see 23 Ga. St. B.J. 19 (Oct. 2017). For annual survey on insurance law, see 69 Mercer L. Rev. 117 (2017). For annual survey on trial practice and procedure, see 69 Mercer L. Rev. 321 (2017). For annual survey on trial practice and procedure, see 70 Mercer L. Rev. 253 (2018). For annual survey on insurance law, see 70 Mercer L. Rev. 111 (2018). For annual survey on trial practice and procedure, see 71 Mercer L. Rev. 305 (2019).

For note, "Conflicts of Interest in the Liability Insurance Setting," see 13 Ga. L. Rev. 973 (1979). For note, "Stacking of Uninsured Motorist and Medical Expense Insurance Coverages in Automobile Insurance Policies," see 13 Ga. L. Rev. 1014 (1979). For note on 1991 amendment of this Code section, see 8 Ga. St. U.L. Rev. 99 (1992). For note on the 2001 amendment of this Code section, see 18 Ga. St. U.L. Rev. 177 (2001).

For comment on Travelers Indem. Co. v. Williams, 119 Ga. App. 414, 167 S.E.2d 174 (1969), see 21 Mercer L. Rev. 341 (1969). For comment on State Farm Mut. Auto. Ins. Co. v. Board of Regents of Univ. Sys., 226 Ga. 310, 174 S.E.2d 920 (1970), see 22 Mercer L. Rev. 621 (1971).

JUDICIAL DECISIONS

Analysis

General Consideration
Who Is Covered
Who Is "Uninsured Motorist"
Refusal to Pay Loss
Waiver of Coverage
Procedure

General Consideration

The purpose of this section is to place the insured in the same position as if the tortfeasor had the $10,000.00 minimum coverage. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973); Travelers Indem. Co. v. Liberty Loan Corp., 140 Ga. App. 458, 231 S.E.2d 399 (1976), cert. dismissed, 238 Ga. 667, 235 S.E.2d 39 (1977); American Protection Ins. Co. v. Parker, 150 Ga. App. 732, 258 S.E.2d 540 (1979).

The purpose in providing for uninsured motorist protection was to afford the public generally with the same protection that it would have had if the uninsured motorist had carried the same amount of coverage under a public liability policy issued in his name. Wages v. State Farm Mut. Auto. Ins. Co., 132 Ga. App. 79, 208 S.E.2d 1 (1974).

The purpose of uninsured motorist insurance is to afford the public generally (not just the insured driver) the same protection that would ensue if the uninsured motorist had carried the minimum limits of public liability coverage. Travelers Indem. Co. v. Liberty Loan Corp., 140 Ga. App. 458, 231 S.E.2d 399 (1976), cert. dismissed, 238 Ga. 667, 235 S.E.2d 39 (1977).

The purpose of uninsured motorist legislation is to require some provision for first-party insurance coverage to facilitate indemnification for injuries to a person who is legally entitled to recover damages from an uninsured motorist, and thereby to protect innocent victims from the negligence of irresponsible drivers. Smith v. Commercial Union Assurance Co., 246 Ga. 50, 268 S.E.2d 632 (1980).

Legislative intent. — As pertinently provided in paragraph (a)(1), O.C.G.A. § 33-7-11 on its face reveals the intent of the legislature that the covered risk be limited to those damages arising from incidents involving the owner or operator of an uninsured motor vehicle. Hinton v. Interstate Guar. Ins. Co., 220 Ga. App. 699, 470 S.E.2d 292 (1996), rev'd on other grounds, 267 Ga. 516, 480 S.E.2d 842 (1997).

Because Georgia public policy prohibited an exclusion within an insurer's uninsured coverage for the use of any motor vehicle by an insured to carry persons or property for a fee, as such denied the statutorily mandated coverage to an oth-

General Consideration (Cont'd)

erwise qualified insured, and the requirements under O.C.G.A. § 33-7-11 were plain and not illogical, summary judgment in favor of the insurer on this issue was reversed. Wagner v. Nationwide Mut. Fire Ins. Co., 288 Ga. App. 132, 653 S.E.2d 526 (2007).

Construction with Captive Insurance Company Act. — To the extent uninsured motorist provisions are inconsistent with the Georgia Captive Insurance Company Act, O.C.G.A. § 33-4-1 et seq., those provisions would not apply to captive insurance companies as set forth in the Act, O.C.G.A. § 33-41-24, because other controlling statutory mandates and strictures may result in the insurer providing some uninsured motorist coverage without being subject to other provisions of the uninsured motorist statute; the captive insurer is not required to insure a risk that the insurer is prohibited from insuring under the Act. VFH Captive Ins. Co. v. Pleitez, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

Construction with excess insurance policies. — By operation of Georgia's uninsured motorist statute, each insurer's excess liability policy provided uninsured motorist coverage up to the liability limits of that policy. However, the insurers were under no obligation to provide any coverage, uninsured motorist or otherwise, until the plaintiffs exhausted the policy limits of the policy that provided second-layer umbrella coverage, which the plaintiffs did not do. Coker v. Am. Guar. & Liab. Ins. Co., 825 F.3d 1287 (11th Cir. 2016) (accident occurred in 2007).

Nothing in O.C.G.A. § 33-7-11 voids the vertical exhaustion requirements of umbrella and excess liability policies governed by Georgia law. Additionally, the policy's vertical exhaustion requirement does not undermine the remedial purpose of that statute. Coker v. Am. Guar. & Liab. Ins. Co., 825 F.3d 1287 (11th Cir. 2016).

Coverage agreement with Georgia Interlocal Risk Management Agency excluded uninsured and underinsured motorist protection. — Court of appeals correctly determined that no statute required that a city's agreement with the Georgia Interlocal Risk Management Agency (GIRMA) had to meet the uninsured and underinsured motorist coverage requirements that an insurance policy issued by an insurer had to meet pursuant to O.C.G.A. § 33-7-11 because the General Assembly explicitly declared that GIRMA was not an insurer; the city's agreement with GIRMA was limited to its express terms and did not include underinsured motorist protection. Godfrey v. Ga. Interlocal Risk Mgmt. Agency, 290 Ga. 211, 719 S.E.2d 412 (2011).

Applicability. — O.C.G.A. § 33-7-11 provides the basis for stacking by requiring insurance companies to have a provision in their contracts to pay the insured all sums which said insured shall be legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle. Furthermore, the section creates two categories of insured persons; the first consists of the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise; and the second category of insured persons consists of any person who uses, with the expressed or implied consent of the named insured, the motor vehicle to which the policy applies, i.e., a guest in such motor vehicle to which the policy applies. Unlike the first provision, this second one contains language that conditions status as an insured on the involvement of the motor vehicle to which the policy applies and this class of insured persons is covered only when the insured automobile is involved. Beard v. Nunes, 269 Ga. App. 214, 603 S.E.2d 735 (Aug. 23, 2004).

Language of O.C.G.A. § 33-7-11(a)(1) is plain and is not illogical; the statute clearly states that an insurer is to pay all sums that the insured is legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle, and "all" means every single one. Gordon v. Atlanta Cas. Co., 279 Ga. 148, 611 S.E.2d 24 (2005).

Enforcing the intra-family exclusion did not conflict with Georgia's compulsory insurance law because a decedent was insured, and the decedent's spouse's estate

was compensated under a general liability policy for the full amount required under such law; moreover, an intra-family exclusion under the decedent's insurance policy did not violate public policy because it did not prevent recovery of the compulsory minimum insurance amount. Hoque v. Empire Fire & Marine Ins. Co., 281 Ga. App. 810, 637 S.E.2d 465 (2006).

Because a personal injury plaintiff failed to file said action against an uninsured/underinsured motorist insurer within the applicable statutory period, and the action was not subject to renewal, as the magistrate court's determined that service was made by an unauthorized person, thus rendering the original action void, the insurer was entitled to dismissal. Lewis v. Waller, 282 Ga. App. 8, 637 S.E.2d 505 (2006).

When an insured settled with a driver who injured the insured, the insured could not also recover uninsured motorist benefits from the insured's insurer because an amendment to O.C.G.A. § 33-7-11 which would allow such recovery did not apply retroactively to the relevant accident as the amendment: (1) created new rights on the part of an insured, by giving an insured the ability to elect to have excess uninsured motorist coverage, a reduction in that coverage, or no uninsured motorist coverage at all; and (2) affected an insurer's rights by requiring an insurer to provide excess coverage unless an insured specifically rejected such coverage, so the amendment was substantive in nature. McConville v. Cotton States Mut. Ins. Co., 315 Ga. App. 11, 726 S.E.2d 481 (2012).

Effect of 1980 amendment on stacking of policies. — The 1980 amendment to the definition of "uninsured motor vehicle" in subparagraph (b)(1)(D) now allows an insured to "stack" his multiple policies of uninsured motorist coverage where the tortfeasor is minimally insured, and use of word "policy" rather than "policies" in the amendment does not affect this result. State Farm Mut. Auto. Ins. Co. v. Hancock, 164 Ga. App. 32, 295 S.E.2d 359 (1982).

Nothing in the 2001 amendment required an insurer to notify its policyholders who had chosen the statutory minimum amounts of uninsured motorist (UM) coverage that optional UM coverage was required to be equal to the liability limits of the underlying policy; an injured person's UM coverage was the minimum elected before the 2001 amendment to O.C.G.A. § 33-7-11, despite the fact that the liability limits of the policy at issue were higher than the elected UM coverage. Tice v. Am. Employers' Ins. Co., 275 Ga. App. 125, 619 S.E.2d 797 (2005).

In an action concerning the limits of uninsured motorist (UM) coverage available under a claimant's policy, which was held with the claimant's husband who was the named insured thereunder, their insurer was properly granted summary judgment on the issue, as the 2001 amendment to O.C.G.A. § 33-7-11 had no effect on the limits of UM coverage under the policy covering the claimant's vehicle, and as such, the insurer was not required to notify the claimant of the change in the law or to secure a separate UM election at the time this vehicle was added to the original insurance policy. Soufi v. Haygood, 282 Ga. App. 593, 639 S.E.2d 395 (2006).

Uninsured motorist statutes are remedial in nature and must be broadly construed to accomplish the legislative purpose. Smith v. Commercial Union Assurance Co., 246 Ga. 50, 268 S.E.2d 632 (1980).

Section compared with provisions for motor carrier's surety bonds. — The structure of this section is to offer the insurer as a substitute defendant, whereas the structure of the Uninsured Motorist Act (see O.C.G.A. T. 46, C. 7) is to offer the insurer as a substitute surety bond, action against which is based on its contract with the carrier for the protection of the public as a third-party beneficiary. Farley v. Continental Ins. Co., 150 Ga. App. 389, 258 S.E.2d 8 (1979).

Subsection (a) of this section establishes a state policy that Georgia drivers shall have available to them a minimum amount of automobile liability insurance compensation. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Section requires policies to include uninsured motorist coverage. — This section requires insurance companies writing liability policies to include protec-

General Consideration (Cont'd)

tion against uninsured motorists. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

Requirement of subsection (d) as to prompt notice. — Trial court committed no error in rejecting the insured's argument predicated on O.C.G.A. § 33-7-11(d) because the contractual notice provision requiring notification of the uninsured motorist carrier promptly after an accident or loss served a different purpose than § 33-7-11(d) and did not conflict with the statute's terms. Thus, § 33-7-11(d) did not render unenforceable the insured's separate contractual obligation to provide the insurer with prompt notice of the accident. Silva v. Liberty Mut. Fire Ins. Co., 344 Ga. App. 81, 808 S.E.2d 886 (2017), cert. denied, No. S18C0653, 2018 Ga. LEXIS 498 (Ga. 2018).

Change in policy did not trigger insurer's duty to offer statutory minimum coverage. — Change in an existing policy during the course of one of the policy periods that has no impact on an insured's uninsured/underinsured motorist coverage is not sufficient to trigger the duty to offer the statutory minimum coverage in O.C.G.A. § 33-7-11 or to reobtain a rejection of that coverage. Hunter v. Progressive Mountain Ins. Co., 353 Ga. App. 444, 838 S.E.2d 112 (2020).

Lack of standing to pursue declaratory judgment action. — Trial court erred in denying the rental defendants' motion to dismiss because a declaratory judgment action was improper against the defendants as the widow had not shown standing since the widow sought declaratory judgment as to liability beyond that minimum amount and had no direct relationship with rental defendants until (and if) the widow obtained a judgment in an underlying tort suit, thus, only a hypothetical and generalized economic interest existed. U-Haul Co. v. Rutland, 348 Ga. App. 738, 824 S.E.2d 644 (2019).

Captive insurance company act does not prohibit uninsured motorist coverage. — There is nothing in the Georgia Captive Insurance Company Act, O.C.G.A. § 33-41-1 et seq., that explicitly prohibits a captive insurer from offering uninsured motorist coverage, and thus the Act does not directly conflict with the requirement contained in O.C.G.A. § 33-7-11 that motor vehicle liability policies must include uninsured motorist coverage unless the insured has rejected that coverage in writing, but the mandate contained in the Act, O.C.G.A. § 33-41-3(b) is explicit; uninsured motorist coverage, unless rejected in writing, is such a minimum requirement under Georgia law, and the General Assembly is presumed to have acted with full knowledge of that requirement in enacting the provisions of the Act. VFH Captive Ins. Co. v. Pleitez, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

No setoff for personal injury benefits. — The plain meaning of O.C.G.A. § 33-7-11(i) is that an uninsured motorist carrier can set off benefits which its insured may have received to compensate for property loss; this being so, the Supreme Court of Georgia must conclude that the legislature did not intend to authorize an insurer to set off benefits received for personal injury. That is because when a statute expressly mentions one of many things, the omitted things must be regarded as having been deliberately excluded. Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

An uninsured motorist carrier was not entitled to set off sums the insureds had received from workers' compensation, Social Security disability, and a settlement with a liability insurer. O.C.G.A. § 33-7-11(i) did not state that an insurer could set off benefits received for personal injuries; inasmuch as a policy provision such as the one here permitted a setoff for personal injury benefits, it was in conflict with the Uninsured Motorist Act and was thus unenforceable. Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

Uninsured motorist carrier's motion to reduce a jury verdict to a motorist, who was injured in a motor vehicle accident, by the amount of pre-trial medical expense payments the insurer made to the motorist under an insurance policy was properly denied as the carrier was not permitted to set off benefits received for personal injury from collateral sources under O.C.G.A. § 33-7-11(i). State Farm Mut. Auto. Ins. Co. v. Hall, 309 Ga. App. 271, 709 S.E.2d 867 (2011).

Insurer entitled to set off. — Trial court did not err in granting the summary judgment motion of the plaintiff's parent's insurer finding that it was entitled to a set-off for the $25,000 paid by the insurer for the other driver because the parent's insurer was the sole difference-in-limits underinsured motorist (UM) carrier whose policy potentially provided coverage for the plaintiff's claims; and, after applying the $25,000 set-off to the $25,000 limits under the policy of the parent's insurer, there was no further coverage with that carrier, no issue of fact remained regarding the availability of UM coverage under that policy, and the parent's insurer was entitled to summary judgment as a matter of law. Donovan v. State Farm Mut. Auto. Ins. Co., 329 Ga. App. 609, 765 S.E.2d 755 (2014).

UM coverage reduced by the amount paid by the tortfeasor's insurer. — When an injured motorist had received $100,000 from the tortfeasor's insurer, which did not cover the motorist's damages, and the motorist had a personal policy and the motorist's employer's policy that provided UM coverage, the motorist's personal policy provided "reduced by" coverage, O.C.G.A. § 33-7-11(b)(1)(D)(ii)(II), so the personal insurer was entitled to a set-off of $100,000 received from the tortfeasor, leaving the insurer's policy, which provided "added on" coverage, responsible for the motorist's excess damages. Allstate Fire & Cas. Ins. Co. v. Rothman, 332 Ga. App. 670, 774 S.E.2d 735 (2015).

Insurer not obligated to offer increase in uninsured motorist coverage. — Insurer was not obligated to offer an increase of the limits of the insureds' uninsured/underinsured motorist (UM) coverage to the statutory minimum coverage level because the insureds did not request an increase in UM coverage at the time the insureds increased their level of standard automobile coverage; the insureds failed to establish that the insureds request for a change in the amount of standard coverage would have triggered the insurer's duty to offer the statutory minimum UM coverage again as a new policy was not created; and there was nothing in the statute requiring the insurer to re-offer the statutory minimum UM coverage based on a change to an already existing policy when the insureds did not make any request to change their UM coverage at that time. Hunter v. Progressive Mountain Ins. Co., 353 Ga. App. 444, 838 S.E.2d 112 (2020).

Uninsured motorist insurer entitled to credit for hospital lien paid by tortfeasor's insurer. — Under O.C.G.A. §§ 33-7-11(b)(1)(D)(ii) (underinsured motorist coverage) and 44-14-470(b) (hospital liens), a tortfeasor's insurer's payment of a hospital lien represented partial satisfaction of an injured insured's claim; the injured insured's UM carrier was entitled to a credit for the payment of the lien against its coverage. State Farm Mut. Auto. Ins. Co. v. Adams, 288 Ga. 315, 702 S.E.2d 898 (2010).

Conflict of laws. — Enforcement, under conflict of laws rules, of a Tennessee statute allowing an insurer's liability for uninsured motorist benefits to be offset by any collateral benefits received by the injured person did not contravene the public policy of Georgia. Dacosta v. Allstate Ins. Co., 188 Ga. App. 10, 372 S.E.2d 7, cert. denied, 188 Ga. App. 911, 372 S.E.2d 7 (1988).

Choice-of-law question as to whether a judgment against the unknown tortfeasor is a prerequisite to recovery from the uninsured motorist carrier in Georgia was a procedural and remedial matter covered by Georgia law. Allstate Ins. Co. v. Duncan, 218 Ga. App. 552, 462 S.E.2d 638 (1995).

Effect on out-of-state policy. — With respect to an automobile insurance policy which covers vehicle principally garaged and used in another state but which is sold and delivered to a resident of Georgia, this section does not act to invalidate an underinsured coverage exclusion which attempts to limit coverage because the insured was injured in a vehicle not covered by the policy. Amica Mut. Ins. v. Bourgault, 263 Ga. 157, 429 S.E.2d 908 (1993).

Because automobiles which were insured both in Georgia and in New York were garaged and used in New York, it was reasonable for the parties to assume that New York was the principal location

General Consideration (Cont'd)

of risk. Thus, this section did not apply to the policy, which was issued in New York pursuant to and as required by New York law, on New York forms, and used New York rates. Amica Mut. Ins. v. Bourgault, 263 Ga. 157, 429 S.E.2d 908 (1993).

When the policy under which the plaintiff was making an uninsured motorist claim was issued in New York to the plaintiff's parents, New York residents, and provided coverage for vehicles owned and operated by those residents in New York, New York law applied to the policy and O.C.G.A. § 33-7-11 did not invalidate the exclusion. Smith v. Prudential Property & Cas. Ins. Co., 236 Ga. App. 188, 511 S.E.2d 282 (1999).

Federal preemption. — Trial court erroneously granted summary judgment to an UM insurer, where the injured claimant, who was also a federal employee, fell under the purview of federal compensation law; thus, under these federal provisions, the medical benefits insurer and the workers' compensation insurer had subrogation liens and were able to enforce them upon the injured party's receipt of a settlement from the liable third party, regardless of Georgia's requirement that such action be preceded by a determination that the injured person had been fully compensated. Thurman v. State Farm Mut. Auto. Ins. Co., 278 Ga. 162, 598 S.E.2d 448 (2004).

Minimum coverage presumed. — Jefferson-Pilot Fire & Cas. Co. v. Combs, 166 Ga. App. 274, 304 S.E.2d 448 (1983).

No need for increase on renewal. — Uninsured motorist coverage did not need to be increased in a renewal policy from the amount shown for coverage existing before July 1, 2001; under O.C.G.A. § 33-7-11(a)(3), an insurer was under no obligation to increase uninsured motorist limits to the amount of the policy's bodily injury liability coverage when the policy, which was initially issued before July 1, 2001, was later renewed. McKinnon v. Progressive Bayside Ins. Co., 278 Ga. App. 429, 629 S.E.2d 100 (2006).

A self-insurer may decline to offer optional PIP coverage despite the language in O.C.G.A. § 33-7-11 requiring it to offer such coverage. Proctor v. Rapid Group, Inc., 203 Ga. App. 232, 416 S.E.2d 774, cert. denied, 203 Ga. App. 907, 416 S.E.2d 774 (1992).

Farm tractor a "motor vehicle" when operated on public road. — The term "motor vehicle" in O.C.G.A. § 33-7-11 includes vehicles that, while designed primarily to operate off the public highways, are operating on the public highway at the time of an accident; accordingly, a farm tractor towing a mobile home on a county road was a "motor vehicle" for uninsured motorist purposes. Hinton v. Interstate Guar. Ins. Co., 267 Ga. 516, 480 S.E.2d 842 (1997).

Designating additional automobile is issuance of insurance policy. — Issuance of an endorsement which designates an additional automobile to be covered by automobile liability insurance under the provisions of a policy previously issued effects insurance with respect to the additional automobile and therefore constitutes the issuance of a policy within the meaning of this section. Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

Renewal with insurer assuming policy. — An insurer who assumes a policy issued by a predecessor and who then renews the policy is "the same insurer" for purposes of paragraph (3) of subsection (a) of O.C.G.A. § 33-7-11 and may rely on the written rejection of uninsured motorist coverage obtained at the time of the original application. Merastar Ins. Co. v. Wheat, 220 Ga. App. 695, 469 S.E.2d 882 (1996).

Renewal status limited amount of liability. — In a suit wherein a driver sought uninsured motorist coverage from the insurer of an employer, the trial court erred by granting summary judgment to the driver and holding that the driver was entitled to uninsured motorist benefits in the amount of $1,000,000, the liability limits, as the policy at issue was a renewal policy under O.C.G.A. § 33-7-11(a)(1) and, therefore, the amount of coverage was $75,000. Zurich Am. Ins. Co. v. Beasley, 293 Ga. App. 8, 666 S.E.2d 83 (2008).

Because an insurance policy was issued by the same insurer to supersede an existing policy and to extend the term of the

existing policy beyond its policy period conditioned upon payment of a continuation premium, the fact that it bore a slightly different number and that there were changes in the premium amounts and the vehicles insured did not mean that it was a new policy rather than a renewal under O.C.G.A. § 33-24-45(b)(2) (now paragraph (b)(3)). Thus, uninsured motorist coverage was not the $1,000,000 liability limit under O.C.G.A. § 33-7-11(a), but the $25,000 per person limit that the insureds had previously selected. Roberson v. Leone, 315 Ga. App. 459, 726 S.E.2d 565 (2012).

Renewal of earlier policy continued coverage. — Trial court erred in denying a commercial vehicle liability insurer's motions for directed verdict and judgment notwithstanding the verdict because the insurer was entitled to judgment, as a matter of law, that an employer's 2007 commercial vehicle insurance policy provided uninsured motorist (UM) coverage of $ 50,000 per person, as indicated on the policy's declarations page; by the policy's terms, the 2006 policy, which was unambiguous, carried forward the same obligation to insure that the insurer had under the prior policy, and because, as a matter of law, the 2006 policy was a renewal of an earlier policy, under O.C.G.A. § 33-7-11(a)(3), the employer was not required to make a new affirmative election of UM coverage to retain the $ 50,000 in coverage provided under the earlier policy. Infinity Gen. Ins. Co. v. Litton, 308 Ga. App. 497, 707 S.E.2d 885 (2011), cert. denied, No. S11C1110, 2011 Ga. LEXIS 580 (Ga. 2011).

Coverage limited by insured's election. — In an appeal regarding the amount of uninsured/underinsured (UM) coverage available to the insured, the trial court did not err in holding that the insured affirmatively chose a UM bodily injury limit of $25,000, which was less than the liability limit on the policy, and that the insured's spouse signed a disclosure form explaining the UM coverage. Cline v. Allstate Prop. & Cas. Ins., 354 Ga. App. 415, 841 S.E.2d 63 (2020).

Uninsured motorist coverage not mandated in renewal of umbrella policy. — Offer/rejection requirements of the Georgia Uninsured Motorist Act, O.C.G.A. § 33-7-11, do not apply to umbrella policies renewed on or after January 1, 2009. Wilson v. Auto. Ins. Co., 293 Ga. 251, 744 S.E.2d 732 (2013).

Section controls conflicting insurance policy. — Where there is a conflict in an insurance policy and this section, this section controls. Hartford Accident & Indem. Co. v. Booker, 140 Ga. App. 3, 230 S.E.2d 70 (1976).

Conflicting provisions void. — Provisions in insurance which conflict with the requirements of this section are void. Travelers Indem. Co. v. Williams, 119 Ga. App. 414, 167 S.E.2d 174 (1969). For comment, see 21 Mercer L. Rev. 341 (1969).

Any policy provision which attempts to contravene the clear intent of this section is void and not enforceable. State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972).

Under this section, no automobile liability insurance policy shall be issued (unless rejected in writing) which does not undertake to pay the insured for bodily injury which results from the fault of an uninsured motorist, and any policy provision conflicting with this requirement is void. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

Summary judgment for an insurer was reversed as: (1) there was no judicial exemption in O.C.G.A. § 33-7-11 for umbrella or excess policies, absent express direction from the Georgia legislature, and umbrella and excess policies that provided motor vehicle or automobile liability coverage were subject to O.C.G.A. § 33-7-11; (2) the insurer's claim that uninsured motorist (UM) coverage was not required because the policy was a renewal policy was rejected since O.C.G.A. § 33-7-11(a)(3) provided that an insurer was not required to increase UM coverage in renewal policies; and (3) the provisions in the insureds' umbrella policy that excluded UM coverage conflicted with O.C.G.A. § 33-7-11 and were void. Abrohams v. Atl. Mut. Ins. Agency, 282 Ga. App. 176, 638 S.E.2d 330 (2006), cert. denied, No. S07C0399, 2007 Ga. LEXIS 155 (Ga. 2007).

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Inasmuch as an uninsured policy provision permits a setoff for personal injury benefits, it is in conflict with the plain mandate of the Uninsured Motorist Act. It follows that such a policy provision is void and unenforceable. Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

Provision for forfeiture of coverage for settlement or judgment not consented to. — A provision for forfeiture of the uninsured motorists coverage if the insured should, without written consent of the insurer, settle with or prosecute to judgment any action against any person who might be legally liable for the insured's injuries, is repugnant to subsection (a) of this section and therefore void. Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

Named driver exclusion not effective when no written rejection of coverage. — Under O.C.G.A. § 33-7-11, a written rejection of uninsured motorist coverage was required to properly exclude an insured's husband from the policy's uninsured motorist coverage; because the record contained no such rejection, the policy's exclusion specifically naming the husband as an excluded driver was ineffective. Roberson v. 21st Century Nat'l Ins. Co., 327 Ga. App. 545, 759 S.E.2d 614 (2014).

Provisions requiring agreement or arbitration. — Policy provisions requiring agreement or arbitration as to claims arising under uninsured motorists coverage are repugnant to subsection (g) of this section and void. Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

This section does not create a new right in plaintiffs to sue an uninsured owner or driver of another vehicle; it merely provides a new procedure whereby such plaintiffs may recover their losses from their own insurer whether the real defendant's identity is known or not. Houston v. Doe, 136 Ga. App. 583, 222 S.E.2d 131 (1975); Norman v. Daniels, 142 Ga. App. 456, 236 S.E.2d 121 (1977), overruled on other grounds, Ragan v. Mallow, 319 Ga. App. 443, 744 S.E.2d 337 (2012).

"Accident," as used in O.C.G.A. § 33-7-11, encompasses intentional as well as unintentional injuries inflicted upon innocent persons by drivers whose liability would otherwise be covered by the policy. Martin v. Chicago Ins. Co., 184 Ga. App. 472, 361 S.E.2d 835 (1987).

The right to recover for "injury or damages" contemplated by this section existed at common law and was not created anew by the Legislature. Houston v. Doe, 136 Ga. App. 583, 222 S.E.2d 131 (1975).

The language of this section makes clear that the suit is for "injury or damages," and the right to recover for such injury or damages long preceded the enactment of this section. Houston v. Doe, 136 Ga. App. 583, 222 S.E.2d 131 (1975).

"Physical contact." — Bullets fired from an uninsured vehicle into the plaintiff's vehicle did not constitute the required "physical contact" between the vehicles. Fisher v. Clarendon Nat'l Ins. Co., 210 Ga. App. 711, 437 S.E.2d 344 (1993).

Direct evidence of physical contact. — Grant of summary judgment was reversed because the statements of the deceased spouse were evidence of direct physical contact for the purposes of O.C.G.A. § 33-7-11(b)(2) and the statements were admissible because the spouse made the statements to the spouse's physicians while seeking medical treatment and diagnosis shortly after the spouse's accident. Reaves v. State Farm Mut. Auto. Ins. Co., 319 Ga. App. 426, 734 S.E.2d 773 (2012).

Insurer in effect insures uninsured motorist's legal liability to insured. — Subsection (a) of this section requires that the insurance company afford coverage against any loss sustained by the insured as the result of an accident involving an uninsured automobile, which loss the insured "shall be legally entitled to recover as damages from the owner or operator" thereof. This language cannot be construed other than as imposing upon the insured's insurer the duty of assuming the position of an insurer of the uninsured motorist's legal liability as respects the claim of the plaintiff insured against such uninsured motorist. The language is equivalent to a requirement that the defendant insurer pay such sums as such uninsured motorist would be legally liable

to pay to its insured up to the limits required by this section. State Farm Mut. Auto. Ins. Co. v. Girtman, 113 Ga. App. 54, 147 S.E.2d 364 (1966).

Denial of coverage for driver did not render automobile uninsured. — A liability insurer's denial of coverage for a claim against the driver after having paid the policy limits in settlement of a claim against the owner did not render the automobile uninsured for purposes of an action against the driver seeking uninsured motorist benefits. Young v. Maryland Cas. Co., 228 Ga. App. 388, 491 S.E.2d 839 (1997).

There is no privity of contract between the insurer and one who injured one of its policyholders. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Insurer's payment does not discharge tortfeasor's liability. — Payments made to an insured under the uninsured motorist coverage of a liability insurance policy are payments made pursuant to a contractual obligation and not in discharge of the tortfeasor's liability to the injured or damaged person. State Farm Mut. Auto. Ins. Co. v. Board of Regents of Univ. Sys., 226 Ga. 310, 174 S.E.2d 920 (1970). For comment, see 22 Mercer L. Rev. 621 (1971).

Insurer entitled to uninsured motorist coverage. — Trial court did not err by finding that an insured was entitled to uninsured motorist coverage under the insured's policy with a captive insurer because the policy the insurer issued to the insured did not expressly include uninsured motorist coverage, and the insurer did not obtain a written rejection of that coverage from the insured; the accident involved the named insured, and the insured was engaged in responsibilities arising out of the insured's job as a taxi cab driver, not personal or family responsibilities, at the time the insured was injured. VFH Captive Ins. Co. v. Pleitez, 307 Ga. App. 240, 704 S.E.2d 476 (2010).

A general release in favor of an underinsured tortfeasor and his liability carrier, given in exchange for a settlement, operated to bar the insureds from further recovery against their uninsured motorist coverage. Darby v. Mathis, 212 Ga. App. 444, 441 S.E.2d 905 (1994).

Effect of release. — Insured defeated the insured's ability to collect underinsured motorist benefits from the insured's insurer by executing a general release to the tortfeasor, rather than a limited release. Rodgers v. St. Paul Fire & Marine Ins. Co., 228 Ga. App. 499, 492 S.E.2d 268 (1997).

This section is designed to protect the insured as to actual loss, within the limits of the policy or policies of which the insured is the beneficiary. St. Paul Fire & Marine Ins. Co. v. Goza, 137 Ga. App. 581, 224 S.E.2d 429 (1976).

The plain mandate of this section is to provide payment for "all sums" which the insured is "legally entitled to recover as damages" from the "uninsured motorist." St. Paul Fire & Marine Ins. Co. v. Goza, 137 Ga. App. 581, 224 S.E.2d 429 (1976).

There are no exceptions or qualifications to the statutory requirement that every policy issued or delivered in this state shall undertake to pay the insured all sums which he is legally entitled to recover from the owner or operator of an uninsured motor vehicle. St. Paul Fire & Marine Ins. Co. v. Goza, 137 Ga. App. 581, 224 S.E.2d 429 (1976).

There is no judicial exemption from O.C.G.A. § 33-7-11's requirement for uninsured motorist coverage for umbrella or excess policies, absent express direction from the Georgia legislature; umbrella and excess policies that provide motor vehicle or automobile liability coverage are subject to O.C.G.A. § 33-7-11. Abrohams v. Atl. Mut. Ins. Agency, 282 Ga. App. 176, 638 S.E.2d 330 (2006), cert. denied, No. S07C0399, 2007 Ga. LEXIS 155 (Ga. 2007).

Policy provision excluded when in conflict with statute. — Trial court properly denied an insurance company's cross-motion for summary judgment on the limited issue of whether the policy provided uninsured motorist coverage because the company was licensed in Georgia, the truck at issue was principally used and garaged in Georgia, and the policy's exclusion conflicted with O.C.G.A. § 33-7-11 and was, therefore, void. St.

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Paul Fire & Marine Ins. Co. v. Hughes, 321 Ga. App. 738, 742 S.E.2d 762 (2013).

Notice of uninsured options not required. — Given that O.C.G.A. § 33-7-11(a)(3) excluded umbrella policies from the requirement to offer uninsured motorist coverage, an insurer was not required to provide an insured with notice of the types of uninsured motorist coverage options that the insurer was not obligated to provide. Wilson v. Auto. Ins. Co., 293 Ga. 251, 744 S.E.2d 732 (2013).

Umbrella insurance policy subject to stacking. — In a dispute involving priority of coverage between two uninsured motorist carriers and three policies, the trial court erred by placing an umbrella policy last in priority of the three since the decedent involved in a motor vehicle incident was more closely identified with the umbrella policy. The trial court's decision placing the umbrella policy third in priority was misplaced as such policies were to be stacked as other policies to provide uninsured motorist coverage under O.C.G.A. § 33-7-11(b)(1)(D)(ii). Progressive Classic Ins. Co. v. Nationwide Mut. Fire Ins. Co., 294 Ga. App. 787, 670 S.E.2d 497 (2008), cert. denied, No. S09C0494, 2009 Ga. LEXIS 202 (Ga. 2009).

Other insurance is not ground for denying coverage. — There appears no latitude in this section for an insurer limiting its liability through "other insurance," "excess-escape" or "pro rata" clauses. If the statute is to be meaningful and controlling in respect to the nature and extent of the coverage and to the sources of recovery and subrogation of the insurer, all inconsistent clauses in the policy to the controlling statutory language must be judicially rejected. State Farm Mut. Auto. Ins. Co. v. Barnard, 115 Ga. App. 857, 156 S.E.2d 148 (1967) (decided prior to enactment of subsection (i) of this section).

An automobile liability insurance carrier providing coverage against injury by uninsured motorists in accordance with this section, after accepting a premium for such coverage, cannot deny coverage on the ground that the insured has other similar insurance available to him. Travelers Indem. Co. v. Williams, 119 Ga. App. 414, 167 S.E.2d 174 (1969), for comment, see 21 Mercer L. Rev. 341 (1969) (decided prior to enactment of subsection (i) of this section).

Uninsured motorist insurance cannot be limited to "excess" insurance only. Travelers Indem. Co. v. Liberty Loan Corp., 140 Ga. App. 458, 231 S.E.2d 399 (1976), cert. dismissed, 238 Ga. 667, 235 S.E.2d 39 (1977) (liability for death).

Restriction of coverage with "other insurance" clause. — Since this section makes the insurer liable for all sums which the insured is legally entitled to recover from the owner or operator of an uninsured motor vehicle, the insurer cannot restrict this coverage with an "other insurance" clause. Phillips v. State Farm Mut. Auto. Ins. Co., 437 F.2d 365 (5th Cir. 1971).

Sublimits permissible. — Statutory minimum for underinsured motorist (UM) coverage is provided in O.C.G.A. § 33-7-11(a)(1)(A); under O.C.G.A. § 33-34-3.1(b), as long as the mandatory UM minimum is met and optional UM coverage is offered pursuant to statutory requirements, a combination of sublimits and interests restricted to named insureds and resident relatives contravenes neither the law nor public policy. Crouch v. Federated Mut. Ins. Co., 257 Ga. App. 604, 571 S.E.2d 574 (2002).

"Other insurance" provision is void. — Where an "other insurance" policy provision attempts to limit coverage to sums which are in excess of other uninsured motorist protection, it conflicts with subsection (a) of this section and is of no effect. State Farm Mut. Auto. Ins. Co. v. Murphy, 226 Ga. 710, 177 S.E.2d 257 (1970); St. Paul Fire & Marine Ins. Co. v. Goza, 137 Ga. App. 581, 224 S.E.2d 429 (1976).

Where an insurer contended that while the "other insurance" provisions in its policy were void as to persons coming within the definition of "insured" as contained in subsection (b) of this section, the provisions were nevertheless valid as to an injured person who was an "insured" within the policy definitions but did not meet the definition of "insured" under this

section, it was held that since the provisions applied across the board to an "insured," including an "insured" as defined in this section, they were in conflict with this section and void on their face. State Farm Mut. Auto. Ins. Co. v. Jones, 133 Ga. App. 920, 213 S.E.2d 73 (1975).

Setoff not restriction on uninsured coverage. — Prior to 1968, uninsured motorist coverage could not be restricted by a setoff provision which allowed a deduction for sums recovered under property insurance. Phillips v. State Farm Mut. Auto. Ins. Co., 437 F.2d 365 (5th Cir. 1971) (accident in 1967).

Sums paid under medical provisions of a policy cannot serve to reduce the amount owed as uninsured motorist coverage. State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972).

No uninsured motorist coverage. — Where an insured was a passenger in a vehicle that the insured owned and had insured at the time of a single-car accident, the insured was not entitled to uninsured motorist protection under the terms of an insurance policy or O.C.G.A. § 33-7-11(b)(1)(D); accordingly, the trial court did not err in so finding and properly granted summary judgment. Smith v. Nationwide Mut. Ins. Co., 258 Ga. App. 570, 574 S.E.2d 627 (2002).

Minimum in section does not limit recovery. — While this section does provide a minimum of $10,000.00 (now $15,000.00) coverage under the uninsured motorists endorsement, it does not limit an insured to recover only that amount when his loss for bodily injury exceeds that sum. Travelers Indem. Co. v. Williams, 119 Ga. App. 414, 167 S.E.2d 174 (1969). For comment, see 21 Mercer L. Rev. 341 (1969).

Stacking of coverages permitted where tortfeasor minimally insured. — An insured is permitted to stack multiple policies of uninsured motorist coverage where the tortfeasor is minimally insured. Travelers Indem. Co. v. Maryland Cas. Co., 190 Ga. App. 455, 379 S.E.2d 183 (1989).

Stacking of separate schedules from same policy not permitted. — Insured could not "stack" two separate schedules of uninsured motorist coverage from the same policy, where each schedule applied to distinct factual situations and provided separate coverages in consideration for the separate premiums paid. Jenkins v. Lanigan, 196 Ga. App. 424, 396 S.E.2d 28, cert. denied, 196 Ga. App. 908, 396 S.E.2d 28 (1990).

Clarification of procedure for addressing stacking. — Statement in Dairyland Ins. Co. v. State Farm Automobile Ins. Co., 289 Ga. App. 216 (2008), that courts may also look to other insurance clauses in the contracts for resolution of the priority issue contradicts other cases and does not address the issue of stacking uninsured motorist policies, but rather considers which of several policies provide primary insurance and which insurer had the duty to defend. Accordingly, the Court of Appeals of Georgia disapproves of the language in Dairyland to the extent that the language conflicts with the court's decision in Nationwide Mutual Fire Insurance Company v. Progressive Classic Insurance Company, 278 Ga. App. 73 (2006). Progressive Classic Ins. Co. v. Nationwide Mut. Fire Ins. Co., 294 Ga. App. 787, 670 S.E.2d 497 (2008), cert. denied, No. S09C0494, 2009 Ga. LEXIS 202 (Ga. 2009).

An insured under two separate uninsured motorist policies may recover on both policies not to exceed his actual damages pursuant to this section. State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972); Jefferson-Pilot Fire & Cas. Co. v. Combs, 166 Ga. App. 274, 304 S.E.2d 448 (1983).

Other policy not providing uninsured motorist coverage will be disregarded. — If two policies exist, they may be stacked, but if only one exists, it is applicable without regard to the other. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

If a vehicle is not covered, no benefits under the liability policy of that vehicle exist so far as uninsured motorist insurance is concerned, but if there is another policy between the same insurer and the owner, and other coverage, such policy will be construed according to its own

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provisions, unaffected by the existence or nonexistence of an unrelated policy of insurance. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

Several Georgia cases have held that "anti-stacking" or "other insurance" clauses in automobile insurance contracts are not enforceable, but those cases are limited to uninsured motorist cases where a specific statute, O.C.G.A. § 33-7-11(a)(1), has been interpreted to render such clauses unenforceable in the context of an uninsured motorist case. Plantation Pipeline Co. v. Cont'l Cas. Co., No. 1:03-CV-2811-WBH, 2008 U.S. Dist. LEXIS 80680 (N.D. Ga. July 8, 2008).

Insured could not show entitlement to recovery. — Trial court properly granted an insurer's summary judgment motion in an insured's suit for uninsured motorist benefits as the insured's suit against a sheriff's deputy in the deputy's official capacity was barred by the statute of limitations, and the insured could not establish that the insured was legally entitled to recover from the deputy, as required by O.C.G.A. § 33-7-11(a)(1). Soley v. State Farm Mut. Auto. Ins. Co., 267 Ga. App. 606, 600 S.E.2d 707 (2004).

Insured is not legally entitled to recover amounts beyond his actual damages no matter how many policies he is the beneficiary of. State Farm Mut. Auto. Ins. Co. v. Murphy, 226 Ga. 710, 177 S.E.2d 257 (1970).

Only requirement is entitlement to recover damages. — All that O.C.G.A. § 33-7-11(a)(1) requires is that an insured person be legally entitled to recover damages. Gordon v. Atlanta Cas. Co., 279 Ga. 148, 611 S.E.2d 24 (2005).

Insurer obligated to pay under policy limits. — O.C.G.A. § 33-7-11(i) and the policies' nonduplication provisions did not relive the insurer of the insurer's obligation to pay for uncompensated losses up to the uninsured/underinsured motorist policy limits. Mabry v. State Farm Mut. Auto. Ins. Co., 334 Ga. App. 785, 780 S.E.2d 533 (2015), cert. denied, No. S16C0491, 2016 Ga. LEXIS 175 (Ga. 2016).

Uncompensated losses up to coverage limit available. — Trial court did not err in finding that the insurance company was liable to the worker for the worker's uncompensated losses up to the coverage limit of the worker's uninsured motorist (UM) policies because the UM statutes only permitted the exclusion of an uninsured motorist insurer's liability for damages for which the insured has been compensated. Ga. Farm Bureau Mut. Ins. Co. v. Rockefeller, 343 Ga. App. 36, 805 S.E.2d 660 (2017), cert. denied, No. S18C0338, 2018 Ga. LEXIS 258 (Ga. 2018).

Policy may limit stacking of coverage to actual damages. — The policy of this section is not to allow an insured to "stack coverage" in order to recover amounts in excess of his actual damages. Thus, policy provisions which would limit coverage in this respect would not be void but would be enforceable. State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972).

Insured permitted to stack coverages of wife's and employer's policies. — Insured who was injured by an underinsured motorist could stack the uninsured motorist coverages of his wife's and his employer's policies, wherein he was an additional insured, and was not restricted to stacking only the uninsured motorist coverages of those policies wherein he was the named insured. Ford v. Georgia Farm Bureau Mut. Ins. Co., 191 Ga. App. 735, 382 S.E.2d 659 (1989).

There can be no stacking or pyramiding of the uninsured motorists provisions as to single policy coverage of two or more automobiles. Hartford Cas. Ins. Co. v. O'Callaghan, 176 Ga. App. 135, 335 S.E.2d 407 (1985); Georgia Farm Bureau Mut. Ins. Co. v. Owens, 178 Ga. App. 446, 343 S.E.2d 699 (1986).

Determination of primary carrier. — Where an injured plaintiff may be covered by two policies, but has not paid a premium for either policy, the primary uninsured motorist carrier is the one that is more "closely identified" with the plaintiff. Travelers Indem. Co. v. Maryland Cas. Co., 190 Ga. App. 455, 379 S.E.2d 183 (1989).

Apportionment of coverage among insurers. — In apportioning coverage

among three insurers, the insurer of the tortfeasor and two uninsured motorist insurers, the trial court must first determine the coverages available to each plaintiff under the tortfeasor's policy, as defined in subdivision (b)(1)(D)(ii) of O.C.G.A. § 33-7-11, and then calculate the difference between that amount and the limits of the uninsured motorist coverage provided by the latter insurers, stacking them in the established order. Merchant v. Canal Ins. Co., 238 Ga. App. 727, 520 S.E.2d 57 (1999).

A judgment obtained against the uninsured motorist is a condition precedent to recovery against an automobile liability carrier under the provisions of uninsured motorist coverage. Continental Ins. Co. v. Echols, 145 Ga. App. 112, 243 S.E.2d 88, cert. dismissed, 242 Ga. 419, 249 S.E.2d 616 (1978).

Showing rendition of judgment against uninsured motorist. — This section provides that to show liability against an insurance company under a policy insuring against injury caused by an uninsured motorist it is only necessary to show the rendition of a judgment against the uninsured motorist. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

That part of subsection (a) of this section providing that liability insurance policies shall contain "provisions undertaking to pay the insured all sums which he shall be legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle," means that the injured party must reduce his claim to a judgment in order to establish the amount he is legally entitled to recover. Wilkinson v. Vigilant Ins. Co., 236 Ga. 456, 224 S.E.2d 167 (1976).

Whether uninsured motorist is known or unknown. — It is a condition precedent to an action against an automobile liability insurance carrier to recover under this section on account of injuries and damages to the plaintiff resulting from the negligence of a known uninsured motorist, that action shall have been brought and judgment recovered against the uninsured motorist. State Farm Mut. Auto. Ins. Co. v. Girtman, 113 Ga. App. 54, 147 S.E.2d 364 (1966); Cash v. Balboa Ins. Co., 130 Ga. App. 60, 202 S.E.2d 252 (1973); Peagler & Manley Ins. Agency, Inc. v. Studebaker, 156 Ga. App. 786, 275 S.E.2d 385 (1980).

Before an action will lie against an insurer for loss caused by a known uninsured motorist under this section, it is an essential condition precedent that action must first be brought and judgment recovered against the uninsured motorist. Smith v. Allstate Ins. Co., 114 Ga. App. 127, 150 S.E.2d 354 (1966); Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

It is a condition precedent to an action against an automobile liability insurance carrier under the provisions of subsection (d) of this section on account of injuries and damages to the plaintiff resulting from the negligence of an unknown uninsured motorist, that action shall have been brought and judgment entered against the unknown uninsured motorist. King v. State Farm Mut. Auto. Ins. Co., 117 Ga. App. 192, 160 S.E.2d 230 (1968).

A condition precedent to an action against an insurer to recover benefits under uninsured motorists coverage is the bringing of an action and the recovery of judgment against the known uninsured motorist. Quattlebaum v. Allstate Ins. Co., 119 Ga. App. 791, 168 S.E.2d 596 (1969); State Farm Mut. Auto. Ins. Co. v. Lorenz, 202 Ga. App. 123, 413 S.E.2d 782 (1991).

In order to recover for the negligence of a known uninsured motorist, action must be brought and judgment recovered against the uninsured motorist. Watkins v. United States, 462 F. Supp. 980 (S.D. Ga. 1977), aff'd, 587 F.2d 279 (5th Cir. 1979).

This section requires, as a condition precedent to a suit against the insurance carrier, that the insured first sue and recover a judgment against the uninsured motorist, whether known or unknown. Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

Unless insurer elects to defend in own name. — In cases in which the insurer elects to defend in its own name, the legislature's expansion of the insurer's role has obviated the requirement that a judgment be obtained against the uninsured motorist as a condition precedent to

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a determination of questions of coverage. Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

Insurer waives requirement. — The provisions of this section, requiring a complainant to first sue and obtain a judgment against the tortfeasor as a condition precedent to recovery against the complainant's insurer under the uninsured motorist coverage provisions of a policy, are for the benefit of the insurer and may be waived where the insurer has lead the insured to believe that the insured will be paid without suit by its actions in negotiating for settlement or direct promises to pay. United States Fid. & Guar. Co. v. Lockhart, 124 Ga. App. 810, 186 S.E.2d 362 (1971), aff'd, 229 Ga. 292, 191 S.E.2d 59 (1972).

It is a condition precedent to an action against an automobile liability insurance carrier to recover under the provisions of this section on account of injuries and damages to the plaintiff resulting from the negligence of a known uninsured motorist, that action shall have been brought and judgment recovered against the uninsured motorist. This requirement may be waived by the insurer. Hartford Accident & Indem. Co. v. Studebaker, 139 Ga. App. 386, 228 S.E.2d 322 (1976).

Negotiating with damaged party is not waiver. — A party allegedly damaged must obtain judgment against the tortfeasor before he can obtain judgment against the insurer. This statutory requirement is not and cannot be waived by the insurer, at any time during the period of the statute of limitations, by negotiating with the damaged party with respect to the amount of damages to be paid. United States Fid. & Guar. Co. v. Lockhart, 229 Ga. 292, 191 S.E.2d 59 (1972).

Uninsured motorist's liability may be determined by confession of judgment. — The phrase "legal liability" in subsection (g) of this section means the securing of a judgment against the uninsured motorist even one based on a confession of judgment by the uninsured motorist's private attorney without a trial of the issues. Continental Ins. Co. v. Echols, 145 Ga. App. 112, 243 S.E.2d 88, cert. dismissed, 242 Ga. 419, 249 S.E.2d 616 (1978).

Where no judgment shown, agent's failure to procure uninsured motorist coverage not cause of loss. — Even if appellant had obtained uninsured motorist coverage, appellees could not recover against the insurance carrier unless they proved they had previously obtained a judgment against the uninsured motorist. Where there has been no showing that recovery against the insurance carrier would have been possible, the alleged negligence of the insurance agent in failing to procure uninsured motorist coverage has not been shown to have caused the loss. Peagler & Manley Ins. Agency, Inc. v. Studebaker, 156 Ga. App. 786, 275 S.E.2d 385 (1980).

It is the liability to the insured under the contract of insurance that is to be adjudicated, whether the uninsured motorist is known or unknown. Wilkinson v. Vigilant Ins. Co., 236 Ga. 456, 224 S.E.2d 167 (1976); Watkins v. United States, 462 F. Supp. 980 (S.D. Ga. 1977), aff'd, 587 F.2d 279 (5th Cir. 1979).

Insured may recover although recovery against uninsured motorist barred. — Recovery against an uninsured motorist carrier may be had where an insured would be legally entitled to recover against an uninsured motorist but for some legal bar to recovery unrelated to the facts of the collision. Watkins v. United States, 462 F. Supp. 980 (S.D. Ga. 1977), aff'd, 587 F.2d 279 (5th Cir. 1979) (recovery against federal employee barred by 28 U.S.C. § 2679(b)).

Insurer obligated even though injured person not covered under policy. — Insured was entitled to recover from the insurer under O.C.G.A. § 33-7-11(a)(1) for a son's death, even though the son was not a "covered person" under the policy, because the insured was entitled to recover damages from an owner or an operator of an uninsured motor vehicle. Gordon v. Atlanta Cas. Co., 279 Ga. 148, 611 S.E.2d 24 (2005).

If insured can establish tort liability. — If an insured can establish tort liability, he can recover from his uninsured motorist carrier regardless of

whether he can recover against the uninsured motorist. Watkins v. United States, 462 F. Supp. 980 (S.D. Ga. 1977), aff'd, 587 F.2d 279 (5th Cir. 1979) (recovery against federal employee barred by 28 U.S.C. § 2679(b)).

Insurer cannot escape liability because of uninsured's bankruptcy. — To allow an insurer to escape liability under its contract because of the uninsured's bankruptcy would be contrary to the intent and purpose of this section. Wilkinson v. Vigilant Ins. Co., 236 Ga. 456, 224 S.E.2d 167 (1976).

Thirty-day notice of claim provision reasonable. — Although there is a general public policy that motorists be protected by uninsured motorist insurance coverage, there is also a compelling need on the part of the insurer to receive timely notice of the events giving rise to such a claim. A 30 day notice provision in the policy is a reasonable balancing of conflicting policy considerations. Flamm v. Doe, 167 Ga. App. 587, 307 S.E.2d 105 (1983).

Notice of accident or loss. — In a policy provision requiring notice to the insurer "in no event later than 60 days, of how, when and where the accident or loss happened," the 60 day period begins on the date of the accident or loss and not, with respect to uninsured motorist claims, 60 days after discovery of the uninsured status. Manzi v. Cotton States Mut. Ins. Co., 243 Ga. App. 277, 531 S.E.2d 164 (2000).

Tire assembly not "motor vehicle." — Since a tire assembly was neither a self-propelled vehicle nor a vehicle having more than three wheels, the court could not conclude that the tire assembly was a motor vehicle within the meaning of the uninsured motorist statute. State Farm Fire & Cas. Co. v. Guest, 203 Ga. App. 711, 417 S.E.2d 419, cert. denied, 203 Ga. App. 907, 417 S.E.2d 419 (1992).

Contact with "integral part" of another vehicle. — State Farm Fire & Casualty Co. v. Guest, 203 Ga. App. 711, 417 S.E.2d 419 (1992), holding that O.C.G.A. § 33-7-11(b)(2)'s "actual physical contact" requirement could be met by showing that the insured's vehicle made contact with an integral part of an unknown vehicle was non-precedential under Ga. Ct. App. R. 33(a). Further, a log that was cargo in the unknown vehicle was not an "integral part" of that vehicle. Am. Alternative Ins. Co. v. Bennett, 334 Ga. App. 713, 780 S.E.2d 686 (2015).

Two requirements for recovery in absence of physical contact. — There are two requirements for recovery under an uninsured motorist endorsement when there is no physical contact between the claimant's vehicle and one operated by an unknown person. The first requirement is "a description by the claimant of how the occurrence occurred." The second requirement is that the description must be corroborated by an eyewitness other than the claimant. Hoffman v. Doe, 191 Ga. App. 319, 381 S.E.2d 546, cert. denied, 191 Ga. App. 922, 381 S.E.2d 546 (1989); Bell v. Coronet Ins. Co., 197 Ga. App. 211, 398 S.E.2d 242 (1990).

Plaintiff, in an action against a tortfeasor and John Doe, was not able to describe the accident as having been caused by an unknown vehicle since the only vehicles he remembered were his own and that of tortfeasor and, because his description did not include a "phantom" vehicle, this section did not apply and no coverage existed under the uninsured motorist endorsement. Carter v. Bennett, 220 Ga. App. 128, 469 S.E.2d 279 (1996).

There was "physical contact" between the plaintiff's truck and an unidentified truck where the trucks' mirrors hit each other in passing and the plaintiff's truck was run off the road. Insurance Co. of N. Am. v. Dorris, 161 Ga. App. 46, 288 S.E.2d 856 (1982).

No "physical contact." — Plaintiff could not prevail on his uninsured John Doe motorist claim because there was no physical contact between plaintiff's vehicle and the John Doe truck, as a pipe which had fallen as loose cargo was not "a component or integral part" of the unknown truck. Murphy v. Georgia Gen. Ins. Co., 208 Ga. App. 501, 431 S.E.2d 147 (1993).

A pedestrian injured as a result of walking into a stationary object located in the back of a parked vehicle cannot obtain uninsured motorist benefits. Corouthers v.

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Doe, 244 Ga. App. 491, 536 S.E.2d 165 (2000).

In an injured truck driver's suit against John Does and the driver's employer's UM carrier, the driver could not recover against the UM insurer because the vehicle that struck the driver's truck was unknown, and there were no witnesses to corroborate that the incident occurred as the driver described as required under O.C.G.A. § 33-7-11(b)(2). A log protruding from the unknown vehicle was not an integral part of the unknown vehicle. Am. Alternative Ins. Co. v. Bennett, 334 Ga. App. 713, 780 S.E.2d 686 (2015).

There is "actual physical contact" if unknown motorist strikes vehicle which strikes insured's. — The requirement of "actual physical contact" under subsection (c) of this section is met where an unknown hit-and-run motorist strikes a third vehicle, which third vehicle in turn strikes the insured vehicle. State Farm Mut. Auto. Ins. Co. v. Carlson, 130 Ga. App. 27, 202 S.E.2d 213 (1973).

Owner of vehicle unknown and no physical contact. — The statutory requirement under paragraph (b)(2), in cases where there is no physical contact, is "description by the claimant of how the occurrence occurred corroborated by an eyewitness to the occurrence other than the claimant." If the General Assembly had intended to require corroboration by a disinterested third party, it could have so specified. Universal Sec. Ins. Co. v. Lowery, 257 Ga. 363, 359 S.E.2d 898 (1987); Hoffman v. Doe, 191 Ga. App. 319, 381 S.E.2d 546, cert. denied, 191 Ga. App. 922, 381 S.E.2d 546 (1989).

No evidence of physical contact and no corroborating evidence. — Insurer was properly granted summary judgment in an insured's action for uninsured motorist coverage when there was no evidence of actual physical contact between the insured and an unknown driver, who allegedly struck either a manhole cover or the bottom of a construction barrel that then struck the insured's car, nor was there any corroborating eyewitness evidence. Hambrick v. State Farm Fire & Cas. Co., 260 Ga. App. 266, 581 S.E.2d 299 (2003).

The eyewitness corroboration requirement means that the description must be corroborated in its material allegation, i.e., implication of the unidentified vehicle, for that is the subject addressed by the statute. Hoffman v. Doe, 191 Ga. App. 319, 381 S.E.2d 546, cert. denied, 191 Ga. App. 922, 381 S.E.2d 546 (1989).

Unless the policy issued by an uninsured motorist carrier actually limited the coverage to require corroboration by an eyewitness when no physical contact occurred as required by paragraph (b)(2) of O.C.G.A. § 33-7-11, insured's failure to produce corroborative evidence in accordance with the statute would be immaterial; material issue of fact as to whether policy contained corroboration provision precluded summary judgment. Walker v. United Servs. Auto. Ass'n, 205 Ga. App. 693, 423 S.E.2d 299 (1992).

Under O.C.G.A. § 33-7-11(b)(2), physical contact is not required to be established when the descriptive representation or statement contained in claimant's pleadings of how the incident occurred is corroborated, that is, made more certain or strengthened, by an eyewitness to the occurrence other than the claimant. Langford v. Royal Indem. Co., 208 Ga. App. 128, 430 S.E.2d 98 (1993).

Husband and wife could serve as each other's corroborating eyewitness. American Ambassador Cas. Co. v. Cash, 213 Ga. App. 606, 445 S.E.2d 364 (1994).

An insured met the corroborative evidence requirement necessary to pursue an uninsured motorist claim involving a phantom vehicle, even though the eyewitness may have failed to corroborate the insured in some respects and may have actually contradicted the insured in other respects; it was not required that the eyewitness corroborate each and every detail of the insured's description. Meredith v. Nationwide Mut. Fire Ins. Co., 215 Ga. App. 286, 450 S.E.2d 322 (1994).

Speculative allegation insufficient. — Alternative averment constituted nothing more than a speculative allegation of how the occurrence may have occurred; and the speculative nature of the averment was not cured by a subsequent general averment. Langford v. Royal Indem. Co., 208 Ga. App. 128, 430 S.E.2d 98 (1993).

The res gestae evidentiary rule does not supply the "eyewitness" required under subsection (b)(2) of O.C.G.A. § 33-7-11; thus, when the plaintiff was injured as the result of gunshots fired from a "phantom" vehicle, the testimony of a witness about plaintiff's condition and what he told her about the incident after it happened was not sufficient to corroborate the plaintiff's claim. Fisher v. Clarendon Nat'l Ins. Co., 210 Ga. App. 711, 437 S.E.2d 344 (1993).

Injury by intentional act may be caused by "accident." — The word "accident" does not mean that under all circumstances the occurrence must be pure accident, but the fact that injury is caused by an intentional act does not preclude it from being caused by "accident" if in that act something unforeseen, unusual, and unexpected occurs which produces the result. American Protection Ins. Co. v. Parker, 150 Ga. App. 732, 258 S.E.2d 540 (1979).

Whether or not an occurrence is "accidental" must be decided by viewing it through the eyes of the victim, and if as to the latter it is unforeseen and not caused by his own misconduct, it is, although an intentional assault, "accidental" as to him. American Protection Ins. Co. v. Parker, 150 Ga. App. 732, 258 S.E.2d 540 (1979).

Vehicle not in use. — Use of a vehicle as contemplated within O.C.G.A. § 33-7-11 did not include a situation where decedent had, by standing in the vicinity of the front yard of the decedent's home, parked, exited and relinquished control of the vehicle. Bernard v. Nationwide Mut. Fire Ins. Co., 206 Ga. App. 519, 426 S.E.2d 29 (1992).

Existence of non-contacting vehicle corroborated. — In a wrongful death case where a second vehicle rear-ended the car in which the decedent was riding after a third car driven by an unknown person abruptly turned, the trial court did not err in denying an insurer's motion for directed verdict and motion for judgment notwithstanding the verdict. Although the third car had no contact with the vehicle in which the decedent was riding, numerous eyewitnesses corroborated the existence of the third car and testified that it was at least to some degree responsible for the accident; furthermore, there was evidence from which the jury could conclude that the third driver was 90 percent negligent in causing the accident. State Farm v. Nelson, 296 Ga. App. 47, 673 S.E.2d 588 (2009).

Fraud and misrepresentation defense. — An uninsured motorist insurance coverage can be rejected; thus, it is not a form of mandatory insurance coverage to which the defense of misrepresentation would be precluded as a matter of public policy. Platt v. National Gen. Ins. Co., 205 Ga. App. 705, 423 S.E.2d 387, cert. denied, 205 Ga. App. 900, 423 S.E.2d 283 (1992).

Impact on complete compensation doctrine from Medicare payment. — A trial court erred by dismissing an insured's uninsured motorist (UM) benefits suit against the insured's UM carrier as the insured's settlement with the tortfeasor was reduced by the amount of a Medicare lien; therefore, the insured's UM recovery should not have been reduced (nor rejected) under the complete compensation doctrine. Toomer v. Allstate Ins. Co., 292 Ga. App. 60, 663 S.E.2d 763 (2008).

Public policy allows contribution to be sought from uninsured motorist carrier. — It is the public policy of this state that where there are codefendants one of whom would be entitled to contribution from the others on paying off the judgment, such contribution may be sought, as to an uninsured codefendant, from the uninsured motorist carrier. Travelers Indem. Co. v. Liberty Loan Corp., 140 Ga. App. 458, 231 S.E.2d 399 (1976), cert. dismissed, 238 Ga. 667, 235 S.E.2d 39 (1977).

By codefendant. — An insured codefendant with sufficient liability insurance to satisfy judgments rendered in favor of the plaintiffs against such insured codefendant and an uninsured motorist is entitled to recover contribution and indemnification from the plaintiff's uninsured motorist carrier. Wages v. State Farm Mut. Auto. Ins. Co., 132 Ga. App. 79, 208 S.E.2d 1 (1974).

By insurer. — An insurer of a codefendant has the right to seek contribution from the plaintiff's liability insurer which provides uninsured motorist coverage to

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an uninsured codefendant. Wages v. State Farm Mut. Auto. Ins. Co., 132 Ga. App. 79, 208 S.E.2d 1 (1974).

Failing to file accident report only abates right to file action against insurer, not uninsured. — Subsection (c) of this section, requiring notification, applies only when recovery is sought against an insurer "under the endorsement" providing uninsured motorist coverage; this action is not against plaintiff's insurer, but against "John Doe" for the purpose of obtaining a judgment, which has been held to be a condition precedent to the institution of an action against the insurer. Doe v. Moss, 120 Ga. App. 762, 172 S.E.2d 321 (1969).

The failure to file in accordance with subsection (c) of this section results only in abatement of the right to file an action against an insurer carrier until the report is filed. Jones v. Doe, 143 Ga. App. 451, 238 S.E.2d 555 (1977).

Effect of failure to report accident as required by O.C.G.A. § 40-6-273. — Motorcyclist's failure to report involvement in a collision to the police for 29 days violated O.C.G.A. § 40-6-273, which was a condition precedent to uninsured motorist coverage under O.C.G.A. § 33-7-11(c); summary judgment to the insurer was properly granted. Pender v. Doe, 276 Ga. App. 178, 622 S.E.2d 888 (2005).

Release to insurer does not bar action against tortfeasor by insured. — The fact that an insured, for a stated consideration, executes to his insurance carrier a release of liability for bodily injury under the terms of the uninsured motorist provision of his policy does not preclude him from maintaining an action against the party negligently causing his injuries. Thompson v. Milam, 115 Ga. App. 396, 154 S.E.2d 721 (1967).

Loan receipt not bar to suit. — The fact that the insured gave a loan receipt to her collision insurer is not a bar to her suit and legal right to recover against the uninsured motorist, as loan receipts do not constitute assignment of causes of action. State Farm Mut. Auto. Ins. Co. v. Barnard, 115 Ga. App. 857, 156 S.E.2d 148 (1967).

Subrogation unavailable on policy issued outside state. — Subsection (f) does not purport to give right of subrogation to insurer paying claim on policy issued or delivered outside the state. Liberty Mut. Ins. Co. v. Clark, 165 Ga. App. 31, 299 S.E.2d 76 (1983).

Effect of insurer's representation that judgment against uninsured motorist is not necessary. — Provision of O.C.G.A. § 33-7-11 requiring judgment against uninsured motorist as condition precedent to recovery against insurer is for benefit of insurer and is waived unless contrary to public policy, when insurer has led insured to believe that insured will be paid without suit. Rosenberg v. Liberty Mut. Ins. Co., 163 Ga. App. 82, 293 S.E.2d 737 (1982).

Insurance policy uninsured motorist provision that "determination as to whether injured person is legally entitled to recover damages from owner or operator of responsible auto will be by agreement between us and injured person …" entitled insured to believe that suit against uninsured motorist was not condition precedent to recovery under insurance contract, and suit was properly grounded in contract rather than tort. Rosenberg v. Liberty Mut. Ins. Co., 163 Ga. App. 82, 293 S.E.2d 737 (1982).

Nonresident claimant exempt from policy exclusion. — The enforcement of a policy exclusion of coverage for settlement without consent of the insurer is contrary to subsection (g) of O.C.G.A. § 33-7-11, but it does not prevent the enforcement of the provision against a nonresident in the courts of Georgia only because the nonresident could not obtain service on the defendant uninsured motorist in the uninsured's own state. Terry v. Mays, 161 Ga. App. 328, 291 S.E.2d 44 (1982).

Effect of settlement with one insurer. — Where two separate policies apply, by settling a potentially larger recovery with one insurer, the plaintiffs are not limited to a maximum recovery against the other of half the jury's verdict, since, if litigation had established that the compromising insurer had not been liable at all, the other insurer would have been liable for the full amount of its coverage,

but the trial court errs in not crediting other insurer with the $3,000 previously paid by the compromising insurer. Jefferson-Pilot Fire & Cas. Co. v. Combs, 166 Ga. App. 274, 304 S.E.2d 448 (1983).

Plan and certificate of self-insurance serves as substantial equivalent of an insurance "policy" for the purposes of O.C.G.A. § 33-7-11. Unless the plan of self-insurance submitted to the commissioner of public safety rejects the minimum uninsured motorist coverage in writing, such coverage will be implied as contained in the plan. Twyman v. Robinson, 255 Ga. 711, 342 S.E.2d 313 (1986).

Punitive damages not permitted. — The proper construction of this statute, as well as the proper public policy of this state, is that no recovery of punitive damages may be had against an uninsured motorist carrier; thus, State Farm Mut., Auto. Inc. v. Weathers, 193 Ga. App. 557, 388 S.E.2d 393 (1989) is overruled. Roman v. Terrell, 195 Ga. App. 219, 393 S.E.2d 83 (1990).

The trial court did not err in granting partial summary judgment to an uninsured motorist (UM) insurance provider because the UM provider was not statutorily obligated under O.C.G.A. § 33-7-11(a)(1) to pay a punitive damages judgment in the event that one was awarded to the insureds; no recovery of punitive damages could be had against a UM provider. Bonamico v. Kisella, 290 Ga. App. 211, 659 S.E.2d 666 (2008).

Penalties and attorney fees. — Insured who tried to recover damages for injuries the insured sustained in a motor vehicle accident in Florida, but who alleged that the insured's claim was denied because the insured did not have the right to sue under Florida's no-fault statute, was entitled to collect uninsured motorist benefits from the insured's own insurance company, pursuant to O.C.G.A. § 33-7-11. However, the trial court, which heard the insured's action against the insured's insurance company, erred when it denied the company's motion for summary judgment on the insured's claim seeking penalties and attorney fees, pursuant to O.C.G.A. § 33-4-6, because the case presented a unique issue of law and there was no evidence that the company acted in bad faith when it denied the insured's claim. Ga. Farm Bureau Mut. Ins. Co. v. Williams, 266 Ga. App. 540, 597 S.E.2d 430 (2004).

Because an insured's bad faith claim was based upon a tortfeasor's conduct, the insured did not incur attorney's fees and expenses because of the bodily injury or property damage that the insured sustained; thus, pursuant to the plain language of O.C.G.A. § 33-7-11(b)(1)(D)(ii), the insured could not recover attorney's fees and expenses from the insured's uninsured motorist insurer under O.C.G.A. § 13-6-11. Smith v. Stoddard, 294 Ga. App. 679, 669 S.E.2d 712 (2008).

Nonduplication of benefits clause. — Nonduplication of benefits clause providing for setoff of medical benefits paid is enforceable when damages are equal to or below the uninsured motor vehicle policy limits because in such circumstances the clause only reduces the uninsured motorist payment by the amount of the prior medical payment without reducing recovery of all damages. Johnson v. State Farm Mut. Auto. Ins. Co., 216 Ga. App. 541, 455 S.E.2d 91 (1995), overruled by Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

Excess damages not split between uninsured motorist carriers. — Injured passenger's uninsured motorist carrier was initially liable for damages in excess of the coverage of the driver of the other car, and the excess damages were to be borne by the injured passenger's carrier and not to be split between the two carriers. Georgia Farm Bureau Mut. Ins. Co. v. State Farm Mut. Auto. Ins. Co., 255 Ga. 166, 336 S.E.2d 237 (1985).

Recovery of legal costs by uninsured motorist carrier. — Where an insured's motor vehicle liability insurer entered a defense on his behalf pursuant to a reservation of rights and then filed a declaratory judgment action seeking a ruling that no coverage existed under the policy, and the plaintiff's uninsured motorist carrier undertook the insurer's defense in the declaratory judgment action and ultimately obtained a ruling that the insured was covered under the policy, the uninsured motorist carrier may not re-

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cover its legal costs and attorney fees expended in defending the insured in the declaratory judgment action. Hall v. Canal Ins. Co., 195 Ga. App. 16, 392 S.E.2d 340 (1990).

Attempt at service requires due diligence. — Because there was no evidence of any effort to locate or serve driver of vehicle for three months between the initial failed attempt and the insurance company's motion to dismiss, the trial court did not abuse its discretion in finding a lack of due diligence. Brown v. State Farm Mut. Auto. Ins. Co., 242 Ga. App. 313, 529 S.E.2d 439 (2000).

No genuine issue of material fact as to uninsured motorist coverage. — Trial court erred by granting summary judgment to the insurer because the undisputed evidence did not show that the insured made an affirmative choice for less uninsured/underinsured coverage than the statutory default amount set forth in O.C.G.A. § 33-7-11(a)(1)(B); thus, the statutory default amount of coverage applied to the policy, and the trial court erred in construing the policy to provide a lesser amount of coverage. McGraw v. IDS Prop. & Cas. Ins. Co., 323 Ga. App. 408, 744 S.E.2d 891 (2013).

Evidence of lower amount of coverage. — Trial court determination that a policy provided the insured with the default amount of uninsured/underinsured motorist coverage as required by O.C.G.A. § 33-7-11(a)(1) was an amount equal to their policy's liability limit of $100,000 per person was affirmed because there was no evidence that they affirmatively chose a lower amount of coverage and their response to a request for admission did not constitute an admission that their policy provided the statutory minimum amount of UM coverage. Gov't Emples. Ins. Co. v. Morgan, 341 Ga. App. 396, 800 S.E.2d 612 (2017).

Cited in American Mut. Ins. Co. v. Aderholt, 114 Ga. App. 508, 151 S.E.2d 833 (1966); Sutker v. Pennsylvania Ins. Co., 115 Ga. App. 648, 155 S.E.2d 694 (1967); Barras v. State Farm Mut. Auto. Ins. Co., 118 Ga. App. 348, 163 S.E.2d 759 (1968); American Liberty Ins. Co. v. Sanders, 120 Ga. App. 1, 169 S.E.2d 342 (1969); Hemphill v. Home Ins. Co., 121 Ga. App. 458, 121 Ga. App. 323, 174 S.E.2d 251 (1970); Stone v. Cranfield, 122 Ga. App. 178, 176 S.E.2d 498 (1970); Southeastern Fid. Ins. Co. v. Heard, 123 Ga. App. 635, 182 S.E.2d 153 (1971); Fidelity & Cas. Co. v. Wilson, 124 Ga. App. 444, 184 S.E.2d 21 (1971); Corbin v. Gulf Ins. Co., 125 Ga. App. 281, 187 S.E.2d 312 (1972); State Farm Mut. Auto. Ins. Co. v. Johnson, 126 Ga. App. 45, 190 S.E.2d 113 (1972); Fisher v. Womack, 128 Ga. App. 62, 195 S.E.2d 753 (1973); Henry v. Allstate Ins. Co., 129 Ga. App. 223, 199 S.E.2d 338 (1973); State Farm Mut. Auto. Ins. Co. v. Bass, 231 Ga. 269, 201 S.E.2d 444 (1973); Fowler v. United States Fid. & Guar. Co., 133 Ga. App. 842, 212 S.E.2d 486 (1975); Gregory v. Allstate Ins. Co., 134 Ga. App. 461, 214 S.E.2d 696 (1975); Woods v. State Farm Mut. Auto. Ins. Co., 234 Ga. 782, 218 S.E.2d 65 (1975); Vaughn v. Collum, 236 Ga. 582, 224 S.E.2d 416 (1976); Jones v. Associated Indem. Corp., 143 Ga. App. 139, 237 S.E.2d 651 (1977); Davenport v. Aetna Cas. & Sur. Co., 144 Ga. App. 474, 241 S.E.2d 593 (1978); Hughes v. Cotton States Mut. Ins. Co., 146 Ga. App. 117, 245 S.E.2d 466 (1978); Lawrence v. Whittle, 146 Ga. App. 686, 247 S.E.2d 212 (1978); Georgia Mut. Ins. Co. v. Cook, 151 Ga. App. 328, 259 S.E.2d 717 (1979); Smith v. State Farm Mut. Auto. Ins. Co., 152 Ga. App. 825, 264 S.E.2d 296 (1979); Smith v. Commercial Union Assurance Co., 153 Ga. App. 38, 264 S.E.2d 530 (1980); Georgia Farm Bureau Mut. Ins. Co. v. Nelson, 153 Ga. App. 623, 266 S.E.2d 299 (1980); Commercial Union Ins. Co. v. Wraggs, 159 Ga. App. 596, 284 S.E.2d 19 (1981); Kirkpatrick v. Mackey, 162 Ga. App. 876, 293 S.E.2d 461 (1982); Colbert v. Doe, 164 Ga. App. 618, 298 S.E.2d 592 (1982); Gibson v. Dempsey, 167 Ga. App. 23, 306 S.E.2d 32 (1983); Cotton States Mut. Ins. Co. v. McFather, 251 Ga. 739, 309 S.E.2d 799 (1983); Maryland Cas. Co. v. Rhoden, 170 Ga. App. 704, 318 S.E.2d 175 (1984); Kelley v. Integon Indem. Corp., 253 Ga. 269, 320 S.E.2d 526 (1984); McCoy v. Southern Bell Tel. & Tel. Co., 172 Ga. App. 26, 322 S.E.2d 76 (1984); Smith v. Phillips, 172 Ga. App. 459, 323 S.E.2d 669 (1984); Gandy v. Brown, 173

Ga. App. 740, 327 S.E.2d 850 (1985); Cotton States Mut. Ins. Co. v. Neese, 254 Ga. 335, 329 S.E.2d 136 (1985); Martin v. Doe, 174 Ga. App. 156, 329 S.E.2d 291 (1985); Howard v. Doe, 174 Ga. App. 415, 330 S.E.2d 370 (1985); Wood v. Jones, 175 Ga. App. 534, 334 S.E.2d 9 (1985); Whatley v. Universal Sec. Ins. Co., 177 Ga. App. 424, 339 S.E.2d 398 (1986); Tennessee Farmers Mut. Ins. Co. v. Wheeler, 178 Ga. App. 73, 341 S.E.2d 898 (1986); Blalock v. Southern Ins. Co., 180 Ga. App. 319, 349 S.E.2d 32 (1986); Butler v. Doe, 180 Ga. App. 313, 349 S.E.2d 34 (1986); McCallister v. Doe, 181 Ga. App. 602, 353 S.E.2d 89 (1987); Nationwide Gen. Ins. Co. v. Parnham, 182 Ga. App. 823, 357 S.E.2d 139 (1987); Chapman v. Burks, 183 Ga. App. 103, 357 S.E.2d 832 (1987); National Union Fire Ins. Co. v. Johnson, 183 Ga. App. 38, 357 S.E.2d 859 (1987); Roderick v. International Indem. Co., 183 Ga. App. 393, 358 S.E.2d 923 (1987); Harwell v. Continental Ins. Co., 183 Ga. App. 410, 359 S.E.2d 172 (1987); Yarbrough v. Dickinson, 183 Ga. App. 489, 359 S.E.2d 235 (1987); Fire & Cas. Ins. Co. v. Spell, 183 Ga. App. 675, 359 S.E.2d 705 (1987); Utica Mut. Ins. Co. v. Chasen, 187 Ga. App. 796, 371 S.E.2d 448 (1988); Scott v. Allstate Ins. Co., 190 Ga. App. 135, 378 S.E.2d 332 (1989); Cincinnati Ins. Co. v. Holbrook, 867 F.2d 1330 (11th Cir. 1989); Southern Trust Ins. Co. v. Georgia Farm Bureau Mut. Ins. Co., 194 Ga. App. 751, 391 S.E.2d 793 (1990); Cotton States Mut. Ins. Co. v. Starnes, 260 Ga. 235, 392 S.E.2d 3 (1990); Lee v. Fulton Concrete Co., 195 Ga. App. 348, 393 S.E.2d 449 (1990); Maxwell v. State Farm Mut. Auto. Ins. Co., 196 Ga. App. 545, 396 S.E.2d 291 (1990); Rogers v. Schuman-Mann Supply Co., 197 Ga. App. 59, 397 S.E.2d 463 (1990); Shepard v. Allstate Ins. Co., 198 Ga. App. 144, 400 S.E.2d 682 (1990); McCrary v. Preferred Risk Mut. Ins. Co., 198 Ga. App. 727, 402 S.E.2d 519 (1991); Link v. Doe, 203 Ga. App. 388, 416 S.E.2d 874 (1992); Haynes v. McCambry, 203 Ga. App. 464, 416 S.E.2d 893 (1992); Lowes v. Allstate Ins. Co., 204 Ga. App. 148, 418 S.E.2d 465 (1992); Hicks v. Doe, 206 Ga. App. 596, 426 S.E.2d 174 (1992); Standard Guar. Ins. Co. v. Landers, 206 Ga. App. 803, 426 S.E.2d 574 (1992); State Farm Mut. Auto. Ins. Co. v. Noble, 208 Ga. App. 518, 430 S.E.2d 804 (1993); Daniels v. Johnson, 226 Ga. App. 789, 487 S.E.2d 504 (1997); Daniels v. Johnson, 270 Ga. 289, 509 S.E.2d 41 (1998); Southeastern Sec. Ins. Co. v. Lowe, 242 Ga. App. 535, 530 S.E.2d 231 (2000); Allstate Ins. Co. v. Baldwin, 244 Ga. App. 664, 536 S.E.2d 558 (2000); Woody v. Ga. Farm Bureau Mut. Ins. Co., 250 Ga. App. 454, 551 S.E.2d 837 (2001); Hudson v. Whited, 250 Ga. App. 451, 552 S.E.2d 447 (2001); Horace Mann Ins. Corp. v. Mercer, 257 Ga. App. 278, 570 S.E.2d 589 (2002); Dunn v. Kirsten, 273 Ga. App. 27, 614 S.E.2d 156 (2005); Butler v. Gary, Williams, Parenti, Finney, Lewis, McManus, Watson & Sperando, P.L., 280 Ga. App. 207, 633 S.E.2d 614 (2006); McClellan v. Evans, 294 Ga. App. 595, 669 S.E.2d 554 (2008); Barrett v. Burnette, 348 Ga. App. 838, 824 S.E.2d 701 (2019); Henderson v. James, 350 Ga. App. 361, 829 S.E.2d 429 (2019).

Who Is Covered

Government-owned vehicles may not be excluded from this section by provisions of an insurance policy. Watkins v. United States, 462 F. Supp. 980 (S.D. Ga. 1977), aff'd, 587 F.2d 279 (5th Cir. 1979).

Government owned vehicles not excluded from insurance. — This section does not permit a policy of insurance to exclude from uninsured motorist coverage a government-owned vehicle operated by a government employee acting within the scope of the employee's employment. State Farm Mut. Auto. Ins. Co. v. Carlson, 130 Ga. App. 27, 202 S.E.2d 213 (1973).

Sovereign immunity inapplicable. — It would defeat the intent and purpose of the Uninsured Motorist Act, O.C.G.A. § 33-7-11, if insurer was allowed to escape liability because of the city's discharge from action under the doctrine of sovereign immunity; thus, action should have been allowed to proceed as though it was a John Doe action and the insured can establish "all sums which he shall be legally entitled to recover as damages" caused by the uninsured motorist. Tinsley v. Worldwide Ins. Co., 212 Ga. App. 809, 442 S.E.2d 877 (1994).

Driver's employer's uninsured motorist

Who Is Covered (Cont'd)

(UM) coverage was available to the driver because the policy promised to pay sums the driver was "legally entitled to recover" from a UM, even though the driver had collided with a county vehicle and the county's partial sovereign immunity prevented the driver from establishing in a lawsuit that the driver was legally entitled to recover the full amount of the driver's damages from the county. FCCI Ins. Co. v. McLendon Enters., 297 Ga. 136, 772 S.E.2d 651 (2015).

The term "any insured named in the policy" clearly refers only to the named insured. Miller v. State Farm Mut. Auto. Ins. Co., 155 Ga. App. 487, 271 S.E.2d 14 (1980).

This section provides for two classes of insured persons. One of these classes are insured persons only when the insured automobile is involved, but as to the other they are insured persons even where the insured automobile is not in any way involved in the insured's injuries. This class is: "the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise." State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972).

Relative not covered unless resident of household, and resident not covered unless relative. — The clause, "resident of the same household," does not apply to a relative, however close, living elsewhere, nor to a resident of the same household who is not a member of the family. Cotton States Mut. Ins. Co. v. McEachern, 135 Ga. App. 628, 218 S.E.2d 645 (1975).

When the appellant driver was involved in a collision while driving, accompanied by the appellant's son, since both were severely injured, and since the driver of the other vehicle was killed, the trial court was correct in its conclusion that appellant's son was not covered as a "relative" of appellant driver under the uninsured motorist provisions of the appellant driver's policy, since the term "relative" was defined in the policy to mean "your, i.e., the named insured's, relative residing in your household," and it was apparent without dispute that the father and son were not residents of the same household. Coleman v. State Farm Mut. Auto. Ins. Co., 192 Ga. App. 285, 384 S.E.2d 399 (1989).

Resident relatives of the named insured who own their own automobiles may not be excluded by contract from uninsured motorist coverage since the coverage attaches to all resident relatives of the named insured regardless of whether they are in the automobile or not. White v. Metropolitan Property & Cas. Ins. Co., 266 Ga. 371, 467 S.E.2d 332 (1996).

Separate domestic establishments, not common roof, control. — The critical distinction when a relative of the insured is injured is whether separate domestic establishments are maintained, but a common roof is not the controlling element. State Farm Mut. Auto. Ins. Co. v. Gazaway, 152 Ga. App. 716, 263 S.E.2d 693 (1979).

Permanent residence of relative not required. — Evidence that the insured's stepson intended to live in his stepfather's house until his divorce was final created a question of fact as to whether he was a "resident relative" at the time of the accident; neither the policy language at issue nor state law required the stepson to live with his stepfather permanently in order to qualify. Boston v. Allstate Ins. Co., 218 Ga. App. 726, 463 S.E.2d 155 (1995).

Owner, spouse, and relatives in household covered whether or not in insured car. — "The named insured and, while resident of the same household, the spouse of any such named insured and relatives of either" are insured persons even where the "insured automobile" is not in any way involved in the insured's injuries. Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

If there is an uninsured motorist policy and if it covers the insured wherever he may be, it is irrelevant that he owns another car which he is occupying and which does not have such coverage. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

Uninsured motorists coverage applies not only to the owner of an insured automobile but to his spouse and relatives of either if they live in his household. It covers them while riding in the insured car, or in any other automobile or while pedestrians if the injury is caused by an uninsured motorist. American Protection Ins. Co. v. Parker, 150 Ga. App. 732, 258 S.E.2d 540 (1979).

When a wife's insurance policy on a couple's jointly owned car was cancelled for nonpayment, after which the car was involved in an accident, the car was not an uninsured vehicle under the husband's policy, which excluded a vehicle "furnished for the regular use of you, your spouse or any relative." The policy complied with O.C.G.A. § 33-7-11(a)(1) because the insurer agreed to provide coverage within the statutory limits and with § 33-7-11(b)(1)(B) because the wife was included as an insured as the husband's spouse. Zilka v. State Farm Mut. Auto. Ins. Co., 291 Ga. App. 665, 662 S.E.2d 777 (2008).

Issue regarding decedent's residence. — In an action to recover uninsured/underinsured motorist benefits, the trial court erred in granting the insurer's motion for summary judgment as the mother pointed to evidence creating a genuine issue of material fact about the decedent's primary residence, which was material to whether the defendant's car was an "uninsured motor vehicle" under the subject policy. Parsons v. State Farm Mut. Auto. Ins. Co., 319 Ga. App. 616, 737 S.E.2d 718 (2013).

Listed driver not named insured. — Driver who was a listed driver on a friend's insurance policies was not entitled to stack the friend's policies under the first category of O.C.G.A. § 33-7-11(b)(1)(B). Listed drivers were not named insureds; thus, because the driver was neither the friend's relative nor a named insured, the driver was not an insured under the first category of § 33-7-11(b)(1)(B). Dunn-Craft v. State Farm Mut. Ins. Co., 314 Ga. App. 620, 724 S.E.2d 903 (2012).

Persons using with consent are only covered if insured car involved. — The class of persons using with consent of the named insured are insured persons under this section only when the "insured automobile" is involved. Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

Use of a vehicle determines who is insured for purposes of this section. Hartford Accident & Indem. Co. v. Booker, 140 Ga. App. 3, 230 S.E.2d 70 (1976).

Language in a policy requiring that an individual "occupy" the covered vehicle for uninsured motorist protection was in conflict with the provision of this section that insured persons includes "any person who uses … the motor vehicle." Northbrook Property & Cas. Ins. Co. v. Merchant, 215 Ga. App. 273, 450 S.E.2d 425 (1994), cert. denied, No. S95C0440, 1995 Ga. LEXIS 491 (Ga. 1995); overruled on other grounds, Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

Where employees had driven an insured vehicle to a job site and were working outside the vehicle on a loading operation when it was struck by an uninsured motorist and propelled into the employees, there was a question of fact as to whether they were "using" the vehicle for purposes of uninsured motorist protection. Northbrook Property & Cas. Ins. Co. v. Merchant, 215 Ga. App. 273, 450 S.E.2d 425 (1994), cert. denied, No. S95C0440, 1995 Ga. LEXIS 491 (Ga. 1995); overruled on other grounds, Dees v. Logan, 282 Ga. 815, 653 S.E.2d 735 (2007).

"Use" is defined as contemplated by parties to insurance contract. — In defining the word "use" of the insured vehicle, it is important to look to the contemplation of the parties in entering into the insurance contract. Hartford Accident & Indem. Co. v. Booker, 140 Ga. App. 3, 230 S.E.2d 70 (1976).

Whether injury arose from "use" depends on facts. — Whether or not an injury arose from the "use" of a motor vehicle within the contemplation of this section depends upon the factual context of each case. Hartford Accident & Indem. Co. v. Booker, 140 Ga. App. 3, 230 S.E.2d 70 (1976).

Stacking not permitted for vehicles not involved in accident. — Driver who was a listed driver on a friend's insurance policies was not entitled to stack the

Who Is Covered (Cont'd)

friend's policies under the second category of O.C.G.A. § 33-7-11(b)(1)(B). Because the driver was outside of the vehicle when the driver was struck, there was a genuine issue of material fact as to whether the vehicle was involved, but even if the jury found that the vehicle was involved, the driver would be limited to recovering uninsured motorist (UM) coverage only under the policy covering that vehicle and was not eligible to stack the friend's remaining UM policies on other vehicles. Dunn-Craft v. State Farm Mut. Ins. Co., 314 Ga. App. 620, 724 S.E.2d 903 (2012).

An exclusion in an automobile policy for intentional injury or property damage was enforceable where the injured third party had access to recovery through uninsured motorist coverage under another policy. Auto-Owners Ins. Co. v. Jackson, 211 Ga. App. 613, 440 S.E.2d 242 (1994).

Policy exclusion for public or livery conveyance not applicable. — When the insured was injured while parking the insured's car when the driver in the adjacent space opened the driver's car door in the insured's path and the two collided, the trial court did not err in denying the uninsured motorist carrier's motion for summary judgment as the insured was not operating the insured's vehicle as a public or livery conveyance pursuant to a policy exclusion because there was no evidence that the insured held the insured's self out indiscriminately to the public, or operated a business for hire; the evidence merely showed that the insured occasionally offered a specific friend and neighbor a ride for a fee; and, on the day of the accident, the insured gratuitously offered the friend a ride. Haulers Ins. Co. v. Davenport, 344 Ga. App. 444, 810 S.E.2d 617 (2018).

Vehicle occupancy defined. — The trial court did not err in its interpretation of policy's provision covering context of "getting into vehicle" in accordance with the common meaning of these words to exclude coverage of an insured's relative who was standing behind the insured vehicle when struck by another car. Major v. Allstate Ins. Co., 207 Ga. App. 805, 429 S.E.2d 172 (1993).

Activities which are essential transactions in connection with the insured vehicle are covered by this section. Hartford Accident & Indem. Co. v. Booker, 140 Ga. App. 3, 230 S.E.2d 70 (1976).

Vehicle is insured if anyone's insurance applies to accident. — So long as there is insurance applicable to the accident, the vehicle causing the injury is insured for purposes of uninsured motorist coverage, no matter for whom the insurance was purchased. Travelers Indem. Co. v. Liberty Loan Corp., 140 Ga. App. 458, 231 S.E.2d 399 (1976), cert. dismissed, 238 Ga. 667, 235 S.E.2d 39 (1977).

Vehicle dealer's customer. — Unambiguous provisions of a used vehicle dealer's insurance policy provided that the dealer's customer, who had borrowed a car while the customer's car was repaired, was an insured under the policy but was only insured up to the compulsory legal limits of O.C.G.A. § 33-7-11. Because the car was not rented, the provisions of O.C.G.A. § 40-9-102 did not apply. Grange Mut. Cas. Co. v. Fulcher, 306 Ga. App. 109, 701 S.E.2d 547 (2010).

It is irrelevant whether coverage was not required or was rejected. — It is irrelevant, if the car has no uninsured motorist coverage, whether the reason is that at the time the policy was issued the law requiring uninsured motorist coverage had not come into effect, or whether it was in effect, but the insured had elected to reject the coverage. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

Rejection under one policy does not forfeit coverage under another. — The rejection of uninsured motorist coverage under one policy does not work a forfeiture or estoppel as to coverage which exists under another valid policy. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

When one rejects coverage as to an automobile named in the declaration, he has no right to any coverage under that policy, but if he has another policy which does contain uninsured motorist insur-

ance, he, as the named insured, is covered wherever he is, whether in that car, another car, or no car, although the uninsured car is not covered and certain classes of persons are not covered unless they are in an insured vehicle. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

Rejection signed in husband's name by wife. — Where claimant wife admitted signing rejection of uninsured motorist coverage at the express direction of her husband, the named insured, she was estopped from claiming that she signed her husband's name without proper authority. Miller v. State Farm Mut. Auto. Ins. Co., 155 Ga. App. 487, 271 S.E.2d 14 (1980).

Coverage offered and accepted after rejection. — Paragraph (3) of subsection (a) of this section, providing that an insured may reject coverage in writing and that, if he does so, coverage need not be provided thereafter, has no application where, after the rejection, the insurer again offers the coverage and the insured accepts the offer according to its tenor by retaining the endorsement and paying the increased premium charged for the uninsured motorist coverage. Bass v. State Farm Mut. Auto. Ins. Co., 128 Ga. App. 285, 196 S.E.2d 485, aff'd in part and rev'd in part, 231 Ga. 269, 201 S.E.2d 444 (1973).

That the named insured on policy is a business rather than an individual does not demonstrate that the intent of the policy was not to afford personal coverage. Purcell v. Allstate Ins. Co., 168 Ga. App. 863, 310 S.E.2d 530 (1983).

Uninsured motorist coverage held by insured follows him as a passenger in an uninsured car. Jefferson-Pilot Fire & Cas. Co. v. Combs, 166 Ga. App. 274, 304 S.E.2d 448 (1983).

Insured occupying vehicle not insured under policy. — An insurer may not exclude uninsured motorist coverage under circumstances when an insured is injured through the negligence of an uninsured motorist but at a time when the insured is occupying a motor vehicle furnished for the insured's regular use which is not a vehicle insured by the policy. Doe v. Rampley, 256 Ga. 575, 351 S.E.2d 205 (1987).

Widow of insured. — An exclusion prohibiting recovery by anyone occupying a motor vehicle owned by or furnished by the insured and not insured under the policy did not preclude recovery by decedent's widow, where decedent was the named insured under the policy. Rampley v. Doe, 179 Ga. App. 475, 347 S.E.2d 255 (1986), aff'd, 256 Ga. 575, 351 S.E.2d 205 (1987).

Trial court properly determined that the wrongful death claim and survival claim was limited to the per-person liability of the driver's bodily injury liability insurance and the depletion of $99,000 of the driver's liability insurance by the widow did not entitle the estate to coverage by the deceased insured's uninsured motorist insurance. Erturk v. GEICO Gen. Ins. Co., 315 Ga. App. 274, 726 S.E.2d 757 (2012).

Employee who is not named insured under policy of insurance on employer's vehicle is covered only while actually "using" the vehicle. Where he leaves the vehicle parked in front of a building while he uses a nearby telephone, and is then struck by a car driven by an uninsured motorist, he is using the telephone and not "using" the vehicle. Anderson v. Ford, 168 Ga. App. 864, 309 S.E.2d 854 (1983).

Contract may provide coverage even though section allows exclusion. — Although O.C.G.A. § 33-7-11 allows a policy to be written so as to exclude a guest riding in a vehicle driven but not owned by insured from uninsured motorist coverage, where the plain language of the contract brings such a person within the coverage, the contract is controlling. Jones v. Barnes, 170 Ga. App. 762, 318 S.E.2d 164 (1984).

Officer and major shareholder of corporation not an "insured" under policy issued to corporation. — An individual who was the president, chairman of the board, treasurer, and general counsel of a corporation to which an uninsured motorist policy was issued, who, along with one other individual, owned all of the corporation's shares, and who was

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injured while a passenger in a police vehicle being used to transport him to a company car, which collided with an uninsured motorist, was not an "insured" under the policy, under either the theory that he was a "family member" or the theory that he was a "personal representative." Hogan v. Mayor of Savannah, 171 Ga. App. 671, 320 S.E.2d 555 (1984).

Corporate officers not personal representatives. — Corporate officers are not within the definition of legal or personal representatives for purposes of O.C.G.A. § 33-7-11. Bernard v. Nationwide Mut. Fire Ins. Co., 206 Ga. App. 519, 426 S.E.2d 29 (1992).

Owner not "named insured" under policy issued to corporation. — Minor passengers' mother was not a "named insured" solely because she owned one of the cars listed on a policy issued to a corporation. The corporation had no "family," and the passengers therefore were not "insureds" at the time they were injured while riding in the listed vehicle. Pennsylvania Lumbermens Mut. Ins. Co. v. Haney, 189 Ga. App. 216, 375 S.E.2d 293 (1988).

Vehicle owned by corporate employee and leased to corporation. — Insurance company was not required to provide coverage for automobiles owned by a corporate insured's employees but leased to the corporation. Chastain v. United States Fid. & Guar. Co., 199 Ga. App. 86, 403 S.E.2d 889 (1991).

Corporate employer, not employee driver, was named insured for stacking purposes. — Appellate court erred in concluding that a driver was entitled to stack the uninsured motorist coverage from the driver's employer's insurance policies which covered vehicles that were not involved in the car accident in which the driver was injured under O.C.G.A. § 33-7-11(b)(1)(B) because the driver was not the "named insured." Rather, the corporate employer was the named insured. State Farm Mut. Auto. Ins. Co. v. Staton, 286 Ga. 23, 685 S.E.2d 263 (2009).

Vehicle furnished for regular use by employee not an uninsured motor vehicle. — When the insured was injured while attempting to inflate a tire on the employer's truck, the trial court did not err in granting summary judgment to the insurer as the insured was not entitled to underinsured/uninsured motorist coverage because the truck that injured the insured could not be considered an uninsured motor vehicle under O.C.G.A. § 33-7-11 as the vehicle was furnished by the employer to the insured for the insured's regular use. Hazelwood v. Auto-Owners Insurance Co., 344 Ga. App. 891, 812 S.E.2d 781 (2018).

Inference drawn warranted denying insurer's motion for summary judgment. — Summary judgment denying insured's claim for uninsured motorist benefits was improper where a reasonable inference could be drawn from insured's collision with a tire assembly, an integral part of a motor vehicle, that the tire assembly was negligently attached to an unknown vehicle from which it fell, and left in the roadway by the driver of that unknown vehicle. State Farm Fire & Cas. Co. v. Guest, 203 Ga. App. 711, 417 S.E.2d 419, cert. denied, 203 Ga. App. 907, 417 S.E.2d 419 (1992).

Plaintiff not entitled to coverage. — Plaintiff is not entitled to uninsured motorist coverage where a negligently driven unidentified "white pickup truck" never made physical contact with any vehicle involved in the collision which gave rise to the case and the plaintiff never saw an unidentified "white pickup truck" contribute to the collision. Curtis v. Allstate Ins. Co., 203 Ga. App. 25, 416 S.E.2d 359 (1992).

Students. — Student injured when struck by an uninsured pick-up driver while crossing a highway to board a school bus was an insured user of the bus entitled to uninsured motorist coverage under the school board's insurance policy. The Georgia uninsured motorist statute, O.C.G.A. § 33-7-11, provided that an insured was anyone who, with the insured's consent, used an insured vehicle. State Farm Mut. Auto Ins. Co. v. Vaughn, 253 Ga. App. 217, 558 S.E.2d 769 (2002).

Who Is "Uninsured Motorist"

The term "uninsured automobile" means one as to which there is no insur-

ance applicable under the facts surrounding the occurrence on which the claim is made. American Protection Ins. Co. v. Parker, 150 Ga. App. 732, 258 S.E.2d 540 (1979).

"Uninsured motor vehicle." — The failure of a vehicle to qualify as an "uninsured motor vehicle" under subdivision (b)(1)(D)(ii) is not dispositive of the question whether the vehicle is an "uninsured motor vehicle" under the remaining subsections of O.C.G.A. § 33-7-11(b)(1)(D). Knight v. Georgia Farm Bureau Mut. Ins. Co., 184 Ga. App. 312, 361 S.E.2d 190, cert. denied, 184 Ga. App. 910, 361 S.E.2d 190 (1987).

Since the court has previously held that subdivision (b)(1)(D)(ii) of O.C.G.A. § 33-7-11 must be read in light of the rule of statutory construction contained in O.C.G.A. § 1-3-1(d)(6) that the singular ordinarily includes the plural, there is no basis for plaintiff-appellant's contention that the singular term, motor vehicle, in the code requires that each vehicle be subtracted separately from the total uninsured motorist coverage. Sanborn v. Farley, 192 Ga. App. 376, 385 S.E.2d 6, cert. denied, 192 Ga. App. 903, 385 S.E.2d 6 (1989).

The definition of "uninsured motor vehicle" that is established by subdivision (b)(1)(D)(iii) of O.C.G.A. § 33-7-11 extends to cover the situation where there is liability insurance in existence at the time of the collision, and the insurer issuing that liability policy only subsequently denies coverage on the basis of its own insured's breach of a policy condition. Southern Gen. Ins. Co. v. Thomas, 197 Ga. App. 196, 397 S.E.2d 624 (1990).

In a case involving insurance coverage after an accident, O.C.G.A. § 33-7-11(b)(1)(D)(ii) did not apply to the vehicle driven by a first tortfeasor or the vehicle driven by another tortfeasor; the first tortfeasor was not underinsured, and the second tortfeasor had no available insurance, placing the second tortfeasor's vehicle within O.C.G.A. § 33-7-11(b)(1)(D)(i). Nationwide Mut. Ins. Co. v. Boylan, 263 Ga. App. 723, 589 S.E.2d 280 (2003).

"Legal denial of coverage." — Denial of coverage by a liability insurance carrier resulting from exhaustion of the available coverage by payment of other valid claims constitutes a "legal denial of coverage" under subdivision (b)(1)(D)(iii) of O.C.G.A. § 33-7-11. Knight v. Georgia Farm Bureau Mut. Ins. Co., 184 Ga. App. 312, 361 S.E.2d 190, cert. denied, 184 Ga. App. 910, 361 S.E.2d 190 (1987) (decided prior to 1986 amendment to subdivision (b)(1)(D)(II)).

Insurer was contractually obligated to proceed as if vehicle were "uninsured," even if another insurer's denial of coverage was not "legal," where the insurer's policy omitted the word "legally" and required only that "the insuring company deny coverage" in order to trigger uninsured motorist coverage. Moore v. State Farm Mut. Auto. Ins. Co., 196 Ga. App. 755, 397 S.E.2d 127 (1990).

Policy may exclude insured vehicle or vehicle owned by named insured or resident of household. — A provision in a motor vehicle insurance policy that "the term 'uninsured motor vehicle' shall not include: (a) an 'insured motor vehicle'; or (b) a motor vehicle owned by the named insured or any resident of the same household" is valid and in accordance with, or compatible with, this section. Lauer v. Bodner, 137 Ga. App. 851, 225 S.E.2d 69 (1976).

An uninsured motorist has less than minimum liability insurance on motorist's automobile. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

If driver has minimum insurance, driver is not "uninsured motorist" as to excess damages. — A negligent driver carrying minimum liability insurance is not an "uninsured motorist" under this section to the extent the other driver's actual damages exceed his insurance coverage. Cotton States Mut. Ins. Co. v. Austin, 143 Ga. App. 309, 238 S.E.2d 253 (1977).

Subsection (a) applies to insureds whose policies are subject to Georgia law. — Subsection (a) is directed toward a class of insureds whose policies are subject to regulation by Georgia law. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Policies must each provide minimum uninsured motorist coverage. — Policies issued or delivered pursuant to

Who Is "Uninsured Motorist" (Cont'd)

subsection (a) must provide uninsured motorist coverage for at least $10,000.00 (now $15,000.00) in a single policy. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Subsection (b) refers to insureds not required to have uninsured policy. — Subjection (b) speaks in terms of insureds outside the regulation of Georgia law, who cannot be compelled to hold the type of policy Georgia requires for its own citizens. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Subsection (b) of this section, defining "uninsured motor vehicle," is directed to non-Georgia drivers, or those who have not complied or could not comply with subsection (a). McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Subsection (b) of this section, defining "uninsured motor vehicle," has within its purview out-of-state drivers who are beyond the reach of subsection (a). McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Subsection (b) does not refer to single policy of insurance. — Nothing in this section compels the interpretation of "insurance," as used in subsection (b) of this section, defining "uninsured motor vehicle," to mean "single policy of insurance." McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Policies may be added under subsection (b) in determining if driver is uninsured. — Under subsection (b), automobile liability policies may be aggregated to constitute the $10,000.00 (now $15,000.00) minimum in order to determine whether a driver is an uninsured motorist. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Aggregate of $10,000.00 (now $15,000.00) precludes motorist from being uninsured. — This section requires that a motorist involved in a collision in Georgia have an aggregate of $10,000.00 (now $15,000.00) automobile liability insurance available in order to preclude his being deemed an uninsured motorist. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Insurance of employer inures to employee who causes accident. — Where the negligence of only one defendant causes the injury, and another is liable under principles of respondeat superior, and such other in fact satisfies the entire claim, that other's applicable insurance inures to the wrongdoer; accordingly, he is neither "uninsured" for purposes of uninsured motorist insurance, nor is the employer entitled to collect indemnity from the insurer of the plaintiff. Travelers Indem. Co. v. Liberty Loan Corp., 140 Ga. App. 458, 231 S.E.2d 399 (1976), cert. dismissed, 238 Ga. 667, 235 S.E.2d 39 (1977).

Effect of payments to subrogation claimants. — Defendant insurer was properly granted summary judgment on a claim by plaintiffs, a postal worker and spouse, for underinsured motorist benefits in a case where plaintiffs received $95,554 from the tortfeasor who injured the postal worker, representing the tortfeasor's cumulative policy limits of $100,000 less $4,445 which was paid to the postal service for damage to a postal truck, because, even though $34,666 of the $95,554 went to a workers' compensation program and a health insurer on their subrogation claims, the subrogation sums represented money that the postal worker had already recovered in the form of workers' compensation and health benefits coverage for some of the worker's damages; thus, the subrogation claims did not constitute "payment of other claims or otherwise" which reduced the tortfeasor's available coverage, plaintiffs recovered more than their available $75,000 in uninsured/underinsured motorist coverage, and the trial court was correct that the tortfeasor was not underinsured for purposes of O.C.G.A. § 33-7-11(b)(1)(D)(ii). Thurman v. State Farm Mut. Auto. Ins. Co., 260 Ga. App. 338, 579 S.E.2d 746 (2003).

Person making deposit only deemed insured to its extent. — A person who complies with the Safety Responsibility Act (see T. 40, C. 9), by actually depositing security is deemed to be an insured under this section only to the extent of his deposit. Spence v. State Farm Mut. Auto. Ins. Co., 136 Ga. App. 436, 221 S.E.2d 643 (1975), aff'd, 236 Ga. 714, 225 S.E.2d 238 (1976).

Injured person may recover difference between deposit and uninsured motorist coverage. — Where a person's

coverage under this section is in excess of amounts of the security deposited by another under the Motor Vehicle Responsibility Act (see T. 40, C. 4), the person having the uninsured coverage is entitled to recover the difference between the amount of the security deposit and the uninsured coverage provided by his policy. Spence v. State Farm Mut. Auto. Ins. Co., 136 Ga. App. 436, 221 S.E.2d 643 (1975), aff'd, 236 Ga. 714, 225 S.E.2d 238 (1976).

Being exempt from the deposit of security required by O.C.G.A. § 40-9-32 is not the equivalent of having "deposited security" for purposes of paragraph (d)(2) of O.C.G.A. § 33-7-11. Hall v. Regal Ins. Co., 202 Ga. App. 511, 414 S.E.2d 669 (1991).

Identity unknown is equal to uninsured motorist under this section. Wentworth v. Fireman's Fund Am. Ins. Cos., 147 Ga. App. 854, 250 S.E.2d 543 (1978).

"John Doe" action authorized if either owner or operator unknown. — Even though plaintiff knew the identity of the registered owner of the vehicle that hit him before he filed his lawsuit, because he did not see, and did not know, who was driving the vehicle at the time of the collision, he properly filed a "John Doe" action under the alternative language of the uninsured motorist statute. Finch v. Doe, 247 Ga. App. 298, 543 S.E.2d 105 (2000).

Evidence of unknown owner or operator. — Plaintiffs' description in their complaint as to the involvement of an unknown vehicle satisfied the requirement of paragraph (b)(2) of O.C.G.A. § 33-7-11, as their description of the occurrence was corroborated by eyewitnesses. Lovelady v. Alfa Mut. Ins. Co., 233 Ga. App. 117, 503 S.E.2d 349 (1998).

When an eyewitness adequately corroborated that portion of the insured's description of the occurrence which asserted that a phantom vehicle was present and caused the incident, there was no need to further inquire as to the existence of actual physical contact. Painter v. Continental Ins. Co., 233 Ga. App. 436, 504 S.E.2d 285 (1998).

Physical contact required for an uninsured motorist claim was not met since the injured person's van was struck by cargo being hauled by an unknown motorist's truck; only admissible evidence satisfied the statutory corroboration requirement, and since out of court statements made by the injured person's late husband were inadmissible, summary judgment in favor of the insurance carrier on the injured person's uninsured motorist claim was affirmed. Torstenson v. Doe, 257 Ga. App. 389, 571 S.E.2d 432 (2002).

Action against unidentified driver. — Parent who filed a wrongful death action against an unidentified driver after the child's body was found by the side of a road presented no evidence that the unidentified driver was negligent or that the driver's actions caused the decedent's death, and the appellate court affirmed the trial court's judgment granting a motion for summary judgment which was filed by an insurance company that provided uninsured motorist coverage. Dawkins v. Doe, 263 Ga. App. 737, 589 S.E.2d 303 (2003).

Motorist is now "unknown" if whereabouts is unknown. — Since the adoption of Ga. L. 1972, p. 882, amending this section, a person whose identity is known becomes "unknown" within the meaning of this section if his whereabouts is unknown. Norman v. Daniels, 142 Ga. App. 456, 236 S.E.2d 121 (1977), overruled on other grounds, Ragan v. Mallow, 319 Ga. App. 443, 2012 Ga. App. LEXIS 1061 (Ga. Ct. App. 2012).

Under this section, a motorist or vehicle owner against whom a claim is pending but who cannot be located is treated as an uninsured motorist, since whereabouts unknown is now equal to identity unknown. Wentworth v. Fireman's Fund Am. Ins. Cos., 147 Ga. App. 854, 250 S.E.2d 543 (1978).

Action may be brought against unknown person moving truck into street where plaintiff struck it. — Where during the course of a large party, a truck which had been parked in the driveway between other cars was in some unknown way and by a person or persons unknown, moved out into the street, turned and left parked and unlighted in a traffic lane where it was hit by a motorist, an action by that motorist against the

Who Is "Uninsured Motorist" (Cont'd)

unknown operator was not barred under this section. Brown v. Doe, 125 Ga. App. 22, 186 S.E.2d 293 (1971).

Refusal to Pay Loss

An insurer is required to pay a valid claim within 60 days of its being made, and a valid claim may be made months and years before the plaintiff obtains a judgment against the uninsured motorist. The insurer's bad faith, if any, in failing to pay, would be that involved in not paying within 60 days of the demand. Lewis v. Cherokee Ins. Co., 258 Ga. 839, 375 S.E.2d 850 (1989).

Refusal to pay in bad faith means a frivolous and unfounded denial of liability. If there is any reasonable ground for the insurer to contest the claim, there is no bad faith as contemplated by subsection (j) of this section. State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972); St. Paul Fire & Marine Ins. Co. v. Goza, 137 Ga. App. 581, 224 S.E.2d 429 (1976).

No bad faith if construction of policy depended on hard, undecided questions of law. — Where questions of law as to the proper construction of an insurance policy provision have not been decided by the courts of Georgia and are not of easy solution, then a finding of damages for bad faith and attorney's fees are not authorized by subsection (j) of this section. State Farm Mut. Auto. Ins. Co. v. Harper, 125 Ga. App. 696, 188 S.E.2d 813 (1972); St. Paul Fire & Marine Ins. Co. v. Goza, 137 Ga. App. 581, 224 S.E.2d 429 (1976).

Mere refusal to settle is not bad faith in itself as to uninsured motorist. — An insurer who files defensive pleadings under subsection (d) of this section in the uninsured motorist's name and who offers its policyholder a settlement is not guilty of bad faith in refusing to increase the offer to the policy limits and does not subject itself to liability in an action subsequently brought by the uninsured motorist. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Recovery under general penalty provisions not allowed. — Because the General Assembly has provided a specific procedure and a limited penalty for noncompliance with a specific enactment (e.g., uninsured motorist coverage), the specific procedure and limited penalty are intended by the General Assembly to be the exclusive procedure and penalty, and recovery under general penalty provisions, such as O.C.G.A. §§ 13-6-11, 33-4-6 (now subsection (a)), 51-12-5 and 51-12-6, will not be allowed. McCall v. Allstate Ins. Co., 251 Ga. 869, 310 S.E.2d 513 (1984).

Penalty provision does not eliminate requirement of judgment against uninsured motorist. — Where contentions are made that demand has been made for payment, payment has been refused, and refusal has been made in bad faith, subsection (j) does not eliminate the requirement that a judgment be first obtained against the uninsured motorist as a condition precedent to an action against the insurance carrier. Cash v. Balboa Ins. Co., 130 Ga. App. 60, 202 S.E.2d 252 (1973).

An insurer has no duty to accept an insured's demand for payment of a claim prior to judgment being entered against an uninsured motorist. Allstate Ins. Co. v. McCall, 166 Ga. App. 833, 305 S.E.2d 413 (1983), aff'd, 251 Ga. 869, 310 S.E.2d 513 (1984); Wallis v. Cotton States Mut. Ins. Co., 182 Ga. App. 147, 354 S.E.2d 842 (1987).

Insurer need not pay beyond limits of uninsured motorist policy. — The insurer is not guilty of bad faith in failing to pay the insured the full amount of the verdict, which is beyond the limits of an uninsured motorist policy of which the insured is the beneficiary, where the insurer tenders the limit of the policy to the insured after judgment is entered in the case. Allstate Ins. Co. v. McCall, 166 Ga. App. 833, 305 S.E.2d 413 (1983), aff'd, 251 Ga. 869, 310 S.E.2d 513 (1984).

Limit upon recovery. — "Recovery" under subsection (j) of O.C.G.A. § 33-7-11 is limited to 25 percent of the recovery of sums for which an uninsured motorist carrier is liable and not 25 percent of total damages incurred by the insured. Jones v. Cotton States Mut. Ins. Co., 185 Ga. App.

66, 363 S.E.2d 303 (1987), cert. denied, 185 Ga. App. 910, 363 S.E.2d 303 (1988).

Legal denial of coverage not found. — Because the faulted driver's policy limits had been exhausted, due in part by a $450,000 payment to a suing plaintiff, the denial of any further coverage by that plaintiff's uninsured motorist insurer did not amount to a legal denial of coverage under O.C.G.A. § 33-7-11(b)(1)(D)(iii). Thus, the uninsured motorist's insurer was properly granted summary judgment on that issue. Phillips v. Gov't Emples. Ins. Co., 288 Ga. App. 504, 654 S.E.2d 635 (2007).

Penalty and fees to be awarded in action against uninsured motorist. — Subsection (j) of O.C.G.A. § 33-7-11 contemplates that the penalty of up to 25 percent of the recovery and attorney fees shall be awarded in the action against the uninsured motorist. When such penalty and fees are not sought and assessed in the insured's suit against the uninsured motorist, they cannot be recovered in a subsequent case against the insurer. McCall v. Allstate Ins. Co., 251 Ga. 869, 310 S.E.2d 513 (1984).

Attorney's fees stricken where amount applicable could not be determined. — Although the plaintiff was entitled to recover attorney's fees from the insurer based on the court's determination that the insurer acted in bad faith the award for attorney's fees was stricken where no evidence was presented from which the court could have determined what portion of the total amount of attorney time and litigation expenses incurred in litigation was attributable to the bad faith claim against the insurer. Cherokee Ins. Co. v. Lewis, 204 Ga. App. 152, 418 S.E.2d 616, cert. denied, 204 Ga. App. 921, 418 S.E.2d 616 (1992).

Refusal not in bad faith. — Where husband and wife together presented a demand to their uninsured motorist carrier that their claims be settled in the aggregate for $5,500, the insurer made a counteroffer which plaintiffs rejected, the case proceeded to trial, and the jury rendered its verdict in favor of plaintiff husband and against plaintiff wife, the jury's verdict conclusively demonstrates an absence of bad faith on the part of the insurer. Since plaintiffs made their demand in the aggregate and since plaintiff wife's claim failed, it cannot be said that the insurer refused to pay plaintiffs in bad faith. Nationwide Mut. Ins. Co. v. Whiten, 179 Ga. App. 544, 346 S.E.2d 914 (1986).

Waiver of requirement for judgment against uninsured motorist. — The requirement that a judgment first be obtained against an uninsured motorist as a condition precedent to a claim for bad faith penalties against an insurer is waived where the insurer leads the insured to believe that the insured will be paid without suit by its actions in negotiating for settlement or direct promises to pay. Jones v. Cotton States Mut. Ins. Co., 185 Ga. App. 66, 363 S.E.2d 303 (1987), cert. denied, 185 Ga. App. 910, 363 S.E.2d 303 (1988).

The filing of an answer by the uninsured motorist carrier in its own name does not by itself eliminate the requirement that a judgment first be obtained against the uninsured motorist, as a condition precedent to a claim under the policy against the insurer. Boles v. Hamrick, 194 Ga. App. 595, 391 S.E.2d 418 (1990).

Burden on insured. — In a dispute over an uninsured motorist (UM) insurance policy, the court reversed the grant of summary judgment to the insured because they failed to adduce any evidence of the UM carrier's efforts to secure the at-fault driver's cooperation or the at-fault driver's willful and intentional disregard thereof, thus, the insured failed to satisfy their burden of establishing a genuine issue of material fact on either of the essential elements of their claim of entitlement to UM coverage. Travelers Home & Marine Ins. Co. v. Castellanos, 297 Ga. 174, 773 S.E.2d 184 (2015).

Insured has the burden to prove the existence of a policy of liability insurance containing uninsured motorist protection, and that the at-fault driver was an uninsured motorist at the time of the wreck. Travelers Home & Marine Ins. Co. v. Castellanos, 297 Ga. 174, 773 S.E.2d 184 (2015).

Waiver of Coverage

Third party's waiver of coverage in agreement with insured. — Since a

Waiver of Coverage (Cont'd)

garage was not required by law to carry uninsured/underinsured motorist insurance, then it could not be required to offer such insurance to a customer using a loaner vehicle, and when the customer signed the loan agreement, the customer waived any such coverage that would have been available to the customer as a third party beneficiary of the garage's policy. Nolley v. Maryland Cas. Ins. Co., 222 Ga. App. 901, 476 S.E.2d 622 (1996).

Waiver of excess coverage not required. — An insured did not retain the right to receive excess uninsured motorist coverage after an accident, notwithstanding that the insured had not previously executed a written rejection of such excess coverage, since the statute only requires an insurer to obtain a written rejection of minimum coverage and does not require an insurer to obtain a written rejection of excess coverage. Jones v. Georgia Farm Bureau Mut. Ins. Co., 248 Ga. App. 394, 546 S.E.2d 791 (2001).

Excess coverage was never requested. — Conclusion that an insurer was only obligated to provide its insured with $40,000 of uninsured motorist (UM) coverage was supported by both the unambiguous policy language and by the fact that the insured admitted that the insured had not made a written request pursuant to O.C.G.A. § 33-7-11(a)(3) for an increase in UM coverage above the minimum coverage required at the time of the accident. Payne v. Middlesex Ins. Co., 259 Ga. App. 867, 578 S.E.2d 470 (2003).

Waiver by release. — Insureds' dismissal with prejudice claim against defendant driver, rather than merely executing a limited liability release against her, defeated their ability to recover damages from their underinsured motorist carrier. Kent v. State Farm Mut. Auto. Ins. Co., 233 Ga. App. 564, 504 S.E.2d 710 (1998).

Waiver requirements satisfied. — Under the ordinary rules of contract construction, because: (1) no ambiguity in the insurance contact existed; and (2) the insurer was authorized to reduce the uninsured motorist policy limits per the directions of the insured, no error resulted from the trial court's order granting summary judgment to an insurer as to the issue of coverage. Moreover, separate signatures rejecting bodily injury coverage and property damage coverage were not required, and the court did not rely upon affidavits containing inadmissible evidence. Lambert v. Alfa Gen. Ins. Corp., 291 Ga. App. 57, 660 S.E.2d 889 (2008).

Waiver requirements not satisfied. — Insureds' written rejection of uninsured motorist (UM) coverage under an umbrella policy was not valid because, while the insureds were aware of the possibility of obtaining such coverage, the insureds were misinformed that, in order to obtain such coverage, the insureds had to increase the limits of the insureds' UM coverage in the insureds' primary liability policies to equal the limits of the policies' bodily injury and property damage limits, contrary to the then existing requirement that the umbrella policy be treated the same as primary automobile liability insurance policies as to statutory requirements governing UM coverage. Ga. Farm Bureau Mut. Ins. Co. v. North, 311 Ga. App. 281, 714 S.E.2d 428 (2011).

Insureds' written rejection of uninsured motorist (UM) coverage under an umbrella policy was not valid because it appeared from the wording of the umbrella policy application that if the insureds chose not to increase the insureds' primary liability policies' UM coverage limits, the insureds could only reject UM coverage, but an insurer could not fail to offer coverage options which the statute required, or impose coverage conditions the law did not allow, and the statutory coverage options were not offered to the insureds when the insureds did not increase the insureds' UM primary policy coverage limits to equal those policies' liability coverage limits. Ga. Farm Bureau Mut. Ins. Co. v. North, 311 Ga. App. 281, 714 S.E.2d 428 (2011).

Coverage not included when later date was scrivener's error. — In an action concerning whether an automobile liability insurance policy included uninsured motorist (UM) coverage on the day of the subject collision, the trial court did not err in concluding that the handwritten date on the insurance application, which was three months after the date of the

application, was a scrivener's error and, thus, that the policy did not include UM coverage at the time of the accident. Brown v. Assurance American Insurance Co., 354 Ga. App. 373, 841 S.E.2d 15 (2020).

Procedure

Although service by publication was not sufficient to confer in personam jurisdiction over the tortfeasor, the order granting such service was, in effect, an ex parte finding that plaintiff had exercised due diligence in attempting to locate and personally serve the tortfeasor and it thus served as an ex parte finding that plaintiff had carried the plaintiff's burden of proving the plaintiff had exercised diligence sufficient to justify service by publication under subsection (e) of O.C.G.A. § 33-7-11. Leach v. Monroy, 237 Ga. App. 855, 517 S.E.2d 95 (1999).

The trial court properly denied a plaintiff's motion to serve by publication under O.C.G.A. § 33-7-11(e) on the basis of self-concealment to avoid service. A finding of concealment required more than evidence that the defendant simply could not be located or had moved to a new location, and the plaintiff's affidavit reflected only that efforts to locate the defendant had been unsuccessful. Montague v. Godfrey, 289 Ga. App. 552, 657 S.E.2d 630 (2008).

Judgment not prerequisite for demand against insurer. — This section contemplates a pretrial demand against the insurer. The statute does not permit an insurer to wait until the insured obtained a judgment against the uninsured motorist before considering the merits of the claim. Lewis v. Cherokee Ins. Co., 258 Ga. 839, 375 S.E.2d 850 (1989).

Former Code 1933, § 56-1201 (see O.C.G.A. § 33-4-1), as to venue of actions against insurance companies, applies. — As this section does not contain any provisions in respect of venue of an action against an unknown uninsured motorist, former Code 1933, § 56-1201 (see O.C.G.A. § 33-4-1), relating to such actions against insurance companies, is applicable. Mercer v. Doe, 134 Ga. App. 818, 216 S.E.2d 339, cert. dismissed, 235 Ga. 207, 219 S.E.2d 144 (1975) (decided under former Code 1933, § 56-407A).

Choice of law. — To the extent that the choice of law rules in prior Georgia cases conflict with the plain language of Georgia's Uninsured Motorist Statute, O.C.G.A. § 33-7-11, the statute controls. St. Paul Fire & Marine Ins. Co. v. Hughes, 321 Ga. App. 738, 742 S.E.2d 762 (2013).

Statute of limitations. — Statute of limitations for serving an uninsured motorist carrier is the same as that for serving the defendant tortfeasor, even though the defendant does not qualify as uninsured until after the applicable limitations period has run; thus, an insured's service on an uninsured motorist carrier of an original action was not necessary in order to allow for service in a properly filed renewal action after the running of the limitations period. Stout v. Cincinnati Ins. Co., 269 Ga. 611, 502 S.E.2d 226 (1998).

Plaintiff's service of defendant's uninsured motorist insurer was untimely under O.C.G.A. § 33-7-11(d); the record did not support the plaintiff's claim that plaintiff served the insurer within 90 days of discovery that the defendant's vehicle, which the plaintiff allegedly initially had no reason to believe was uninsured, was uninsured. Rebuelta v. Nkpa, 281 Ga. App. 210, 636 S.E.2d 42 (2006).

Because an insured did not serve a copy of an underinsured motorist complaint upon the insurer within the two year statute of limitations in O.C.G.A. § 9-3-33 or within 90 days of receiving the discovery responses indicating that the vehicle that hit the insured's vehicle was underinsured, the insured did not satisfy the service requirement of O.C.G.A. § 33-7-11(d). Calhoun v. Gov't Emples. Ins. Co., 296 Ga. App. 622, 675 S.E.2d 523 (2009).

Two-year statute of limitations applies to suit against uninsured motorist. — Suit dealing with personal injury, even though brought under this section against an unknown defendant, is subject to a two-year statute of limitations. Houston v. Doe, 136 Ga. App. 583, 222 S.E.2d 131 (1975).

Service on an uninsured motorist carrier in a valid renewal action filed after the running of the statute of limitations is

Procedure (Cont'd)

valid even though the carrier was not served in the original action. Malave v. Allstate Ins. Co., 246 Ga. App. 783, 541 S.E.2d 420 (2000).

Statute of limitations may be invoked by insurer. — Where insurance company had a right under this section to file all available defenses in an action, either in its name or in the name of the defendant, it could invoke the bar of the statute of limitations. Railey v. State Farm Mut. Auto. Ins. Co., 129 Ga. App. 875, 201 S.E.2d 628 (1973).

If action is between insured and uninsured motorist, insurer has full rights of defense. — An insurance carrier, having been served in a tort action between its insured and an alleged uninsured motorist, is free to file in that action whatever defensive pleadings it may consider appropriate to protect its rights without conceding any liability or otherwise jeopardizing its interest. This could include, of course, appropriate pleadings to reach the issues of whether a defendant in that action can implead an alleged John Doe tortfeasor, under this section or for other reasons, or any resulting liability of an insurer in respect to uninsured motorist coverage, if John Doe should be held liable, either jointly or severally. Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

Subsection (d) of O.C.G.A. § 33-7-11 requires service upon an insurance company furnishing uninsured motorist protection and affords it the status of a party if it so chooses. Starks v. Robinson, 189 Ga. App. 168, 375 S.E.2d 86, cert. denied, 189 Ga. App. 913, 375 S.E.2d 86 (1988).

In action against uninsured motorist, insurer is party at interest. — Regardless of who may be named as the defendant in an action against an uninsured motorist — whether the known operator or owner of the offending vehicle or "John Doe" — it is an action in which the carrier of uninsured motorist coverage for the plaintiff is a party at interest. Doe v. Moss, 120 Ga. App. 762, 172 S.E.2d 321 (1969).

The insurance company is the real party in interest under this section and not the uninsured motorist. Wilkinson v. Vigilant Ins. Co., 236 Ga. 456, 224 S.E.2d 167 (1976).

Insurer cannot be named as defendant. — Subsection (d) of this section does not authorize the insurance company to be named and served as a "nominal defendant" in a damage suit against the known uninsured motorist. The use of the words "as though" precludes the naming of the insurance company as a party defendant and the consequent issuance of process against it. State Farm Mut. Auto. Ins. Co. v. Brown, 114 Ga. App. 650, 152 S.E.2d 641 (1966).

If named defendant, insurer may challenge status. — An insurer who had been named a defendant in an action against an uninsured motorist has the right to challenge its status as a defendant and, if successful, is entitled to have its name and all reference to the matter of insurance stricken therefrom. Strickland v. English, 115 Ga. App. 384, 154 S.E.2d 710 (1967).

Insurer may take any steps necessary to question jurisdiction or judgment. — The General Assembly intended that an insurance company in affording the protection to an insured would have a right to take whatever legal steps were necessary and fitting to see to it that the court trying the action against an uninsured motorist, first, had jurisdiction of the case and the person of the uninsured motorist, and second, to insure that the judgment against the uninsured motorist was not in default, and to insure that the judgment was rendered on legal and sufficient evidence. What an insurance company would be allowed to do in any given case would depend on the circumstances of the particular case. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

Late answer filed by uninsured motorist carrier. — Trial court erred in denying an insured's motion for a default judgment and granting the uninsured motorist carrier's motion for summary judgment because the court relied upon a typographical error in case law in determining that the carrier's answer was not filed late and thereby finding that the carrier was not in default. Kelly v. Harris,

329 Ga. App. 752, 766 S.E.2d 146 (2014).

No suit against carrier if judgment had not been obtained from uninsured motorist. — Dismissal of the insured's renewal action for personal injuries was proper because the uninsured motorist was properly dismissed based upon a lack of personal service in the original action before the expiration of the statute of limitation and the dismissal against the carrier was proper because no judgment could be obtained against the motorist. A judgment against the uninsured motorist was a condition precedent to recovery against an uninsured motorist carrier under O.C.G.A. § 33-7-11(a)(1). Durrah v. State Farm Fire & Cas., 312 Ga. App. 49, 717 S.E.2d 554 (2011).

Bad faith claim against insurer. — Bad faith claim against the insurer had to be filed in a separate action after the plaintiffs obtained a judgment against the opposing driver. Morton v. Horace Mann Ins. Co., 282 Ga. App. 734, 639 S.E.2d 352 (2006), cert. denied, No. S07C0570, 2007 Ga. LEXIS 201 (Ga. 2007).

Hiring attorney to represent insurer. — Where the defendant has no insurance and the plaintiff's insurer has included uninsured motorist insurance, this insurer has an interest in the outcome of the litigation, regardless of whether or not it has chosen to intervene, to hire an attorney to represent it in the action, or even whether or not it will be possible for it, in the event of an adverse judgment paid off by it, to recover such sum from the defendant by reason of its subrogation rights. Holland v. Watson, 118 Ga. App. 468, 164 S.E.2d 343 (1968).

Filing pleading raising issue of jurisdiction. — The right to file a plea to the jurisdiction (now answer or motion to dismiss) is not confined to the person directly affected by a lack of jurisdiction. Anyone who would be injured by a failure to raise the jurisdictional question and has such a relation to the case as would justify his intervention may raise the issue. Hence, an insurance company can raise the question of the jurisdiction of the court of subject matter or parties. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

Venue proper in county of either known defendant or "John Doe" defendant. — In an automobile collision case, the trial court properly denied the known defendant's motion to transfer venue to the known defendant's home county because the John Doe defendant was alleged to have played a vital role in causing the plaintiffs' alleged injuries; and, in a tort action, if venue in a particular county was proper as to one joint tort-feasor, it was proper as to the other joint tort-feasor as well; thus, because venue was proper in Bibb County as to the John Doe defendant, it was likewise proper as to the known defendant in that county. Carpenter v. McMann, 341 Ga. App. 791, 802 S.E.2d 74 (2017), aff'd, 304 Ga. 209, 817 S.E.2d 686 (2018).

Venue when one defendant an unknown. — Judgment denying the appellant's motion to transfer venue was affirmed because the appellee had the choice of bringing suit in the county where the accident occurred based on the John Doe driver's unknown identity or appellant's county, and chose the county where the accident occurred pursuant to the venue provision of the uninsured motorist statute, O.C.G.A. § 33-7-11(d)(1). Carpenter v. McMann, 304 Ga. 209, 817 S.E.2d 686 (2018).

Venue provisions of the uninsured motorist statute, O.C.G.A. § 33-7-11(d)(1), were held to apply in a suit related to an automobile collision brought against a known Georgia resident and an unknown defendant under a joint tortfeasor theory. Carpenter v. McMann, 304 Ga. 209, 817 S.E.2d 686 (2018).

Contesting liability of uninsured motorist. — Assuming that the court had jurisdiction on the pleadings and the uninsured motorist had permitted the case to go in default, the insurance company should have the right to contest the liability of the uninsured motorist by whatever name the pleadings might be called, if it in fact was in possession of evidence sufficient to raise a jury question. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

Defending action against unknown motorist. — This section provides that the injured party's insurance company

Procedure (Cont'd)

may defend an action against an unknown motorist. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

Insurer may participate in motorist's defense. — Even if the liability insurer opted on retrial not to be a named defendant in the insured's personal injury action, it could participate in the motorist's defense. Hossain v. Nelson, 234 Ga. App. 792, 507 S.E.2d 243 (1998).

Insurer may file pleadings without becoming party. — The statutory right of the insurer to file pleadings pursuant to this section is one which is not governed by the rules pertaining to intervention but accords to the insurer issuing a policy providing uninsured motorist coverage to the plaintiff, admitted or disputed, the right at its election to participate indirectly in the proceedings, without becoming a named party, by filing pleadings or taking other action allowable by law, in the name of the owner or operator, or both. Home Indem. Co. v. Thomas, 122 Ga. App. 641, 178 S.E.2d 297 (1970); Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

Underinsured motorist carrier did not become a named party defendant in an action by its insured against the underinsured motorist by initially raising a statute of limitations defense in the motion to dismiss or for summary judgment; even if raising the defense could be construed as electing to proceed in its own name, once that issue was decided, there were no further issues as to the insurer's contractual liability and it could elect to withdraw prior to trial and defend only in the tort case against the underinsured motorist. Hill v. Demery, 219 Ga. App. 225, 464 S.E.2d 831 (1995).

It need not obtain nonwaiver agreement from insured. — It is immaterial, under O.C.G.A. § 33-7-11, whether the insurer proceeds under a nonwaiver agreement in the filing of pleadings. Its right to do so is afforded by law and is not dependent upon any notice to or agreement by the insured. Doe v. Moss, 120 Ga. App. 762, 172 S.E.2d 321 (1969).

Insurer has the right to file defensive pleadings and a cross claim under O.C.G.A. § 33-7-11 and it was not error to reject the insured's claim that so doing raised the issue of insurance to the insured's prejudice. Johnson v. Amerson, 179 Ga. App. 75, 345 S.E.2d 94 (1986).

Use of the name of an uninsured on defensive pleadings is exactly what this section authorizes, and there is no lack of due process. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Case may be first tried without issue of insurance. — Subsection (d) provides the opportunity for the case against the uninsured motorist to be first tried without the appearance of issues of insurance. Cash v. Balboa Ins. Co., 130 Ga. App. 60, 202 S.E.2d 252 (1973).

This section gives the insurance company the right to file defensive pleadings in the name of the tortfeasor, with or without her consent, and thereby prevent the injection of the prejudicial issue of the existence of insurance into the trial of the case. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Policy against mentioning insurance does not apply if insurer is party. — The policy of forbidding the mention of liability insurance in the pleadings or trial of a tort action has no application where there is no prejudice to a party, especially where the insurer is a party to the proceeding under subsection (d) of this section. Jiles v. Smith, 118 Ga. App. 569, 164 S.E.2d 730 (1968).

Where an insurer intervened in its own name in compliance with subsection (d) of this section under an uninsured motorist situation, the trial court was correct in overruling a mistrial motion based on the contention that plaintiff had injected "the uninsured motorist coverage." Rutledge v. Glass, 125 Ga. App. 549, 188 S.E.2d 261 (1972).

Enforcement of policy exclusions permitted despite public policy in favor of coverage. — Enforcement of exclusions in a car rental agency agreement did not conflict with Georgia's public policy in favor of compulsory insurance cov-

erage because an accident victim received compensation from the car renter's insurer and from the victim's own insurer in excess of the compulsory minimum amount required by O.C.G.A. § 33-7-11(a)(1)(A). Hix v. Hertz Corp., 307 Ga. App. 369, 705 S.E.2d 219 (2010).

An insurer who is providing underinsured coverage can claim all the rights and benefits pursuant to subsection (d) of O.C.G.A. § 33-7-11, which are normally afforded an insurer providing uninsured coverage. Hall v. Regal Ins. Co., 202 Ga. App. 511, 414 S.E.2d 669 (1991).

Insurer is not entitled to maintain parallel actions in different forums having concurrent jurisdiction. — Automobile insurer served with a copy of a wrongful death complaint brought in Georgia that elected not to answer in the name of the uninsured motorist but instead to file pleadings in its own name and thereby to contest its liability under the policy as well as the tort liability of the uninsured motorist invoked the jurisdiction of the courts for determination of the policy coverage issues; thus, the fact that the insurer was not a Georgia resident was no obstacle to the awarding of an injunction enjoining the insurer from proceeding with a Tennessee declaratory judgment action concerning policy coverage. Tennessee Farmers Mut. Ins. Co. v. Wheeler, 170 Ga. App. 380, 317 S.E.2d 269 (1984).

Requirement of service of legal process on insurer. — Mere settlement negotiations may not excuse a plaintiff from the statutory requirement of subsection (d) of O.C.G.A. § 33-7-11 to serve a suit by legal process on the insurer. Beasley v. Parks, 204 Ga. App. 482, 420 S.E.2d 3 (1992).

Court cannot require defendant to add unknown motorist as party defendant. — In a negligence action arising from an automobile collision, the trial court does not err in denying the plaintiff's motion for an order requiring the defendant to add an unknown motorist as a party defendant for the purpose of asserting a claim for uninsured motorist benefits. The court obviously cannot require the defendant to name an additional defendant for the plaintiff's benefit. McLendon v. Lovejoy, 166 Ga. App. 626, 305 S.E.2d 144 (1983).

When insurer defends in own name, no judgment against uninsured motorist is required as a condition precedent to a determination of questions of coverage. Allstate Ins. Co. v. McCall, 166 Ga. App. 833, 305 S.E.2d 413 (1983), aff'd, 251 Ga. 869, 310 S.E.2d 513 (1984).

What constitutes duplicate original. — The purpose of this statute is to give notice to the insurer of its potential financial responsibility; no purpose is served by requiring that, to constitute a duplicate original copy there must be an original signature. The court finds that the clerk's filing of the original complaint and assigning a case number to it simultaneously with stamping and assigning the same number to the duplicate copy was in compliance with this statute. Southern Guar. Ins. Co. v. Cook, 194 Ga. App. 613, 391 S.E.2d 452 (1990).

Insurer may intervene. — An insurance company issuing uninsured motorist protection to an insured should be permitted to intervene in a suit for personal injuries brought by the insured against a known uninsured defendant. State Farm Mut. Auto. Ins. Co. v. Jiles, 115 Ga. App. 193, 154 S.E.2d 286 (1967).

Intervention by the insurer who provided uninsured motorist coverage is procedurally proper. McCrory v. Hall, 477 F.2d 87 (5th Cir. 1973).

Intervention without regard to technical rules. — The technical rules heretofore obtaining as to interventions, especially the rule that the intervenor takes the case as he finds it and cannot ordinarily file demurrers (now motions to dismiss) to pleadings and the rules on similar matters, no longer are valid insofar as this section is concerned. The fact that the insurance company is not an insurer of the uninsured motorist and bears no contractual relation to him is no bar to the insurer's rights in the premises. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966).

By filing pleadings in its own behalf. — Subsection (d) of this section provides, not only that the insurer may file any pleading that could be filed by the owner or operator of the offending vehicle

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in his own behalf, but in addition it may file in its own behalf any appropriate pleadings allowable by law. State Farm Mut. Auto. Ins. Co. v. Horace Mann Mut. Ins. Co., 125 Ga. App. 411, 188 S.E.2d 171 (1972).

The insurer has the privilege of filing any appropriate pleadings in its own behalf. Southern Trust Ins. Co. v. Eason, 134 Ga. App. 827, 216 S.E.2d 667 (1975).

In insureds' suit seeking to recover damages in connection with an accident in which a daughter struck the insureds' vehicle while driving a car that was titled in the father's name, the insureds' motor vehicle insurer chose to file pleadings in its own name and, thus, under O.C.G.A. § 33-7-11(d), the insurer had assumed the status of a named party, even though the insurer was not originally named as a party to the action. Harris v. Houston, No. 4:04-cv-159 (HL), 2006 U.S. Dist. LEXIS 69099 (M.D. Ga. Sept. 26, 2006).

Whether uninsured motorist is known or sued as "John Doe." — Subsection (d) permits the filing by the company, in the name of the company or in the name of the uninsured motorist, or in the name of "John Doe," of any pleading that could be filed by the owner or operator of the offending vehicle in his own behalf, and, additionally it may file in its own behalf any appropriate pleading allowable by law. This applies to actions against "John Doe" as well as to those brought against a known owner or operator. United States Fid. & Guar. Co. v. Bishop, 121 Ga. App. 75, 172 S.E.2d 855 (1970); Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

Direct participation gives insurer status of named party. — Under this section an insurer may participate directly in its own name in the proceedings by filing pleadings or taking other action allowable by law, in which event it assumes the status of a named party. Home Indem. Co. v. Thomas, 122 Ga. App. 641, 178 S.E.2d 297 (1970); Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

Filing of pleadings does not convert uninsured tortfeasor into insured party. — The filing of defensive pleadings by the insurer under subsection (d) does not convert the uninsured tortfeasor into an insured party under the policy. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Insurer must file pleadings in own name if insured motorist wants to file. — If an uninsured motorist wants pleadings filed by his own counsel, the insurer would be relegated to filing whatever else it wanted in its own name. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Insurer cannot control litigation. — Rights given by the statute to the insurer are not rights to control the litigation contrary to the wishes and desires of the defendants legally expressed by pleadings in court. Londeau v. Davis, 136 Ga. App. 25, 220 S.E.2d 43 (1975).

An uninsured motorist carrier is not subject to judgment in favor of its insured when it is served by the original plaintiff and its insured prevails against the tortfeasor plaintiff but the carrier has not filed an answer or otherwise appeared in its own behalf because the statute, by which the plaintiff is required to serve the carrier, does not by its operation subject the defendant's uninsured motorist carrier to party status in every case. Hulsey v. Standard Guar. Ins. Co., 195 Ga. App. 803, 395 S.E.2d 282 (1990).

Insurer has duty not to deceive or injure uninsured. — In filing defensive pleadings in action brought by its insured against an alleged tortfeasor, the insurer has a duty to the uninsured not to deceive or negligently injure him. Jones v. Southern Home Ins. Co., 135 Ga. App. 385, 217 S.E.2d 620 (1975), appeal dismissed, 424 U.S. 902, 96 S. Ct. 1093, 47 L. Ed. 2d 307 (1976).

Filing pleadings does not admit insurer's liability or coverage. — This section permits the filing by the injured party's insurance company, in the name of the company, or in the name of the uninsured motorist, or in the name of "John Doe," of any pleading that could be filed by the owner or operator of the offending

vehicle in his own behalf, and, additionally it may file in its own behalf any appropriate pleading allowable by law. The filing of these pleadings does not amount to an admission of liability or of coverage by the insurer. Doe v. Moss, 120 Ga. App. 762, 172 S.E.2d 321 (1969); Moss v. Cincinnati Ins. Co., 154 Ga. App. 165, 268 S.E.2d 676 (1980).

The filing of pleadings by the insurer under subsection (d) does not amount to an admission of liability or of coverage by the insurer. United States Fid. & Guar. Co. v. Bishop, 121 Ga. App. 75, 172 S.E.2d 855 (1970).

Uninsured motorist carrier could withdraw despite filing answer. — Even though plaintiff's uninsured motorist carrier answered in its own name when originally served in its insured's negligence action, it could elect to withdraw its answer prior to trial and not participate as a party. Singleton v. Phillips, 229 Ga. App. 286, 494 S.E.2d 66 (1997).

Insurer's right to plead makes separate declaratory judgment action unnecessary. — This section permits the filing by the company, in the name of the company or in the name of the uninsured motorist, or in the name of "John Doe," of any pleading that could be filed by the owner or operator of the offending vehicle in his own behalf, and, additionally it may file in its own behalf any appropriate pleading allowable by law, so that all rights may be asserted in the main action and there is no necessity for direction in a separate action for a declaratory judgment. Employers Liab. Assurance Corp. v. Berryman, 123 Ga. App. 71, 179 S.E.2d 646 (1970).

Required pleading. — Because plaintiff insured number one never attempted to sue the uninsured motorists (UM) motorist in plaintiff's accident, and plaintiff insured number two dismissed plaintiff two's suit against the UM in settling with defendant insurer, their direct action claim against the insurer was barred since neither insured pled the possibility that the insurer waived O.C.G.A. § 33-7-11's condition precedent. Harden v. State Farm Mut. Auto. Ins. Co., No. 08-15008, 2009 U.S. App. LEXIS 16095 (11th Cir. July 22, 2009) (Unpublished).

Pleadings not amended after judgment to allow claims for statutory damages. — After obtaining a judgment in its favor against uninsured motorist, motorist could not amend pleadings to add claims for statutory damages, through this section and O.C.G.A. § 33-4-6 (now subsection (a)), even though the judgment in the action in motorist's favor held that the penalties and fees sought must be sought in action against uninsured motorist, because trial court determined it lacked authority to reopen case after judgment to allow amendment of the complaint. McCall v. Wyman, 173 Ga. App. 131, 325 S.E.2d 629 (1984).

Joinder of uninsured motorist carrier. — Even though an uninsured motorist insurer could not bring a subrogation action in its own name, it should have been permitted to join the action pursuant to O.C.G.A. § 9-11-17, or be joined or substituted in accordance with O.C.G.A. § 9-11-19. State Farm Mut. Auto. Ins. Co. v. Cox, 233 Ga. App. 296, 502 S.E.2d 778 (1998), aff'd, 271 Ga. 77, 515 S.E.2d 832 (1999).

Subrogation rights of uninsured motorist insurer. — Although uninsured motorist coverage in a policy provided the insurer was subrogated to the rights of recovery of its insured, the right of action belonged to the insured, and any action against the uninsured motorist had to be brought in the name of the insured. Generali — United States Branch v. Owens, 218 Ga. App. 584, 462 S.E.2d 464 (1995); Travelers Ins. Co. v. Harris, 226 Ga. App. 269, 486 S.E.2d 427 (1997).

An insurer could not file a subrogation action in its own name because O.C.G.A. § 44-12-24 prohibits the assignment of rights of action for personal torts. State Farm Mut. Auto. Ins. Co. v. Cox, 233 Ga. App. 296, 502 S.E.2d 778 (1998), aff'd, 271 Ga. 77, 515 S.E.2d 832 (1999).

Filing a cross-claim pursuant to subsection (f) of O.C.G.A. § 33-7-11 is simply a means of perfecting an insurer's subrogation right in the event that a judgment is obtained against the uninsured motorist. State Farm Mut. Auto. Ins. Co. v. Wright, 245 Ga. App. 493, 538 S.E.2d 147 (2000).

The subrogation claim under subsection

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(f) does not ripen until the judgment is satisfied. State Farm Mut. Auto. Ins. Co. v. Wright, 245 Ga. App. 493, 538 S.E.2d 147 (2000).

Injured insured's uninsured motorist insurer could sue a tortfeasor in subrogation as provided in O.C.G.A. § 33-7-11(f) even after the insured had released the tortfeasor from personal liability, pursuant to O.C.G.A. § 33-24-41.1, except to the extent that insurance coverage, other than the tortfeasor's personal liability policy, existed. Ramos-Silva v. State Farm Mut. Ins. Co., 300 Ga. App. 699, 686 S.E.2d 345 (2009).

Subrogation rights not barred. — Because an uninsured motorist insurer was required to pay a valid claim to its insured within 60 days, the payment was not voluntary so as to bar subrogation rights of the insurer. Travelers Ins. Co. v. Harris, 226 Ga. App. 269, 486 S.E.2d 427 (1997).

Subrogation action by insurer in its own name is not authorized by subsection (f) of O.C.G.A. § 33-7-11. State Farm Mut. Auto. Ins. Co. v. Cox, 271 Ga. 77, 515 S.E.2d 832 (1999).

Rules of procedure apply to insurer assuming status of named party. — To the extent that an insurer may purport to act directly in its own name and thereby elect to assume the status of a named party, the rules of practice and procedure apply to it, commencing when service is perfected. Glover v. Davenport, 133 Ga. App. 146, 210 S.E.2d 370 (1974).

Rules of procedure apply to insurer acting in name of tortfeasor. — Whether the insurer acted in its own name and thereby elected to assume the status of a named party or in the name of the tortfeasor, the rules of practice and procedure applied to it. Georgia Mut. Ins. Co. v. Willis, 140 Ga. App. 225, 230 S.E.2d 363 (1976).

Time for filing answer by uninsured motorist carrier. — Lewis v. Waller, 282 Ga. App. 8 (2006) notes that to the extent that the uninsured motorist carrier (UMC) purports to act directly in the carrier's own name, the carrier's answer is timely if filed within 30 days from service of the answer and complaint upon the UMC; however, in the opinion from Lewis, the phrase "answer and complaint" should actually read summons and complaint, and the Georgia Court of Appeals corrects that typographical error. Kelly v. Harris, 329 Ga. App. 752, 766 S.E.2d 146 (2014).

Known uninsured motorist's default cannot defeat insurer's right to defend. — Although the named, served uninsured motorist defendant could and did waive his right to defend against the action, his waiver and default cannot be permitted to injure the statutory right of the uninsured motorist insurer to defend the action in its own name, which would be the result if the insurer were held to be bound by the defendant's admissions. Georgia Mut. Ins. Co. v. Willis, 140 Ga. App. 225, 230 S.E.2d 363 (1976).

Default of the known uninsured motorist will not defeat the insurer's statutory right to defend the action in its name. Unigard Ins. Co. v. Kemp, 141 Ga. App. 698, 234 S.E.2d 539 (1977).

One of the options granted to the uninsured motorist insurer by subsection (d) of this section is that it may elect to "file pleadings and take other action allowable by law in the name of either the known owner or operator or both or itself." Thus, the insurer may plead or assert any available defense in the name of the owner, operator, or itself and will not be bound by the actions of the other defendant — even if the other defendant defaults — for a default cannot defeat the insurer's statutory right to defend the action in its name. J.C. Penney Cas. Ins. Co. v. Williams, 149 Ga. App. 258, 253 S.E.2d 878 (1979).

Insurer can only remove uninsured's default in accordance with rules of procedure. — If the insurer purports to act in the name of one of the alleged tortfeasors, its action for that party is governed by the rules of practice and procedure applicable to that party, and if that party is in default, it can only remove the default or defend the action in the same manner and to the extent allowed by law for a party in default. Home Indem. Co. v. Thomas, 122 Ga. App. 641, 178 S.E.2d 297 (1970).

If acting in own name, may be in default itself. — If an insurer purports to

act directly in its own name, and thereby elects to assume the status of a named party, the rules of practice and procedure apply to it, commencing when service is perfected as though actually named as a party defendant, and thus, to preserve its rights as to this status, it must act within the time provided by law to avoid default, and failing to do so, it is in no better position than a defaulting party. Home Indem. Co. v. Thomas, 122 Ga. App. 641, 178 S.E.2d 297 (1970); Planet Ins. Co. v. Woods, 123 Ga. App. 752, 182 S.E.2d 520 (1971).

Insurer could not collaterally attack judgment against uninsured motorist, in insured's action to recover a judgment, by relying on extraneous evidence to show that the uninsured motorist had not been properly served in the underlying action. Chitwood v. Southern Gen. Ins. Co., 189 Ga. App. 697, 377 S.E.2d 210, cert. denied, 189 Ga. App. 911, 377 S.E.2d 210 (1988).

If uninsured motorist unknown, action must be against "John Doe." — The word "may" as used in subsection (d) of this section must be interpreted to mean that an action "shall" be brought against the uninsured motorist as "John Doe," if the uninsured motorist is unknown. U.S. Fid. & Guar. Co. Co. v. Lockhart, 229 Ga. 292, 191 S.E.2d 59 (1972).

Action against "John Doe" defendant. — An action may be instituted against a "John Doe" defendant only when the owner or operator of the vehicle is unknown. Where known, he or she must be named as a defendant, although service by publication is authorized if after due diligence such defendant cannot be found within the state. Kannady v. State Farm Mut. Auto. Ins. Co., 214 Ga. App. 492, 448 S.E.2d 374 (1994).

If insurer and insured dispute identity of uninsured, it is tried in "John Doe" action. — The General Assembly intended the "John Doe" procedure to be available only in a situation where the person who caused the injury or damage is an actual "unknown" motorist. If the plaintiff and his insurer are in dispute about this, the question of identity becomes an issue in the "John Doe" proceeding and is subject to the usual modes of determination. State Farm Mut. Auto. Ins. Co. v. Godfrey, 120 Ga. 560, 171 S.E.2d 735 (1969).

Jurisdiction over "John Doe" defendant. — Presumption that the residence of an unknown uninsured motorist is in the county in which the accident occurred, or in the county of residence of the plaintiff, applies to personal jurisdiction as well as venue; thus, the court had jurisdiction over a "John Doe" defendant where the action was brought in the county of plaintiff's residence. Allstate Ins. Co. v. Duncan, 218 Ga. App. 552, 462 S.E.2d 638 (1995).

The purpose of a John Doe action is merely to fix the liability of the uninsured motorist carrier to its policy-holder for loss caused by an unknown tortfeasor. State Farm Mut. Ins. Co. v. Kuharik, 179 Ga. App. 568, 347 S.E.2d 281 (1986).

Insured's filing of a "John Doe" action with service on his uninsured motorist insurance carrier constituted a valid, pending action which was voidable rather than void, and which was capable of being renewed under O.C.G.A. § 9-2-61. Milburn v. Nationwide Ins. Co., 228 Ga. App. 398, 491 S.E.2d 848 (1997).

It does not defeat unknown tortfeasor's due process rights. — A John Doe action does not operate to defeat the unknown tortfeasor's due process rights. State Farm Mut. Ins. Co. v. Kuharik, 179 Ga. App. 568, 347 S.E.2d 281 (1986).

By electing to participate directly in a suit by filing an answer in its own name, rather than in the name of John Doe (or, where appropriate, in the name of the uninsured motorist), uninsured motorist carrier assumed the status of a named party as a matter of law. Langford v. Royal Indem. Co., 208 Ga. App. 128, 430 S.E.2d 98 (1993).

Service requirement of subsection (d) is a statutory prerequisite a plaintiff must fulfill in order to collect uninsured motorist benefits from the uninsured motorist carrier following a tort judgment in favor of the plaintiff. Bohannon v. Futrell, 189 Ga. App. 340, 375 S.E.2d 637 (1988), aff'd, 259 Ga. 162, 377 S.E.2d 853 (1989); Smith v. Allstate

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Ins. Co., 199 Ga. App. 264, 404 S.E.2d 593 (1991), cert. denied, 199 Ga. App. 907, 404 S.E.2d 593 (1991); Southern Gen. Ins. Co. v. Davis, 205 Ga. App. 274, 421 S.E.2d 780 (1992).

Subsection (d) of O.C.G.A. § 33-7-11 requires service upon both the uninsured motorist and the uninsured motorist carrier. The plaintiff bears the burden of investigating and learning the defendant's whereabouts. Pickens v. Nationwide Mut. Ins. Co., 197 Ga. App. 550, 398 S.E.2d 792 (1990).

Insured cannot avoid the mandate of subsection (d) of O.C.G.A. § 33-7-11 for timely service upon the insurance carrier; thus, filing a motion to add the carrier as a party before expiration of the statute of limitations provided no justification for failing to serve the carrier when the suit was filed. Peoples v. State Farm Mut. Auto. Ins. Co., 211 Ga. App. 55, 438 S.E.2d 167 (1993).

The statute of limitations applying to service on an uninsured motorist carrier was not tolled until the plaintiffs discovered the possible existence of a phantom driver. USF & G Ins. Co. v. Myers, 214 Ga. App. 851, 449 S.E.2d 359 (1994).

Injured party's claim for uninsured motorist benefits was dismissed where the injured party, after failing to perfect service as to the driver, incurred the heightened obligation of exercising the greatest possible diligence to ensure proper and timely service when the insurer raised the defense of defective service, but failed to seek a special process server immediately and failed to move for service by publication until almost two months later. Barabont v. Villanueva, 261 Ga. App. 839, 584 S.E.2d 74 (2003).

When insured brought suit against a driver for negligence, but did not serve the insured's excess uninsured motorist (UM) carrier under O.C.G.A. § 33-7-11 until after renewing the suit under O.C.G.A. § 9-2-61, it was error to grant summary judgment to the excess carrier on ground that service was untimely; purpose of § 33-7-11(d) is to provide notice to a UM carrier, not to obtain personal jurisdiction over it or to make it a party defendant, and service on a UM carrier was permissible at any time within which valid service could be made on the defendant. Hayward v. Retention Alternatives, Ltd., 291 Ga. App. 232, 661 S.E.2d 862 (2008), aff'd, 285 Ga. 437, 678 S.E.2d 877 (2009).

Even if not party, insurer has right to notice as though defendant. — While not actually a defendant, though it can defend the case in its own name, the uninsured motorist carrier has a strong financial interest in the litigation and as such, it is entitled to notice of the pendency of the action on the same basis as though a defendant. Vaughn v. Collum, 136 Ga. App. 677, 222 S.E.2d 37 (1975), aff'd, 236 Ga. 582, 224 S.E.2d 416 (1976).

The insured's uninsured motorist carrier was entitled to be served with notice of defendant's cross-claim as if it were the defendant named in that claim. Georgia Farm Bureau Mut. Ins. Co. v. Kilgore, 216 Ga. App. 384, 454 S.E.2d 587, aff'd, 265 Ga. 836, 462 S.E.2d 713 (1995).

Trial court did not err in granting the employer's insurer's motion to dismiss after the plaintiffs failed to serve the employer's insurer as though the insurer were actually a named party defendant. Sharpe v. Great Midwest Ins. Co., 344 Ga. App. 208, 808 S.E.2d 563 (2017), cert. denied, 2018 Ga. LEXIS 506 (Ga. 2018).

It must be served if uninsured motorist is known. — Subsection (d) of this section provides that a copy of petition and process (now a copy of the action and all pleadings thereto) be served upon the injured party's insurance company in case of an action against a known uninsured motorist. State Farm Mut. Auto. Ins. Co. v. Glover, 113 Ga. App. 815, 149 S.E.2d 852 (1966); State Farm Mut. Auto. Ins. Co. v. Brown, 114 Ga. App. 650, 152 S.E.2d 641 (1966).

Notice is required if uninsured motorist is unknown or if uninsured motorist cannot be found. — Under subsection (d) of this section, the insurance company receives the same notice whether the tortfeasor is unknown or whether his identity (actual or putative) is known but he is not to be found and therefore cannot be served. Norman v. Daniels, 142 Ga. App. 456, 236 S.E.2d 121 (1977), overruled on other grounds, Ragan

v. Mallow, 319 Ga. App. 443, 744 S.E.2d 337 (2012).

Where an uninsured motorist had never been served with process, either personally or by publication, the insured plaintiff had not fulfilled the statutory condition precedent of perfected service against the missing uninsured motorist tortfeasor. Cotton States Mut. Ins. Co. v. Bogan, 194 Ga. App. 824, 392 S.E.2d 33 (1990).

Pleadings amendment provisions inapplicable. — The relation back provisions of O.C.G.A. § 9-11-15(c), governing amendment of pleadings, do not apply to situations involving service of an uninsured motorist carrier, if for no other reason than simply because such service does not necessarily result in the insurer becoming a party to the action. State Auto Ins. Co. v. Reese, 191 Ga. App. 818, 383 S.E.2d 157, cert. denied, 191 Ga. App. 923, 383 S.E.2d 157 (1989).

If insurer not served in time, subsequent service does not relate back. — Where no effort is made to serve the carrier within the time allowed by law for valid service upon the defendant in the case, subsequent service on the carrier will not relate back to the date of filing the complaint against the individual defendant. White v. Wright, 566 F.2d 990 (5th Cir. 1978).

Insurer is afforded benefit of statute of limitations. — Notice given in the form of service of a copy of the complaint and summons almost four years after the collision and over two and one-half years after the suit is served on the individual defendants, affords the uninsured motorist carrier the benefit of the bar of the statute of limitations. Vaughn v. Collum, 136 Ga. App. 677, 222 S.E.2d 37 (1975), aff'd, 236 Ga. 582, 224 S.E.2d 416 (1976).

The uninsured motorist carrier has a strong financial interest in the litigation. As such, it is entitled to notice of the pendency of the action on the same basis as though a defendant. Failure of timely notice affords the uninsured motorist carrier the benefit of the bar of the statute of limitations. White v. Wright, 566 F.2d 990 (5th Cir. 1978).

Delay between filing of claim and service on carrier. — Delay between the insured's filing of a tort claim and service on the uninsured motorist carrier did not require dismissal when, within the applicable period of limitations, the insured sought to serve the insurer and the failure to make service within the limitation period was not the result of the insured's lack of diligence, but the result of the unavailability of the insurer's registered agent; whether diligence was exercised was determined from the time the insured became aware that the process server failed to perfect service, not from the date of filing the complaint. Georgia Farm Bureau Mut. Ins. Co. v. Kilgore, 265 Ga. 836, 462 S.E.2d 713 (1995).

Subsection (e) applies where jurisdiction otherwise proper. — Provision in subsection (e) of O.C.G.A. § 33-7-11 for service by publication and service of a copy of the action upon the UM carrier applies only where jurisdiction is otherwise proper in the state; thus, a nonresident defendant who did not fall within any of the statutory categories giving the state jurisdiction over such person was not subject to suit in Georgia for damages arising from an automobile accident in another state. Watts v. Allstate Ins. Co., 214 Ga. App. 462, 448 S.E.2d 55 (1994).

Provision for service by publication applies where tortfeasor cannot be found. — Where the alleged tortfeasor has disclosed a name and address and is not to be found at such address, or the name, because it is an alias or because he has absconded, cannot be linked to a real person, and diligent inquiry fails to turn him up anywhere, such defendant is in truth and in fact an unknown motorist, and the provisions of subsection (e) of this section should be applied so as to allow the action against the insurer to proceed. Norman v. Daniels, 142 Ga. App. 456, 236 S.E.2d 121 (1977), overruled on other grounds, Ragan v. Mallow, 319 Ga. App. 443, 744 S.E.2d 337 (2012).

Trial court erroneously dismissed the insured party's uninsured motorist action against the insurer; the insured party, by attempting service twice, showed due diligence under O.C.G.A. § 33-7-11(e) in determining that the defendant, who allegedly struck the insured party, had either had departed from the state or could not, after due diligence, be found within the

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state, the insured party made all three requests for service by publication before the statute of limitations under O.C.G.A. § 9-3-33 expired, and the latter two requests were pending for decision by the trial court for more than three months in violation of O.C.G.A. § 15-6-21(b). Luca v. State Farm Mut. Auto. Ins. Co., 281 Ga. App. 658, 637 S.E.2d 86 (2006).

In a personal injury action arising out of a vehicle collision, the trial court erred in denying the plaintiff's motion for service by publication under O.C.G.A. § 33-7-11(e); the correct legal standard was the plaintiff's diligence in determining that an uninsured motorist was either out of state or avoiding service, which was shown. Smith v. Brooks, 354 Ga. App. 78, 840 S.E.2d 156 (2020).

Provided in personam judgment is not sought against defendant. — The provision in subsection (e) of this section for service by publication can apply only in a situation in which an in personam judgment is not sought against the defendant. Railey v. State Farm Mut. Auto. Ins. Co., 129 Ga. App. 875, 201 S.E.2d 628 (1973).

Insurer not denied due process. — Since the injured plaintiff may recover from his own uninsured motorist insurance carrier where the tortfeasor is a hit and run driver who has disappeared from view without revealing his identity by service on the insurer only, it follows that service on the injured plaintiff's own insurer where the person causing damage is known but cannot after due diligence be found is not a denial of due process. Norman v. Daniels, 142 Ga. App. 456, 236 S.E.2d 121 (1977), overruled on other grounds, Ragan v. Mallow, 319 Ga. App. 443, 2012 Ga. App. LEXIS 1061 (Ga. Ct. App. 2012).

Publication is condition precedent for judgment against insurer. — Service by publication on a missing person does not serve as the foundation for an in personam judgment against the tortfeasor, but it does serve as a condition precedent for recovery against the uninsured motorist carrier. Wentworth v. Fireman's Fund Am. Ins. Cos., 147 Ga. App. 854, 250 S.E.2d 543 (1978).

Service by publication proper if due diligence to find tortfeasor shown. — Where due diligence is shown in the attempt to track down the owner or operator of the vehicle causing the injury, the request for service by publication should be granted. Wentworth v. Fireman's Fund Am. Ins. Cos., 147 Ga. App. 854, 250 S.E.2d 543 (1978).

Service not required for yet nonexistent action. — O.C.G.A. § 33-7-11 cannot logically be construed to require service on the insurer of a copy of an action that does not and cannot yet exist, and, in a case where the known uninsured motorist filed a petition in bankruptcy, service was delayable pending termination or modification of the automatic stay. State Farm Mut. Auto. Ins. Co. v. Harris, 207 Ga. App. 8, 427 S.E.2d 1 (1992).

Tortfeasor shown to have concealed himself. — Where it is presumed that a party disappeared because suit had been filed against him, then the due diligence question does not even arise. Thus, a motion for service by publication must be granted, without regard to any questions of due diligence, if it is shown that the alleged tortfeasor has concealed himself to avoid the service of summons. Wentworth v. Fireman's Fund Am. Ins. Cos., 147 Ga. App. 854, 250 S.E.2d 543 (1978).

Preservation of claim against uninsured motorist carrier. — Where plaintiffs' uninsured motorist carrier was released because their uninsured motorist coverage was equal to defendant's bodily injury and property damage liability limits, plaintiffs preserved their rights to reinstate their claim against the carrier if and when defendant was found to be uninsured or underinsured because they served timely notice of their claim upon their carrier. Dewberry v. State Farm Ins. Co., 197 Ga. App. 248, 398 S.E.2d 266 (1990).

Insurer timely filed in insured's renewal action. — Uninsured motorist (UM) insurer was timely served in an insured's renewal action, and summary judgment for the insurer was error because service on a UM carrier under O.C.G.A. § 33-7-11 was valid and timely

within any time allowed for valid service on the tortfeasor in the case, even if such valid service was after the expiration of the statute of limitation; nothing in the 1998 amendment to § 33-7-11 reflected a legislative decision to overrule any of the judicial decisions holding such service valid. Although the insured had voluntarily dismissed the initial suit, the insured timely renewed the action pursuant to O.C.G.A. § 9-2-61, and served the insurer with the renewed complaint. Retention Alternatives, Ltd. v. Hayward, 285 Ga. 437, 678 S.E.2d 877 (2009).

Enforcement or dismissal agreements between parties. — In an action by an insured against his uninsured motorist (UM) carrier brought after the insured had agreed to dismiss the carrier from the action in which he obtained a judgment against the tortfeasor who had subsequently become an uninsured motorist because his insurer ceased operations, the trial court erred in refusing to enforce the dismissal agreement which gave the UM carrier the right to take defensive actions if its insured renewed an uninsured motorist claim. State Farm Fire & Cas. Ins. Co. v. Terry, 230 Ga. App. 12, 495 S.E.2d 66, aff'd, 269 Ga. 777, 504 S.E.2d 194 (1998).

A consent dismissal between an insured and his uninsured motorist (UM) carrier, which afforded the UM carrier the right to defend on the issues of liability and damages, even in the event a judgment had already been obtained in the underlying tort action, was not in conflict with this section. Terry v. State Farm Fire & Cas. Ins. Co., 269 Ga. 777, 504 S.E.2d 194 (1998), affirming State Farm Fire and Cas. Ins. Co. v. Terry, 230 Ga. App. 12, 495 S.E.2d 66 (1998).

Insurer properly permitted offset. — Judgment offsetting the plaintiff's judgment against an insurer arising from a vehicle collision involving an uninsured motorist was affirmed because the plaintiff's policies prohibited the duplication of medical benefits and the plaintiff's verdict included a medical expenses award; thus, the trial court correctly determined that the insurer was entitled to the offset amount. Appling v. State Farm Fire & Cas. Ins. Co., 348 Ga. App. 369, 823 S.E.2d 61 (2019).

Due diligence is a question of fact which addresses itself in the first instance to the discretion of the trial court. Wentworth v. Fireman's Fund Am. Ins. Cos., 147 Ga. App. 854, 250 S.E.2d 543 (1978); Bailey v. Lawrence, 235 Ga. App. 73, 508 S.E.2d 450 (1998), overruled on other grounds, Ragan v. Mallow, 319 Ga. App. 443, 2012 Ga. App. LEXIS 1061 (Ga. Ct. App. 2012).

Evidence sufficient to show plaintiff used due diligence in perfecting service of process on unknown hit and run driver. Giffen v. Burrell, 176 Ga. App. 278, 335 S.E.2d 616 (1985).

Evidence supported a finding that plaintiff failed to exercise due diligence in attempting to perfect service, where approximately eight months passed between the expiration of the statute of limitation and the date that defendants were properly served with a copy of the complaint. Capra v. Rogers, 200 Ga. App. 131, 407 S.E.2d 101 (1991).

Passenger's personal injury action against a driver renewed pursuant to O.C.G.A. § 9-2-61 was dismissed for failure to perfect service of process against the driver due to lack of diligence. Although the passenger attempted to serve the driver for several months, the passenger then allowed 72 days to elapse before making another attempt. The court rejected the passenger's contention that O.C.G.A. § 33-7-11, providing for personal service after service of publication while allowing litigation against an uninsured motorist carrier to proceed, allowed for an additional 12 months after service by publication. Williams v. Patterson, 306 Ga. App. 624, 703 S.E.2d 74 (2010).

Trial court did not abuse the court's discretion in vacating the court's order for service by publication because the order granting service by publication did not expressly find that motorcycle riders had exerted due diligence in the rider's attempts to serve the motorist; the record was not clear that the riders acted with the greatest possible diligence in attempting to serve the motorist after the grant of the motion for service by publication. Milani v. Pablo, 316 Ga. App. 287, 728 S.E.2d 883 (2012).

Procedure (Cont'd)

Proof that the uninsured motorist had not deposited sufficient security was not required where the insured presented facts showing that a claim existed and the judge issued an order for service of process by publication; the issuance of such order was, in effect, a finding of due diligence. General Accident Ins. Co. v. Straws, 220 Ga. App. 496, 472 S.E.2d 312 (1996).

Burden on plaintiff to prove tortfeasor was uninsured. — The courts cannot presume that the tortfeasor was an uninsured motorist. The burden of that proof is on the plaintiffs. Hartford Accident & Indem. Co. v. Studebaker, 139 Ga. App. 386, 228 S.E.2d 322 (1976).

Interested party may corroborate occurrence. — Paragraph (b)(2) of O.C.G.A. § 33-7-11 requires only corroboration by an eyewitness, regardless whether the witness is an interested party, of the "description by the claimant of how the occurrence occurred." Atlanta Cas. Ins. Co. v. Crews, 197 Ga. App. 48, 397 S.E.2d 466 (1990).

Conflicting eyewitness testimony. — Even if the affidavit of an eyewitness contradicted the insured's description of the incident, any inconsistency in the affidavit could not be construed against the insured as to whom no self-inconsistent testimony on the issue was shown. Painter v. Continental Ins. Co., 233 Ga. App. 436, 504 S.E.2d 285 (1998).

Judgment denying an insurer's summary judgment motion was improper, in an action for uninsured motorist benefits under O.C.G.A. § 33-7-11, due to the absence of eyewitness evidence corroborating an allegation by a decedent's spouse that the driver of an unknown vehicle negligently caused the subject accident; although three of the four witnesses deposed established the presence of an unknown vehicle, each described the vehicle in a different location, and none corroborated the spouse's description of how the occurrence occurred. Bituminous Ins. Co. v. Coker, 314 Ga. App. 30, 722 S.E.2d 879 (2012), cert. denied, No. S12C1012, 2012 Ga. LEXIS 527 (Ga. 2012).

Eyewitness corroboration is required. — Only an eyewitness can corroborate the claimant's description of the occurrence. An eyewitness, however, is required. Scott v. Allstate Ins. Co., 200 Ga. App. 296, 407 S.E.2d 492 (1991).

Trial court properly granted summary judgment to an insurer in an action by an insured, seeking uninsured motorist coverage pursuant to O.C.G.A. § 33-7-11, as the vehicle in front of the insured had swerved to avoid a ladder in the highway, which set off the chain of reactions that resulted in the insured's collision and injuries, but there was no witness testimony as to how the ladder ended up in the roadway; there was no testimony from the insured or from any other eyewitness that the ladder had been negligently secured to a vehicle and that it had fallen into the roadway from the unknown vehicle, such that coverage was properly denied in the circumstances. Hohman v. State Farm Fire & Cas. Auto. Ins. Co., 283 Ga. App. 430, 641 S.E.2d 650 (2007).

Corroboration of each detail unnecessary. — It is not required that an eyewitness corroborate each and every detail of the insured's description. All that is required is an eyewitness' corroboration of the insured's contention "that the accident was caused by an unknown vehicle." Garrett v. Standard Guar. Ins. Co., 201 Ga. App. 251, 410 S.E.2d 806 (1991).

Eyewitness corroboration may be provided by another occupant in the vehicle in which the claimant was injured under paragraph (b)(2) of O.C.G.A. § 33-7-11. Universal Sec. Ins. Co. v. Lowery, 182 Ga. App. 125, 354 S.E.2d 840, aff'd, 257 Ga. 363, 359 S.E.2d 898 (1987).

Eyewitness corroboration sufficient to defeat summary judgment. — Where the insured presented evidence that a witness saw the accident and described it to a police officer in a manner corroborating the insured's version of how it occurred, the trial court properly denied the uninsured motorist carrier's motion for summary judgment. State Farm Mut. Auto. Ins. Co. v. Swetmon, 228 Ga. App. 538, 492 S.E.2d 678 (1997).

Driver's testimony sufficiently corroborated. — Witness's testimony that she saw a driver swerve into the other lane to avoid hitting what she described as an "object big enough to be a car" and

that she had observed the driver's predicament to have been "either hit the car or come over into my lane" sufficiently corroborated the driver's testimony that he had to swerve into the other lane to avoid colliding with the "Jane Doe" vehicle that pulled into his lane and stopped suddenly. State Farm Mut. Auto. Ins. Co. v. Yancey, 188 Ga. App. 8, 371 S.E.2d 883 (1988), aff'd, 258 Ga. 802, 375 S.E.2d 39 (1989), overruled on other grounds, Martin v. Williams, 263 Ga. 707, 438 S.E.2d 353 (1994).

Driver's testimony not sufficiently corroborated. — The trial court did not err in granting summary judgment to the uninsured motorist carrier in action by plaintiff maintaining that she struck a utility pole when she swerved to avoid a collision with an automobile whose unknown driver had disregarded a stop sign, and plaintiff filed suit against John Doe and served her uninsured motorist carrier. Plaintiff failed to establish the statutory corroboration required under paragraph (b)(2) of O.C.G.A. § 33-7-11 by a police officer's sworn recollection that an unidentified man appeared to agree with plaintiff's statement of the facts of the collision, since plaintiff's conclusion that the stranger was an eyewitness was hearsay, and was without probative value. Yates v. Doe, 190 Ga. App. 367, 378 S.E.2d 739 (1989).

In a personal injury action, the trial court erred in granting a phantom driver summary judgment because the affidavit and deposition testimony of eyewitness provided requisite corroboration for the driver's claim that the driver lost control of the driver's vehicle when the driver swerved to avoid a car that had pulled out in front of the driver as the vehicle entered the roadway from a parking lot. National Sur. Corp. v. O'Dell, 195 Ga. App. 374, 393 S.E.2d 504 (1990).

Corroboration issue for jury. — In a personal injury action, the trial court erred in granting a phantom driver summary judgment because the affidavit and the deposition testimony of eyewitness provided the requisite corroboration for the driver's claim that the driver lost control of the driver's vehicle when the driver swerved to avoid a car that had pulled out in front of the driver as it entered the roadway from a parking lot. Leslie v. Doe, 326 Ga. App. 154, 756 S.E.2d 238 (2014).

Punitive damages may not be awarded to a plaintiff in a "John Doe" action brought to establish the liability of the plaintiff's uninsured motorist carrier for loss caused by an unknown driver. State Farm Mut. Ins. Co. v. Kuharik, 179 Ga. App. 568, 347 S.E.2d 281 (1986).

Trial court may not identify insurer as party on jury verdict form. — The insurer's right not to appear in its own name was violated, where the trial court provided to the jury a jury verdict form drafted by the court that identified the insurer as an individual defendant and insinuated that the defendant motorist was an "uninsured motorist," and even though the insurer became a party to the case when it answered suit in its own name, it unilaterally withdrew from the action prior to the start of the trial. Hossain v. Nelson, 234 Ga. App. 792, 507 S.E.2d 243 (1998).

Summary judgment in favor of mother's insurer reversed. — Trial court erred by granting summary judgment to a mother's insurer in a suit wherein a driver, a child, claimed residency at both parents' homes with regard to underinsured motorist coverage because a genuine issue of material fact existed as to whether the driver resided at both homes. Daniel v. Allstate Ins. Co., 290 Ga. App. 898, 660 S.E.2d 765 (2008), cert. denied, No. S08C1377, 2008 Ga. LEXIS 698 (Ga. 2008).

Appeal is premature where action pending against insurer electing to file pleading in own behalf. — Where in a suit for damages alleged to be due as the result of an automobile collision, plaintiffs' uninsured motorist insurer has filed an answer in its own behalf pursuant to this section and has thereby elected to assume the status of a named party, and the action is still pending below as to this party defendant, and as there has been no certificate of finality pursuant to Ga. L. 1966, p. 609, § 54(b) (see O.C.G.A. § 9-11-54(b)) nor any permission granted for an interlocutory appeal pursuant to former Code 1933, § 6-701(a)(2) (see O.C.G.A. § 5-6-34(b)), the appeal is pre-

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mature and must be dismissed. Lysius v. Bertha, 151 Ga. App. 702, 261 S.E.2d 459 (1979).

OPINIONS OF THE ATTORNEY GENERAL

Exclusion of vehicles of self-insurers or governmental entities conflicts with section. — Motor vehicles owned or operated by self-insurers or governmental entities do not possess such liability insurance as precludes uninsured motorist coverage, and the exclusion of such vehicles from the operation of this coverage by an insurance company is contrary to the provisions of this section providing such coverage. 1973 Op. Att'y Gen. No. 73-28.

RESEARCH REFERENCES

Am. Jur. 2d. — 7 Am. Jur. 2d, Automobile Insurance, §§ 33 et seq., 41 et seq. 7A Am. Jur. 2d, Automobile Insurance, § 309 et seq. 8 Am. Jur. 2d, Automobiles and Highway Traffic, § 411 et seq.

Am. Jur. Trials. — Uninsured and Underinsured Motorist Claims, 81 Am. Jur. Trials 425.

Litigating the No-Fault Serious Injury Threshold, 59 Am. Jur. Trials 347.

C.J.S. — 46A C.J.S., Insurance, § 2264 et seq.

61A C.J.S., Motor Vehicles, § 1479 et seq.

ALR. — Collision insurance: insured's release of tortfeasor before settlement by insurer as releasing insurer from liability, 38 A.L.R.2d 1095.

Rights and liabilities under "uninsured motorist" coverage, 79 A.L.R.2d 1252.

Necessity and sufficiency of claimant's efforts to recover from other sources as prerequisite of participation in indemnity fund for losses caused by uninsured or unknown motorists, 7 A.L.R.3d 851.

Share-the-ride arrangement or car pool as affecting status of automobile rider as guest, 10 A.L.R.3d 1087.

Uninsured motorist endorsement: validity and enforceability of provision for binding arbitration, and waiver thereof, 24 A.L.R.3d 1325.

Uninsured motorist insurance: reduction of coverage by amounts payable under medical expense insurance, 24 A.L.R.3d 1353.

Automobile insurance: what constitutes an "uninsured" or "unknown" vehicle or motorist, within uninsured motorist coverage, 26 A.L.R.3d 883; 24 A.L.R.4th 13.

Uninsured motorist clause: coverage of claim for wrongful death of insured, 26 A.L.R.3d 935.

Uninsured motorist insurance: validity and construction of "other insurance" provisions, 28 A.L.R.3d 551.

Automobile insurance: time limitations as to claims based on uninsured motorist clause, 28 A.L.R.3d 580.

What issues are arbitrable under arbitration provision of uninsured motorist insurance, 29 A.L.R.3d 328.

Construction of statutory provision governing rejection or waiver of uninsured motorist coverage, 55 A.L.R.3d 216.

What constitutes "automobile" for purposes of uninsured motorist provisions, 65 A.L.R.3d 851.

Coverage under uninsured motorist clause of injury inflicted intentionally, 72 A.L.R.3d 1161.

Insured's right to bring direct action against insurer for uninsured motorist benefits, 73 A.L.R.3d 632.

Conflict of laws as to right of insured to maintain under uninsured motorist clause a direct action against automobile liability insurer, 83 A.L.R.3d 308.

Automobile liability policy: choice of law as to validity of "other insurance" clause of uninsured motorist coverage, 83 A.L.R.3d 321.

When does statute of limitations begin to run upon an action by subrogated insurer against third-party tortfeasor, 91 A.L.R.3d 844.

Who is "member" or "resident" of same "family" or "household," within no-fault or uninsured motorist provisions of motor vehicle insurance policy, 96 A.L.R.3d 804.

Construction and effect of provision excluding liability for automobile-related injuries or damage from coverage of homeowner's or personal liability policy, 6 A.L.R.4th 555.

Risks within "loading and unloading" clause of motor vehicle liability insurance policy, 6 A.L.R.4th 686.

Validity, construction, and effect of "no-consent-to-settlement" exclusion clauses in automobile insurance policy, 18 A.L.R.4th 249.

Uninsured motorist endorsement: validity and enforceability of policy provision purporting to authorize deduction of no-fault benefits from amounts payable under uninsured motorist endorsement, 20 A.L.R.4th 1104.

Combining or "stacking" uninsured motorist coverages provided in policies issued by different insurers to same insured, 21 A.L.R.4th 211.

Combining or "stacking" uninsured motorist coverages provided in single policy applicable to different vehicles of individual insured, 23 A.L.R.4th 12.

Combining or "stacking" uninsured motorist coverages provided in separate policies issued by same insurer to different insured, 23 A.L.R.4th 108.

Uninsured and underinsured motorist coverage: recoverability, under uninsured or underinsured motorist coverage, of deficiencies in compensation afforded injured party by tortfeasor's liability coverage, 24 A.L.R.4th 13.

Drunk driving: Motorist's right to private sobriety test, 24 A.L.R.4th 63.

Validity, construction, and effect of "consent to sue" clauses in uninsured motorist endorsement of automobile insurance policy, 24 A.L.R.4th 1024.

Combining or "stacking" uninsured motorist coverages provided in separate policies issued by same insurer to same insured, 25 A.L.R.4th 6.

Combining or "stacking" uninsured motorist coverages provided in fleet policy, 25 A.L.R.4th 896.

Uninsured motorist coverage: validity of exclusion of injuries sustained by insured while occupying "owned" vehicle not insured by policy, 30 A.L.R.4th 172.

Apportionment of payments of no-fault (personal injury protection) benefits between insurers providing coverage to same insured under policies covering different vehicles, 34 A.L.R.4th 374.

Right of insurer issuing "uninsured motorist" coverage to intervene in action by insured against uninsured motorist, 35 A.L.R.4th 757.

Uninsured motorist insurance: injuries to motorcyclist as within affirmative or exclusionary terms of automobile insurance policy, 46 A.L.R.4th 771.

Automobile liability insurance policy flight from police exclusion: validity and effect, 49 A.L.R.4th 325.

Punitive damages as within coverage of uninsured or underinsured motorist insurance, 54 A.L.R.4th 1186.

Policy provision limiting time within which action may be brought on the policy as applicable to tort action by insured against insurer, 66 A.L.R.4th 859.

Automobile uninsured motorist coverage: "legally entitled to recover" clause as barring claim compensable under workers' compensation statute, 82 A.L.R.4th 1096.

"Excess" or "umbrella" insurance policy as providing coverage for accidents with uninsured or underinsured motorists, 2 A.L.R.5th 922.

Insured's recovery of uninsured motorist claim against insurer as affecting subsequent recovery against tortfeasors causing injury, 3 A.L.R.5th 746.

Uninsured and underinsured motorist coverage: enforceability of policy provision limiting appeals from arbitration, 23 A.L.R.5th 801.

Uninsured or underinsured motorist insurance: Validity and construction of policy provision purporting to reduce recovery by amount of social security disability benefits or payments under similar disability benefits law, 24 A.L.R.5th 766.

Application of automobile insurance "entitlement" exclusion to family member, 25 A.L.R.5th 60.

Uninsured and underinsured motorist coverage: validity, construction, and effect of policy provision purporting to reduce coverage by amount paid or payable under

workers' compensation law, 31 A.L.R.5th 116.

Right of employer or workers' compensation carrier to lien against, or reimbursement out of, uninsured or underinsured motorist proceeds payable to employee injured by third party, 33 A.L.R.5th 587.

Validity and construction of provision of uninsured or underinsured motorist coverage that damages under the coverage will be reduced by amount of recovery from tortfeasor, 40 A.L.R.5th 603.

Automobile insurance coverage for drive-by shootings and other incidents involving the intentional discharge of firearms from moving motor vehicles, 41 A.L.R.5th 91.

No-fault insurance coverage for injury or death of insured occurring during carjacking or attempted carjacking, 42 A.L.R.5th 727.

Validity of territorial restrictions on uninsured/underinsured coverage in automobile insurance policies, 55 A.L.R.5th 747.

Validity, construction, and application of exclusion of government vehicles from uninsured motorist provision, 58 A.L.R.5th 511.

Automobile insurance: what constitutes "occupying" under owned-vehicle exclusion on uninsured or underinsured motorist coverage of automobile insurance policy, 59 A.L.R.5th 191.

Uninsured motorist indorsement: construction and application of requirement that there be "physical contact" with unidentified or hit-and-run vehicle; "miss-and-run" cases, 77 A.L.R.5th 319.

Uninsured motorist indorsement: general issues regarding requirement that there be "physical contact" with unidentified or hit-and-run vehicle, 78 A.L.R.5th 341.

Uninsured motorist indorsement: construction and application of requirement that there be "physical contact" with unidentified or hit-and-run vehicle; "hit-and-run" cases, 79 A.L.R.5th 289.

Conduct or inaction by insurer constituting waiver of, or creating estoppel to assert, right of subrogation, 125 A.L.R.5th 1.

Validity, construction, and application of exhaustion clause of underinsured motorist coverage plan, 75 A.L.R.6th 235.

Application of uninsured or underinsured motorist or no-fault insurance to school bus incidents, 80 A.L.R.6th 389.

33-7-11.1. Commencement of liability of insurer to pay benefits to third party on behalf of insured; applicability of Code section.

(a) As used in this Code section, the term "liability insurance policy" means an automobile liability or motor vehicle liability insurance policy issued or delivered in this state to the owner of such vehicle or issued or delivered by any insurer licensed in this state upon any such motor vehicle then principally garaged or principally used in this state.

(b) Any insurer, upon acceptance of liability, pursuant to any automobile liability or motor vehicle liability insurance policy, shall pay reasonable benefits for losses, including total losses, to a third party on behalf of an insured for loss of use and towing and storage costs of such a motor vehicle, and the liability of the insurer for payment of benefits for losses, including total losses, to the third party shall commence as of the time of the incident or occurrence which results in such losses; provided, however, in no event shall this Code section be construed so as to relieve the claimant of his or her obligation to mitigate his or her losses or to require the payment of loss of use and towing and storage

costs benefits in an amount which is greater than the actual losses suffered.

(c) When making any payment to a third party for damage to an automobile for any loss, the insurer shall have printed on the loss estimate, if prepared directly by the insurer, the following:

> "Failure to use the insurance proceeds in accordance with a security agreement between you and a lienholder, if any, may be a violation of Code Section 16-8-4 of the O.C.G.A. If you have any questions, contact your lending institution."

This subsection does not apply if the insurer does not prepare the loss estimate or if the estimate is not prepared in the State of Georgia.

(d) The provisions of this Code section shall be applicable to all automobile liability or motor vehicle liability insurance policies that pay benefits to a third party on behalf of an insured for the loss of use and towing and storage costs of such motor vehicle issued, delivered, or renewed in this state on or after January 1, 2009.

History. — Code 1933, § 56-407B, enacted by Ga. L. 1982, p. 802, § 1; Code 1981, § 33-7-11.1, enacted by Ga. L. 1982, p. 802, § 2; Ga. L. 2002, p. 1192, § 1; Ga. L. 2003, p. 140, § 33; Ga. L. 2008, p. 828, § 1/HB 673.

33-7-12. Effect of policy provision permitting insurer to settle or compromise claims of third persons against insured; release of claims by third persons.

(a) Any provision in a liability policy of insurance which provides that the insurer shall have the right to compromise or settle claims of third persons against the insured without the consent of the insured shall be deemed to create, as between the insurer and the insured, the relationship of an independent contractor so that the insured shall not be precluded from asserting a claim or cause of action against third persons, notwithstanding the settlement by the insurer of such claims of third persons, unless the insured shall previously have consented in writing to relinquish his claim or cause of action against third persons, provided in all cases where the insurer shall settle the claims of third persons against the insured without written consent that it shall be the duty of the insurer to inform the third persons in writing of the lack of consent of the insured and that the insured is not thereby precluded from the further assertion of claims against the third persons before taking from the third persons any release, covenant not to sue, or other settlement; and upon the failure of the insurer to give the notice to the third persons of the lack of consent of the insured, the release, covenant not to sue, or other settlement shall be of no effect, null, and void.

(b) If such third persons execute a release, covenant not to sue, or other instrument in settlement of their claims after such notice of the

lack of consent of the insured, the same shall be deemed and construed as a bar to the further assertion by such third persons of such claims against all persons whomsoever; and such third persons shall not plead such release, covenant not to sue, or settlement in bar of any action or claim asserted by such insured.

History. — Ga. L. 1963, p. 643, § 1; Ga. L. 1987, p. 3, § 33.

Law reviews. — For survey article on insurance, see 34 Mercer L. Rev. 177 (1982). For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007).

For note, "Conflicts of Interest in the Liability Insurance Setting," see 13 Ga. L. Rev. 973 (1979).

JUDICIAL DECISIONS

This section was enacted to change the Georgia common-law rule that an insured is barred from asserting his own claims if his insurer effected a settlement, even without his consent. Jefferson Mills, Inc. v. Gregson, 124 Ga. App. 96, 183 S.E.2d 529 (1971).

O.C.G.A. § 33-7-12 was enacted to protect the insured and is in derogation of common law and must be strictly construed. Carden v. Burckhalter, 214 Ga. App. 487, 448 S.E.2d 251 (1994).

Section is not to be given retrospective effect. Norton v. Greyhound Corp., 352 F.2d 368 (5th Cir. 1965).

Section only applies if policy permits insurer to settle without insured's consent. — Subsection (a) of this section predicates the entire section upon the basis of there being a provision in a liability policy of insurance permitting the insurer to settle with third persons without the consent of the insured. Accordingly, subsection (b) of this section has no application unless the policy of insurance pursuant to which such payment was made by the insurer contained the required provisions. Scarbrough v. Andrews Motor Co., 121 Ga. App. 29, 172 S.E.2d 451 (1970).

This section only applies to a covenant not to sue where the insurance policy contains a provision permitting the insurer to settle without the consent of the insured. Spearman v. Southeastern Hwy. Contracting Co., 125 Ga. App. 85, 186 S.E.2d 484 (1971).

Insurer has no right of subrogation for payments made without insured's consent. — Where an insurer made payments to a third party without the consent of the insured, it acted as an independent contractor and had no right of subrogation; thus, the insured's action seeking contribution from other alleged tortfeasors was not merited because it amounted to a subrogation claim made for the insurer, as to which the insurer had no right since its payment to the third party was not made as insurer or agent of the insured under the policy. Carden v. Burckhalter, 214 Ga. App. 487, 448 S.E.2d 251 (1994).

Under O.C.G.A. § 33-7-12(a), a general contractor's insurer had no right to indemnification as a subrogee with regard to settlements paid to certain plaintiffs in an underlying personal injury suit; because the settlement payments had been made without the general contractor's consent, the insurer had made the settlement payments not as an insurer but as an independent contractor. BBL-McCarthy, LLC v. Baldwin Paving Co., 285 Ga. App. 494, 646 S.E.2d 682 (2007), cert. denied, 2007 Ga. LEXIS 621, 631, 661 (Ga. 2007).

Pursuant to O.C.G.A. § 33-7-12(a), subcontractors were not liable to an insurer for their share of funds paid in settlement of a homeowner's faulty construction claim against the insurer, a contractor, because the insurer settled the homeowner's claim without obtaining the insured's singed consent to the settlement. Mandato & Assocs., Inc. v. Masonry, 303 Ga. App. 438, 693 S.E.2d 620 (2010).

Insurer may not subordinate interests of insured to its own interest. — The rule that an insurance company must

give equal consideration to the interests of the insured in making decisions concerning the litigation and settlement of a claim under the policy forbids an insurer from subordinating the interests of its insured to its own interest. National Serv. Indus., Inc. v. Hartford Accident & Indem. Co., 661 F.2d 458 (5th Cir. 1981).

Covenant not to sue is equivalent to release under section. — A covenant not to sue without giving prior notice of settlement as required by this section is equivalent to a release. Black v. Cotton States Ins. Co., 149 Ga. App. 71, 253 S.E.2d 565 (1979).

Limitation of scope of covenant not to sue. — The phrase "such claims" in the last sentence is defined as referring only to claims which were the subject of the settlement with the insurer and does not discharge the remaining tortfeasors, overruling Jackson v. Kight, 117 Ga. App. 385, 160 S.E.2d 668 (1968) and cases following it. Milline v. American Can Co., 160 Ga. App. 752, 288 S.E.2d 71 (1981), aff'd, 249 Ga. 486, 292 S.E.2d 75 (1982).

Insured may plead settlement without barring own claim against third person. — When the insured pleads a settlement between his insurer and a third person made in accordance with the terms of this section, the insured is only taking advantage of the controlling statutory provision that the settlement "shall be deemed and construed as a bar to the further assertion by such third persons of such claims against all persons whomsoever"; and to construe the insured's pleading and reliance on the settlement as a ratification of it as a settlement and bar of his claim against the third person would be contrary to the expressed statutory purpose. Roberts v. Goodwin, 113 Ga. App. 656, 149 S.E.2d 420 (1966).

Third person cannot plead settlement pled by insured. — When the insured has introduced the settlement into the pleadings to give effect to this section, and the third person then pleads that the settlement is a bar or accord and satisfaction of the insured's claim, the third person acts contrary to the provision that he "shall not plead such … settlement in bar of any action or claim of the insured"; and to uphold such a position taken by the third person would be to place a severe penalty on the insured — the destruction of the insured's claim — for taking advantage of the statute. This obviously would be contrary to this section. Roberts v. Goodwin, 113 Ga. App. 656, 149 S.E.2d 420 (1966).

Third person may plead release although insured does not plead section. — This section does not say the insured shall not be precluded from asserting a claim against third persons provided the insured does not plead the section in bar to the claim of third persons, nor does it say third persons shall not plead such release in bar of any action or claim asserted by such insured unless the insured pleads the section in bar to a claim of third persons. Roberts v. Goodwin, 113 Ga. App. 656, 149 S.E.2d 420 (1966).

Dismissal with prejudice barred claim. — Insureds' dismissal with prejudice claim against the defendant driver, rather than merely executing a limited liability release against the defendant, defeated their ability to recover damages from their underinsured motorist carrier. Kent v. State Farm Mut. Auto. Ins. Co., 233 Ga. App. 564, 504 S.E.2d 710 (1998).

Insurer must give notice of lack of insured's consent. — If the insurance company did not obtain the written consent of its insured, it was obligatory that it notify the plaintiff of such lack of consent in order to effectuate a binding release. Garrett v. Heisler, 149 Ga. App. 240, 253 S.E.2d 863 (1979).

Without consent settlement is void. — A settlement is not binding on the insured unless the insured consents thereto in writing. If the insured does not consent then the settlement is "of no effect, null, and void," unless the third party is informed in writing of the insured's lack of consent. Garrett v. Heisler, 149 Ga. App. 240, 253 S.E.2d 863 (1979).

If consent given, settlement bars further assertion of third person's claims. — This section concerns the manner in which liability insurers settle claims when the policy provides that the insurer has the right to compromise or settle claims of third persons against the insured without the consent of the insured

and provides that if third persons are informed in writing by the insurer that the insured has not consented to any compromise or settlement and executes a release, covenant not to sue, or other instrument in settlement of their claims, that document shall be a bar to further assertion of their claims by the third persons against all parties. Harden v. Clarke, 123 Ga. App. 142, 179 S.E.2d 667 (1970).

Insured's claims are not barred. — If a third person is given notice of the insured's lack of consent and nevertheless executes a settlement, release, or covenant not to sue, such instrument will be a bar to the assertion of further claims by the third person even though in the reverse situation the instrument is not a bar to claims which might be pressed by the insured. Watson v. Hamil, 122 Ga. App. 120, 176 S.E.2d 276 (1970).

Settlement does not bar all defenses by third person. — When, in a settlement with an insurer, a person gives a general release of all claims against the insured arising out of an occurrence and the insured has not consented to the settlement, then this section does not bar that person from raising matters surrounding the occurrence as defenses to a later action by the insured, even though he could not assert them as affirmative claims. Jefferson Mills, Inc. v. Gregson, 124 Ga. App. 96, 183 S.E.2d 529 (1971).

The language of subsection (b) of this section which states that the release will bar further assertion of "the claims against all persons" can only refer to affirmative claims based on the occurrence and will not be construed to include a waiver of all defenses. Jefferson Mills, Inc. v. Gregson, 124 Ga. App. 96, 183 S.E.2d 529 (1971).

Settlement inures to benefit of joint tortfeasor. — Where the plaintiff, a guest passenger in an automobile driven by the insured, gives the insurer a covenant not to sue in payment of $600.00 by the insurer without insured's consent, the settlement will inure to the benefit of an alleged joint tortfeasor. Fillingame v. Cook, 119 Ga. App. 140, 166 S.E.2d 440 (1969).

Attempted rescission is ineffective as to other defendants. — Where plaintiff executes a covenant not to sue one of three defendants and the covenant is made with the defendant's insurer without defendant's knowledge or consent, the subsequent attempted rescission of the covenant is ineffectual as to the other two defendants. By operation of the law they acquire a vested right to claim the incidental beneficial consequences flowing to them as result of plaintiff's execution of the covenant not to sue with knowledge that the one defendant has not consented thereto. The plaintiff cannot avoid these consequences and divest the remaining defendants of the benefit granted them by statute by the attempted rescission of the covenant not to sue. Spearman v. Southeastern Hwy. Contracting Co., 125 Ga. App. 85, 186 S.E.2d 484 (1971).

Settlement valid. — Plaintiff failed to point to specific evidence giving rise to a triable issue and supporting the plaintiff's claim that settlement was null and void. Wade v. Crannis, 209 Ga. App. 501, 433 S.E.2d 669 (1993).

Cited in Ericson v. Hill, 109 Ga. App. 759, 137 S.E.2d 374 (1964); Brown v. Seaboard Lumber & Supply Co., 221 Ga. 35, 142 S.E.2d 842 (1965); Georgia Power Co. v. McElmurray, 113 Ga. App. 789, 149 S.E.2d 740 (1966); Fisher v. Pirtle, 119 Ga. App. 556, 167 S.E.2d 613 (1969); Henderson v. Garbutt, 121 Ga. App. 291, 173 S.E.2d 445 (1970); Green v. Fagan, 124 Ga. App. 426, 184 S.E.2d 53 (1971); Foundry Sys. & Supply, Inc. v. Industry Dev. Corp., 124 Ga. App. 589, 185 S.E.2d 94 (1971); Spearman v. Southeastern Hwy. Contracting Co., 126 Ga. App. 549, 191 S.E.2d 351 (1972); American Can Co. v. Milline, 249 Ga. 486, 292 S.E.2d 75 (1982); Henry v. Anderson, 164 Ga. App. 110, 296 S.E.2d 410 (1982); Vann v. Williams, 165 Ga. App. 457, 299 S.E.2d 908 (1983); Weaver v. Reed, 282 Ga. App. 831, 640 S.E.2d 351 (2006).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1642.

Am. Jur. Pleading and Practice Forms. — 14A Am. Jur. Pleading and Practice Forms, Insurance, § 211.

C.J.S. — 46A C.J.S., Insurance, § 1878 et seq.

ALR. — Liability of insurer to insured for settling third-party claim within policy limits resulting in detriment to insured, 18 A.L.R.5th 474.

Conduct or inaction by insurer constituting waiver of, or creating estoppel to assert, right of subrogation, 125 A.L.R.5th 1.

33-7-13. Limitation of risks.

(a) A "subject of insurance," for the purposes of this Code section, as to insurance against fire and hazards other than catastrophic hazards includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or other such hazard insured against.

(b) "Surplus to policyholders," for the purpose of this Code section shall be deemed to include any voluntary reserves which are not required pursuant to law and shall be determined from the last sworn statement of the insurer on file with the Commissioner or by the last report of examination by the Commissioner, whichever is the more recent at the time of assumption of such risk.

(c) No insurer shall retain any risk on any one subject of insurance, whether located or to be performed in Georgia or elsewhere, in an amount exceeding 10 percent of its surplus to policyholders.

(d) Reinsurance authorized by Code Section 33-7-14 shall be deducted in determining risk retained. As to surety risks, deduction shall also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

(e) As to alien insurers, this Code section shall relate only to risks and surplus to policyholders of the insurer's United States branch.

(f) This Code section shall not apply to life insurance, accident and sickness insurance, annuities, title insurance, insurance of ocean marine risks or marine protection and indemnity risks, workers' compensation insurance, employers' liability coverages, nor to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

History. — Code 1933, § 56-412, enacted by Ga. L. 1960, p. 289, § 1.

33-7-14. Reinsurance of risks.

(a) Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7) of this subsection, and the Commissioner may adopt by regulation pursuant to subsection (d) of this Code section specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection (d) of this Code section, and the circumstances in which credit will be reduced or eliminated. Credit shall be allowed under paragraph (1), (2), or (3) of this subsection only with respect to cessions of those kinds of classes of business for which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile, or in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. If meeting the requirements of paragraph (3) or (4) of this subsection, the requirements of paragraph (8) of this subsection shall also be met:

(1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state;

(2) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer by the Commissioner in this state. In order to be eligible for accreditation, a reinsurer shall:

(A) File with the Commissioner evidence of its submission to this state's jurisdiction;

(B) Submit to this state's authority to examine its books and records;

(C) Be licensed to transact insurance or reinsurance in at least one state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one state;

(D) File annually with the Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(E) Demonstrate to the satisfaction of the Commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic

insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount of not less than $20 million and its accreditation has not been denied by the Commissioner within 90 days after the submission of its application;

(3) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or, in the case of a United States branch of an alien assuming insurer, is entered through a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this Code section and the assuming insurer or United States branch of an alien assuming insurer:

(A) Maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(B) Submits to the authority of this state to examine its books and records.

Subparagraph (A) of this paragraph shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system;

(4)(A) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in subsection (c) of this Code section, for the payment of the valid claims of its United States ceding insurers, their assigns, and successors in interest. The assuming insurer shall report annually to the Commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by licensed insurers to enable the Commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million; provided, however, that, at any time after the assuming insurer has permanently discontinued underwriting new business secured by trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction of the required trusteed surplus, but only after a finding, based upon an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and

cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust. In the case of a group including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group for all years of account; the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the Commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator or, if a certification is unavailable, financial statements prepared by independent public accountants of each member of the group.

(B) In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in subparagraph (A) of this paragraph and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, and submits to this state's authority to examine its books and records and bears the expense of the examination, and which has aggregate policyholders' surplus of $10 billion; the trust shall be in an amount equal to the group's several liabilities attributable to business ceded by the United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of such group; plus the group shall maintain a joint trusteed surplus of which $100 million shall be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities, and within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, each member of the group shall make available to the Commissioner an annual certification of the member's solvency by the member's domiciliary regulator and financial statements prepared by its independent public accountant.

(C) Credit for reinsurance shall not be granted under this paragraph unless the form of the trust and any amendments to the trust have been approved by the commissioner of the state where the trust is domiciled or the commissioner of another state, who, pursuant to the terms of the trust agreement, has accepted principal regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States ceding insurers, their assigns, and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the Commissioner. The trust must remain in effect for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust.

(D) No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing setting forth the balance of the trust and listing the trust's investments as of the end of the preceding year and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31;

(5) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (1), (2), (3), or (4) of this subsection if such assuming insurer has been certified by the Commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this subsection.

(A) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(i) The assuming insurer shall be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the Commissioner pursuant to subparagraph (C) of this paragraph;

(ii) The assuming insurer shall maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the Commissioner pursuant to regulation;

(iii) The assuming insurer shall maintain financial strength ratings from two or more rating agencies deemed acceptable by the Commissioner pursuant to regulation;

(iv) The assuming insurer shall agree to submit to the jurisdiction of this state, appoint the Commissioner as its agent for

service of process in this state, and agree to provide security for 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(v) The assuming insurer shall agree to meet applicable information filing requirements as determined by the Commissioner, both with respect to an initial application for certification and on an ongoing basis; and

(vi) The assuming insurer shall satisfy any other requirements for certification deemed relevant by the Commissioner.

(B) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of subparagraph (A) of this paragraph:

(i) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association of any of its members, in an amount determined by the Commissioner to provide adequate protection;

(ii) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(iii) Within 90 days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the Commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(C) The Commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the Commissioner as a certified reinsurer.

(i) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an

ongoing basis, and consider the rights, benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the Commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the Commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the Commissioner.

(ii) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners (NAIC) Committee Process. The Commissioner shall consider this list in determining qualified jurisdictions. If the Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.

(iii) United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

(iv) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the Commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(D) The Commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the Commissioner pursuant to regulation. The Commissioner shall publish a list of all certified reinsurers and their ratings.

(E) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subparagraph at a level consistent with its rating, as specified in regulations promulgated by the Commissioner.

(i) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the Commissioner and consistent with the provisions of subsection (b) of this Code section, or in a multibeneficiary trust in accordance with paragraph (4) of this subsection, except as otherwise provided in this paragraph.

(ii) If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph (4) of this subsection, and

chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection or comparable laws of other United States jurisdictions and for its obligations subject to paragraph (4) of this subsection. It shall be a condition to the grant of certification under this paragraph that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

(iii) The minimum trusteed surplus requirements provided in paragraph (4) of this subsection are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection, except that such trust shall maintain a minimum trusteed surplus of $10 million.

(iv) With respect to obligations incurred by a certified reinsurer under this subparagraph, if the security is insufficient, the Commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and shall have the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(v) For purposes of this subparagraph, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100 percent of its obligations:

(I) As used in this subparagraph, the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

(II) If the Commissioner continues to assign a higher rating as permitted by other provisions of this paragraph, this requirement shall not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(F) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Commissioner shall have the discretion to defer to that jurisdiction's certification, and shall have the discretion to defer to the rating assigned by that

jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(G) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this paragraph, and the Commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business;

(6)(A) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below:

(i) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. For purposes of this paragraph, the term "reciprocal jurisdiction" means a jurisdiction that is one of the following:

(I) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this paragraph, the term 'covered agreement' means an agreement entered into pursuant to the federal Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and that addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(II) A United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(III) A qualified jurisdiction, as determined by the Commissioner pursuant to subparagraph (C) of paragraph (5) of this subsection, which is not otherwise described in subdivision (I) or (II) of this division and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the Commissioner in regulation;

(ii) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent,

calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents, net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction and a central fund containing a balance in amounts to be set forth in regulation;

(iii) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, which shall be set forth in regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed;

(iv) The assuming insurer must agree and provide adequate assurance to the Commissioner, in a form specified by the Commissioner pursuant to regulation, as follows:

(I) The assuming insurer must provide prompt written notice and explanation to the Commissioner if it falls below the minimum requirements set forth in division (ii) or (iii) of this subparagraph, or if any regulatory action is taken against it for serious noncompliance with applicable law;

(II) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the Commissioner as agent for service of process. The Commissioner may require that consent for service of process be provided to the Commissioner and included in each reinsurance agreement. Nothing in this subdivision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(III) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(IV) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to such agree-

ment if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(V) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers and agree to notify the ceding insurer and the Commissioner and to provide security in an amount equal to 100 percent of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of paragraph (5) of this subsection and subsection (b) of this Code section and as specified by the Commissioner in regulation;

(v) The assuming insurer or its legal successor must provide, if requested by the Commissioner, on behalf of itself and any legal predecessors, certain documentation to the Commissioner, as specified by the Commissioner in regulation;

(vi) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in regulation; and

(vii) The assuming insurer's supervisory authority must confirm to the Commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in divisions (ii) and (iii) of this subparagraph.

Nothing in this paragraph precludes an assuming insurer from providing the Commissioner with information on a voluntary basis.

(B)(i) The Commissioner shall timely create and publish a list of reciprocal jurisdictions.

(ii) A list of reciprocal jurisdictions is published through the NAIC Committee Process. The Commissioner's list shall include any reciprocal jurisdiction as defined in subdivision (A)(i)(I) or (A)(i)(II) of this paragraph and shall consider any other reciprocal jurisdiction included on the NAIC list. The Commissioner may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with criteria to be developed under regulations issued by the Commissioner.

(iii) The Commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the juris-

diction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in regulation issued by the Commissioner, except that the Commissioner shall not remove from the list a reciprocal jurisdiction as defined in subdivision (A)(i)(I) or (A)(i)(II) of this paragraph. Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in such jurisdiction shall be allowed, if otherwise allowed pursuant to this Code section.

(C) The Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this paragraph and to which cessions shall be granted credit in accordance with this paragraph. The Commissioner may add an assuming insurer to such list if an NAIC accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits information to the Commissioner as required under division (iv) of subparagraph (A) of this paragraph and complies with any additional requirements that the Commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

(D)(i) If the Commissioner determines that an assuming insurer no longer meets one or more of the requirements under this paragraph, the Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this paragraph in accordance with procedures set forth in regulation.

(ii) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with subsection (b) of this Code section.

(iii) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Commissioner and consistent with the provisions of subsection (b) of this Code section.

(E) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which

the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(F) Nothing in this paragraph shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in such reinsurance agreement, except as expressly prohibited by this Code section or other applicable law or regulation.

(G) Credit may be taken under this paragraph only for reinsurance agreements entered into, amended, or renewed on or after July 1, 2020, and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements pursuant to subparagraph (A) of this paragraph or the effective date of the new reinsurance agreement, amendment, or renewal; provided, however, that:

(i) This subparagraph shall not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this paragraph, so long as the reinsurance qualifies for credit under any other applicable provision of this Code section;

(ii) Nothing in this paragraph shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement; and

(iii) Nothing in this paragraph shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(H) This paragraph does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this paragraph, as long as the reinsurance qualifies for credit under any other applicable provision of this Code section.

(I) Nothing in this paragraph shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(J) Nothing in this paragraph shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (1), (2),

(3), (4), (5), or (6) of this subsection, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction;

(8) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by paragraphs (3) and (4) of this subsection shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(A) That, in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give the court jurisdiction, and shall abide by the final decision of the court or of any appellate court in the event of an appeal; and

(B) To designate the Commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

This paragraph is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement;

(9) If the assuming insurer does not meet the requirements of paragraph (1), (2), (3), or (6) of this subsection, the credit permitted by paragraph (4) or (5) of this subsection shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(A) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by subparagraphs (A) and (B) of paragraph (4) of this subsection, as applicable, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund;

(B) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies;

(C) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement; and

(D) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this paragraph.

(10) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the Commissioner may suspend or revoke the reinsurer's accreditation or certification.

(A) The Commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation shall not take effect until after the Commissioner's order on hearing, unless:

(i) The reinsurer waives its right to hearing;

(ii) The Commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subparagraph (F) of paragraph (5) of this subsection; or

(iii) The Commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the Commissioner's action.

(B) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with subsection (b) of this Code section. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subparagraph (E) of paragraph (5) of this subsection or subsection (b) of this Code section.

(11) Concentration Risk:

(A) A ceding insurer shall take steps to manage its reinsurance recoverable proportionate to its own book of business. A domestic ceding insurer shall notify the Commissioner within 30 days after reinsurance recoverables from any single assuming insurers, or

group of affiliated assuming insurers, exceeds 50 percent of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(B) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the Commissioner within 30 days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than 20 percent of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(b) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of subsection (a) of this Code section shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, and the Commissioner may adopt by regulation pursuant to subsection (d) of this Code section specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection (d) of this Code section, and the circumstances in which credit will be reduced or eliminated. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (2) of subsection (c) of this Code section. This security may be in the form of:

(1) Cash;

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Validation Office, and qualifying as admitted assets;

(3) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (1) of subsection (c) of this Code section, no later than December 31 of the year for which filing is being made, and in

the possession of, or in the trust for, the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; or

(4) Any other form of security acceptable to the Commissioner.

(c)(1) For purposes of paragraph (3) of subsection (b) of this Code section, the term "qualified United States financial institution" means an institution that:

(A) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;

(B) Is regulated, supervised, and examined by the United States federal or state authorities having regulatory authority over banks and trust companies; and

(C) Has been determined by either the Commissioner or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner.

(2) The term "qualified United States financial institution" means, for the purposes of those provisions of this Code section specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(A) Is organized or, in the case of a United States branch or agency office of a foreign banking organization, licensed under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(B) Is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(d)(1) The Commissioner may adopt rules and regulations implementing the provisions of this Code section.

(2)(A) The Commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in subparagraph (B) of this paragraph.

(B) Any regulation adopted pursuant to this paragraph may apply only to reinsurance relating to:

(i) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(ii) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(iii) Variable annuities with guaranteed death or living benefits;

(iv) Long-term care insurance policies; or

(v) Such other life and health insurance and annuity products for which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(C) A regulation adopted pursuant to division (i) or (ii) of subparagraph (B) of this paragraph may apply to any treaty containing policies issued on or after January 1, 2015, or policies issued prior to January 1, 2015, if risk pertaining to policies issued prior to January 1, 2015, is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(3) A regulation adopted pursuant to this subsection may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this subsection, to use the valuation manual adopted by the NAIC under Section 11B(1) of the NAIC Standard Valuation Law, including all amendments adopted by the NAIC and in effect on the date on which the calculation is made, to the extent applicable.

(4) A regulation adopted pursuant to this subsection shall not apply to cessions to an assuming insurer that:

(A) Meets the conditions set forth in paragraph (6) of subsection (a) of this Code section;

(B) Is certified in this state or, if this state has not adopted provisions substantially equivalent to Section 2E of the National Association of Insurance Commissioners Credit for Reinsurance Model Law (#785), certified in a minimum of five other states; or

(C) Maintains at least $250 million in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is:

(i) Licensed in at least 26 states; or

(ii) Licensed in at least ten states and licensed or accredited in at least 35 states.

(5) The authority to adopt regulations pursuant to this subsection shall not limit the Commissioner's general authority to adopt regulations pursuant to paragraph (1) of this subsection.

History. — Code 1933, § 56-413, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 1; Ga. L. 1990, p. 1275, § 4; Ga. L. 1991, p. 1424, § 3; Ga. L. 1995, p. 1165, § 7; Ga. L. 1996, p. 705, § 2; Ga. L. 2012, p. 1117, § 5/SB 385; Ga. L. 2020, p. 141, § 1/SB 188.

The 2020 amendment, effective July 1, 2020, in subsection (a), substituted "(6), or (7) of this subsection, and the Commissioner may adopt by regulation pursuant to subsection (d) of this Code section specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection (d) of this Code section, and the circumstances in which credit will be reduced or eliminated." for "or (6)." in the first sentence and substituted "paragraph (8)" for "paragraph (7)" near the end of the last sentence; added paragraph (a)(6); redesignated former paragraphs (a)(6) through (a)(10) as present paragraphs (a)(7) through (a)(11), respectively; substituted "(4), (5), or (6)" for "(4) or (5)" in paragraph (a)(7); in paragraph (a)(9), substituted "(3), or (6)" for "or (3)" and substituted "or (5)" for "or (6)" ; substituted "paragraph" for "provision" at the end of subdivision (a)(9)(D); in subsection (b), added ", and the Commissioner may adopt by regulation pursuant to subsection (d) of this Code section specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in subsection (d) of this Code section, and the circumstances in which credit will be reduced or eliminated" at the end of the first sentence and substituted "Such" for "and such" at the beginning of the second sentence; inserted "financial" in the first sentence of paragraph (b)(3); inserted "the term" in paragraph (c)(1); substituted "The term" for "A" at the beginning of paragraph (c)(2); and added subsection (d). See Editor's notes for applicability.

Cross references. — Paid-in capital required of a domestic stock insurer, § 33-3-6. Investments qualifying as admitted assets for a domestic insurer, T. 33, C. 11.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, a colon was substituted for the period at the end of the introductory language of subsection (a).

Pursuant to Code Section 28-9-5, in 2020, "July 1, 2020" was substituted for "the effective date of this Act" in division (a)(6)(G).

Editor's notes. — Ga. L. 1991, p. 1424, § 9/SB 347, not codified by the General Assembly, contained inconsistencies in references to the sections of the bill due to differences in the section numbers contained in the Senate version of the bill and the final version of the bill. Subsection (c) of Section 9 refers to Code Sections 33-13-3.1 and 33-13-5 in the Senate version of SB 347. Subsection (b) of Section 9, which refers to this Code section in the Senate version of SB 347, provides as follows: "Section 2 of this Act shall apply to all reinsurance cessions after July 1, 1991, which have had an inception, anniversary, or renewal date not less than six months after July 1, 1991."

Ga. L. 1991, p. 1424, § 9(c)/SB 347, not codified by the General Assembly, provides that this Code section shall apply to transactions between affiliates or subsidiaries taking place on or after July 1, 1991.

Ga. L. 2020, p. 141, § 2/SB 188, not codified by the General Assembly, provides that this Act shall apply to all cessions after July 1, 2020, under reinsurance agreements that have an inception, anniversary, or renewal date not less than one year after July 1, 2020.

Law reviews. — For note on 1991 amendment of this Code section, see 8 Ga. St. U.L. Rev. 89 (1992).

JUDICIAL DECISIONS

Reinsurance involves no transaction or privity between the reinsurer and those originally assured. Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971).

Cited in Consumer Life Ins. Co. v. United States, 524 F.2d 1167 (Ct. Cl. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1812 et seq.

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 717 et seq.

C.J.S. — 46A C.J.S., Insurance, § 2077 et seq.

ALR. — Effect of reinsurance of life policy as modifying the amount of liability upon death of insured, 25 A.L.R. 1535.

Who may enforce liability of reinsurer, 35 A.L.R. 1348; 103 A.L.R. 1485; 103 A.L.R. 1485.

Reciprocal or interinsurance, 141 A.L.R. 765; 145 A.L.R. 1121.

Reinsurer's liability for primary liability insurer's failure to compromise or settle, 42 A.L.R.4th 1130.

33-7-15. Cooperation by insured with insurer in defense of action or threatened action under policy.

(a) No motor vehicle liability insurance policy covering a motor vehicle principally garaged or principally used in this state shall be issued, delivered or issued for delivery, or renewed in this state unless such policy contains provisions or has an endorsement thereto which specifically requires the insured to send his insurer, as soon as practicable after the receipt thereof, a copy of every summons or other process relating to the coverage under the policy and to cooperate otherwise with the insurer in connection with the defense of any action or threatened action covered under the policy.

(b) Noncompliance by the insured with this required provision or endorsement shall constitute a breach of the insurance contract which, if prejudicial to the insurer, shall relieve the insurer of its obligation to defend its insureds under the policy and of any liability to pay any judgment or other sum on behalf of its insureds.

(b.1) In the event the insurer denies coverage and it is determined by declaratory judgment or other civil process that there is in fact coverage, the insurer shall be liable to the insured for legal cost and attorney's fees as may be awarded by the court.

(c) Subsections (a) and (b) of this Code section shall not operate to deny coverage for failure to send a copy of a summons or other process

relating to policy coverage if such documents are sent by a third party to the insurer or to the insurer's agent by certified mail or statutory overnight delivery within ten days of the filing of such documents with the clerk of the court. If the name of the insurer or the insurer's agent is unknown, the third party shall have a period of 30 days from the date the insurer or agent becomes known in which to send these required documents. Such documents must be sent to the insurer or agent at least 30 days prior to the entry of any judgment against the insured.

History. — Code 1933, § 56-414, enacted by Ga. L. 1982, p. 1624, § 1; Code 1981, § 33-7-15, enacted by Ga. L. 1982, p. 1624, § 3; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33; Ga. L. 2000, p. 1589, § 3.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

Law reviews. — For survey article on insurance, see 34 Mercer L. Rev. 177 (1982).

JUDICIAL DECISIONS

Applicability. — O.C.G.A. § 33-7-15 does not apply to lack of notice of accident. Ginn v. State Farm Mut. Auto. Ins. Co., 196 Ga. App. 640, 396 S.E.2d 582 (1990) (questioning holding of Rucker v. Allstate Ins. Co., 194 Ga. App. 407, 390 S.E.2d 642 (1990), to the contrary).

Because O.C.G.A. § 33-7-15(c) was limited to motor vehicle liability insurance and had no effect on the notice received by an insurance company in an action concerning a general liability policy. Holbrook-Myers Co. v. Transp. Ins. Co., 354 F. Supp. 2d 1349 (N.D. Ga. Jan. 7, 2005).

Burden of proof of reasonableness of delay and prejudice. — Lack of timely notice to the insurer of lawsuits may relieve the insurer of its duty to defend and pay if the delay is unreasonable and the insurer is prejudiced by the delay. The insurer bears the burden of showing both unreasonable delay and prejudice. State Farm Mut. Auto. Ins. Co. v. Stanley, 773 F. Supp. 1539 (S.D. Ga. 1991), rev'd on other grounds, 966 F.2d 628 (11th Cir. 1992).

Exculpatory clause valid where insured failed to notify company of claim. — Policy provision excusing insurance company from liability for insured's failure to notify insurance company of a claim or suit against insured constituted a valid defense for the company to a judgment against the insured. Berryhill v. State Farm Fire & Cas. Co., 174 Ga. App. 97, 329 S.E.2d 189 (1985).

Notice received from named insured was sufficient, even though he had sold the vehicle to the person who was driving it at the time of the accident but had retained possession of the title certificate as security for the balance owing on the purchase price, and the policy had not yet expired. Mahone v. State Farm Mut. Auto. Ins. Co., 188 Ga. App. 664, 373 S.E.2d 809, cert. denied, 188 Ga. App. 912, 373 S.E.2d 809 (1988).

Third party notice. — The notice requirement contemplated by O.C.G.A. § 33-7-15 is satisfied if the insurer receives notice of the suit either from an insured or from a third party. Georgia Farm Bureau Mut. Ins. Co. v. Martin, 209 Ga. App. 237, 433 S.E.2d 315 (1993), rev'd on other grounds, 264 Ga. 347, 444 S.E.2d 739 (1994).

Third party's failure to certify her notice to the insurer was not dispositive on the issue of whether notice of the pending suit was, in fact, given within ten days of filing the claim. Weekes v. Nationwide Gen. Ins. Co., 232 Ga. App. 144, 500 S.E.2d 620 (1998).

Unfiled, unstamped, and unverified copy of complaint that counsel for motor-

ist and passenger sent to insurance company was not a summons "or other process" pursuant to O.C.G.A. § 33-7-15(c) sufficient to inform the insurance company of a third party action involving its insured, and thus, did not trigger the insurance company's duties to defend or pay. Peachtree Cas. Ins. Co. v. Bhalock, 252 Ga. App. 328, 556 S.E.2d 218 (2001).

When an injured party sued the insurer of a motorist against whom the injured party obtained a judgment, both to collect on the judgment and to assert a claim, as assignee of the motorist, for bad faith failure to settle, the insurer was not entitled to summary judgment because, even though the motorist did not provide the insurer with notice of the claim, the injured party provided the insurer with sufficient notice, under O.C.G.A. § 33-7-15(c), when it provided the insurer a copy of the complaint, with a court clerk's notation of the case number and the date on which the complaint was filed, and the insurer did not show that the injured party's failure to provide the insurer with a copy of the summons deprived it of the ability to timely and adequately investigate the claim. Canal Indem. Co. v. Greene, 265 Ga. App. 67, 593 S.E.2d 41 (2003).

Insufficient notice. — Where the information received by the insurer, through various requests for production of documents and other discovery requests barren of a copy of the summons or complaint, did not inform it of even the most basic facts concerning the accident, notice was clearly inadequate. Chadbrooke Ins. Co. v. Fowler, 206 Ga. App. 778, 426 S.E.2d 578 (1992).

Notice requirement not negated. — O.C.G.A. § 33-7-15 does not negate the requirement that an in personam judgment must be obtained against the insured tortfeasor before the insurer will be obligated to pay it. Southeastern Sec. Ins. Co. v. Lowe, 242 Ga. App. 535, 530 S.E.2d 231 (2000).

Default judgment entered although no notice to insurer. — The provisions of O.C.G.A. § 33-7-15 do not apply to relieve defendant of its liability when a default judgment was entered against the defendant, despite not being notified of the action by either the insured or any third party. Progressive Cas. Ins. Co. v. Bryant, 205 Ga. App. 164, 421 S.E.2d 329 (1992).

Attorney's fees. — Where an insured's motor vehicle liability insurer entered a defense on the insured's behalf pursuant to a reservation of rights and then filed a declaratory judgment action seeking a ruling that no coverage existed under the policy, and the plaintiff's uninsured motorist carrier undertook the insurer's defense in the declaratory judgment action and ultimately obtained a ruling that the insured was covered under the policy, the uninsured motorist carrier may not recover its legal costs and attorney fees expended in defending the insured in the declaratory judgment action. Hall v. Canal Ins. Co., 195 Ga. App. 16, 392 S.E.2d 340 (1990).

Recovery of attorney fees under paragraph (b.1) of O.C.G.A. § 33-7-15 is limited to those situations involving non-cooperation by an insured with the insured's insurance company. Gibson v. Southern Gen. Ins. Co., 199 Ga. App. 776, 406 S.E.2d 121 (1991); Standard Guar. Ins. Co. v. Hulsey, 204 Ga. App. 508, 420 S.E.2d 54 (1992).

Since the instant declaratory judgment action was not predicated upon insured's failure to cooperate with the insurance company, a recovery of attorney's fees would not be authorized. Standard Guar. Ins. Co. v. Hulsey, 204 Ga. App. 508, 420 S.E.2d 54 (1992).

Trial court did not err in denying an insured's motion for attorney fees under O.C.G.A. § 33-7-15(b.1) as the insured could have requested attorney fees under § 33-7-15(b.1) at the time the insured sought O.C.G.A. § 13-6-11 attorney fees below; thus, the request for § 33-7-15(b.1) fees was barred by the doctrine of res judicata. Ponse v. Atlanta Cas. Co., 270 Ga. App. 122, 605 S.E.2d 826 (2004).

Nonprejudicial failure to comply with notice provisions. — Insured's failure to comply with the notice provisions of a policy of automobile insurance issued pursuant to Georgia's assigned risk plan would not operate to defeat recourse to the policy by a third party, where the insurer received prompt and adequate no-

tice of the pendency of litigation, and there was no suggestion that its ability to defend had been prejudiced in any way by the failure of the insured to provide it with prior notice of an accident. Starnes v. Cotton States Mut. Ins. Co., 194 Ga. App. 320, 390 S.E.2d 419, aff'd, 260 Ga. 235, 392 S.E.2d 3 (1990).

Insurer failed to carry its burden of proving that insured's actions in failing to notify insurer of a pending suit sufficiently prejudiced insurer's ability to defend insured so as to support a summary judgment order relieving insurer of its obligation to defend insured. To establish prejudice the insurer must show some deficiency in the investigation or defense undertaken prior to its notification of the suit, as well as evidence as to what the insurer would have done differently to prevent the prejudice which it alleges to have suffered. State Farm Mut. Auto. Ins. Co. v. Stanley, 966 F.2d 628 (11th Cir. 1992).

No per se material prejudice. — There is no per se rule that if an insured, who was involved in the underlying occurrence of the litigation, dies prior to the insurer's receipt of notice of suit, then the insurer is considered materially prejudiced, warranting reversal of district courts grant of insurer's motion for summary judgment. State Farm Mut. Auto. Ins. Co. v. Stanley, 773 F. Supp. 1539 (S.D. Ga. 1991), rev'd on other grounds, 966 F.2d 628 (11th Cir. 1992).

Evidence sufficient to carry insurer's burden of showing prejudice. — The insurer's introduction of sworn testimony establishing that the insurer received no notification of a suit brought against its insured until after final judgment had been entered in a default situation is sufficient to carry the insurer's burden of showing prejudice under subsection (b) so as to relieve the insurer of its obligations under the policy to defend the suit and pay any judgment entered against its insured. Champion v. Southern Gen. Ins. Co., 198 Ga. App. 129, 401 S.E.2d 36 (1990), cert. denied, 198 Ga. App. 897, 401 S.E.2d 36 (1991).

Failure to cooperate. — When an injured party sued the insurer of the motorist against whom the injured party obtained a judgment, the insurer was not entitled to summary judgment based on its argument, under O.C.G.A. § 33-7-15(a), that it was relieved of liability due to its insured's failure to cooperate with it because there were genuine issues of material fact as to whether the insured failed to cooperate. Canal Indem. Co. v. Greene, 265 Ga. App. 67, 593 S.E.2d 41 (2003).

Trial court did not err in entering judgment in favor of an insurer in a couple's action seeking satisfaction of a judgment they recovered against an insured in a personal injury suit because the evidence supported a finding that the insurer reasonably requested the insured's cooperation, that the insured willfully and intentionally failed to cooperate, that the insured's failure to cooperate was prejudicial to the insurer, and that the insured's justification for failing to respond was insufficient. Vaughan v. ACCC Ins. Co., 314 Ga. App. 741, 725 S.E.2d 855 (2012).

Cited in Georgia Mut. Ins. Co. v. Rollins, Inc., 209 Ga. App. 744, 434 S.E.2d 581 (1993); Aetna Cas. & Sur. Co. v. Empire Fire & Marine Ins. Co., 212 Ga. App. 642, 442 S.E.2d 778 (1994); Thomas v. Atlanta Cas. Co., 253 Ga. App. 199, 558 S.E.2d 432 (2001).

RESEARCH REFERENCES

Am. Jur. Trials. — Actions Against Insurer for Bad Faith Failure to Settle Claim, 21 Am. Jur. Trials 229.

CHAPTER 8

FEES AND TAXES

Sec.
33-8-1. Fees and charges generally.
33-8-2. Fees and taxes imposed upon representatives of insurers of other states.
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33-8-4.2. Assignment, carryover, and liability regarding tax credits.
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33-8-8.1. County and municipal corporation taxes on life insurance companies.
33-8-8.2. County and municipal corporation taxes on other than life insurance companies.
33-8-8.3. Funding of services, or reduction of ad valorem taxes, in unincorporated areas of counties; powers and duties of governing authority.
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33-8-10. Confidential treatment of tax information; information to be disclosed by local officials engaged in collection of taxes; violations.
33-8-11. Issuance of execution against persons delinquent in payment of fees or taxes.
33-8-12. Waiver of penalties and interest.
33-8-13. Exemption of certain insurance companies from taxes.

Administrative rules and regulations. — Premium tax, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-6.

Law reviews. — For annual survey on state and local taxation, see 36 Mercer L. Rev. 307 (1984).

OPINIONS OF THE ATTORNEY GENERAL

Hospital service nonprofit corporations subject to chapter. — Despite paragraph (1) of former Code 1933, § 56-108 (see (O.C.G.A. § 33-1-3), hospital service nonprofit corporations (see O.C.G.A. T. 33, C. 19) are subject to the fees and taxes imposed by this chapter. 1973 Op. Att'y Gen. No. 73-74 (decided under former Code 1933, § 56-1301 et seq.).

Any action to recover insurance taxes under this chapter must be brought within seven years from the date that the execution may be lawfully issued. 1969 Op. Att'y Gen. No. 69-396.

RESEARCH REFERENCES

ALR. — Taxation of insurance reserves, 13 A.L.R. 186; 78 A.L.R. 562.

33-8-1. Fees and charges generally.

The Commissioner is authorized to assess and collect in advance, and persons so assessed shall pay in advance to the Commissioner, fees and charges under this title as follows:

(1) Unless specifically provided otherwise, for each certificate of authority, original license, renewal of a certificate of authority, or renewal of a license:	
(A) Agent, subagent, counselor, adjuster, or principal office of an insurance agency (new license)	$ 100.00
(B) Agent, subagent, counselor, adjuster, or principal office of an insurance agency (biennial license renewal)	100.00
(B.1) Each branch office of an insurance agency other than the principal office (new license)	20.00
(B.2) Each branch office of an insurance agency other than the principal office (biennial license renewal)	20.00
(C) Agent certificate of authority for subagent	5.00
(D) Automobile self-insurance	100.00
(E) Captive insurance company:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(F) Continuing care provider	75.00
(G) Duplicate certificate of authority, license, or permit	25.00
(H) Farmers mutual fire insurance company:	
(i) Original license or certificate	500.00
(ii) Renewal license or certificate	25.00

(I) Fraternal benefit society:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(I.1) Health care corporations:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(J) Health maintenance organization:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(K) Insurer certificate of authority for agent	10.00
(L) Life, accident, and sickness insurance company:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(M) Managing general agent:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(N) Multiple employer self-insurance plan	400.00
(O) Premium finance company (full power)	500.00
(P) Premium finance company (limited power)	300.00
(Q) Reserved.	
(R) Prepaid legal services plans	500.00
(S) Private review agents:	
(i) Original license or certificate	1,000.00
(ii) Renewal license or certificate	500.00
(T) Property and casualty insurance company:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(U) Reserved.	
(V) Rating or advisory organization	100.00
(W) Reinsurance intermediary	50.00
(X) Surplus lines broker	600.00

(Y) Third-party administrators:	
(i) Original license or certificate	500.00
(ii) Renewal license or certificate	400.00
(Z) Title insurance company:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(AA) Utilization review agent	200.00
(BB) Each vending machine licensed under Chapter 23 of this title	25.00
(CC) Workers' compensation group self-insurance fund:	
(i) Original license or certificate	600.00
(ii) Renewal license or certificate	500.00
(2) Bond or security deposits:	
(A) Not over $5,000.00	4.00
(B) Not over $10,000.00	8.00
(C) Not over $25,000.00	15.00
(D) Not over $50,000.00	25.00
(E) Over $50,000.00 but less than $100,000.00	40.00
(F) $100,000.00 or more	50.00
(3) Examination fee for agent's, subagent's, counselor's, or adjuster's license	25.00
(4) Application fee for agent's, subagent's, adjuster's, or counselor's license	15.00
(5) Status letter for agent, subagent, counselor, or adjuster	10.00
(6) For the following filings:	
(A) Bylaws amendments	25.00
(B) Certification of annual statement	10.00
(C) Certification of examination report	10.00
(D) Certification of other documents	5.00
(E) Charter amendments	25.00

(F) Education course provider (original filing)	100.00
(G) Education course provider (renewal filing)	50.00
(H) Education course or program	10.00
(I) Education course instructor	10.00
(J) Financial statement	50.00
(K) Form A	5,000.00
(L) Form A exemption	1,000.00
(M) Form B	500.00
(N) Form B exemption	100.00
(O) Individual risk rate or form	10.00
(P) Insurance policy form	25.00
(Q) Insurance rate filing	75.00
(R) Listing of licensed agents, subagents, counselors, or adjusters	1,000.00
(S) Listing of insurer's certificates of authority filed for agents	5.00
(T) Listing of agent's certificates of authority filed for subagents	5.00
(U) List of licensees or permit or certificate holders other than agents, subagents, counselors, or adjusters	40.00
(V) License, permit, or certificate of authority amendment	25.00
(W) Late fee for filings	15.00
(X) Registration of risk retention groups	100.00
(Y) Registration of purchasing groups	100.00
(Z) Filing of other documents	50.00
(AA) Amendment of filings	25.00

Provided, however, that the Commissioner, in his or her discretion, may exempt from such fee change of address filings done offline by agents, subagents, counselors, and adjusters.

(AA.1) Change of address filings done online by agents, subagents, counselors, and adjusters ..... No charge

(BB) Service of process 15.00

(7) For refiling of corrected documents under this Code section, provided that fees were paid with original filing ..... No charge

History. — Code 1933, § 56-1301, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1973, p. 499, § 3; Ga. L. 1976, p. 535, § 3; Ga. L. 1983, p. 729, § 1; Ga. L. 1985, p. 1399, § 4; Ga. L. 1987, p. 3, § 33; Ga. L. 1988, p. 1519, §§ 2, 3; Ga. L. 1992, p. 2725, § 11; Ga. L. 1994, p. 858, § 1; Ga. L. 1995, p. 745, §§ 2.2, 2.3; Ga. L. 1997, p. 1296, § 2; Ga. L. 2000, p. 882, § 3; Ga. L. 2006, p. 652, § 6/HB 1257; Ga. L. 2011, p. 623, § 1/SB 251; Ga. L. 2017, p. 164, § 7/HB 127; Ga. L. 2018, p. 1112, § 33/SB 365; Ga. L. 2019, p. 337, § 1-39/SB 132.

The 2018 amendment, effective May 8, 2018, part of an Act to revise, modernize, and correct the Code, added a period at the end of subparagraph (1)(Q); substituted "offline" for "off line" in the proviso of subparagraph (6)(AA); and substituted "online" for "on line" in subparagraph (6)(AA.1).

The 2019 amendment, effective July 1, 2019, designated the formerly undesignated divisions of subparagraphs (1)(E), (1)(H), (1)(I), (1)(I.1), (1)(J), (1)(L), (1)(M), (1)(S), (1)(T), (1)(Y), (1)(Z), and (1)(CC) as divisions (i) and (ii), respectively.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2017, the numerals "5" and "6" were deleted from subparagraph (1)(U).

Administrative rules and regulations. — Regulations regarding agents, subagents, counselors, adjusters, surplus lines brokers, and agencies, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-3.

OPINIONS OF THE ATTORNEY GENERAL

Private contractor charging for recordkeeping services. — A private contractor may not collect a fee for recordkeeping services associated with insurance agent licensing renewal, since such action would be an improper delegation of authority and contrary to O.C.G.A. § 33-8-1, which already prescribes the specific amounts the Commissioner of Insurance may collect for such activities. 1993 Op. Att'y Gen. No. 93-21.

RESEARCH REFERENCES

ALR. — Constitutionality of statutes requiring payment to state of fee on appointment of agent by foreign insurance company, 60 A.L.R. 1172; 64 A.L.R. 1434.

Validity, construction, and application of statutes or ordinances prohibiting or regulating automatic vending machines, 111 A.L.R. 755; 151 A.L.R. 1195.

33-8-2. Fees and taxes imposed upon representatives of insurers of other states.

The same fees or taxes imposed upon Georgia agents, brokers, adjusters, or any other representatives of insurers, as listed in this

chapter, for the privilege of doing business in another state shall be imposed upon agents, brokers, adjusters, or any other representatives of insurers of such other state doing business in this state, in accordance with Code Section 33-3-26.

History. — Code 1933, § 56-1302, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1983, p. 3, § 24.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 51.

C.J.S. — 44 C.J.S., Insurance, § 141 et seq.

ALR. — Construction, application, and operation of state "retaliatory" statutes imposing special taxes or fees on foreign insurers doing business within the state, 30 A.L.R.4th 873.

33-8-3. License fees of insurance companies generally.

(a) Each and every insurance company, domestic, foreign, or alien, carrying on an insurance business in Georgia shall pay to the Commissioner, annually in advance, on or before July 1, a license fee in an amount as provided in Code Section 33-8-1, which payment shall be in lieu of all other license fees of said companies. Foreign companies entering the state and domestic companies beginning business at any time during the license year as fixed by this Code section shall pay said license fee in full for the remaining portion of that license year.

(b) The license fees provided for in Code Section 33-8-1 are expressly imposed on and shall be the obligation of the licensees.

History. — Code 1933, § 56-1309, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1983, p. 729, § 2; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 1399, § 5; Ga. L. 1992, p. 2725, § 12.

JUDICIAL DECISIONS

County taxing power preempted prior to 1984. — O.C.G.A. § 33-8-8.2, effective January 1, 1984, does not affect the validity of a DeKalb county license tax imposed for the years 1974 through 1981, when preemption of the county's power to tax casualty insurance companies could be fairly implied from the sweeping language and broad scope of the 1960 general Act regulating the insurance industry on a state-wide basis, and particularly from the state-wide gross premium tax on casualty insurance companies contained in O.C.G.A. § 33-8-4. Cotton States Mut. Ins. Co. v. DeKalb County, 251 Ga. 309, 304 S.E.2d 386 (1983).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 30, 43.

C.J.S. — 44 C.J.S., Insurance, § 77 et seq.

ALR. — What organizations are within provisions of tax statutes relating to insurance companies, 146 A.L.R. 454.

33-8-4. Amount and method of computing tax on insurance premiums generally; exclusion of annuity considerations.

(a) All foreign, alien, and domestic insurance companies doing business in this state shall pay a tax of 2 1/4 percent upon the gross direct premiums received by them. The tax shall be levied upon persons, property, or risks in Georgia, from January 1 to December 31, both inclusive, of each year without regard to business ceded to or assumed from other companies. The tax shall be imposed upon gross premiums received from direct writings without any deductions allowed for premium abatements of any kind or character or for reinsurance or for cash surrender values paid, or for losses or expenses of any kind; provided, however, that deductions shall be allowed for premiums returned on change of rate or canceled policies; provided, further, that deductions may be permitted for return premiums or assessments, including all policy dividends, refunds, or other similar returns paid or credited to policyholders and not reapplied as premium for additional or extended life insurance. The term "gross direct premiums" shall not include annuity considerations.

(b) For purposes of this chapter, annuity considerations received by nonprofit corporations licensed to do business in this state issuing annuities to fund retirement benefits for teachers and staff personnel of private secondary schools and colleges and universities shall not be considered gross direct premium.

(c) Insurers shall be exempt from otherwise applicable state premium taxes as provided for in subsection (a) of this Code section on premiums paid by Georgia residents for high deductible health plans as defined by Section 223 of the Internal Revenue Code.

History. — Code 1933, § 56-1303, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-1312, enacted by Ga. L. 1973, p. 499, § 4; Ga. L. 1976, p. 1080, § 2; Ga. L. 1979, p. 850, § 2; Ga. L. 2008, p. 292, § 1/HB 977; Ga. L. 2009, p. 652, § 1/HB 410; Ga. L. 2019, p. 337 § 1-40/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (a), deleted "on and after July 1, 1955" at the end of the first sentence and inserted "that" following "provided, however," in the middle of the third sentence.

Editor's notes. — Ga. L. 1979, p. 850, § 2, amended this section so as to exempt annuity considerations from taxation, such amounts being more akin to deposits in savings accounts than insurance premiums. In order to minimize the adverse effects of such exemption on revenues received from the taxation of insurance premiums, subsection (2) of Ga. L. 1979, p. 850, § 2, provides for a gradual elimination over a three-year period of the tax on annuity considerations, such reductions to commence in the calendar year commencing on January 1, 1980.

Ga. L. 2008, p. 292, § 6(a)/HB 977, not

codified by the General Assembly, provides in part that the 2008 amendment is applicable to all taxable years beginning on or after January 1, 2009.

Ga. L. 2009, p. 652, § 6(a)/HB 410, not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2009".

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979). For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990). For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U.L. Rev. 217 (2011).

JUDICIAL DECISIONS

County taxing power preempted prior to 1984. — O.C.G.A. § 33-8-8.2, effective January 1, 1984, does not affect the validity of a DeKalb county license tax imposed for the years 1974 through 1981, when preemption of the county's power to tax casualty insurance companies could be fairly implied from the sweeping language and broad scope of the 1960 general Act regulating the insurance industry on a state-wide basis, and particularly from the state-wide gross premium tax on casualty insurance companies contained in this section. Cotton States Mut. Ins. Co. v. DeKalb County, 251 Ga. 309, 304 S.E.2d 386 (1983).

OPINIONS OF THE ATTORNEY GENERAL

The legislative intent of O.C.G.A. § 33-8-4 is clear. Annuity considerations are to be excluded from the tax because they are more akin to savings deposits than insurance premiums, and the exclusion is to be phased in over a three-year period commencing January 1, 1980, to minimize the impact of lost revenues on the state budget. 1981 Op. Att'y Gen. No. 81-63.

A conflict arises in Ga. L. 1979, p. 850, § 2, the "to read" clause, which provides that the tax is to be reduced by .75 percent effective January 1, 1980, by 1.50 percent effective January 1, 1981, and by 2.25 percent effective January 1, 1982; if this schedule of reduction is followed literally, the taxation of annuity premiums would end on January 1, 1982, as opposed to January 1, 1983. However, this schedule of reductions is followed immediately by the words "so that for the calendar years beginning on and after January 1, 1983, there shall be no further taxation of annuity considerations under this Title", which words reaffirm the General Assembly's intent for a three-year phaseout ending January 1, 1983. 1981 Op. Att'y Gen. No. 81-63.

Sponsor of prepaid legal service plan is an "insurance company" which owes premium taxes on risks placed in Georgia whether or not it is authorized to do business as an insurance company in Georgia. 1982 Op. Att'y Gen. No. 82-46.

Tax rate for legal services insurance. — Companies offering prepaid legal services insurance should pay taxes on those premiums at the statutory rate established for nonlife insurance companies. 1990 Op. Att'y Gen. No. 90-44.

Premiums for group insurance covering Georgia residents written outside Georgia are taxable. — The Insurance Commissioner may legally collect taxes on insurance premiums received by an insurer covering Georgia residents on a group insurance contract written outside Georgia. 1969 Op. Att'y Gen. No. 69-396.

Premiums for Metropolitan Atlanta Rapid Transit Authority insurance. — Insurance companies and surplus line brokers who provide insurance coverage for the Metropolitan Atlanta Rapid Tran-

sit Authority are not exempt from paying tax on the premiums collected for such coverage. 1975 Op. Att'y Gen. No. 75-54.

Premiums for out-of-state life insurance on nonresidents subsequently moving into state. — Life insurers not admitted in Georgia whose only contact with this state is the receipt of premiums on policies written and delivered without this state to persons not then residents of this state but who have subsequently moved to this state are not liable for the premium taxes imposed by this section. 1979 Op. Att'y Gen. No. 79-72.

Any action to recover insurance taxes under this chapter must be brought within seven years from the date that the execution may be lawfully issued. 1969 Op. Att'y Gen. No. 69-396.

Insurance companies exempt from federal income tax as religious and charitable organizations are subject to state and local premium tax liability unless specifically exempted. 1995 Op. Att'y Gen. No. 95-19.

HMO receipts of Medicaid premium payments. — The Insurance Commissioner has the authority to tax HMO receipts of Medicaid premium payments. 1998 Op. Att'y Gen. No. 98-17.

RESEARCH REFERENCES

ALR. — "Dividends" on policies as affecting computation of tax insurance premiums, 141 A.L.R. 1411.

What organizations are within provisions of tax statutes relating to insurance companies, 146 A.L.R. 454.

33-8-4.1. State insurance premiums tax credits for insurance companies located in certain counties designated as less developed areas; authority of commissioner of community affairs and Commissioner.

(a) As used in this Code section, the term:

(1) "Business enterprise" means any insurance company or the headquarters of any insurance company required to pay the tax under Code Section 33-8-4.

(2) "Existing business enterprise" means any insurance company or the headquarters of any insurance company required to pay the tax under Code Section 33-8-4 which has operated for the immediately preceding three years a facility in this state.

(b)(1) Not later than December 31 of each year, using the most current data available from the Department of Labor and the United States Department of Commerce, the commissioner of community affairs shall rank and designate as less developed areas all 159 counties in this state using a combination of the following equally weighted factors:

(A) Highest unemployment rate for the most recent 36 month period;

(B) Lowest per capita income for the most recent 36 month period; and

(C) Highest percentage of residents whose incomes are below the poverty level according to the most recent data available.

(2) Counties ranked and designated as the first through seventy-first least developed counties shall be classified as tier 1, counties ranked and designated as the seventy-second through one hundred sixth least developed counties shall be classified as tier 2, counties ranked and designated as the one hundred seventh through one hundred forty-first least developed counties shall be classified as tier 3, and counties ranked and designated as the one hundred forty-second through one hundred fifty-ninth least developed counties shall be classified as tier 4.

(c) The commissioner of community affairs shall be authorized to include in the tier 2 designation provided for in subsection (b) of this Code section any tier 3 county which, in the opinion of the commissioner of community affairs, undergoes a sudden and severe period of economic distress caused by the closing of one or more business enterprises located in such county. No designation made pursuant to this subsection shall operate to displace or remove any other county previously designated as a tier 2 county.

(d) The commissioner of community affairs shall be authorized to include in the tier 1 designation provided for in subsection (b) of this Code section any tier 2 county which, in the opinion of the commissioner of community affairs, undergoes a sudden and severe period of economic distress caused by the closing of one or more business enterprises located in such county. No designation made pursuant to this subsection shall operate to displace or remove any other county previously designated as a tier 1 county.

(e) For business enterprises which plan a significant expansion in their labor forces, the commissioner of community affairs shall prescribe redesignation procedures to ensure that the business enterprises can claim credits in future years without regard to whether or not a particular county is reclassified in a different tier.

(f)(1) Business enterprises in counties designated by the commissioner of community affairs as tier 1 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to $3,500.00 annually per eligible new full-time employee job for five years beginning with years two through six after the creation of such job. Business enterprises in counties designated by the commissioner of community affairs as tier 2 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to $2,500.00 annually, business enterprises in counties designated by the commissioner of community affairs as tier 3 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to

$1,250.00 annually, and business enterprises in counties designated by the commissioner of community affairs as tier 4 counties shall be allowed a job tax credit for taxes imposed under Code Section 33-8-4 equal to $750.00 annually for each new full-time employee job for five years beginning with years two through six after the creation of the job. The number of new full-time jobs shall be determined by comparing the monthly average number of full-time employees subject to Georgia income tax withholding for the calendar year with the corresponding period of the prior calendar year. In tier 1 counties, those business enterprises that increase employment by five or more shall be eligible for the credit. In tier 2 counties, only those business enterprises that increase employment by ten or more shall be eligible for the credit. In tier 3 counties, only those business enterprises that increase employment by 15 or more shall be eligible for the credit. In tier 4 counties, only those business enterprises that increase employment by 25 or more shall be eligible for the credit. The average wage of the new jobs created must be above the average wage of the county that has the lowest average wage of any county in the state to qualify as reported in the most recently available annual issue of the Georgia Employment and Wages Averages Report of the Department of Labor. To qualify for a credit under this paragraph, the employer must make health insurance coverage available to the employee filling the new full-time job; provided, however, that nothing in this paragraph shall be construed to require the employer to pay for all or any part of health insurance coverage for such an employee in order to claim the credit provided for in this paragraph if such employer does not pay for all or any part of health insurance coverage for other employees. Credit shall not be allowed during a year if the net employment increase falls below the number required in such tier. Any credit received for years prior to the year in which the net employment increase falls below the number required in such tier shall not be affected. The Commissioner of Insurance shall adjust the credit allowed each year for net new employment fluctuations above the minimum level of the number required in such tier.

(2) Existing business enterprises as defined under paragraph (2) of subsection (a) of this Code section shall be allowed an additional tax credit for taxes imposed under Code Section 33-8-4 equal to $500.00 per eligible new full-time employee job for one year after the creation of such job. The additional credit shall be claimed in year two after the creation of such job. The number of new full-time jobs shall be determined by comparing the monthly average number of full-time employees subject to Georgia income tax withholding for the calendar year with the corresponding period of the prior calendar year. In tier 1 counties, those existing business enterprises that increase employment by five or more shall be eligible for the credit. In tier 2 counties,

only those existing business enterprises that increase employment by ten or more shall be eligible for the credit. In tier 3 counties, only those existing business enterprises that increase employment by 15 or more shall be eligible for the credit. In tier 4 counties, only those existing business enterprises that increase employment by 25 or more shall be eligible for the credit. The average wage of the new jobs created must be above the average wage of the county that has the lowest average wage of any county in the state to qualify as reported in the most recently available annual issue of the Georgia Employment and Wages Averages Report of the Department of Labor. To qualify for a credit under this paragraph, the employer must make health insurance coverage available to the employee filling the new full-time job; provided, however, that nothing in this paragraph shall be construed to require the employer to pay for all or any part of health insurance coverage for such an employee in order to claim the credit provided for in this paragraph if such employer does not pay for all or any part of health insurance coverage for other employees. Credit shall not be allowed during a year if the net employment increase falls below the number required in such tier. Any credit received for years prior to the year in which the net employment increase falls below the number required in such tier shall not be affected. The Commissioner of Insurance shall adjust the credit allowed each year for net new employment fluctuations above the minimum level of the number required in such tier.

(g) Tax credits for five years for the taxes imposed under Code Section 33-8-4 shall be awarded for additional new full-time jobs created by business enterprises qualified under subsection (b), (c), or (d) of this Code section. Additional new full-time jobs shall be determined by subtracting the highest total employment of the business enterprise during years two through six, or whatever portion of years two through six which has been completed, from the total increased employment. The Commissioner of Insurance shall adjust the credit allowed in the event of employment fluctuations during the additional five years of credit.

(h) The sale, merger, acquisition, or bankruptcy of any business enterprise shall not create new eligibility in any succeeding business entity, but any unused job tax credit may be transferred and continued by any transferee of the business enterprise. The commissioner of community affairs shall determine whether or not qualifying net increases or decreases have occurred and may require reports, promulgate regulations, and hold hearings as needed for substantiation and qualification.

(i)(1) Except as provided in paragraph (2) of this subsection, any credit claimed under this Code section but not used in that calendar

year may be carried forward for ten years from the close of the calendar year in which the qualified jobs were established, but in tiers 3 and 4 the credit established by this Code section taken in any one calendar year shall be limited to an amount not greater than 50 percent of the taxpayer's tax liability under Code Section 33-8-4 which is attributable to operations in this state for that calendar year. In tier 1 and 2 counties, the credit allowed under this Code section against taxes imposed under Code Section 33-8-4 in any calendar year shall be limited to an amount not greater than 100 percent of the taxpayer's tax liability under Code Section 33-8-4 attributable to operations in this state for such calendar year.

(2) The additional credit claimed by an existing business enterprise pursuant to the provisions of paragraph (2) of subsection (f) of this Code section must be applied against taxes imposed for the calendar year in which such credit is available and may not be carried forward to any subsequent calendar year.

(j) The Commissioner of Insurance may require such reports, promulgate such regulations, and gather such relevant data necessary and advisable for the evaluation of the job tax credits established by this Code section.

History. — Code 1981, § 33-8-4.1, enacted by Ga. L. 2008, p. 874, § 7/HB 1246; Ga. L. 2019, p. 337, § 1-41/SB 132.

The 2019 amendment, effective July 1, 2019, deleted the former last sentence of paragraph (f)(2), which read: "This paragraph shall apply only to new eligible full-time jobs created on or after January 1, 2009, and prior to January 1, 2014."

33-8-4.2. Assignment, carryover, and liability regarding tax credits.

(a) As used in this Code section, the term "affiliated entity" means:

(1) A corporation that is a member of the taxpayer's "affiliated group" within the meaning of Section 1504(a) of the Internal Revenue Code and which corporation has a tax liability under Code Section 33-8-4; or

(2) An entity affiliated with a corporation, business, partnership, or limited liability company taxpayer, which entity has a tax liability under Code Section 33-8-4 and which entity:

(A) Owns or leases the land on which a project is constructed;

(B) Provides capital for construction of the project; and

(C) Is the grantor or owner under a management agreement with a managing company of the project.

(b) In lieu of claiming any tax credit under Code Section 33-8-4.1 for which a taxpayer otherwise is eligible for the calendar year (such

eligibility being determined for this purpose without regard to any limitation imposed by reason of the taxpayer's precredit tax liability under Code Section 33-8-4), the taxpayer may elect to assign such credit in whole or in part to one or more affiliated entities for such calendar year by attaching a statement to the taxpayer's return for the calendar year; provided, however, that no carryover attributable to the unused portion of any previously claimed or assigned credit may be assigned or reassigned, except as provided in subsection (d) of this Code section. Such election must be made on or before the due date for filing the applicable tax return under Code Section 33-8-4, including any extensions which have been granted. In the case of any credit that must be claimed in installments in more than one calendar year, the election under this subsection may be made on an annual basis with respect to each such installment, provided that the taxpayer shall notify the Commissioner with respect to the assignment of each such installment by filing a separate copy of the election statement for such installment no later than the due date for filing the applicable tax return under Code Section 33-8-4, including any extensions which have been granted. Once made, an election under this subsection shall be irrevocable.

(c) The recipient of a tax credit assigned under subsection (b) of this Code section shall attach a statement to its tax return under Code Section 33-8-4 identifying the assignor of the tax credit, in addition to providing any other information required to be provided by a claimant of the assigned tax credit.

(d) If the assignor and the recipient of a tax credit assigned under subsection (b) of this Code section cease to be affiliated entities, any carryover attributable to the unused portion of such credit shall be transferred back to the assignor of the credit. Such assignor shall be permitted to use any such carryover itself and also shall be permitted to assign such carryover to one or more affiliated entities, as if such carryover were a tax credit under Code Section 33-8-4.1 for which the assignor became eligible in the calendar year in which the carryover was transferred back to the assignor.

(e) The assignor and recipient of a tax credit assigned under subsection (b) of this Code section shall be jointly and severally liable for any tax under Code Section 33-8-4 (plus interest and penalties, if any) attributable to the disallowance or recapture of the assigned credit.

History. — Code 1981, § 33-8-4.2, enacted by Ga. L. 2008, p. 874, § 8/HB 1246; Ga. L. 2019, p. 337, § 1-42/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" in the third sentence of subsection (b).

33-8-5. Abatement or reduction of tax on insurance premiums.

Whenever any insurance company doing business in this state shall make it appear to the Commissioner, by evidence satisfactory to him, that one-fourth of its total assets, as of December 31 of any taxable year, exclusive of direct obligations of the United States, consists of or is invested in any or all of the following classes of property:

(1) General obligation bonds of this state or of any political subdivision of the State of Georgia;

(2) Revenue bonds or revenue anticipation certificates of any county, municipality, or political subdivision of this state;

(3) Revenue bonds or revenue anticipation certificates of any authority or public corporation created by or pursuant to the laws of this state;

(4) Real estate situated in and subject to taxation by this state or its political subdivisions;

(5) Tangible personal property located in this state and subject to taxation by this state or its political subdivisions;

(6) Loans secured by liens on real estate situated in this state;

(7) Policy loans on insurance policies issued by the company on lives of persons resident in this state;

(8) Intangible property having a taxable situs in this state; or

(9) Shares in Georgia corporations in which the insurance companies are authorized to invest under the laws of this state,

then the gross premium tax levied by Code Section 33-8-4 shall be abated or reduced to 1 1/4 percent upon the gross premium of any company subject to taxation by said Code section and, if the amount so invested by any company shall be as much as three-fourths of its total assets, exclusive of direct obligations of the United States, then the said premium tax shall be abated or reduced to one-half of 1 percent upon the gross premiums of the company subject to taxation by said Code section.

History. — Code 1933, § 56-1305, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990).

OPINIONS OF THE ATTORNEY GENERAL

Retaliatory tax may be added to premium tax to which this section applies. — The retaliatory tax provisions (see O.C.G.A. § 33-3-26) and this section are not mutually exclusive; a company having met the statutory standards could qualify for the abatement provisions allowed on the gross premium tax; the same company could also be subject to retaliation because of the existing tax structure of its home state; thus, a foreign insurer coming within both provisions, i.e., abatement and retaliation, would first have the gross premium tax figured at the applicable rate; to this dollar amount would be added the amount of retaliatory tax, if any, computed against the foreign insurer because of the existing differential between the Georgia aggregate tax and free structure and that of the foreign state in which the company is based. 1963-65 Op. Att'y Gen. p. 138.

Certificates of deposit issued by Georgia banks to an insurance company domiciled in another state, but licensed in Georgia, where these certificates are not funds received directly from Georgia premiums or funds which are used as working capital for carrying on the Georgia business of this company, are not intangible property having a tax situs in this state. 1967 Op. Att'y Gen. No. 67-55.

Bank account in another state owned by foreign insurer whose principal place of business and administrative offices are in Georgia is intangible property with a taxable situs in Georgia and is therefore available for use in reducing the insurer's premium tax rate pursuant to O.C.G.A. § 33-8-5. 1982 Op. Att'y Gen. No. 82-22.

33-8-6. Time of payment of tax on insurance premiums; filing of returns; penalties.

(a) The annual premium taxes required in this chapter shall be paid to the Commissioner annually on or before March 1 following the close of the preceding calendar year upon all the premiums received during that calendar year. At the same time each such insurance company shall file with the Commissioner an annual return on a form prescribed by the Commissioner showing, by quarters, the gross direct premiums received during the preceding calendar year and the installment payments made during that year.

(b) Installments of the annual premium taxes shall be due and payable for each calendar quarter on the twentieth day of March, June, September, and December in each year based upon the estimated amount of gross direct premiums received during that calendar quarter. A final payment of tax due for the year shall be made at the time each such insurance company files its annual return for such year.

(c) Any insurance company which fails to report and pay any installment of tax or which estimates any installment of tax to be less than 80 percent of the amount finally shown to be due in any quarter shall be subject to penalty and interest as provided in subsection (d) of this Code section for any underpayment of taxes due and payable for that quarter. Any insurance company paying, for each installment required in this chapter, 25 percent of the amount of the annual

premium taxes reported on its annual return for the preceding year shall not be subject to any penalty or interest for such underpayment.

(d) A penalty of 10 percent of the amount owed, together with interest on the principal amount at the rate of 1 percent per month, or any part of a month, from the date due until the date paid shall be imposed for late payment, underpayment, or nonpayment of any taxes or amounts imposed under this chapter.

(e) When the date prescribed by or imposed pursuant to law for the making of any return, the filing of any paper or document, or the payment of any tax or license fee pursuant to this chapter falls on a Saturday, Sunday, or legal holiday, the making of the return, the filing of the paper or document, or the payment of the tax or license fee shall be postponed until the first day following which is not a Saturday, Sunday, or legal holiday.

(f) Subsections (b) and (c) of this Code section shall not apply to any such insurance company whose annual premium taxes for the immediately preceding calendar year was less than $500.00.

History. — Code 1933, § 56-1304, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1974, p. 4, § 1; Ga. L. 1984, p. 1284, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Penalty applies to late payments of quarterly installments. — Since this section clearly specifies that payments of premium taxes are due on specific dates, i.e., the twentieth day of March, June, September and December, late payments are equivalent to a failure to pay, and the 10 percent penalty is assessable as to the underpayment. Since the underpayment constitutes all the tax that is due and payable, the 10 percent penalty is assessable against the total amount of tax owed by the insurer during that quarter. With respect to the failure to pay any tax at all, a 10 percent penalty is assessable against all of the amount of the tax due and owing for that particular quarter. 1978 Op. Att'y Gen. No. 78-8.

RESEARCH REFERENCES

ALR. — "Dividends" on policies as affecting computation of tax insurance premiums, 141 A.L.R. 1411.

33-8-7. Deduction from taxes of retaliatory taxes paid other states.

Any insurance company, corporation, or association domiciled in this state and issuing insurance policies on fire, lightning, extended coverage, and windstorm, which policy covers property within this state, may deduct any retaliatory tax actually paid to another state from their Georgia taxes due for the tax year for which such retaliatory tax was

paid only at the time when such Georgia taxes for that year are paid and upon furnishing proof of payment of the retaliatory tax to the Commissioner.

History. — Code 1933, § 56-1306, enacted by Ga. L. 1960, p. 289, § 1.

Administrative rules and regulations. — Premium tax, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-6.

33-8-8. Preemption of taxation of insurance companies by state; exceptions; collection of license fees by municipal corporations.

(a) Except as otherwise provided in this chapter, the State of Georgia preempts the field of imposing taxes, except taxes on real property and tangible personal property taxed ad valorem, upon insurance companies and their agents and other representatives, including, but not limited to, excise, privilege, franchise, income, license, permit, registration, and similar taxes and fees measured by premiums, income, or volume of transactions; and no county or unincorporated area of such county, city, municipality, district, school district, or other political subdivision or agency of this state shall impose, levy, charge, or require the same, except as provided in this chapter.

(b) Municipal corporations are authorized, in conformity with the requirements of their charters, to impose and collect the following license fees upon insurance companies for the privilege of engaging in the business of insurance within said municipal corporation:

(1) An annual license fee on each insurance company doing business within the municipal corporate limits not to exceed the following schedule:

Population of Municipal Corporation	Amount
Under 1,000	$ 15.00
1,000 - 1,999	25.00
2,000 - 4,999	40.00
5,000 - 9,999	50.00
10,000 - 24,999	75.00
25,000 - 49,999	100.00
50,000 and over	150.00

and an additional annual license fee in the same amount for each separate business location in excess of one operated and maintained by such company within the same municipality; and

(2) An additional annual license fee of $10.00 or 35 percent of the schedule set forth in paragraph (1) of this subsection, whichever

amount is greater, on each insurance company for each separate business location not otherwise subject to a license fee under this Code section, which company is operated and maintained by a business organization which is engaged in the business of lending money or transacting sales involving term financing and which, in connection with the loans or sales involving term financing, offers, solicits, or takes applications for insurance through a licensed agent of the insurance company for insurance.

(c) Within 45 days after the date of their enactment, each municipal corporation shall file with the Commissioner a certified copy of the pertinent parts of all ordinances and amendments thereto which impose any such license fee, and such filing shall be a condition to the validity and enforceability of such an ordinance.

(d) Insurance agencies which are maintained and operated by a company may not be separately licensed by municipal corporations except under the provisions of this Code section; but nothing contained in this Code section shall prevent municipal corporations from separately imposing and collecting business licenses from independent insurance agencies or brokers doing an insurance business not otherwise taxed under this Code section. No such license may be imposed on such independent agents or brokers, which license is measured by the premiums of insurance companies.

(e) Life insurance companies may deduct from premium taxes otherwise payable to this state under Code Section 33-8-4, in addition to all credits and abatements allowed by law, the license fees imposed pursuant to this Code section and paid to any municipal corporation during the preceding calendar year.

(f) As used in this Code section, the term "life insurance company" means a company which is authorized to transact only the class of insurance designated in Code Section 33-3-5 as class (1).

History. — Code 1933, § 56-1310, enacted by Ga. L. 1964, p. 122, § 2; Ga. L. 1967, p. 631, § 1; Ga. L. 1968, p. 1396, § 1; Ga. L. 1981, p. 380, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 1595, § 1; Ga. L. 1984, p. 1284, § 2.

Editor's notes. — Ga. L. 1983, p. 1595, § 5 not codified by the General Assembly, provided that that Act would apply to all tax years beginning on or after January 1, 1984.

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981).

JUDICIAL DECISIONS

Classification for tax on gross insurance premiums is constitutionally permissible. — General Assembly may classify different businesses for the purpose of taxation and may make subclassifications within one type of business. These classifications have been held constitutional where there was a business tax

involved as opposed to a property tax. A tax on gross insurance premiums is a business tax. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

Section not "irrevocable" in violation of Constitution. — Neither Ga. Const. 1976, Art. I, Sec. I, Para. VII, nor Art. VII, Sec. I, Para. I (see Ga. Const. 1983, Art. I, Sec. I, Para. X, and Art. VII, Sec. I, Para. I), is applicable to this section, because the constitutional provisions contain the words "irrevocable" and "irrevocably," respectively. Webster's Third New International Dictionary defines the word "irrevocable" as "incapable of being recalled or revoked." Statutes passed by the General Assembly such as this section are clearly revocable at the will of the Legislature. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

Enactment of section held constitutional. — The Act enacting this section, Ga. L. 1964, p. 122, which empowered only municipal corporations to levy life insurance taxes and fees and prohibited all other political subdivisions from doing so, did not prevent there being uniformity of the laws. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966) (decided prior to 1981 amendment to this section and enactment of O.C.G.A. § 33-8-8.1).

The Act enacting this section, Ga. L. 1964, p. 122, did not refer to more than one subject matter even though it dealt with the powers of both county and municipal government, since the act dealt with the taxing of insurance company premiums and that alone was the subject matter of the act. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

Even though the title of Ga. L. 1964, p. 122, enacting this section, did not indicate that the Act dealt with business licenses issued by the county, the words "fees and taxes" as used in the title were sufficient to include those various and specific types which were set out in detail in the body of the Act, including business licenses. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

Even though no reference was made in the title that the purpose of Ga. L. 1964, p. 122, which enacted this section, was to preempt to the state the field of imposing taxes upon life insurance companies, the title did state that the Act was to "provide a uniform policy," and there could be no such uniform policy established in this field unless total authority in this matter was preempted and placed into one policy-making body, in this case the General Assembly. The fact that the body of the Act mentioned preemption did not violate the Constitution because it was incidental and necessary to carry out the purpose of establishing a uniform policy. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

Even though there was no reference in the title to the provision in Ga. L. 1964, p. 122, enacting this section, that no county or unincorporated area should be permitted to impose, levy, or charge any of the taxes and fees mentioned therein, no reference in the title had to be specifically made to the fact that no county or unincorporated area thereof could impose such taxes and fees under the Act, since the title sufficiently covered this provision by stating that the Act involved the "exercise of the powers of municipal corporations and other political subdivisions." This phrase was sufficient to cover both the granting and the taking of power from the various political subdivisions in the establishment of a uniform policy. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

Independent agencies held not subject to assessment of multiple license fees. — Independent insurance agencies which furnished and paid for their own offices and supplies, and retained a percentage of the premiums on the policies they sold, were not subject to the assessment of multiple license fees as agencies "operated and maintained" by an insurer. Columbus v. Stanton, 189 Ga. App. 251, 375 S.E.2d 503 (1988).

Municipalities may impose both license fees and gross premium taxes on life insurance companies. — Subsection (b) of this section authorizes only municipalities to levy a license fee and divides all municipalities into seven population categories with fees ranging from

$15.00 to $150.00 per annum depending upon which classification a municipality falls within. This subsection also authorizes municipalities to impose a tax based upon gross direct premiums received by life insurance companies. Nash v. National Preferred Life Ins. Co., 222 Ga. 14, 148 S.E.2d 402 (1966).

OPINIONS OF THE ATTORNEY GENERAL

Municipal tax cannot be based upon premiums received in current year. — Under this section, a municipality may not collect premium taxes upon the premiums received by a life insurance company during the current calendar year rather than the preceding calendar year from policies upon the lives of persons residing within the municipal limits. 1963-65 Op. Att'y Gen. p. 673.

Tax paid upon current year premiums, cannot be deducted from state taxes. — If an insurance company pays municipal taxes assessed upon the current rather than the preceding calendar year's business, the Insurance Commissioner may not allow such payment to be deducted from the premium taxes otherwise payable to this state under former Code 1933, § 56-1303 (see O.C.G.A. § 33-8-4). 1963-65 Op. Att'y Gen. p. 673.

33-8-8.1. County and municipal corporation taxes on life insurance companies.

(a) As used in this Code section, the term "life insurance company" means a company which is authorized to transact only the class of insurance designated in Code Section 33-3-5 as class (1).

(b) Life insurance companies are subject to county and municipal corporation taxes levied as follows:

(1) There is imposed a county tax for county purposes on each life insurance company doing business within the state, which tax shall be based solely upon gross direct premiums, as defined in Code Section 33-8-4, which are received during the preceding calendar year from policies insuring persons residing within the unincorporated area of the counties pursuant to the provisions of this Code section. The rate of such tax shall be 1 percent of such premiums, except that such tax shall not apply to the gross direct premiums of an insurance company which qualifies, pursuant to Code Section 33-8-5, for the reduction to one-half of 1 percent of the state tax imposed by Code Section 33-8-4. The tax imposed by this Code section shall not apply to annuity considerations; and

(2) Municipal corporations whose ordinances have been filed with the Commissioner are authorized to impose a tax on each life insurance company doing business within the state, which tax shall be based solely upon the gross direct premiums, as defined in Code Section 33-8-4, which are received during the preceding calendar year from policies insuring persons residing within the corporate limits of the municipal corporation pursuant to the provisions of this

Code section; provided, however, that the rate of the tax may not exceed 1 percent of the premiums. The tax imposed shall not apply to annuity considerations.

(c)(1) On March 1 of each year, each life insurance company shall file a certified return on a form prescribed by the Commissioner showing gross direct premiums received during the preceding calendar year that will appear in the company's certified annual statement.

(2) Reserved.

(3) On or before August 1 of each year, the Commissioner shall collect taxes imposed pursuant to subsection (b) of this Code section on behalf of counties and municipal corporations whose ordinances have been filed with the Commissioner. The tax collected for each year shall be based upon gross direct premiums written during the preceding calendar year. Penalty and interest as prescribed in subsection (d) of Code Section 33-8-6 shall be imposed for late payment, underpayment, or nonpayment of such taxes.

(d) Taxes imposed by subsection (b) of this Code section shall be allocated and distributed to counties and municipal corporations as follows:

(1) A portion of the total amount of life insurance premiums taxable by the state, exclusive of premiums collected by companies which qualify for the reduction to one-half of 1 percent of the state tax, shall be allocated to counties based upon the ratio that the total population of all unincorporated areas in the state bears to the total population in the state. The amount of the tax base so allocated to counties shall be taxed at the rate levied for county purposes. The tax shall be distributed to each county governing authority by the Commissioner based upon a fraction, the numerator of which is the population of the unincorporated area of that county and the denominator of which is the population of all unincorporated areas of the state; and

(2) A portion of the total amount of life insurance premiums taxable by the state shall be allocated to all municipal corporations based upon the ratio that the total population of all municipal corporations bears to the total state population. The amount of the tax base so allocated to municipalities shall be distributed to each municipal corporation based upon the fraction, the numerator of which is the population of that municipal corporation and the denominator of which is the population of all municipal corporations in the state. The amount of the tax base so distributed to each municipality shall be taxed at the rate levied by that municipality; and taxes levied by each municipal corporation shall be distributed based upon the tax rate levied by each such municipal corporation.

(e) On or before January 1 of the first year that the tax is levied, each municipal corporation levying the tax shall file with the Commissioner a certified copy of the pertinent parts of all ordinances and amendments thereto which impose the tax, and such filing shall be a condition to the validity and enforceability of such an ordinance. On or before February 1 of each year the Commissioner shall furnish a list of all municipal corporations levying the tax for that year to each life insurance company in the state.

(f) Life insurance companies may deduct from premium taxes otherwise payable to this state under Code Section 33-8-4, in addition to all credits and abatements allowed by law, the taxes imposed pursuant to subsection (b) of this Code section and paid to the Commissioner on behalf of any county and municipal corporation during the preceding calendar year.

(g) On or before October 15 of each year, the Commissioner shall distribute the taxes imposed by counties and municipal corporations which are actually remitted to and collected by the Commissioner. On or before October 15 of each year, the Commissioner shall distribute any delinquent taxes actually collected by the Commissioner for a previous year, exclusive of any interest or penalty on such delinquent taxes, which delinquent taxes have not previously been distributed.

(h) For purposes of this Code section, population shall be measured by the United States decennial census of 1990 or any future such census plus any corrections or revisions contained in official statements by the United States Bureau of the Census made prior to the first day of September immediately preceding the distribution of the proceeds of such taxes by the Commissioner and any additional official census data received by the Commissioner from the United States Bureau of the Census or its successor agency pertaining to any newly incorporated municipality. Such corrections, revisions, or additional data shall be certified to the Commissioner by the Office of Planning and Budget on or before August 31 of each year.

History. — Code 1933, § 56-1310.1, enacted by Ga. L. 1981, p. 380, § 2; Ga. L. 1983, p. 1595, § 2; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1284, § 2; Ga. L. 1988, p. 13, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1994, p. 528, § 1; Ga. L. 2009, p. 652, § 2/HB 410; Ga. L. 2019, p. 337, § 1-43/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "March 1 of each year" for "March 1, 1984, and on that date in each subsequent year" in paragraph (c)(1); substituted "August 1 of each year" for "August 1, 1988, and on the same date in each subsequent year" at the beginning of paragraph (c)(3); in subsection (g), substituted "October 15 of each year" for "October 15, 1988, and on the same date in each subsequent year" in two places; deleted former subsection (h), which read: "Amounts collected by the Commissioner under or due under former Code Section 33-8-8.1 shall be collected and disbursed as provided in former Code Section 33-8-8.1."; and redesignated former subsection (i) as present subsection (h).

Cross references. — Specific, business, and occupation taxes, T. 48, C. 13.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, "United States Bureau of the Census" was substituted for "United States Census Bureau" in subsection (i) (now subsection (h)).

Editor's notes. — Ga. L. 1983, p. 1595, § 5, not codified by the General Assembly, provided that that Act would apply to all tax years beginning on or after January 1, 1984.

Ga. L. 2009, p. 652, § 6(b)/HB 410, not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2010".

Pursuant to its own terms, subsection (a.1), as added by Ga. L. 2009, p. 652, § 2/HB 410, concerning exemption from local premium taxes, was repealed effective January 1, 2015.

Law reviews. — For article surveying developments in Georgia local government law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 187 (1981).

OPINIONS OF THE ATTORNEY GENERAL

Gross premium tax imposed by O.C.G.A. § 33-8-8.1 is applicable to all premiums received during calendar year 1981. 1981 Op. Att'y Gen. No. 81-108.

No credit for premium taxes paid directly to localities. — In administering O.C.G.A. § 33-8-8.1, the Insurance Commissioner may not give credit for premium taxes paid by insurance companies directly to city and county governments. 1984 Op. Att'y Gen. No. 84-24.

Taxes based on pre-1991 contract year not prohibited by 5 U.S.C. § 8909(e). — County and municipal taxes otherwise properly assessed pursuant to O.C.G.A. § 33-8-8.1 based on a pre-1991 contract year (i.e., any contract year beginning before January 1, 1991) between an insurance company and the Federal Employees Health Benefits Fund are not prohibited by 5 U.S.C. § 8909(f) regardless of when such tax is, payable and/or collected. 1993 Op. Att'y Gen. No. 93-6.

Disbursement of proceeds. — The premium tax imposed by O.C.G.A. § 33-8-8.1 is to be disbursed by the Insurance Commissioner in accordance with the formula set forth in subsection (f). 1982 Op. Att'y Gen. No. 82-42.

RESEARCH REFERENCES

Am. Jur. 2d. — 71 Am. Jur. 2d, State and Local Taxation, § 387.

33-8-8.2. County and municipal corporation taxes on other than life insurance companies.

(a) Counties and municipal corporations are authorized to levy tax at a rate not to exceed 2.5 percent upon the gross direct premiums of all foreign, alien, and domestic insurance companies doing business in this state other than life insurance companies. The tax shall be in addition to the taxes levied by Code Section 33-8-4, and it may be levied upon the gross direct premiums received by such companies during the preceding calendar year. The tax shall be levied upon premiums derived from policies insuring persons, property, or risks in Georgia from January 1 to December 31, both inclusive, of each year without regard to business ceded to or assumed from other companies. The tax shall be imposed upon gross premiums received during the preceding calendar year from direct writing without any deductions allowed from premium abate-

ment of any kind or character or for reinsurance or for losses or expenses of any kind; provided, however, deductions shall be allowed for premiums returned or change of rate or canceled policies; provided, further, that deductions shall be permitted for returned premiums or assessments, including all policy dividends, refunds, or other similar returns paid or credited to policyholders.

(b) The taxes provided in this Code section are county and municipal taxes and shall be levied for county and municipal purposes and shall be collected and distributed as follows:

(1) On or before January 1 of the first year that the tax is levied, each county and municipal corporation levying the tax shall file with the Commissioner a certified copy of the pertinent parts of all ordinances and resolutions and amendments thereto which impose the tax, and such filing shall be a condition to the validity and enforceability of such an ordinance or resolution;

(2) On or before February 1 of each year, the Commissioner shall furnish to each insurance company a list of all counties and municipal corporations where the tax as authorized by this Code section has been imposed for the then current year together with the applicable tax rate levied by each such county and municipal corporation and the population percentages by which the taxes are to be allocated to each such county and municipal corporation as provided in this Code section;

(3)(A) On March 1 of each year, each insurance company upon which a tax is imposed by subsection (b) of this Code section shall file a certified return on a form prescribed by the Commissioner showing gross direct premiums received during the preceding calendar year that will appear in the company's certified annual statement.

(B) Reserved.

(C) On or before August 1 of each year, the Commissioner shall collect taxes imposed pursuant to this Code section on behalf of counties and municipal corporations whose ordinances have been filed with the Commissioner. The premiums tax collected for each year shall be based upon gross direct premiums written during the preceding calendar year. Penalty and interest as prescribed in subsection (d) of Code Section 33-8-6 shall be imposed for late payment, underpayment, or nonpayment of such taxes;

(4) The total amount of premiums taxable by the state on insurance companies as defined in this Code section shall be allocated to each county unincorporated area and each municipal corporation based upon a fraction, the numerator of which is the population of the

unincorporated area or municipal corporation and the denominator of which is the total population of the state. Tax rates levied by each county shall be applied to the premiums allocated to its unincorporated area, and tax rates levied by each municipal corporation shall be applied to the premiums allocated to it; and

(5) On or before October 15 of each year, the Commissioner shall distribute the taxes imposed by counties and municipal corporations which are actually remitted to and collected by the Commissioner. On or before October 15 of each year, the Commissioner shall distribute any delinquent taxes actually collected by the Commissioner for a previous year, exclusive of any interest or penalty on such delinquent taxes, which delinquent taxes have not previously been distributed.

(c) For purposes of this Code section, population shall be measured by the United States decennial census of 1990 or any future such census plus any corrections or revisions contained in official statements by the United States Bureau of the Census made prior to the first day of September immediately preceding the distribution of the proceeds of such taxes by the Commissioner and any additional official census data received by the Commissioner from the United States Bureau of the Census or its successor agency pertaining to any newly incorporated municipality. Such corrections, revisions, or additional data shall be certified to the Commissioner by the Office of Planning and Budget on or before August 31 of each year.

(d) Any county or municipal corporation which, on January 1, 1983, levied a tax on all premiums of insurance companies, other than life insurance companies, at a rate in excess of 2.5 percent may continue to levy the tax at a rate in excess of 2.5 percent, provided that the rate of such tax shall not exceed the rate which was in effect in such county or municipal corporation on January 1, 1983, reduced annually beginning January 1, 1984, by one-third of the difference between such January 1, 1983, rate and 2.5 percent, so that the rate levied on January 1, 1986, shall not exceed 2.5 percent.

(e) It shall be in contravention of public policy for a county or a municipal corporation that levies taxes for county or municipal purposes on foreign, alien, and domestic insurance companies doing business in this state, as provided in subsection (a) of this Code section, to impose additional taxes or any other fees of any kind for services provided by such county or municipal corporation to such insurance companies for accidents involving motor vehicles except for the following:

(1) Where the coverage for such services is expressly provided by an insurance company to the insured and the services are lawfully billed to the insured;

(2) Where emergency medical services are provided to the insured by the county or municipal corporation, whenever the insured's medical insurance covers the services provided and the insured assigns the right to collect to the service provider; or

(3) Where other services are provided to the insured by the county or municipal corporation which are expressly authorized by state or federal law to be billed directly to an insurance company.

History. — Code 1981, § 33-8-8.2, enacted by Ga. L. 1983, p. 1595, § 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1284, § 2; Ga. L. 1985, p. 149, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1994, p. 528, § 2; Ga. L. 2008, p. 292, § 2/HB 977; Ga. L. 2008, p. 490, § 1/SB 348; Ga. L. 2009, p. 652, § 3/HB 410; Ga. L. 2019, p. 337, § 1-44/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "March 1 of each year" for "March 1, 1984, and on the same date in each subsequent year" in subparagraph (b)(3)(A); substituted "August 1 of each year" for "August 1, 1988, and on the same date in each subsequent year" in subparagraph (b)(3)(C); and substituted "October 15 of each year" for "October 15, 1988, and on the same date in each subsequent year" in two places in paragraph (b)(5).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, "United States Bureau of the Census" was substituted for "United States Census Bureau" in subsection (c).

Editor's notes. — Ga. L. 1983, p. 1595, § 5, not codified by the General Assembly, provided that that Act would apply to all tax years beginning on or after January 1, 1984.

Although subparagraph (b)(3)(A) imposes certain duties on insurance companies to be fulfilled on March 1, 1984, Ga. L. 1984, p. 1284, § 2, which added this language, was not approved until April 4, 1984. It seems, therefore, that such duties will not be imposed on insurance companies until March 1, 1985, and on the same date in each subsequent year, as called for in subparagraph (b)(3)(A).

Ga. L. 2008, p. 292, § 6(b)/HB 977, not codified by the General Assembly, provides: "Section 2 of this Act shall expire on January 1, 2015, unless the General Assembly acts to extend these provisions." The General Assembly took no action to extend these provisions prior to January 1, 2015, and therefore, subsection (a.1) was repealed effective January 1, 2015.

Ga. L. 2009, p. 652, § 6(a)/HB 410, not codified by the General Assembly, provides, in part, that the amendment to this Code section "shall be applicable to all taxable years beginning on or after January 1, 2009".

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990). For article, "Revenue and Taxation: Amend Titles 48, 2, 28, 33, 36, 46, and 50 of the Official Code of Georgia Annotated, Relating Respectively to Revenue and Taxation, Agriculture, the General Assembly, Insurance, Local Government, Public Utilities, and State Government," see 28 Ga. St. U.L. Rev. 217 (2011).

JUDICIAL DECISIONS

County taxing power preempted prior to 1984. — O.C.G.A. § 33-8-8.2, effective January 1, 1984, does not affect the validity of a DeKalb county license tax imposed for the years 1974 through 1981, when preemption of the county's power to tax casualty insurance companies could be fairly implied from the sweeping language and broad scope of the 1960 general Act regulating the insurance industry on a state-wide basis, and particularly from the state-wide gross premium tax on casualty insurance companies contained in O.C.G.A. § 33-8-4. Cotton States Mut.

Ins. Co. v. DeKalb County, 251 Ga. 309, 304 S.E.2d 386 (1983).

Holding in Cotton State Mut. Ins. Co. v. DeKalb County, 251 Ga. 309, 304 S.E.2d 386 (1983), is to be applied prospectively only. Federated Mut. Ins. Co. v. DeKalb County, 176 Ga. App. 70, 335 S.E.2d 873 (1985), aff'd, 255 Ga. 522, 341 S.E.2d 3 (1986).

OPINIONS OF THE ATTORNEY GENERAL

Inactive municipalities. — The population of an inactive municipality may not be assigned to the county for premium tax purposes under O.C.G.A. § 33-8-8.2. 1983 Op. Att'y Gen. No. 83-76.

Tax rate for legal services insurance. — Companies offering prepaid legal services insurance should pay taxes on those premiums at the statutory rate established for nonlife insurance companies. 1990 Op. Att'y Gen. No. 90-44.

Flood insurance premiums. — Flood insurance premiums collected by private insurance companies pursuant to the National Flood Insurance Program are not subject to municipal and county taxes as provided in subsection (a) of O.C.G.A. § 33-8-8.2. 1995 Op. Att'y Gen. No. 95-12.

Insurance companies exempt from federal income tax as religious and charitable organizations are subject to state and local premium tax liability unless specifically exempted. 1995 Op. Att'y Gen. No. 95-19.

33-8-8.3. Funding of services, or reduction of ad valorem taxes, in unincorporated areas of counties; powers and duties of governing authority.

(a) The proceeds from the county taxes levied for county purposes, as provided by this chapter, shall be separated from other county funds and shall be used by the county governing authorities solely for the purpose of either:

(1) Funding the provision of the following services to inhabitants of the unincorporated areas of such counties directly or by intergovernmental contract as authorized by Article IX, Section III, Paragraph I of the Constitution of the State of Georgia:

(A) Police protection, except such protection provided by the county sheriff;

(B) Fire protection;

(C) Curbside or on-site residential or commercial garbage and solid waste collection;

(D) Curbs, sidewalks, and street lights; and

(E) Such other services as may be provided by the county governing authority for the primary benefit of the inhabitants of the unincorporated area of the county; or

(2) Reducing ad valorem taxes of the inhabitants of the unincorporated areas of those counties in which the governing authority of a county does not provide any of the services enumerated in paragraph (1) of this subsection to inhabitants of the unincorporated areas. In

fixing the ad valorem tax millage rate for the year, the governing authorities of such counties shall be authorized and directed to reduce such ad valorem tax millage rate on taxable property within the unincorporated areas of such counties to offset any of the proceeds derived from any tax provided for in this chapter which cannot be expended pursuant to paragraph (1) of this subsection.

(b) In the adoption of the budget utilizing any of the funds derived from the tax imposed by Code Sections 33-8-8.1 and 33-8-8.2 the governing authority of a county shall specify in such budget the amount of such funds expended as authorized by paragraph (1) of subsection (a) of this Code section or used to reduce ad valorem taxes as provided in paragraph (2) of subsection (a) of this Code section. Said budget shall also specify the amount of any other funds expended for such purpose or purposes as are authorized to be expended for services referred to in paragraph (1) of subsection (a) of this Code section. Such provisions shall be spread on the minutes of the meeting at which such budget is adopted.

History. — Code 1981, § 33-8-8.3, enacted by Ga. L. 1983, p. 1595, § 4; Ga. L. 1984, p. 22, § 33; Ga. L. 1988, p. 1581, § 1; Ga. L. 1989, p. 1151, § 1; Ga. L. 1997, p. 561, § 1; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2019, p. 337, § 1-45/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "1984 and any year thereafter" following "rate for the year" near the beginning of the second sentence of paragraph (a)(2).

Editor's notes. — Ga. L. 1983, p. 1595, § 5, not codified by the General Assembly, provided that that Act would apply to all tax years beginning on or after January 1, 1984.

Law reviews. — For annual survey on local government law, see 69 Mercer L. Rev. 205 (2017).

JUDICIAL DECISIONS

County's funding of solid waste collection and disposal convenience centers. — In a class action suit seeking a refund of Insurance Premium Tax proceeds (IPTP) used to fund convenience centers for collecting and disposing of solid waste, the court reversed the trial court's grant of summary judgment to the class members because the trial court erroneously concluded that the county's use of IPTP to operate the county's convenience centers could not be authorized; however, if it met the primary benefit requirement under O.C.G.A. § 33-8-8.3(a)(1)(E), the use was authorized. Montgomery County v. Hamilton, 337 Ga. App. 500, 788 S.E.2d 89 (2016), cert. denied, No. S16C1805, 2017 Ga. LEXIS 113 (Ga. 2017).

Under the plain language of O.C.G.A. § 33-8-8.3, the use of Insurance Premium Tax proceeds to operate the county's convenience centers may be authorized by the statute's catch-all provision, but only if it meets the requirement that these remote, off-site waste-collection centers primarily benefit the residents of the unincorporated area. Montgomery County v. Hamilton, 337 Ga. App. 500, 788 S.E.2d 89 (2016), cert. denied, No. S16C1805, 2017 Ga. LEXIS 113 (Ga. 2017).

33-8-8.4. Inactive municipalities.

For purposes of levying, collecting, distributing, and applying the proceeds of local insurance taxes and for all other purposes of Code Sections 33-8-8.1, 33-8-8.2, and 33-8-8.3, the population of an inactive municipality shall be considered to be population of the unincorporated area of the county or counties within which the municipality is located. Any municipality whose governing authority has neither met nor taken any official action during a calendar year shall be considered to be an inactive municipality during the next calendar year.

History. — Code 1981, § 33-8-8.4, enacted by Ga. L. 1984, p. 1284, § 3; Ga. L. 1984, p. 1294, § 1.

Editor's notes. — Both Ga. L. 1984, p. 1284, § 3, effective April 4, 1984, and Ga. L. 1984, p. 1294, § 1, effective April 4, 1984, enacted a § 33-8-8.4, the language of which is the same in both provisions. Section 33-8-8.4 is set out above as enacted by Ga. L. 1984, p. 1284, § 3, and as reenacted without change by Ga. L. 1984, p. 1294, § 1.

Ga. L. 1984, p. 1294, § 4, not codified by the General Assembly, provided that § 1 of that Act, which reenacted this Code section, would apply to taxes collected during 1984 and all future years.

33-8-8.5. Distribution of reimbursement of illegally assessed tax by insurance companies.

Any insurance company, other than a life insurance company, which receives reimbursement for the payment of an insurance premium tax levied by a county or municipality which was illegally assessed and collected shall distribute on a pro rata basis the proceeds of such reimbursement to its policyholders of record for the year the tax was levied. The distribution of the reimbursement shall be made as soon as practicable and in no event later than 90 days after such reimbursement is received by the insurance company.

History. — Code 1981, § 33-8-8.5, enacted by Ga. L. 1984, p. 1294, § 2.

Editor's notes. — Ga. L. 1984, p. 1294, § 4, not codified by the General Assembly, provided that § 2 of that Act, which enacted this Code section, would apply to taxes collected prior to January 1, 1984.

Law reviews. — For annual survey of state and local taxation, see 38 Mercer L. Rev. 337 (1986).

JUDICIAL DECISIONS

Cited in Federated Mut. Ins. Co. v. DeKalb County, 176 Ga. App. 70, 335 S.E.2d 873 (1985).

33-8-8.6. Nonprotested premium taxes.

Notwithstanding any other provision of law, any payment by an insurance company, other than a life insurance company, of premium taxes levied by a county or municipality heretofore made which when

made was not accompanied by a written protest of the legality or amount of such tax shall be deemed to have been a voluntary payment and shall not be recoverable from such county or municipality.

History. — Code 1981, § 33-8-8.6, enacted by Ga. L. 1984, p. 1294, § 3.

JUDICIAL DECISIONS

Purpose of O.C.G.A. § 33-8-8.6 is to protect local governments by assuring that their coffers would not be depleted by tax refund requests by requiring that a written protest must accompany the protested tax payment at the time that the payment is made. Federated Mut. Ins. Co. v. DeKalb County, 176 Ga. App. 70, 335 S.E.2d 873 (1985), aff'd, 255 Ga. 522, 341 S.E.2d 3 (1986).

OPINIONS OF THE ATTORNEY GENERAL

Construction with O.C.G.A. § 48-5-380. — With respect to certain tax refunds, the requirements of O.C.G.A. § 48-5-380 should be read in conjunction with O.C.G.A. § 33-8-8.6. 1984 Op. Att'y Gen. No. 84-24.

33-8-9. Granting of refunds and credits by Commissioner.

Refunds and credits of license fees and taxes levied by this chapter shall be made by the Commissioner in accordance with the provisions of Code Sections 33-2-29 through 33-2-31.

History. — Code 1933, § 56-1312, enacted by Ga. L. 1973, p. 499, § 4; Ga. L. 1976, p. 1080, § 2.

OPINIONS OF THE ATTORNEY GENERAL

Section not intended for refunds or credits of local taxes. — O.C.G.A. § 33-8-9 was not intended to authorize refunds or credits with respect to taxes paid directly to cities or counties by the insurance companies. 1984 Op. Att'y Gen. No. 84-24.

33-8-10. Confidential treatment of tax information; information to be disclosed by local officials engaged in collection of taxes; violations.

(a) The information secured by the Commissioner incident to the administration of any tax provided for in this title shall be confidential and privileged. Neither the Commissioner nor any members of his staff nor any of his authorized representatives shall without prior written consent of the taxpayer divulge or disclose any confidential information obtained from the department's records or from an examination of the business of the taxpayer to any person, except that upon request the information shall be divulged and disclosed to any officer or represen-

tative of any political subdivision of the state which has an ordinance on file with the Commissioner, as contemplated by subsection (c) of Code Section 33-8-8, and which has designated the officer or representative to the Commissioner in writing over the signature of an officer of the political subdivision. Information so divulged and disclosed shall be used by the political subdivisions, their agents, employees, officers, or representatives only for the purpose of assisting in the enforcement of local ordinances and shall not be divulged by the agents, employees, officers, or representatives of the political subdivisions except as may be reasonably required in connection with the enforcement and collection of any taxes due under the ordinances. The Commissioner shall not be responsible for the use or disclosure of any information by the political subdivisions or by their agents, employees, officers, or representatives. The information may also be disclosed to any other officer or representative of a state or local government entitled to such information in his official capacity or to the taxpayer or his authorized representative, provided that the Commissioner may furnish the confidential information to the appropriate insurance regulatory, tax, or legal official of another state, territory, country, or of the United States government if the office or officer of such state, territory, country, or of the United States government makes its own records available to the Commissioner.

(b) Any person who is designated by a local government or any other political subdivision of this state to assist in the collection of any tax relating to the transaction of insurance shall disclose to the Commissioner in writing annually any and all commissions, fees, or any other payments which such person receives for the assistance in the collection of any such tax. All disclosures which are filed with the Commissioner shall be available for public inspection and shall in no manner be treated as confidential information.

(c) Any person who violates this Code section shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not less than $500.00 nor more than $1,000.00 or imprisoned for not less than one month nor more than 12 months, or both; and, if the offender is an officer or employee of the state, he shall be dismissed from office and shall be incapable of holding any public office in this state for a period of five years thereafter.

History. — Code 1933, § 56-1313, enacted by Ga. L. 1976, p. 1517, § 1; Ga. L. 1978, p. 215, § 1; Code 1933, § 56-9912, enacted by Ga. L. 1978, p. 215, § 2; Ga. L. 1979, p. 786, § 1; Ga. L. 1992, p. 6, § 33.

Law reviews. — For comment, "Confidentiality and Dissemination of Personal Information: An Examination of State Laws Governing Data Protection," see 41 Emory L.J. 1185 (1992).

33-8-11. Issuance of execution against persons delinquent in payment of fees or taxes.

In addition to other remedies provided for in this title for the collection of fees and taxes, the Commissioner is authorized to issue executions against delinquents who have failed to pay the fees and taxes when due.

History. — Code 1933, § 56-1311, enacted by Ga. L. 1960, p. 289, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Any action to recover insurance taxes must be brought within seven years from the date that the execution may be lawfully issued. 1969 Op. Att'y Gen. No. 69-396.

33-8-12. Waiver of penalties and interest.

The Commissioner is authorized to waive the collection of any amount due the state as a penalty under provisions of this title providing for fees, premium taxes, or other miscellaneous charges collected by the Commissioner, whenever or to the extent that he may determine that the default giving rise to the penalty was due to reasonable cause and not due to gross or willful neglect or disregard of the law, regulations, or instructions pertaining thereto. The Commissioner may waive the collection of any interest, in whole or in part, due the state on any unpaid taxes whenever or to the extent that he reasonably determines that the delay in payment of the taxes was attributable to the action or inaction of the department.

History. — Code 1933, § 56-1314, enacted by Ga. L. 1977, p. 1281, § 1; Ga. L. 1984, p. 1284, § 4.

33-8-13. Exemption of certain insurance companies from taxes.

Any other provision of this chapter to the contrary notwithstanding, an insurance company exempt from federal income tax pursuant to the provisions of 26 U.S.C. Section 501(c)(3) or (4) and which only insures the risks of places of worship shall be exempt from the taxes levied upon insurance companies pursuant to Code Sections 33-8-4, 33-8-8, 33-8-8.1, and 33-8-8.2. Any insurance company desiring the exemption provided by this Code section shall present to the Commissioner the certificate issued by the federal Internal Revenue Service demonstrating the company's tax exempt status and such evidence of the scope of the company's business as the Commissioner shall deem necessary.

History. — Code 1981, § 33-8-13, enacted by Ga. L. 1996, p. 1264, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "Commissioner" was substituted for "commissioner" in two places in the second sentence.

CHAPTER 9

REGULATION OF RATES, UNDERWRITING RULES, AND RELATED ORGANIZATIONS

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33-9-42. Reduction in premiums for motor vehicle liability, first-party medical, and collision coverages for certain named drivers.
33-9-43. Reduction in premiums for motor vehicle liability, first-party medical, and collision coverage for named drivers under 25 years of age.
33-9-44. Legislative intent.

Cross references. — Deceptive trade practices generally, § 10-1-370 et seq. Provision that contracts in general restraint of trade contravene public policy, § 13-8-2. Unfair trade practices pertaining to insurance transactions, T. 33, C. 6.

Administrative rules and regulations. — Business requirements, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-18.

Review of health benefit plan increases, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-98.

Law reviews. — For annual survey of

torts law, see 35 Mercer L. Rev. 291 (1983).

For note, "Price-Fixing in Georgia," see 3 Mercer L. Rev. 314 (1952). For note on 1991 amendments to this chapter, see 8 Ga. St. U.L. Rev. 99 (1992).

JUDICIAL DECISIONS

Law recognizes an authorized rating organization as a legal entity for the conducting of business pertaining to rating matters on behalf of its members and subscribers both before the Commissioner and in the courts. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958) (decided under former Code 1933, Chs. 56-20 and 56-21, repealed and replaced by Ga. L. 1960, p. 289).

Cited in Sutker v. Pennsylvania Ins. Co., 115 Ga. App. 648, 155 S.E.2d 694 (1967).

OPINIONS OF THE ATTORNEY GENERAL

Setting rates. — Law does not allow the Insurance Commissioner to set insurance rates, but there are no state or federal restrictions which would preclude such a statutory enactment. 1985 Op. Att'y Gen. No. U85-40.

RESEARCH REFERENCES

ALR. — Increase in insurance rates or loss of opportunity to obtain insurance in consequence of another's tort as ground of liability, 92 A.L.R. 1205.

Decision of United States Supreme Court that insurance is interstate commerce as affecting state statutes relating to foreign insurance companies, 164 A.L.R. 500.

33-9-1. Purpose and construction of chapter.

(a) The purpose of this chapter is to promote the public welfare by regulating insurance rates as provided in this chapter to the end that they shall not be excessive, inadequate, or unfairly discriminatory; to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers; and to authorize cooperation between insurers in rate making and other related matters.

(b) It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis to the fullest extent possible. However, nothing in this chapter is intended or should be construed to restrict the Commissioner in any way, on his own motion or otherwise, to take any affirmative action by rule, regulation, or administrative determination in a particular case, cases, or class of cases which he may deem necessary to protect the public's interest in maintaining the standards prescribed in Code Section 33-9-4; and Code Sections 33-9-26 through 33-9-29 in particular shall in no way be viewed as exhaustive or restrictive of the powers or procedures available to the Commissioner for this purpose.

History. — Code 1933, § 56-501, enacted by Ga. L. 1967, p. 684, § 1.

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Commissioner may prohibit rates but not require refund of collected premiums. — The Commissioner has authority only to prohibit the use of rates and not to order refunds of premiums already collected under rates subsequently prohibited. Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

Regulation of profits is not authorized. — The rate statute is not concerned with profits and does not authorize the regulation of profits. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Profits may be considered but do not alone taint rate. — While profits may be an element to be considered in the determining of other ultimate prohibiting factors, profit alone does not taint a rate. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Cited in Bentley v. Allstate Ins. Co., 227 Ga. 708, 182 S.E.2d 770 (1971).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 38 et seq.

C.J.S. — 44 C.J.S., Insurance, § 103 et seq.

33-9-2. Definitions.

As used in this chapter, the term:

(1) "Advisory organization" means every person other than an admitted insurer, whether located within or outside this state, who prepares policy forms or makes underwriting rules incident to but not including the making of rates, rating plans, or rating systems, or who collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate-making, capacity. No duly authorized attorney at law acting in the usual course of his profession shall be deemed to be an advisory organization.

(2) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory, or other organization.

(3) "Rating organization" means every person other than an admitted insurer, whether located within or outside this state, who has as his object or purpose the making of rates, rating plans, or rating systems. Two or more admitted insurers who act in concert for the purpose of making rates, rating plans, or rating systems and who do not operate within the specific authorizations contained in Code Sections 33-9-6, 33-9-7, 33-9-11, 33-9-20, and 33-9-22 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

(4) "Subscriber" means an insurer which is furnished at its request with rates and rating manuals by a rating organization of which it is not a member, or with advisory services by an advisory organization of which it is not a member.

History. — Code 1933, §§ 56-502, 56-503, and 56-504, enacted by Ga. L. 1967, p. 684, § 1.

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990).

33-9-3. Application of chapter.

(a) This chapter shall apply to all insurance on risks or on operations in this state, except:

(1) Reinsurance other than joint reinsurance to the extent stated in Code Section 33-9-19;

(2) Life insurance;

(3) Disability income, specified disease, or hospital indemnity policies;

(4) Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from transportation, insurance policies. Inland marine insurance shall be deemed to include insurance defined by statute, or by interpretation thereof or, if not so defined or interpreted, by ruling of the Commissioner or as established by general custom of the business, as inland marine insurance;

(5) Insurance against loss of or damage to aircraft, insurance of hulls of aircraft, including their accessories and equipment, or insurance against liability arising out of the ownership, maintenance, or use of aircraft;

(6) Title insurance; or

(7) Annuities.

(a.1) The Commissioner may by rule or regulation establish criteria by which defined commercial risks may be exempted from the filing requirements of this chapter.

(b) This chapter shall apply to all insurers, including stock and mutual companies, Lloyd's associations, and reciprocal and interinsurance exchanges, which under any laws of this state write any of the kinds of insurance to which this chapter applies.

History. — Code 1933, § 56-506, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1978, p. 2073, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 644, § 1; Ga. L. 1996, p.

705, § 3; Ga. L. 1999, p. 335, § 1; Ga. L. 2017, p. 164, § 8/HB 127; Ga. L. 2019, p. 337, § 1-46/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (b), deleted the paragraph (b)(1) designation and deleted former paragraph (b)(2), which read: "The provisions of this chapter regarding rates shall apply to any insurer, fraternal benefit society, health care plan, health maintenance organization, or preferred provider organization providing any accident or sickness insurance or health benefit plan issued, delivered, issued for delivery, or renewed in this state to the extent required by subsection (c) of this Code section."; and deleted subsection (c), which read: "Provisions of this chapter regarding rates shall apply only to a proposed rate for any insurance or health benefit plan:

"(1) Which alone or in combination with any previous rate change for such insurance or plan would result in a rate increase of:

"(A) Any amount, but no decrease shall be subject to such provisions; provided, however,

"(B) The provisions of this chapter shall not apply to accident and sickness insurance; or

"(2) Made within 36 months after any rate change described by paragraph (1) of this subsection."

Law reviews. — For note on 1999 amendment to this Code section, see 16 Ga. St. U.L. Rev. 133 (1999).

RESEARCH REFERENCES

ALR. — Validity, construction, and effect of provisions of statute with respect to rates of workmen's compensation insurance, 82 A.L.R. 943.

Reciprocal or interinsurance, 145 A.L.R. 1121.

33-9-4. Standards applicable to making and use of rates.

The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which this chapter is applicable:

(1) Rates shall not be excessive or inadequate, as defined in this Code section, nor shall they be unfairly discriminatory;

(2) No rate shall be held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable; provided, however, with respect to rate filings involving an increase in rates, no rate for personal private passenger motor vehicle insurance shall be held to be excessive unless such rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist;

(3) No rate shall be held inadequate unless it is unreasonably low for the insurance provided and continued use of it would endanger solvency of the insurer, or unless the use of such rate by the insurer using such rate has, or will, if continued, tend to destroy competition or create a monopoly;

(4) Consideration shall be given to the extent applicable to past and prospective loss experience within and outside this state, to

conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both country wide and those specially applicable to this state, to the insurer's average yield from investment income, and to all other factors, including judgment factors, deemed relevant within and outside this state; and, in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period;

(5) Consideration may also be given, in the making and use of rates, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(6) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance or with respect to any subdivision or combination thereof;

(7) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions; provided, however, the Commissioner shall establish the maximum amount of any such modification;

(8) Nothing contained in this Code section or elsewhere in this chapter shall be construed to repeal or modify Chapter 6 of this title, relating to unfair trade practices, and any rate, rating classification, rating plan or schedule, or variation thereof established in violation of Chapter 6 of this title shall, in addition to the consequences stated in Chapter 6 of this title or elsewhere, be deemed violative of this Code section;

(9) No insurer shall base any standard or rating plan on vehicle insurance, in whole or in part, directly or indirectly, upon race, creed, or ethnic extraction; and

(10) No insurer shall base any standard or rating plan on vehicle insurance, in whole or in part, directly or indirectly, upon any physical disability of an insured unless the disability directly impairs the ability of the insured to drive a motor vehicle.

History. — Code 1933, § 56-507, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1978, p. 1423, § 1; Ga. L. 1978, p. 1936, § 1; Ga. L. 1980, p. 1011, § 2; Ga. L. 1982, p. 3, § 33; Ga. L. 1987, p. 911, § 1; Ga. L. 1988, p. 13, § 33; Ga. L. 1991, p. 1608, § 1.5; Ga. L. 1995, p. 1302, § 13; Ga. L. 2008, p. 1192, § 3/SB 276.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1987, "country wide" was substituted for "country-wide" in paragraph (4).

Editor's notes. — Ga. L. 1991, p. 1608, § 3.2, effective April 17, 1991, not codified by the General Assembly, provides: "(a) Each insurer shall file its proposed forms, manuals, underwriting rules, rates, and rating plans for coverages under motor vehicle insurance policies to be issued, issued for delivery, delivered, or renewed on and after October 1, 1991, with the Commissioner of Insurance for such examination and approval as is required by law. The Commissioner shall not approve such filings unless such filings contain optional medical payments coverage. Rates and rating plans for motor vehicle insurance coverages filed pursuant to this subsection shall reflect a reduction of the rates or rating plans for such coverages on file with the Commissioner as of January 28, 1991, of not less than 15 percent, as compared to rates in effect for coverages required to be offered by the former 'Georgia Motor Vehicle Accident Reparations Act,' with the exception of physical damage coverages, as specified in paragraph (3) of subsection (a) of former Code Section 33-34-5 and third-party property damage coverages. On October 1, 1991, the Commissioner shall reduce by 15 percent or such higher amount as he determines appropriate, after notice and hearing as required by law, any rate or rating plan for such coverages under motor vehicle insurance policies for which no filing has been received.

"(b) Any insurer aggrieved by the rate filing required pursuant to subsection (a) of this section may petition the Commissioner for a hearing to grant relief from the rate filing as the result of extraordinary circumstances. The insurer shall have the burden of proof to establish the extraordinary circumstances which justify relief. A hearing conducted pursuant to this subsection shall be conducted in accordance with the provisions of Chapter 2 of Title 33. Upon conclusion of any hearing conducted pursuant to this subsection, the Commissioner shall enter an order specifying the rates to be used by the insurer and shall indicate in his order all factors entering into a decision to relieve the insurer from full compliance with the provisions of subsection (a) of this section."

JUDICIAL DECISIONS

It makes no difference what process or method an insurance company follows in reaching its rate structure unless it violates the law in the particulars provided in this chapter. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Violation of any one standard makes rate illegal. — A failure to comply with any one of the three criteria of paragraphs (1) through (3) of this section in the making of a rate causes the rate to be illegal and offensive to this chapter. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Violation justifies Commissioner's prohibiting order. — Paragraphs (1) through (8) of this section list different standards, for violation of any one of which the Commissioner may prohibit use of rates. Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

Each standard must be met. — The three statutory criteria of paragraphs (1) through (3) of this section must each be met in order for a challenged rate to withstand a possible prohibiting order of the Commissioner. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Purpose of paragraph (2). — The "reasonable degree of competition" provision in paragraph (2) of this section is intended to promote the establishment of premium rates at a reasonable level.

Bentley v. Allstate Ins. Co., 227 Ga. 708, 182 S.E.2d 770 (1971).

Paragraph (2) relates to industry-wide competition. — The provision of paragraph (2) of this section prohibiting the Insurance Commissioner from disapproving a rate as excessive when a reasonable degree of competition exists is directed to the sufficiency of the competition to keep rates at a fair level. The question is not whether a particular insurer is competing nor whether there is some competition in the area, but whether the competition in the industry is vigorous enough to assure that rates are not excessive. Bentley v. Allstate Ins. Co., 227 Ga. 708, 182 S.E.2d 770 (1971).

Requires rate to be measured against other companies collectively. — To authorize the Commissioner's conclusion of law that an insurer's rates are excessive because a reasonable degree of competition does not exist in the area with respect to the classification to which the rates are applicable, the evidence must substantially support the principle that the insurer is not reasonably competitive with other companies collectively. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Rates may be held unreasonably high under paragraph (2) without finding no reasonable competition. — Under paragraph (2) of this section, it is not necessary to first find that a reasonable degree of competition does not exist before a rate may be considered to be excessive because it is unreasonably high for the insurance provided. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Rate may be excessive although less than rates of majority of companies. — The fact that a particular insurance company's rate may be less than the rate for the majority of the companies does not require a conclusion that the rate is not excessive. Bentley v. Allstate Ins. Co., 227 Ga. 708, 182 S.E.2d 770 (1971).

Paragraph (4) requires consideration of entire industry's experience. — The language of paragraph (4) of this section means the experiences of no one company but the combined experience of the entire industry shall be considered. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

Merely considering data before rejecting its import will not satisfy paragraph (4) of this section when it is plain that the factors being considered are quite significant, are generally recognized as such, may be expected to continue over a long period, and are capable of being figured in some manner into prospective loss experience. Caldwell v. Insurance Co. v. N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

This section authorizes classifications of risks based upon a reduced expense factor. Caldwell v. Standard Nat'l Ins. Co., 229 Ga. 777, 194 S.E.2d 456 (1972).

The burden of proof is on the insurance company to show that its new rates are not subject to the criticism charged by the Commissioner and thus not offensive to the statute. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971).

OPINIONS OF THE ATTORNEY GENERAL

Offer of group rate valid when offered under statutory standards. — A filing which purports to offer insurance rates on a group basis does not violate O.C.G.A. § 33-6-5(4) when the rates are derived on the basis of rate-making considerations and standards set forth in O.C.G.A. § 33-9-4. 1984 Op. Att'y Gen. No. 84-88.

Loss experience, expense factors, and income investment factors are legitimate rate-making considerations under O.C.G.A. § 33-9-4. 1984 Op. Att'y Gen. No. 84-88.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 38 et seq.

C.J.S. — 44 C.J.S., Insurance, § 103 et seq.

ALR. — Dividends on policies as violation of statutory prohibition of rebate, remission, refund, or other discrimination in respect to premiums, 137 A.L.R. 1029.

Recovery of damages as remedy for wrongful discrimination under state or local civil rights provisions, 85 A.L.R.3d 351.

Liability insurance: intoxication or other mental incapacity avoiding application of clause in liability policy specifically exempting coverage of injury or damage caused intentionally by or at direction of insured, 33 A.L.R.4th 983.

33-9-5. Authorized joint actions by insurers generally.

Subject to and in compliance with this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research.

History. — Code 1933, § 56-508, enacted by Ga. L. 1967, p. 684, § 1.

RESEARCH REFERENCES

ALR. — Who are entitled to benefit of statutes giving right to combine, 166 A.L.R. 161.

Exchange among insurers of medical information concerning insured or applicant for insurance as invasion of privacy, 98 A.L.R.3d 561.

33-9-6. Authorized joint actions by two or more admitted insurers having common ownership or operating under common management or control generally.

With respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research, two or more admitted insurers having a common ownership or operating in this state under common management or control are authorized to act in concert between or among themselves the same as if they constituted a single insurer; and to the extent that the matters relate to cosurety bonds, two or more admitted insurers executing the bonds are authorized to act in concert between or among themselves the same as if they constituted a single insurer.

History. — Code 1933, § 56-509, enacted by Ga. L. 1967, p. 684, § 1.

RESEARCH REFERENCES

ALR. — Who are entitled to benefit of statutes giving right to combine, 166 A.L.R. 161.

33-9-7. Authorized agreements among admitted insurers for apportionment of property and casualty insurance; approval by Commissioner; review of practices and activities.

(a) Agreements may be made among admitted insurers with respect to the equitable apportionment among them of property and casualty insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods, and with respect to the use of reasonable rate modifications for such insurance, such agreements to be subject to the approval of the Commissioner.

(b) All such agreements shall be submitted in writing to the Commissioner for his consideration and approval together with such information as he may reasonably require. The Commissioner shall approve only such agreements as are found by him to contemplate the use of rates which meet the standards prescribed by this chapter and activities and practices that are not unfair, unreasonable, or otherwise inconsistent with this chapter.

(c) At any time after such agreements are in effect, the Commissioner may review the practices and activities of the adherents to such agreements and, if after a hearing upon not less than ten days' notice to such adherents he finds that any such practice or activity is unfair or unreasonable or is otherwise inconsistent with this chapter, he may issue a written order to the parties to any such agreement specifying in what respect such act or practice is unfair or unreasonable or otherwise inconsistent with this chapter and requiring the discontinuance of such activity or practice. For good cause, and after hearing upon not less than ten days' notice to the adherents to such agreement, the Commissioner may revoke approval of any such agreement.

History. — Code 1933, § 56-512, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1986, p. 698, § 1.

33-9-8. Agreements to share high-risk applicants; approval of rates.

(a) Agreements shall be made among admitted property and casualty insurers with respect to the equitable apportionment among them of property and casualty insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods upon the determination by the Commissioner in writing that an agreement relative to a given kind or kinds of property and casualty insurance is necessary to protect the health, property, and welfare of the citizens of Georgia. All of the agreements shall be subject to the approval of the Commissioner and upon his or her approval shall have the effect of rules and regulations promulgated by the Commissioner.

(b) All of the agreements shall be submitted in writing to the Commissioner for his or her consideration and approval within the period of time specified by the Commissioner in his or her determination, as provided for in this Code section, together with such information as he or she may reasonably require. The approval of the agreements shall comply with the requirements of the rule-making process as set forth in Code Section 33-2-9. The Commissioner shall approve only such agreements as are found by him or her to contemplate the use of rates which meet the standards prescribed by this chapter and activities and practices that are not unfair, unreasonable, or otherwise inconsistent with this chapter.

(c) If, as provided in this Code section, the Commissioner determines that it is necessary to protect the health, property, and welfare of the citizens of this state, in addition to all other authority granted in this title, the Commissioner shall also have and may exercise the following authority:

(1) The Commissioner may require that any rates contemplated to be used under this Code section shall be approved by him or her prior to their use;

(2) The Commissioner may declare that any policies, contracts, or rates used pursuant to any agreement or plan established under this Code section shall be the exclusive policies, contracts, or rates authorized to be used in Georgia for the kind or kinds of insurance; and he or she may prohibit the use by any person of policies, contracts, or rates in this state which are different from those established in accordance with this Code section; and

(3) The Commissioner may amend or modify in whole or in part and may adopt any agreement submitted to him or her in accordance with this Code section. If no agreement is submitted within the time

prescribed by the Commissioner or if after a hearing the agreement submitted is unacceptable to the Commissioner, the Commissioner may on his or her own motion promulgate and adopt a reasonable plan to implement this Code section which plan shall become effective on a date not sooner than ten days as specified by the Commissioner in his or her order.

(d) At any time after the agreements are in effect the Commissioner may review the practices and activities of the adherents to such agreements and, if after a hearing upon not less than ten days' notice to such adherents, he or she finds that any such practice or activity is unfair or unreasonable, or is otherwise inconsistent with this chapter, he or she may issue a written order to the parties of the agreement specifying in what respect the act or practice is unfair or unreasonable or otherwise inconsistent with this chapter and requiring the discontinuance of the activity or practice. For good cause, and after hearing upon not less than ten days' notice to the adherents thereto, the Commissioner may revoke approval of the agreement.

(e) Whenever the Commissioner determines that a lack of competition or a lack of availability exists in this state in either property or casualty insurance, the Commissioner is authorized to protect the health, property, and welfare of the citizens of this state by exercising the following authority:

(1) The Commissioner shall approve all rates contemplated to be used under this Code section prior to their use;

(2) The Commissioner shall approve any policies or contracts used pursuant to any agreement or plan established under this Code section and such policies or contracts shall be used exclusively in this state for those kinds of insurance. The use by any person of any policies or contracts which are different from those established in accordance with this Code section shall be prohibited; and

(3) The Commissioner may by order implement a plan or program to provide the necessary insurance coverages to the citizens of this state by equitable apportionment among all property and casualty insurers licensed to transact those kinds of insurance in this state.

(f) The powers contained in this Code section are cumulative and shall be in addition to all other powers of the Commissioner contained elsewhere in this title or under the laws of this state.

History. — Code 1933, § 56-512.1, enacted by Ga. L. 1975, p. 1192, § 1; Ga. L. 1976, p. 347, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1986, p. 698, § 2; Ga. L. 1987, p. 870, § 1; Ga. L. 2019, p. 337, § 1-47/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "or her" in the last sentence in subsection (a), in three places in subsection (b), in paragraph (c)(1), and in three places in paragraph (c)(3); inserted "or she" in subsection (b), in paragraph

(c)(2), and in two places in subsection (d); and deleted ", as now or hereafter amended" following "Code Section 33-2-9" at the end of the second sentence of subsection (b).

33-9-9. Use of rating systems, underwriting rules, or forms of rating or advisory organizations.

Members and subscribers of rating or advisory organizations may use the rating systems, underwriting rules, or policy or bond form of the organizations and the rates filed by such organizations for all lines of insurance covered by the provisions of this chapter, either consistently or intermittently, but, except as provided in Code Sections 33-9-3, 33-9-7, 33-9-19, and 33-9-20, shall not agree with each other or rating organizations or others to adhere to such rates, rating systems, underwriting rules, or policy or bond form. The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization shall not be sufficient in itself to support a finding that an agreement so to adhere exists and may be used only for the purpose of supplementing or explaining any competent evidence of the existence of the agreement.

History. — Code 1933, § 56-510, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1982, p. 644, § 2; Ga. L. 1983, p. 629, §§ 1, 3.

Editor's notes. — Ga. L. 1982, p. 644, § 2, which amended this Code section and which was to have taken effect January 1, 1984, was repealed by Ga. L. 1983, p. 629, § 3, effective March 16, 1983. However, since the 1983 Act amended this Code section "as amended by … Ga. L. 1982, p. 644," the restated language of this Code section in the 1983 Act reflected many of the changes effected by the 1982 Act.

33-9-10. Conduct of operations by organizations engaging in joint underwriting or reinsurance.

Upon compliance with this chapter as applicable thereto, any rating organization, advisory organization, and any group, association, or other organization of admitted insurers which engages in joint underwriting or joint reinsurance through such organization or by standing agreement among the members thereof may conduct operations in this state. With respect to insurance risks or operations in this state, no insurer shall be a member or subscriber of any such organization, group, or association that has not complied with this chapter.

History. — Code 1933, § 56-513, enacted by Ga. L. 1967, p. 684, § 1.

33-9-11. Authorization of cooperation among rating organizations and insurers; review of cooperative activities and practices by Commissioner and proceedings thereon.

Cooperation among rating organizations or among rating organizations and insurers in rate making or in other matters within the scope of this chapter is authorized. The Commissioner may review the cooperative activities and practices and, if after a hearing he finds that the activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, he may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter and requiring the discontinuance of the activity or practice.

History. — Code 1933, § 56-511, enacted by Ga. L. 1967, p. 684, § 1.

Law reviews. — For survey article on insurance, see 34 Mercer L. Rev. 177 (1982).

33-9-12. Requirement of license for rating organization; application; fee.

(a) No rating organization shall conduct its operations in this state without first filing with the Commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for a license set forth in this chapter. Every rating organization shall file with its application:

(1) A copy of its constitution; its articles of incorporation, agreement or association; and of its bylaws, rules, and regulations governing the conduct of its business, all duly certified by the custodian of the originals of the constitution, articles of incorporation, agreement or association, bylaws, rules, and regulations;

(2) A list of its members and subscribers;

(3) The name and address of a resident of this state upon whom notices or orders of the Commissioner or process affecting the rating organization may be served; and

(4) A statement of its qualifications as a rating organization.

(b) The fee for filing an application for license as a rating organization shall be an amount as provided in Code Section 33-8-1, payable in advance to the Commissioner.

History. — Code 1933, § 56-514, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1992, p. 2725, § 13.

RESEARCH REFERENCES

ALR. — Right to enjoin business competitor from unlicensed or otherwise illegal acts or practices, 90 A.L.R.2d 7.

33-9-13. Evidence to be submitted by rating organization for license.

To obtain and retain a license, a rating organization shall provide satisfactory evidence to the Commissioner that it will:

(1) Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination, or withdraw therefrom;

(2) Neither have nor adopt any rule or exact any agreement the effect of which would be to require any member or subscriber, as a condition to membership or subscribership, to adhere to its rates, rating plans, rating systems, underwriting rules, or policy or bond forms;

(3) Neither adopt any rule nor exact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(4) Neither practice nor sanction any plan or act of boycott, coercion, or intimidation;

(5) Neither enter into nor sanction any contract or act by which any person is restrained from lawfully engaging in the insurance business;

(6) Notify the Commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules, and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the Commissioner or process affecting such organization may be served; and

(7) Comply with Code Section 33-9-20.

History. — Code 1933, § 56-515, enacted by Ga. L. 1967, p. 684, § 1.

33-9-14. Examination of rating organization application; investigation of applicant; issuance of license; duration of license.

(a) The Commissioner shall examine each application for license to act as a rating organization and the documents filed therewith and may make such further investigation of the applicant, its affairs, and its proposed plan of business as he deems desirable.

(b) The Commissioner shall issue the license applied for within 60 days of its filing with him, if from such examination and investigation he is satisfied that:

(1) The business reputation of the applicant and its officers is good;

(2) The facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish; and

(3) The applicant and its proposed plan of operation conform to the requirements of this chapter.

(c) Otherwise, but only after hearing upon notice, the Commissioner shall in writing deny the application and notify the applicant of his decision and his reasons therefor.

(d) The Commissioner may grant an application in part only and issue a license to act as a rating organization for one or more of the classes of insurance or subdivisions thereof or class of risk or a part or combination thereof as are specified in the application if the applicant qualifies for only a portion of the classes applied for.

(e) Licenses issued pursuant to this Code section shall remain in effect until revoked as provided in this chapter.

History. — Code 1933, § 56-516, enacted by Ga. L. 1967, p. 684, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 42.

C.J.S. — 44 C.J.S., Insurance, §§ 45 et seq., 63 et seq.

33-9-15. Annual license fee for rating organizations.

Notwithstanding Code Section 33-9-14, each rating organization possessing a license of indefinite term pursuant to such Code section shall owe and pay to the Commissioner an annual fee as provided in Code Section 33-8-1 in advance on account of such license until its final termination. Such fee shall be for periods commencing on July 1 of each year and ending on June 30 and shall be due and payable on March 1 of each year and shall be delinquent on April 1 of each year.

History. — Code 1933, § 56-517, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1992, p. 2725, § 14.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 42.

C.J.S. — 44 C.J.S., Insurance, § 45 et seq.

33-9-16. Adoption by rating organizations of rules governing eligibility for membership generally.

Subject to the approval of the Commissioner, licensed rating organizations may make reasonable rules governing eligibility for membership.

History. — Code 1933, § 56-518, enacted by Ga. L. 1967, p. 684, § 1.

33-9-17. Requirement by rating organizations of membership by all insurers having common ownership or operating under common management.

If two or more insurers having a common ownership or operating in this state under common management are admitted for the classes or types of insurance for which a rating organization is licensed to make rates, the rating organization may require as a condition to membership or subscribership of one or more that all the insurers shall become members or subscribers.

History. — Code 1933, § 56-519, enacted by Ga. L. 1967, p. 684, § 1.

33-9-18. Requirements for conduct of operations by advisory organizations generally; engaging in unfair or unreasonable practices.

(a) No advisory organization shall conduct its operations in this state unless and until it has filed with the Commissioner a copy of its constitution, articles of incorporation, agreement, or association, and of its bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals of the constitution, articles of incorporation, agreement or association, and bylaws or rules and regulations; a list of its members and subscribers; and the name and address of a resident of this state upon whom notices or orders of the Commissioner or process may be served.

(b) Each advisory organization shall notify the Commissioner promptly of every change in its constitution, its articles of incorpora-

tion, agreement, or association, and of its bylaws or rules and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the Commissioner or process affecting the organization may be served.

(c) No advisory organization shall engage in any unfair or unreasonable practice with respect to its activities.

(d) Each advisory organization shall pay an annual fee as provided in Code Section 33-8-1.

History. — Code 1933, § 56-520, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1992, p. 2725, § 15.

33-9-19. Requirements for conduct of operations by organizations engaging in joint underwriting and joint reinsurance generally; engaging in unfair or unreasonable practices.

(a) Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance through the group, association, or organization or by standing agreement among the members of the group, association, or organization shall file with the Commissioner a copy of its constitution, its articles of incorporation, agreement, or association, and of its bylaws or rules and regulations governing its activities, all duly certified by the custodian of the originals of such constitution, articles of incorporation, agreement or association, bylaws or rules and regulations; a list of its members; and the name and address of a resident of this state upon whom notices or orders of the Commissioner or process may be served.

(b) Each group, association, or other organization shall notify the Commissioner promptly of every change in its constitution, its articles of incorporation, agreement, or association, and its bylaws, rules, and regulations governing the conduct of its business; its list of members; and the name and address of the resident of this state designated by it upon whom notices or orders of the Commissioner or process affecting the group, association, or organization may be served.

(c) No group, association, or organization shall engage in any unfair or unreasonable practice with respect to its activities.

(d) Each joint underwriting and joint reinsurance organization shall pay an annual fee as provided in Code Section 33-8-1.

History. — Code 1933, § 56-521, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1992, p. 2725, § 16.

RESEARCH REFERENCES

ALR. — Reciprocal or interinsurance, 94 A.L.R. 836; 141 A.L.R. 765; 145 A.L.R. 1121.

33-9-20. Maintenance of records by organizations generally; maintenance and reporting of statistics by insurers.

(a) Every insurer, rating organization, or advisory organization and every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall maintain reasonable records of the type and kind reasonably adapted to its method of operation, of its experience or the experience of its members, and of the data, statistics, or information collected or used by it in connection with the rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys, or inspections made or used by it so that the records will be available at all reasonable times to enable the Commissioner to determine whether the organization, insurer, group, or association and, in the case of an insurer or rating organization, every rate, rating plan, and rating system made or used by it complies with this chapter as applicable to it. The maintenance of the records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this Code section for any insurer maintaining membership or subscribership in the organization to the extent that the insurer uses the rates, rating plans, rating systems, or underwriting rules of the organization. Such records shall be maintained in an office within this state and shall be made available for examination or inspection by the Commissioner at any time.

(b) Each insurer shall maintain statistics under statistical plans compatible with the rating plans used. An insurer shall report its statistics through a recognized statistical agency or advisory organization. No insurer shall be required to report its statistics through such agencies or organizations with respect to any unique or unusual risks or with respect to any risks rated in accordance with Code Section 33-9-32 or any lines or sublines of insurance for which such agencies or organizations do not promulgate rates or rating systems. Moreover, the Commissioner shall withhold from public inspection any proprietary information of any insurer, agency, or organization.

History. — Code 1933, § 56-522, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1988, p. 1857, § 1.

Administrative rules and regulations. — Workers' compensation insurance statistical agent - Forms and rating plans, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-36.

Regulations regarding proxies, consents, and authorizations of domestic stock insurers, subagents, counselors, adjusters, surplus lines brokers, and agen-

cies, Official Compilation of the Rules and Regulations of the State of Florida, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-37.

33-9-21. Maintenance and filing rates, rating plans, rating systems, or underwriting rules; examination of claim reserve practices by Commissioner.

(a) Every insurer shall maintain with the Commissioner copies of the rates, rating plans, rating systems, underwriting rules, and policy or bond forms used by it. The maintenance of rates, rating plans, rating systems, underwriting rules, and policy or bond forms with the Commissioner by a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this Code section for any insurer maintaining membership or subscriberships in such organization, to the extent that the insurer uses the rates, rating plans, rating systems, underwriting rules, and policy or bond forms of such organization; provided, however, that the Commissioner, when he or she deems it necessary, without compliance with the rule-making procedures of this title or Chapter 13 of Title 50, the "Georgia Administrative Procedure Act":

(1) May require any domestic, foreign, and alien insurer to file the required rates, rating plans, rating systems, underwriting rules, and policy or bond forms used independent of any filing made on its behalf or as a member of a licensed rating organization, as the Commissioner shall deem to be necessary to ensure compliance with the standards of this chapter and Code Section 34-9-130 and for the best interests of the citizens of this state;

(2) Shall require each domestic, foreign, and alien insurer, writing or authorized to write workers' compensation insurance in this state, to file such insurer's own individual rate filing for rates to be charged for workers' compensation insurance coverage written in this state. Such rates shall be developed and established based upon each individual insurer's experience in the State of Georgia to the extent actuarially credible. The experience filed shall include the loss ratios, reserves, reserve development information, expenses, including commissions paid and dividends paid, investment income, pure premium data adjusted for loss development and loss trending, profits, and all other data and information used by that insurer in formulating its workers' compensation rates which are used in this state and any other information or data required by the Commissioner. In establishing and maintaining loss reserves, no workers' compensation insurer shall be allowed to maintain any excess loss reserve for any claim or potential claim for more than 90 days after the amount of liability for such claim or potential claim has been established, whether by final judgment, by settlement agreement, or otherwise.

This limitation on the maintenance of loss reserves shall be enforced through this Code section, as well as through Code Section 33-9-23, relating to examination of admitted insurers, and any other appropriate enforcement procedures. The Commissioner is authorized to accept such rate classifications as are reasonable and necessary for compliance with this chapter. A rate filing required by this paragraph shall be updated by the insurer at least once every two years; and

(3) As used in paragraph (2) of this subsection, the term "excess loss reserve" means any reserve amount in excess of the reserve required by law.

(b) Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule for all personal private passenger motor vehicle insurance:

(1) For private passenger motor vehicle insurance providing only the mandatory minimum limits required by Code Section 33-34-4 and subsection (a) of Code Section 40-9-37, no such rate, rating plan, rating system, or underwriting rule shall become effective, nor may any premium be collected by any insurer thereunder, unless the filing has been received by the Commissioner in his or her office and such filing has been approved by the Commissioner or a period of 45 days has elapsed from the date such filing was received by the Commissioner during which time such filing has not been disapproved by the Commissioner. The Commissioner shall be authorized to extend such 45 day period by no more than 55 days at his or her discretion. If a filing is disapproved, notice of such disapproval order shall be given within 100 days of receipt of filing by the Commissioner, specifying in what respects such filing fails to meet the requirements of this chapter. The filer shall be given a hearing upon written request made within 30 days after the issuance of the disapproval order, and such hearing shall commence within 30 days after such request unless postponed by mutual consent. Such hearing, once commenced, may be postponed or recessed by the Commissioner only for weekends, holidays, or after normal working hours or at any time by mutual consent of all parties to the hearing. The Commissioner may also, at his or her discretion, recess any hearing for not more than two recess periods of up to 15 consecutive days each. In connection with any hearing or judicial review with respect to the approval or disapproval of such rates, the burden of persuasion shall fall upon the affected insurer or insurers to establish that the challenged rates are adequate, not excessive, and not unfairly discriminatory. After such a hearing, the Commissioner must affirm, modify, or reverse his or her previous action within the time period provided in subsection (a) of Code Section 33-2-23 relative to orders of the Commissioner. The

requirement of approval or disapproval of a rate filing by the Commissioner under this subsection shall not prohibit actions by the Commissioner regarding compliance of such rate filing with the requirements of Code Section 33-9-4 brought after such approval or disapproval.

(2) For personal private passenger motor vehicle insurance other than that described in this subsection, such rate, rating plan, rating system, or underwriting rule for all such personal private passenger motor vehicle insurance shall be effective upon filing and shall be implemented without approval of the Commissioner. This subsection shall apply to the entire personal private passenger motor vehicle insurance policy with limits above the mandatory minimum required by Code Section 33-34-4 and subsection (a) of Code Section 40-9-37 and shall apply to the entire personal private passenger motor vehicle policy with minimum limits if such policy has any additional nonmandatory coverage or coverages.

(c) When a rate filing of an insurer required under paragraph (1) of subsection (b) of this Code section is not accompanied by the information upon which the insurer supports the filing and the Commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, then the Commissioner shall request in writing, within 20 days of the date he or she receives the filing, the specifics of such additional information as he or she requires, and the insurer shall be required to furnish such information, and in such event the 45 day period provided for in paragraph (1) of subsection (b) of this Code section shall commence as of the date such information is furnished.

(d) Any domestic, foreign, or alien insurer that is authorized to write insurance in this state must file with the Commissioner any rate, rating plan, rating system, or underwriting rule at least 45 days prior to any indicated effective date for all insurance other than personal private passenger motor vehicle insurance. No rate, rating plan, rating system, or underwriting rule required to be filed under this subsection will become effective, nor may any premium be collected by any insurer thereunder, unless the filing has been received by the Commissioner in his office not less than 45 days prior to its effective date.

(e) When a rate filing of an insurer required under subsection (d) of this Code section results in any overall rate increase of 10 percent or more within any 12 month period, the Commissioner shall order an examination of that insurer to determine the accuracy of the claim reserves, the applicability of the claim reserve practices for the loss data used in support of such filing, and any other component of the rate filing; provided, however, that in the event the overall increase is less than 25 percent within any 12 month period and the Commissioner

affirmatively determines that he or she has sufficient information to evaluate such rate increase and that the cost thereof would not be justified, he or she may waive all or part of such examination. In all other rate filings required under subsection (d) of this Code section, the Commissioner may order an examination of that insurer as provided in this subsection. Such examination shall be conducted in accordance with the provisions of Chapter 2 of this title. Upon notification by the Commissioner of his or her intent to conduct such examination, the insurer shall be prohibited from placing the rates so filed in effect until such examination has been reviewed and certified by the Commissioner as being complete. Such examination, if conducted by the Commissioner, shall be reviewed and certified within 90 days of the date such rate, rating plan, rating system, or underwriting rule is filed; provided, however, that if the Commissioner makes an affirmative finding that the examination may not be completed within the 90 day period, he or she may extend such time for one additional 60 day period. Any examination required under this Code section shall be conducted in accordance with Chapter 2 of this title.

(f) Notwithstanding the provisions of subsection (d) of this Code section, in the event the filing of any rate, rating plan, rating system, or underwriting rule under subsection (d) of this Code section is not necessary, in the judgment of the Commissioner, to accomplish the purposes of this chapter as set forth in Code Section 33-9-1, then the Commissioner may exempt all domestic, foreign, and alien insurers from being required to file such rate, rating plan, rating system, or underwriting rule.

(g) Filings required pursuant to this Code section shall be accompanied by a fee or fees as provided in Code Section 33-8-1.

History. — Code 1933, § 56-522.1, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1978, p. 2073, § 2; Ga. L. 1980, p. 1063, § 1; Ga. L. 1982, p. 644, § 3; Ga. L. 1983, p. 629, §§ 2, 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1987, p. 870, § 2; Ga. L. 1990, p. 1409, § 16; Ga. L. 1991, p. 1608, § 1.6; Ga. L. 1992, p. 2725, § 17; Ga. L. 1994, p. 647, § 1; Ga. L. 1996, p. 705, § 4; Ga. L. 2008, p. 1192, § 4/SB 276; Ga. L. 2009, p. 42, § 2/SB 76; Ga. L. 2019, p. 337, § 1-48/SB 132; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, in paragraph (a)(2), deleted ", not later than July 30, 1990," following "Shall require" at the beginning of the first sentence, deleted "premium" preceding "rates" in the first, second and third sentences, inserted "admitted" following "examination of" in the fifth sentence, and deleted ", the initial two-year period to be calculated from July 30, 1990" following "two years" at the end; and, in paragraph (b)(2), inserted "personal" preceding "private passenger" in four places and substituted "this subsection" for "paragraph (1) of subsection (b) of Code Section 33-9-21" in the first sentence.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "provided, however, that the Commissioner" for "provided, however, the Commissioner" in the proviso in the second sentence of subsection (a); and substituted "provided, however, that if the Commissioner" for "provided, however, if the Commissioner" in the next-to-last sentence of subsection (e).

Cross references. — Management and public inspection of state documents, T. 50, C. 18.

Editor's notes. — Ga. L. 1982, p. 644, § 3, which amended this Code section and which was to have taken effect January 1, 1984, was repealed by Ga. L. 1983, p. 629, § 3, effective March 16, 1983. However, since the 1983 Act amended this Code section "as amended by said 1982 Act," the restated language of this Code section in the 1983 Act reflected many of the changes effected by the 1982 Act.

Ga. L. 1991, p. 1608, § 3.2, not codified by the General Assembly, effective April 17, 1991, provides: "(a) Each insurer shall file its proposed forms, manuals, underwriting rules, rates, and rating plans for coverages under motor vehicle insurance policies to be issued, issued for delivery, delivered, or renewed on and after October 1, 1991, with the Commissioner of Insurance for such examination and approval as is required by law. The Commissioner shall not approve such filings unless such filings contain optional medical payments coverage. Rates and rating plans for motor vehicle insurance coverages filed pursuant to this subsection shall reflect a reduction of the rates or rating plans for such coverages on file with the Commissioner as of January 28, 1991, of not less than 15 percent, as compared to rates in effect for coverages required to be offered by the former 'Georgia Motor Vehicle Accident Reparations Act,' with the exception of physical damage coverages, as specified in paragraph (3) of subsection (a) of former Code Section 33-34-5 and third-party property damage coverages. On October 1, 1991, the Commissioner shall reduce by 15 percent or such higher amount as he determines appropriate, after notice and hearing as required by law, any rate or rating plan for such coverages under motor vehicle insurance policies for which no filing has been received.

"(b) Any insurer aggrieved by the rate filing required pursuant to subsection (a) of this section may petition the Commissioner for a hearing to grant relief from the rate filing as the result of extraordinary circumstances. The insurer shall have the burden of proof to establish the extraordinary circumstances which justify relief. A hearing conducted pursuant to this subsection shall be conducted in accordance with the provisions of Chapter 2 of Title 33. Upon conclusion of any hearing conducted pursuant to this subsection, the Commissioner shall enter an order specifying the rates to be used by the insurer and shall indicate in his order all factors entering into a decision to relieve the insurer from full compliance with the provisions of subsection (a) of this section."

Administrative rules and regulations. — Workers' compensation insurance statistical agent - Forms and rating plans, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-36.

Georgia workers' compensation insurance rate filings, Official Compilation of the Rules and Regulations of the State of Florida, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-37.

Law reviews. — For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008).

JUDICIAL DECISIONS

Commissioner has discretion to give greatest weight to the information that the Commissioner considers most valuable; this includes the discretion to consider composite filings as advisory or as "benchmark" filings against individual filings. Caldwell v. Liberty Mut. Ins. Co., 248 Ga. 282, 282 S.E.2d 885 (1981).

OPINIONS OF THE ATTORNEY GENERAL

Filed copyrighted materials may be copied without infringement. — Copying of copyrighted manuals, rates, and rules which must be filed with the Insur-

ance Commissioner would not constitute an unfair use and hence would not amount to an infringement, but to the contrary would constitute a fair use and one within the purpose for which the filing was made with the Commissioner. 1965-66 Op. Att'y Gen. No. 66-178 (rendered under former Code 1933, §§ 56-504a and 56-504b, repealed by Ga. L. 1967, p. 684).

Offer of group rate valid when offered under statutory standards. — A filing which purports to offer insurance rates on a group basis does not violate O.C.G.A. § 33-6-5(4) when the rates are derived on the basis of rate-making considerations and standards set forth in O.C.G.A. § 33-9-4. 1984 Op. Att'y Gen. No. 84-88.

33-9-21.1. Filing and maintenance of information relating to certain casualty insurance.

The following types of casualty insurance shall be filed separately and data relative to such types of insurance shall be maintained separately:

(1) Nonrecording insurance or nonfiling insurance; and

(2) Vendors' single interest insurance.

History. — Code 1981, § 33-9-21.1, enacted by Ga. L. 1995, p. 437, § 2; Ga. L. 1996, p. 912, § 4; Ga. L. 2019, p. 337, § 1-49/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "The following types" for "In order to facilitate the handling of form and rate filings of certain types of miscellaneous casualty insurance which prior to July 1, 1995, has been filed generally under paragraph (10) of Code Section 33-7-3, the following types" at the beginning of this Code section.

33-9-21.2. Petition for hearing by aggrieved insurer.

Any insurer aggrieved by the Commissioner's disapproval of any rate filing may petition the Commissioner for a hearing within ten days of the notification of such disapproval, unless otherwise specifically provided by law. A hearing conducted pursuant to this Code section shall be conducted in accordance with the provisions of Chapter 2 of this title.

History. — Code 1981, § 33-9-21.2, enacted by Ga. L. 2002, p. 8, § 3.

33-9-22. Conduct of examinations of organizations by Commissioner generally; acceptance of reports of insurance supervisory officials of other states.

(a) The Commissioner shall, at least once every five years, and may, as often as may be reasonable and necessary, make or cause to be made an examination of each licensed rating organization; and he may, as often as may be reasonable and necessary, make or cause to be made an examination of any advisory organization or group, association, or other

organization of insurers which engages in joint underwriting or joint reinsurance.

(b) In lieu of the examination required in subsection (a) of this Code section, the Commissioner may accept the report of an examination made by the insurance supervisory official of another state.

(c) In examining any organization, group, or association pursuant to this Code section, the Commissioner shall ascertain whether the organization, group, or association and, in the case of a rating organization, any rate or rating system made or used by it complies with the applicable requirements and standards of this chapter.

History. — Code 1933, § 56-523, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1982, p. 3, § 33.

33-9-23. Examination of admitted insurers; examination of insurers transacting workers' compensation insurance.

(a) The Commissioner may, at any reasonable time, make or cause to be made an examination of every admitted insurer transacting any class of insurance to which this chapter is applicable to ascertain whether the insurer and every rate and rating system used by it for each class of insurance complies with the requirements and standards of this chapter applicable thereto. The examination shall not be a part of a periodic general examination participated in by representatives of more than one state.

(b) In addition to and apart from the examination required by subsection (a) of this Code section, the Commissioner may, at any reasonable time, examine or cause to be examined by some examiner duly authorized by him or her all insurers transacting workers' compensation insurance in this state. This examination will include a review of the loss ratios, reserves, reserve development information, expenses including commissions paid and dividends paid, investment income, pure premium data adjusted for loss development and loss trending, profits, and all other data and information used by that insurer in formulating its workers' compensation rates which are used in this state and any other information or data required by the Commissioner. Upon completion of this examination, a report in such form as the Commissioner shall prescribe shall be filed in his or her office.

History. — Code 1933, § 56-524, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1982, p. 644, § 4; Ga. L. 2019, p. 337, § 1-50/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (b), inserted "or her" in the first sentence and near the end of the last sentence and deleted "premium" following "workers' compensation" in the second sentence.

JUDICIAL DECISIONS

Cited in Bentley v. Allstate Ins. Co., 227 Ga. 708, 182 S.E.2d 770 (1971).

33-9-24. Examination of officers, managers, agents, and employees of organizations and insurers.

The officers, managers, agents, and employees of any such organization, group, association, or insurer may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation, together with all data, statistics, and information of every kind and character collected or considered by such organization, group, association, or insurer in the conduct of the operations to which the examination relates.

History. — Code 1933, § 56-525, enacted by Ga. L. 1967, p. 684, § 1.

33-9-25. Payment of costs of examinations.

The reasonable cost of any examination authorized by this chapter shall be paid by the organization, group, association, or insurer to be examined.

History. — Code 1933, § 56-526, enacted by Ga. L. 1967, p. 684, § 1.

33-9-26. Review of rate, rating plan, rating system, or underwriting rule by insurer or rating organization.

Any person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request the insurer or rating organization to review the manner in which the rate, plan, system, or rule has been applied with respect to insurance afforded him. The request may be made by his authorized representative and shall be written. If the request is not granted within 30 days after it is made, the requestor may treat it as rejected. Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested may file a written complaint and request for hearing with the Commissioner, specifying the grounds relied upon. If the Commissioner has information concerning a similar complaint, he may deny the hearing. If he believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, he shall deny the hearing. Otherwise, and if he finds that the complaint charges a violation of this

chapter and that the complainant would be aggrieved if the violation is proven, he shall proceed as provided in Code Section 33-9-27.

History. — Code 1933, § 56-527, enacted by Ga. L. 1967, p. 684, § 1.

JUDICIAL DECISIONS

Cited in Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

33-9-27. Issuance of notice by Commissioner upon determination of noncompliance with requirements of chapter.

If after examination of an insurer, rating organization, advisory organization, or group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance, or upon the basis of other information, or upon sufficient complaint as provided in Code Section 33-9-26 the Commissioner has good cause to believe that the insurer, organization, group, or association, or any rate, rating plan, or rating system made or used by any insurer or rating organization does not comply with the requirements and standards of this chapter applicable to it, he shall, unless he has good cause to believe such noncompliance is willful, give notice in writing to such insurer, organization, group, or association stating in the notice to the extent practicable in what manner such noncompliance is alleged to exist and specifying in the notice a reasonable time, not less than ten days after notice, in which the noncompliance may be corrected.

History. — Code 1933, § 56-528, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1982, p. 3, § 33.

JUDICIAL DECISIONS

Cited in Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 30.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-9-28. Conduct of hearing by Commissioner upon failure to correct noncompliance; notice of hearing; matters considered at hearing.

If the Commissioner has good cause to believe the noncompliance to be willful, or if within the period prescribed by the Commissioner in the

notice required by Code Section 33-9-27 the insurer, organization, group, or association does not make the changes necessary to correct the noncompliance specified by the Commissioner or establish to the satisfaction of the Commissioner that the specified noncompliance does not exist, then the Commissioner may hold a public hearing in connection with the noncompliance, provided that within a reasonable period of time, which shall be not less than ten days before the date of the hearing, he shall mail written notice specifying the matters to be considered at the hearing to the insurer, organization, group, or association. If no notice has been given as provided in Code Section 33-9-27, the notice provided for in this Code section shall state to the extent practicable in what manner such noncompliance is alleged to exist. The hearing shall not include any additional subjects not specified in the notices required by Code Section 33-9-27 or this Code section.

History. — Code 1933, § 56-529, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1982, p. 3, § 33.

Cross references. — Suspension of action pending hearing or decision on holding hearing, § 33-2-17(d).

JUDICIAL DECISIONS

Commissioner may not suspend approved rate without notice or hearing. — Commissioner's ex parte order purporting to suspend rate filings which had previously been approved by the Commissioner, without notice or hearing provided for by statute, was issued without lawful authority and void. Cravey v. Southeastern Underwriter's Ass'n, 214 Ga. 450, 105 S.E.2d 497 (1958) (decided under former Code 1933, Chs. 56-20 and 56-21); Cravey v. General Accident Fire & Life Ins. Co., 214 Ga. 460, 105 S.E.2d 504 (1958).

Cited in Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 20.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-9-28.1. Assessment of investigation costs against parties.

The costs incurred by the Commissioner in conducting any hearing under this chapter may be assessed against the parties to the hearing in such proportion as the Commissioner may determine upon consideration of all relevant circumstances including, but not limited to, the nature of the hearing; whether the hearing was instigated by or for the benefit of a particular party or parties; whether there is a successful party on the merits of the proceeding; and the relative levels of participation by the parties. For purposes of this Code section, costs incurred shall include payments made by the Commissioner to obtain the services of independent contractors or outside experts and travel expenses of such contractors or experts. The Commissioner shall make the assessment of costs incurred as part of the final order or decision

arising out of the proceeding; provided, however, that any order or decision shall include findings and conclusions of the Commissioner or his designee to support the assessment of costs.

History. — Code 1981, § 33-9-28.1, enacted by Ga. L. 1987, p. 870, § 3.

33-9-29. Issuance of remedial orders by Commissioner generally; suspension or revocation of certificate of authority or license.

If after a hearing pursuant to Code Section 33-9-28 the Commissioner finds:

(1) That any rate, rating plan, or rating system violates the applicable provisions of this chapter, he may issue an order to the insurer or rating organization which has been the subject of the hearing specifying in what respects the violation exists and stating when, within a reasonable period of time, the further use of the rate or rating system by the insurer or rating organization in contracts of insurance made thereafter shall be prohibited and may further order that the portion of premiums received from current policyholders as a result of the most recent rate increase at the time the notice of such hearing is issued shall be refunded to the policyholders;

(2) That an insurer, rating organization, advisory organization, or a group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance is in violation of the provisions of this chapter applicable to it other than the provisions dealing with rates, rating plans, or rating system, he may issue an order to the insurer, organization, group, or association which has been the subject of the hearing specifying in what respects the violation exists and requiring compliance within a reasonable time thereafter;

(3) That the violation of this chapter applicable to it by any insurer or rating organization which has been the subject of the hearing was willful, he may suspend or revoke, in whole or in part, the certificate of authority of each insurer or the license of each rating organization with respect to the class of insurance which has been the subject matter of the hearing;

(4) That any rating organization has willfully engaged in any fraudulent or dishonest act or practices, he may suspend or revoke, in whole or in part, the license of the organization in addition to any other penalty provided in this chapter.

History. — Code 1933, § 56-530, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1986, p. 698, § 3; Ga. L. 1987, p. 3, § 33.

JUDICIAL DECISIONS

Commissioner may prohibit rate but not require refund of collected premiums. — Under paragraph (1) of this section the limit of the Commissioner's authority where the Commissioner finds a rate to be violative of this chapter is to direct that the rate shall thereafter be prohibited. The Commissioner cannot order the insurer to make refunds of excessive premiums already paid. Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970), modified, 227 Ga. 708, 182 S.E.2d 770 (1971) (decided prior to 1986 amendment).

The Commissioner has authority only to prohibit the use of rates and not to order refunds of premiums already collected under rates subsequently prohibited. Caldwell v. Insurance Co. of N. Am., 235 Ga. 141, 218 S.E.2d 754 (1975) (decided prior to 1986 amendment).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 20 et seq.

C.J.S. — 44 C.J.S., Insurance, § 63 et seq.

33-9-30. Suspension or revocation of license or certificate of authority for failure to comply with order of Commissioner.

In addition to other penalties provided in this title, the Commissioner, by order pursuant to Code Section 33-9-29, may suspend or revoke, in whole or in part, the license of any rating organization or the certificate of authority of any insurer with respect to the class or classes of insurance specified in such order if such entity fails to comply within the time limited by such order or any extension thereof that the Commissioner may grant.

History. — Code 1933, § 56-531, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 2019, p. 337, § 1-51/SB 132.

The 2019 amendment, effective July 1, 2019, inserted ", by order pursuant to Code Section 33-9-29," near the beginning, substituted "if such entity fails" for "which fails" in the middle, and substituted "that the Commissioner" for "which the Commissioner" and deleted "with an order of the Commissioner lawfully made by him pursuant to Code Section 33-9-29" following "may grant" at the end of this Code section.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 20 et seq.

C.J.S. — 44 C.J.S., Insurance, § 79.

33-9-31. Manner of conduct of proceedings in connection with denial, suspension, or revocation of license or certificate of authority.

Except as otherwise provided in this chapter, all proceedings in connection with the denial, suspension, or revocation of a license or certificate of authority under this chapter shall be conducted in accordance with Chapter 2 of this title; and the Commissioner shall have all the powers granted to him in Chapter 2 of this title.

History. — Code 1933, § 56-532, enacted by Ga. L. 1967, p. 684, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 42, 43.

C.J.S. — 44 C.J.S., Insurance, §§ 63 et seq, 79.

33-9-32. Validity of contracts to use rates in excess of, or lower than, generally applicable rates.

Nothing contained in this chapter shall be deemed to prohibit an insurer and its insured from contracting to use a rate on a specific risk or risks which is in excess of or lower than that otherwise applicable, provided that the contract and rate deviation by consenting parties have been filed with the Commissioner prior to the use of the rate in accordance with the procedures, conditions, and limitations as may be established by the Commissioner; and provided, further, that, if the resulting premium exceeds $1,000.00, a binder of coverage may be issued and the contract and rate deviation shall be filed within 20 days after the issuance of the binder. Such contract and rate deviation shall be subject to challenge by the Commissioner for a period of ten days after filing. If such challenge is upheld, the insurer shall be required to use its regular filed rates for the first 30 days of coverage in accordance with the requirements of applicable law. If there is no challenge or if a challenge is not upheld, the contract and rate deviation agreed upon may be used from and after the effective date of the binder.

History. — Code 1933, § 56-522.2, enacted by Ga. L. 1976, p. 691, § 1; Ga. L. 1985, p. 994, § 1.

33-9-33. Payment of dividends, savings, or unabsorbed premium deposits by insurers.

Nothing in this chapter shall be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or

subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers shall not be deemed a rating plan or system.

History. — Code 1933, § 56-537, enacted by Ga. L. 1967, p. 684, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 79 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 180, 196 et seq.

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

Dividends on policies as violation of statutory prohibition of rebate, remission, refund, or other discrimination in respect of premiums, 137 A.L.R. 1029.

33-9-34. Acts done, actions taken, or agreements made pursuant to chapter not to constitute violation under other laws.

No act done, action taken, or agreement made pursuant to the authority conferred by this chapter shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this state which does not specifically refer to insurance.

History. — Code 1933, § 56-538, enacted by Ga. L. 1967, p. 684, § 1.

33-9-35. Withholding of information; false or misleading information.

No person, insurer, or organization shall willfully withhold information from, or knowingly give false or misleading information to, the Commissioner or to any rating organization, advisory organization, insurer, or group, association, or other organization of insurers which will affect the rates, rating systems, or premiums for the classes of insurance to which this chapter is applicable.

History. — Code 1933, § 56-534, enacted by Ga. L. 1967, p. 684, § 1.

33-9-36. Unauthorized premiums; unlawful inducements.

(a) As used in this Code section, the term:

(1) "Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.

(2) "Insurance" includes suretyship.

(3) "Policy" includes bond.

(4) "Store gift card" shall have the same meaning as provided in Code Section 10-1-393.

(b) No broker or agent shall knowingly charge, demand, or receive a premium for any policy of insurance except in accordance with this chapter.

(c) No insurer or employee of such insurer and no broker or agent shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly as an inducement to insurance or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue on such policy of insurance, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in an applicable filing. No insured named in a policy of insurance nor any employee of the insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any special favor or advantage or valuable consideration or inducement.

(d) Nothing in this Code section shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents and brokers, nor as prohibiting any insurer from allowing or returning to its participating policyholders, members, or subscribers dividends, savings, or unabsorbed premium deposits.

(e) Nothing in this Code section shall be construed as prohibiting the payment for food or refreshments by an insurer or employee of such insurer or a broker or an agent for current or prospective clients during sales presentations and seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars.

(f) Nothing in this Code section shall be construed as prohibiting an insurer or employee of such insurer or a broker or an agent from advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy.

History. — Code 1933, § 56-535, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 2005, p. 563, § 3/HB 407; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2016, p. 381, § 2/HB 784; Ga. L. 2019, p. 337, § 1-52/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "employee of such

insurer or a broker or an agent" for "an agent, broker, or employee of an insurer" in the middle of subsection (e); and substituted "an insurer or employee of such insurer or a broker or an agent" for "insurers or insurance producers" near the beginning of subsection (f).

Law reviews. — For article, "The Regulation of Group Property and Liability Insurance," see 20 J. of Pub. L. 479 (1971).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Code 1933, §§ 56-218 and 56-9903 are included in the annotations for this Code section.

Settlement with beneficiary held not to involve rebate of premiums. — Promise of defendant to pay widow $600.00 in consideration of the widow ceasing to attempt to insist that the widow receive "20 installments certain" from proceeds of the deceased husband's life insurance, as directed by his will, rather than an annuity purchased with such proceeds, did not involve a contract to rebate an insurance premium at the instance or in behalf of the insurer, as prohibited by statute in this state. Wolfe v. Breman, 69 Ga. App. 813, 26 S.E.2d 633 (1943) (decided under former Code 1933, § 56-218, 56-9903).

OPINIONS OF THE ATTORNEY GENERAL

Validity of sales promotions. — An insurer who offers a gift to a prospective insured in exchange for the opportunity to compare the insured's current policy violates O.C.G.A. § 33-6-4(b)(8)(B) and subsection (b) of O.C.G.A. § 33-9-36, but an insurer who makes a charitable contribution based on a portion of the total sales of a particular policy for a specified period of time violates neither code provision. 1984 Op. Att'y Gen. No. 84-78.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 817, 818.

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

Dividends on policies as violation of statutory prohibition of rebate, remission, refund, or other discrimination in respect of premiums, 137 A.L.R. 1029.

Insurance anti-rebate statutes: validity and construction, 90 A.L.R.4th 213.

33-9-37. Liability of insurer conspiring to fix insurance rates unauthorized by chapter.

In the event any insurer shall in collusion with any other insurer conspire to fix, set, or adhere to insurance rates, except as expressly sanctioned by this chapter, the insurer shall be liable to any person damaged thereby for an amount equal to three times the amount of the damage together with the damaged party's attorney's fees.

History. — Code 1933, § 56-539, enacted by Ga. L. 1967, p. 684, § 1.

JUDICIAL DECISIONS

Cited in Georgia Ass'n of Indep. Ins. Agents v. Travelers Indem. Co., 313 F. Supp. 841 (N.D. Ga. 1970).

RESEARCH REFERENCES

ALR. — Validity of statutory provision for attorneys' fees, 90 A.L.R. 530.

What persons or corporations, contracts or policies, are within statutory provisions allowing recovery of attorneys' fees or penalty against insurance companies or against companies dealing in specified kinds of insurance, 126 A.L.R. 1439.

When does statute of limitations begin to run against civil action or criminal prosecution for conspiracy, 62 A.L.R.2d 1369.

What constitutes "trial," "final trial," or "final hearing" under statute authorizing allowance of attorneys' fees as costs on such proceeding, 100 A.L.R.2d 397.

Validity of statute allowing attorneys' fee to successful claimant but not to defendant, or vice-versa, 73 A.L.R.3d 515.

33-9-38. Penalty for failure to comply with final order of Commissioner; penalty for willful violation of provision of chapter.

(a) Any person, insurer, organization, group, or association who fails to comply with a final order of the Commissioner under this chapter shall be liable to the state in an amount not exceeding $50.00; but, if such failure is willful, the person, insurer, organization, group, or association shall be liable to the state in an amount not exceeding $5,000.00. The Commissioner shall collect the amount so payable and may bring an action in the name of the people of the State of Georgia to enforce collection. Such penalties may be in addition to any other penalties provided by law.

(b) Any person who willfully violates this chapter shall be guilty of a misdemeanor.

History. — Code 1933, § 56-536, enacted by Ga. L. 1967, p. 684, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33.

Cross references. — Punishment for misdemeanors generally, § 17-10-3.

JUDICIAL DECISIONS

Cited in Allstate Ins. Co. v. Bentley, 122 Ga. App. 738, 178 S.E.2d 700 (1970).

RESEARCH REFERENCES

ALR. — Recovery of cumulative statutory penalties, 71 A.L.R.2d 986.

33-9-39. Restrictions on motor vehicle insurance surcharges relating to accidents involving law enforcement officers, firefighters, or emergency medical technicians.

No insurer shall surcharge the premium or rate charged on a policy of motor vehicle insurance that provides coverage for the personal motor vehicles of any law enforcement officer, firefighter, or emergency medical technician in this state for any accident:

(1) That occurred while the law enforcement officer, firefighter, or emergency medical technician was lawfully engaged in the performance of official duties; and

(2) For which the law enforcement officer, firefighter, or emergency medical technician furnishes proof, in the form of copies of the accident report, 9-1-1 emergency dispatch log, or the employing agency's documents, to the insurer of the condition provided in paragraph (1) of this Code section.

History. — Code 1981, § 33-9-39, enacted by Ga. L. 1986, p. 1184, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1988, p. 13, § 33; Ga. L. 1993, p. 542, § 1; Ga. L. 2004, p. 579, § 1; Ga. L. 2005, p. 660, § 5/HB 470.

33-9-40. Prohibition of motor vehicle insurance surcharges relating to accidents in which insured not at fault.

No insurer shall surcharge the premium or rate charged on a policy of motor vehicle insurance or cancel such policy as a result of the insured person's involvement in a multivehicle accident when such person was not at fault in such accident.

History. — Code 1981, § 33-9-40, enacted by Ga. L. 1986, p. 1184, § 1; Ga. L. 1987, p. 3, § 33.

JUDICIAL DECISIONS

Statutory term "cancel" does not include "nonrenewal." — While an insurance carrier could not cancel a policy for accidents not the fault of its insured, it was not prohibited from declining to renew the policy for that reason. Banks v. Aetna Cas. & Sur. Co., 189 Ga. App. 758, 377 S.E.2d 685 (1989).

33-9-40.1. Rates of workers' compensation policies issued to business entities with majority interest held by the same person; limitation on maintenance of reserves; investigations of complaints.

(a) An insurer shall not assign an adverse experience modification factor which is applicable to the rate of a workers' compensation insurance policy issued to a particular business entity to the rate of a

workers' compensation policy issued to another business entity maintaining a separate payroll for federal and state tax purposes and engaging in a distinctly different business enterprise for the sole reason that the majority interest in both business entities is held by the same person.

(b) For experience rating purposes, no workers' compensation insurer shall maintain any case reserve for any claim in excess of the amount established by final judgment, by settlement, or otherwise. All reductions in case reserves shall be made and reported to the appropriate rating organization within 90 days. Any further adjustments upward in the case reserve shall only be made due to additional paid claims or a case reserve established on a claim which was previously closed but reopened due to a claimant's request for additional benefits. This limitation on the maintenance of reserves shall be enforced through this Code section, as well as through Code Section 33-9-21, relating to rate filings, Code Section 33-9-23, relating to examination of insurers, and any other appropriate enforcement procedures.

(c)(1) The Commissioner shall cause an investigation to be made of each complaint filed by a licensee under this title or under Article 5 of Chapter 9 of Title 34 or a person acting for or on behalf of such licensee against an insurer or workers' compensation group self-insurance fund alleging that such insurer or fund is:

(A) Using an improper rate;

(B) Using an improper classification; or

(C) Using an improper experience modification in issuing a contract of workers' compensation insurance.

(2) If the Commissioner finds the complaint to be justified, in addition to all other appropriate action under this title, the Commissioner may assess the cost of such investigation against the insurer or workers' compensation group self-insurance fund and retain the proceeds therefrom for reimbursement of the cost of conducting such investigation.

(3) If the person making the complaint is a licensee under this title or under Article 5 of Chapter 9 of Title 34 or a person acting for or on behalf of such licensee and the Commissioner finds the complaint not to be justified, the Commissioner may, in addition to all other appropriate action under this title:

(A) Assess the reasonable verified cost of such investigation against such person and retain the proceeds therefrom for reimbursement of the cost of conducting such investigation; and

(B) If such person files six or more complaints the Commissioner finds not to be justified in any 12 month period, assess an

administrative penalty not to exceed $2,000.00 for the sixth and each subsequent complaint found to be not justified.

History. — Code 1981, § 33-9-40.1, enacted by Ga. L. 1992, p. 1286, § 1; Ga. L. 1996, p. 705, § 5; Ga. L. 1997, p. 927, § 1; Ga. L. 2009, p. 42, § 3/SB 76.

33-9-40.2. Workers' compensation insurance premium discount for insured with drug-free workplace program.

(a) For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 1993, there shall be granted by the insurer not less than a 7 1/2 percent reduction in the premium for such policy if the insured has been certified by the State Board of Workers' Compensation as having a drug-free workplace program which complies with the requirements of Article 11 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification.

(b) The premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives certification by the State Board of Workers' Compensation and shall continue for as long as the insured maintains the certification as having a drug-free workplace; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification by an insured shall be required for each year in which such premium discount is granted.

(c) The workers' compensation insurance policy of an insured shall be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy if it is determined by the State Board of Workers' Compensation that such insured misrepresented the compliance of its drug-free workplace program with the provisions of Article 11 of Chapter 9 of Title 34.

(d) Each insurer shall make an annual report to the rating and statistical organization designated by the Commissioner pursuant to this chapter illustrating the total dollar amount of drug-free workplace premium credit. Standard earned premium figures reported pursuant to this subsection on the aggregate calls for experience must reflect the effects of such credits. The net standard premium will then be the basis of any premium adjustment. The drug-free workplace credits must be reported under a unique classification code or unit statistical reports submitted to the rating and statistical organization designated by the Commissioner pursuant to this chapter.

(e) The Commissioner shall conduct a study to determine the impact of this chapter on reducing workers' compensation losses and on the

impact of the premium credit provided pursuant to this Code section in encouraging employers to implement and maintain the program for which the credit is provided.

(f) The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section.

History. — Code 1981, § 33-9-40.2, enacted by Ga. L. 1993, p. 1512, § 1; Ga. L. 1997, p. 1581, § 2; Ga. L. 2005, p. 1210, § 1/HB 327; Ga. L. 2006, p. 72, § 33/SB 465.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1993, "this chapter" was substituted for "Chapter 9 of this title" in the last sentence of subsection (d).

Law reviews. — For note on 1993 enactment of this Code section, see 10 Ga. St. U.L. Rev. 152 (1993).

33-9-40.3. Employers to provide work based learning opportunities for students age 16 and older.

(a) For each policy of workers' compensation insurance issued or renewed in the state on and after July 1, 2016, there may be granted by the insurer up to a 5 percent reduction in the premium for such policy if the insured has been certified by the State Board of Education to the State Board of Workers' Compensation as a work based learning employer pursuant to Article 12 of Chapter 9 of Title 34 and has notified its insurer in writing of such certification.

(b) If granted, the premium discount provided by this Code section shall be applied to an insured's policy of workers' compensation insurance pro rata as of the date the insured receives such certification and shall continue for as long as the insured maintains the certification; provided, however, that an insurer shall not be required to credit the actual amount of the premium discount to the account of the insured until the final premium audit under such policy. Certification of an insured shall be required for each year in which a premium discount is granted.

(c) If it is determined that an insured misrepresented its qualifications for certification pursuant to Article 12 of Chapter 9 of Title 34, the workers' compensation insurance policy of such insured may be subject to an additional premium for the purposes of reimbursement of a previously granted premium discount and to cancellation in accordance with the provisions of the policy.

(d) Each insurer shall make an annual report, in accordance with guidelines established by the Commissioner, to the rating and statistical organization designated by the Commissioner illustrating the total dollar amount of the premium discounts applied pursuant to this Code section.

(e) The Commissioner shall conduct a study to determine the impact of the premium discounts provided pursuant to this Code section in encouraging employers to provide work based learning opportunities for students age 16 or older.

(f) The Commissioner shall be authorized to promulgate rules and regulations necessary for the implementation and enforcement of this Code section.

History. — Code 1981, § 33-9-40.3, enacted by Ga. L. 2016, p. 207, § 2/HB 402.

Editor's notes. — Ga. L. 2016, p. 207, § 1/HB 402, not codified by the General Assembly, provides that: "The General Assembly finds that it would be beneficial to students, employers, and the economic health of the state to assist in providing highly trained, technologically sophisticated, and career oriented students which will aid in the development of a successful twenty-first century work force. By opening their doors to work based learning opportunities, employers can play an active role in shaping the quality of their future work force, by preparing potential leaders for their company and their community, and by helping shape future curriculum to create an educated work force for their industry as a whole. Work based learning programs can provide students the opportunity to work and learn in a real-world environment and prepare them for future career opportunities. Such work based learning opportunities can be accomplished by developing partnerships between and among the business community, industry, students, parents, school systems, and postsecondary education institutions."

33-9-41. Study of effect of 1987 legislation on loss experience; cooperation of insurers; report to General Assembly.

Reserved. Repealed by Ga. L. 2001, p. 4, § 33, effective February 12, 2001.

Editor's notes. — This Code section was based on Code 1981, § 33-9-41, enacted by Ga. L. 1987, p. 870, § 4.

33-9-42. Reduction in premiums for motor vehicle liability, first-party medical, and collision coverages for certain named drivers.

(a) For each personal or family-type policy of private passenger motor vehicle insurance issued or issued for delivery in this state, there shall be offered by the insurer a reduction of not less than 10 percent in premiums for motor vehicle liability, first-party medical, and collision coverages to the policyholder if all named drivers, as listed or who should be listed on the policy application or provided in information subsequent to such application, of each motor vehicle covered by such policy satisfy the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

(b) Reductions in premiums shall be available if all named drivers who are 25 years of age or older:

(1) Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

(2) Have had no claims based on fault against an insurer for the prior three years; and

(3) Complete one of the following types of driving courses:

(A) A defensive driving course of not less than six hours from a driver improvement clinic or commercial or noncommercial driving school approved by and under the jurisdiction of the Department of Driver Services;

(B) An emergency vehicles operations course at the Georgia Public Safety Training Center;

(C) A defensive driving course of not less than six hours from a driver improvement program which is administered by a nonprofit organization such as the AARP, the American Automobile Association, the National Safety Council, or a comparable organization and which meets the rules and regulations of the Department of Driver Services pursuant to subsection (g) of this Code section; or

(D) A defensive driving course of not less than six hours which is offered by an employer to its employees and their immediate families and which meets the rules and regulations of the Department of Driver Services.

(c) Reductions in premiums shall be available if all named drivers who are under 25 years of age:

(1) Have committed no traffic offenses for the prior three years or since the date of licensure, whichever is shorter;

(2) Have had no claims based on fault against an insurer for the prior three years; and

(3) Complete a preparatory course offered to new drivers of not less than 30 hours of classroom training and not less than six hours of practical training by a driver's training school approved by and under the jurisdiction of the Department of Driver Services or by an accredited secondary school, junior college, or college.

(d) Upon completion of one of the defensive driving courses specified in paragraph (3) of subsection (b) or preparatory courses offered to new drivers specified in paragraph (3) of subsection (c), as applicable, of this Code section by each named driver, eligibility for reductions in premiums for such policy shall continue for a period of three years, provided any named driver under such policy does not commit a traffic offense or have a claim against the policy based on any such driver's fault.

(e) The Department of Driver Services shall assure through the supervision of driver improvement clinics, emergency vehicles opera-

tions courses, driver improvement programs administered by nonprofit organizations, and commercial or noncommercial driving schools approved by the Department of Driver Services that defensive driving courses shall be available and accessible wherever practicable as determined by the department to licensed drivers throughout the state.

(f) Each insurer providing premium discounts under this Code section shall provide, upon the request of the Commissioner, information regarding the amount of such discounts in a form acceptable to the Commissioner.

(g) The power of supervision granted to the Department of Driver Services over driver improvement programs administered by nonprofit organizations under this Code section shall be limited to the establishment of minimum standards and requirements relative to the content of specific courses offered by such programs and relative to investigation and resolution of any complaints directed towards the content or operation of any course by a person enrolled in such course. The Department of Driver Services may adopt rules and regulations necessary to carry out the provisions of this subsection. The Department of Driver Services shall not require a nonprofit organization to obtain a license or permit or to pay a fee in order to administer a driver improvement program in the state. The Department of Driver Services shall not require a commercial driving school licensed by such department to obtain an additional license to teach a defensive driving course, as described in subparagraph (b)(3)(A) or preparatory course offered to new drivers as described in paragraph (3) of subsection (c) of this Code section, at any location in this state.

(h) Nothing in this Code section shall prevent an insurer from offering the reduction in premium specified in subsection (a) of this Code section to a driver who does not meet all of the requirements of subsection (b) or subsection (c), as applicable, of this Code section.

History. — Code 1981, § 33-9-42, enacted by Ga. L. 1991, p. 1608, § 1.7; Ga. L. 1992, p. 2464, § 1; Ga. L. 1993, p. 611, § 1; Ga. L. 2002, p. 415, § 33; Ga. L. 2005, p. 334, § 13-1/HB 501; Ga. L. 2014, p. 710, § 1-4/SB 298; Ga. L. 2019, p. 337, § 1-53/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "AARP" for "American Association of Retired People" in subparagraph (b)(3)(C).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "school" was substituted for "schools" in subparagraph (b)(3)(A).

Pursuant to Code Section 28-9-5, in 1996, "than" was substituted for "that" in paragraph (c)(3).

Editor's notes. — Ga. L. 1991, p. 1608, § 3.2, effective April 17, 1991, not codified by the General Assembly, provides: "(a) Each insurer shall file its proposed forms, manuals, underwriting rules, rates, and rating plans for coverages under motor vehicle insurance policies to be issued, issued for delivery, delivered, or renewed on and after October 1, 1991, with the Commissioner of Insurance for such examination and approval as is required by law. The Commissioner shall not approve such filings unless such filings contain optional medical payments coverage.

Rates and rating plans for motor vehicle insurance coverages filed pursuant to this subsection shall reflect a reduction of the rates or rating plans for such coverages on file with the Commissioner as of January 28, 1991, of not less than 15 percent, as compared to rates in effect for coverages required to be offered by the former 'Georgia Motor Vehicle Accident Reparations Act,' with the exception of physical damage coverages, as specified in paragraph (3) of subsection (a) of former Code Section 33-34-5 and third-party property damage coverages. On October 1, 1991, the Commissioner shall reduce by 15 percent or such higher amount as he determines appropriate, after notice and hearing as required by law, any rate or rating plan for such coverages under motor vehicle insurance policies for which no filing has been received.

"(b) Any insurer aggrieved by the rate filing required pursuant to subsection (a) of this section may petition the Commissioner for a hearing to grant relief from the rate filing as the result of extraordinary circumstances. The insurer shall have the burden of proof to establish the extraordinary circumstances which justify relief. A hearing conducted pursuant to this subsection shall be conducted in accordance with the provisions of Chapter 2 of Title 33. Upon conclusion of any hearing conducted pursuant to this subsection, the Commissioner shall enter an order specifying the rates to be used by the insurer and shall indicate in his order all factors entering into a decision to relieve the insurer from full compliance with the provisions of subsection (a) of this section."

33-9-43. Reduction in premiums for motor vehicle liability, first-party medical, and collision coverage for named drivers under 25 years of age.

(a) For each personal or family-type policy of private passenger motor vehicle insurance issued, delivered, issued for delivery, or renewed, there shall be offered by the insurer a reduction in the premium for motor vehicle liability, first-party medical, and collision coverage for each named driver under 25 years of age, as listed on the policy application or provided in information subsequent to such application, of each motor vehicle covered by such policy, if that driver:

(1) Is unmarried;

(2) Is enrolled as a full-time student in:

(A) High school;

(B) Academic courses in a college or university; or

(C) Vocational-technical school;

(3) Is an honor student because the scholastic records for the immediately preceding quarter, semester, or comparable segment show that such person:

(A) Ranks scholastically in the upper 20 percent of the class;

(B) Has a "B" average or better;

(C) Has a 3.0 average or better; or

(D) Is on the "Dean's List" or "Honor Roll"; and

(4) Is a driver whose use of the automobile is considered by the insurer in determining the applicable classification.

(b) Proof of meeting the requirements for the discount provided by this Code section shall be provided annually to the insurer by the insured student or policyholder upon such forms as the Commissioner shall prescribe. The premium reduction required by this Code section shall be approved by the Commissioner and reflected in the insurer's automobile rating plan.

(c) An insurer shall not be required to offer the premium reduction provided in subsection (a) of this Code section to a driver who, at any time within a period of three years prior to the beginning of the policy year during which that reduction is otherwise required, has:

(1) Been involved in any motor vehicle accident in which that person has been determined to have been at fault;

(2) Been finally convicted of, pleaded nolo contendere to, or been found to have committed a delinquent act constituting any of the following offenses:

(A) Any serious traffic offense described in Article 15 of Chapter 6 of Title 40;

(B) Any traffic offense for which three or more points may be assessed pursuant to Code Section 40-5-57; or

(C) Any felony or any offense prohibited pursuant to Chapter 13 of Title 16, relating to dangerous drugs, marijuana, and controlled substances; or

(3) Had that person's driver's license suspended for refusal to submit to chemical tests pursuant to Code Section 40-5-67.1 and that suspension has not been reversed, if appealed from.

History. — Code 1981, § 33-9-43, enacted by Ga. L. 1991, p. 1608, § 1.7; Ga. L. 1992, p. 2564, § 14; Ga. L. 1995, p. 1348, § 1; Ga. L. 2019, p. 337, § 1-54/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "on or after October 1, 1991" following "or renewed" in the introductory language of subsection (a).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, in subparagraph (a)(2)(C), "Vocational-technical" was substituted for "Vocational technical".

Editor's notes. — Ga. L. 1991, p. 1608, § 3.2, effective April 17, 1991, not codified by the General Assembly, provides: "(a) Each insurer shall file its proposed forms, manuals, underwriting rules, rates, and rating plans for coverages under motor vehicle insurance policies to be issued, issued for delivery, delivered, or renewed on and after October 1, 1991, with the Commissioner of Insurance for such examination and approval as is required by law. The Commissioner shall not approve such filings unless such filings contain optional medical payments coverage. Rates and rating plans for motor vehicle insurance coverages filed pursuant to this subsection shall reflect a reduction of the rates or rating plans for such coverages on file with the Commissioner as of January 28, 1991, of not less than 15 percent, as compared to rates in effect for coverages required to be offered by the former 'Geor-

gia Motor Vehicle Accident Reparations Act,' with the exception of physical damage coverages, as specified in paragraph (3) of subsection (a) of former Code Section 33-34-5 and third-party property damage coverages. On October 1, 1991, the Commissioner shall reduce by 15 percent or such higher amount as he determines appropriate, after notice and hearing as required by law, any rate or rating plan for such coverages under motor vehicle insurance policies for which no filing has been received.

"(b) Any insurer aggrieved by the rate filing required pursuant to subsection (a) of this section may petition the Commissioner for a hearing to grant relief from the rate filing as the result of extraordinary circumstances. The insurer shall have the burden of proof to establish the extraordinary circumstances which justify relief. A hearing conducted pursuant to this subsection shall be conducted in accordance with the provisions of Chapter 2 of Title 33. Upon conclusion of any hearing conducted pursuant to this subsection, the Commissioner shall enter an order specifying the rates to be used by the insurer and shall indicate in his order all factors entering into a decision to relieve the insurer from full compliance with the provisions of subsection (a) of this section."

Law reviews. — For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 298 (1992).

33-9-44. Legislative intent.

It is specifically intended that the discounts provided in Code Sections 33-9-42 and 33-9-43 shall be provided by the insurer to any person who qualifies for such discounts.

History. — Code 1981, § 33-9-44, enacted by Ga. L. 1991, p. 1608, § 1.7; Ga. L. 2019, p. 337, § 1-55/SB 132.

The 2019 amendment, effective July 1, 2019, deleted the former last sentence, which read: "It is further intended that any similar discounts granted to qualified persons under Chapter 34 of this title as such chapter existed on September 30, 1991, shall not be discontinued nor duplicated by the enactment of Code Sections 33-9-42 and 33-9-43 for policies in effect on September 30, 1991."

Editor's notes. — Ga. L. 1991, p. 1608, § 3.2, effective April 17, 1991, not codified by the General Assembly, provides: "(a) Each insurer shall file its proposed forms, manuals, underwriting rules, rates, and rating plans for coverages under motor vehicle insurance policies to be issued, issued for delivery, delivered, or renewed on and after October 1, 1991, with the Commissioner of Insurance for such examination and approval as is required by law. The Commissioner shall not approve such filings unless such filings contain optional medical payments coverage. Rates and rating plans for motor vehicle insurance coverages filed pursuant to this subsection shall reflect a reduction of the rates or rating plans for such coverages on file with the Commissioner as of January 28, 1991, of not less than 15 percent, as compared to rates in effect for coverages required to be offered by the former 'Georgia Motor Vehicle Accident Reparations Act,' with the exception of physical damage coverages, as specified in paragraph (3) of subsection (a) of former Code Section 33-34-5 and third-party property damage coverages. On October 1, 1991, the Commissioner shall reduce by 15 percent or such higher amount as he determines appropriate, after notice and hearing as required by law, any rate or rating plan for such coverages under motor vehicle insurance policies for which no filing has been received.

"(b) Any insurer aggrieved by the rate filing required pursuant to subsection (a) of this section may petition the Commissioner for a hearing to grant relief from the rate filing as the result of extraordinary circumstances. The insurer shall have the burden of proof to establish the extraordinary circumstances which justify relief. A hearing conducted pursuant to this subsection shall be conducted in

accordance with the provisions of Chapter 2 of Title 33. Upon conclusion of any hearing conducted pursuant to this subsection, the Commissioner shall enter an order specifying the rates to be used by the insurer and shall indicate in his order all factors entering into a decision to relieve the insurer from full compliance with the provisions of subsection (a) of this section."

CHAPTER 10

ASSETS AND LIABILITIES

Sec.
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33-10-1. Assets considered in determining financial condition of insurers generally.

In any determination of the financial condition of an insurer, there shall be allowed as assets only such assets as are owned by the insurer and which consist of:

(1) Cash in the possession of the insurer or in transit under its control, including the true balance of any deposit in a solvent bank, a trust company, a savings and loan association, or a building and loan association;

(2) Investments, securities, properties, and loans acquired or held in accordance with this title and in connection therewith the following items:

(A) Interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

(B) Declared and unpaid dividends on stock and shares, unless such amount has otherwise been allowed as an asset;

(C) Interest due or accrued upon a collateral loan in an amount not to exceed one year's interest thereon;

(D) Interest due or accrued on deposits in solvent banks, trust companies, savings and loan associations, or building and loan associations and interest due or accrued on other assets, if such interest is in the judgment of the Commissioner a collectable asset;

(E) Interest due or accrued on a mortgage loan, in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes on the property over the unpaid principal; but in no event shall interest accrued for a period in excess of 18 months be allowed as an asset;

(F) Rent due or accrued on real property if such rent is not in arrears for more than three months and rent more than three months in arrears if the payment of such rent be adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral; or

(G) The unaccrued portion of taxes paid prior to the due date on real property;

(3) Electronic and mechanical machines and software constituting a data processing, record-keeping, or accounting system if the cost of such system does not exceed 10 percent of admitted assets or $7.5 million, whichever is less;

(4) Good will up to 10 percent of the acquiring insurer's capital and surplus shown on its statutory balance sheet for its most recently filed statement with the Commissioner adjusted to exclude any net positive good will, electronic data processing equipment, operating system software, and net deferred tax asset;

(5) Premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest thereon, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(6) The net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer;

(7) Premiums in the course of collection, other than for life insurance and annuity considerations, not more than three months past due, less commissions payable thereon. The foregoing limitation shall not apply to premiums payable directly or indirectly by the United States government or by any state or by any of their instrumentalities;

(8) Installment premiums other than life insurance premiums to the extent of the unearned premium reserves carried thereon;

(9) Notes and similar written obligations not past due taken for premiums other than life insurance premiums on policies permitted

to be issued on such basis to the extent of the unearned premium reserves carried thereon;

(10) The full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under Code Section 33-7-14;

(11) Amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(12) Deposit or equities recoverable from underwriting associations, syndicates, and reinsurance funds or from any suspended banking institution to the extent deemed by the Commissioner available for the payment of losses and claims and at values to be determined by the Commissioner;

(13) All assets, whether or not consistent with this Code section, as may be allowed pursuant to the annual statement form approved by the Commissioner for the kinds of insurance to be reported upon therein; and

(14) Other assets, not inconsistent with this Code section, deemed by the Commissioner to be available for the payment of losses and claims at values to be determined by the Commissioner.

History. — Code 1933, § 56-901, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 2; Ga. L. 1995, p. 481, § 1; Ga. L. 1996, p. 6, § 33; Ga. L. 2008, p. 469, § 1/SB 347; Ga. L. 2013, p. 690, § 21/SB 185; Ga. L. 2019, p. 869, § 1/HB 277.

The 2019 amendment, effective July 1, 2019, inserted "a" preceding "trust company" in paragraph (1); in paragraph (3), deleted ", as such term is defined in Code Section 11-9-102," following "software" near the middle and substituted "$7.5 million" for "$7,500,000.00"; added paragraph (4); redesignated former paragraphs (4) through (13) as present paragraphs (5) through (14), respectively; and substituted "the Commissioner" for "him" at the end of paragraph (12).

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990).

OPINIONS OF THE ATTORNEY GENERAL

"Admitted assets" is just another expression having the same meaning as "allowed assets," and both "admitted assets" and "allowed assets" mean those investments which come within the definition of former Code 1933, § 56-901 (O.C.G.A. § 33-10-1) and not excluded therefrom either impliedly by the language of former Code 1933, § 56-901 or expressly by former Code 1933, § 56-903 (see O.C.G.A. § 33-10-2). 1963-65 Op. Att'y Gen. p. 312.

33-10-2. Excluded assets.

In addition to assets impliedly excluded by Code Section 33-10-1, the following expressly shall not be allowed as assets in any determination of the financial condition of an insurer:

(1) Trade names and other similar intangible assets;

(2) Advances to officers other than policy loans whether secured or not and advances other than policy loans to employees, agents, and other persons on personal security only;

(3) Stock of such insurer, owned by such insurer, or any equity in such stock or loans secured by such stock or any proportionate interest in such stock acquired or held through the ownership by such insurer of a controlling interest in another firm, corporation, or business unit;

(4) Furniture, fixtures, furnishings, safes, vehicles, libraries, stationery, literature, and supplies other than data processing and accounting system authorized under paragraph (3) of Code Section 33-10-1, except, in the case of title insurers, such materials and plants as the insurer is expressly authorized to invest in under Code Section 33-11-27 and except, in the case of any insurer, such personal property as the insurer is permitted to hold pursuant to Chapter 11 of this title or which is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by such insurer for home office, branch office, or similar purposes; and

(5) The amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this chapter.

History. — Code 1933, § 56-903, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1988, p. 1540, § 1; Ga. L. 2019, p. 337, § 1-56/SB 132; Ga. L. 2019, p. 869, § 2/HB 277.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "such insurer" for "him" near the beginning of paragraph (3) and near the end of paragraph (4). The second 2019 amendment, effective July 1, 2019, substituted the present provisions of paragraph (1) for the former provisions, which read: "Good will, trade names, and other similar intangible assets, except that good will may be allowed as an asset under such limitations as are imposed by rule of the Commissioner;".

33-10-3. Deduction of assets from liabilities and liabilities from assets generally.

Assets may be allowable as deductions from corresponding liabilities, and liabilities may be charged as deductions from assets, in accordance

with the form of annual statement applicable to such insurer as directed by the Commissioner or otherwise in his or her discretion.

History. — Code 1933, § 56-902, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-57/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "as directed" for "as prescribed" and inserted "or her" near the end of this Code section.

33-10-4. Reporting of unallowed assets and assets of doubtful value or character as deduction from gross assets.

All assets not allowed and all other assets of doubtful value or character included as assets in any statement by an insurer to the Commissioner or in any examiner's report to said Commissioner shall also be reported, to the extent of the value disallowed, as deductions from the gross assets of such insurer.

History. — Code 1933, § 56-904, enacted by Ga. L. 1960, p. 289, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Treasury stock cannot be considered in determining condition. — A Georgia insurance company may acquire by purchase shares of its own capital stock out of its earned surplus over and above its liabilities and hold the shares as treasury stock, provided such purchases do not reduce the amount of outstanding stock below the statutory minimum and the minimum set forth in its charter and bylaws; such shares cannot be voted and cannot participate in dividends or distribution, and such shares cannot be considered as an admitted asset in any determination of the financial condition of the company, nor shall such shares be counted as outstanding shares of capital stock for the purpose of any stockholder's quorum or vote. 1962 Op. Att'y Gen. p. 292.

33-10-5. Capital stock and liabilities charged against assets.

In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

(1) The amount of its capital stock outstanding, if any;

(2) The amount, estimated consistent with this title, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement thereof;

(3) With reference to life and disability insurance and annuity contracts:

(A) The amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to this title which are applicable thereto;

(B) Reserves for disability benefits for both active and disabled lives;

(C) Reserves for accidental death benefits; and

(D) Any additional reserves which may be required by the Commissioner consistent with practice formulated or approved by him on account of such insurance;

(4) With reference to insurance other than that specified in paragraph (3) of this Code section and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter; and

(5) Taxes, expenses, and other obligations due or accrued at the date of the statement.

History. — Code 1933, § 56-905, enacted by Ga. L. 1960, p. 289, § 1.

33-10-6. Unearned premium reserve required for property, general casualty, and surety insurance generally.

(a) With reference to insurance against loss or damage to property, except as provided in Code Section 33-10-7, and with reference to all general casualty insurance and surety insurance, every insurer shall maintain an unearned premium reserve on all policies in force.

(b) The Commissioner may require that such reserves shall be equal to the unearned portions of the gross premiums in force after deducting reinsurance in solvent insurers as computed on each respective risk from the policy's date of issue. If the Commissioner does not so require, the portions of the gross premium in force, less reinsurance in solvent insurers to be held as a premium reserve, shall be computed according to the following table:

Term for Which Policy Was Written	Reserve for Unearned Premium
1 year or less	1/2
2 years	First year 3/4
	Second year 1/4
3 years	First year 5/6
	Second year 1/2
	Third year 1/6

4 years .....First year 7/8

.....Second year 5/8

.....Third year 3/8

.....Fourth year 1/8

5 years .....First year 9/10

.....Second year 7/10

.....Third year 1/2

.....Fourth year 3/10

.....Fifth year 1/10

Over 5 years .....Pro rata

(c) Unearned premium reserves on policies written for an intermediate period shall be calculated on a monthly pro rata basis.

(d) In lieu of computation according to the foregoing table, all of such reserves may be computed, at the option of the insurer, on a monthly or more frequent pro rata basis.

(e) After adopting a method for computing such reserve, a domestic insurer shall not change methods without approval of the Commissioner, and a foreign or alien insurer shall not change methods without approval of the insurance supervisory official of the state of its domicile.

(f) This Code section does not apply to title insurance.

History. — Code 1933, § 56-906, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Definition of casualty insurance, § 33-7-3. Definition of property insurance, § 33-7-6. Definition of surety insurance, § 33-7-7.

JUDICIAL DECISIONS

Cited in Consumer Life Ins. Co. v. United States, 524 F.2d 1167 (Ct. Cl. 1975).

33-10-7. Marine insurance, required reserves.

With reference to marine insurance, premiums on trip risks not terminated shall be deemed unearned, and the Commissioner may require the insurer to carry a reserve thereon equal to 100 percent on trip risks written during the month ended as of the date of statement.

History. — Code 1933, § 56-907, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Definition of marine and transportation insurance, § 33-7-5.

33-10-8. Accident and sickness insurance, required reserves.

For all accident and sickness insurance policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under such policies and which shall not be less in the aggregate than the reserve according to such method of calculation as the Commissioner may approve.

History. — Code 1933, § 56-908, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 3; Ga. L. 1985, p. 1087, § 2.

Cross references. — Definition of accident and sickness insurance, § 33-7-2.

Law reviews. — For note, "Misrepresentations and Nondisclosures in the Insurance Application," see 13 Ga. L. Rev. 876 (1979).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 36.

C.J.S. — 46A C.J.S., Insurance, § 1789 et seq.

33-10-9. Employers' liability and workers' compensation insurance, required reserves.

Reserved. Repealed by Ga. L. 2005, p. 655, § 1, effective May 2, 2005.

Editor's notes. — This Code section was based on Code 1933, § 56-909, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

33-10-10. Title insurance, required reserves.

In addition to an adequate reserve as to outstanding losses as required under Code Section 33-10-5, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(1) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts shall be assigned originally to the reserve; and

(2) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract may be reduced by 5 percent of the original amount of the reserve.

History. — Code 1933, § 56-911, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-58/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "hereafter" following "risk premiums" in paragraph (1).

Cross references. — Definition of title insurance, § 33-7-8.

33-10-11. Requirement of special reserve for certain bonds.

In lieu of the unearned premium reserve required on surety insurance under subsection (a) of Code Section 33-10-6, the Commissioner may require any surety insurer or limited surety insurer to set up and maintain a reserve on all bail bonds or other single premium bonds without definite expiration data, furnished in judicial proceedings, equal to 25 percent of the total consideration charged for any bonds as are outstanding as of the date of any then current financial statement of the insurer.

History. — Code 1933, § 56-917, enacted by Ga. L. 1973, p. 499, § 2; Ga. L. 2019, p. 337, § 1-59/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "then" near the end of this Code section.

33-10-12. Requirement by Commissioner of increase in loss reserves.

If the loss experience shows that an insurer's loss reserves, however estimated, are inadequate, the Commissioner shall require the insurer to maintain loss reserves of increased amounts as are needed to make them adequate. This Code section does not apply to life insurance.

History. — Code 1933, § 56-910, enacted by Ga. L. 1960, p. 289, § 1.

33-10-13. Standard valuation.

(a) This Code section shall be known and may be cited as the "Standard Valuation Law."

(b) The following definitions shall apply on or after the operative date of the valuation manual. For the purposes of this Code section, the term:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in paragraph (2) of subsection (d) of this Code section.

(3) "Company" means an entity, which:

(A) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one such policy in force or on claim; or

(B) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(4) "Deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Policyholder behavior" means any action a policyholder, contract holder, or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this Code section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (p) of this Code section as specified in the valuation manual.

(9) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(10) "Tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(11) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this Code section or as subsequently amended.

(c)(1)(A) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all

outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued on or after January 1, 1966, and prior to the operative date of the valuation manual. In calculating reserves, the Commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this Code section.

(B) The provisions set forth in subsections (e) through (n) of this Code section shall apply to all policies and contracts, as appropriate, subject to this Code section issued on or after January 1, 1966, and prior to the operative date of the valuation manual, and the provisions set forth in subsections (o) and (p) of this Code section shall not apply to any such policies and contracts.

(C) The minimum standard for the valuation of such policies and contracts issued prior to January 1, 1966, shall be as required under the laws in effect immediately prior to January 1, 1966, or the minimum provided in subsection (e) of this Code section if less.

(2)(A) The Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the Commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this Code section.

(B) The provisions set forth in subsections (o) and (p) of this Code section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(d)(1)(A) Prior to the operative date of the valuation manual, every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by regulation are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The Commissioner shall

define by regulation the specifics of this opinion and add any other items deemed to be necessary to its scope.

(B)(i) Every life insurance company, except as exempted by regulation, shall also annually include in the opinion required by subparagraph (A) of this paragraph an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the Commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(ii) The Commissioner may provide by regulation for a transition period for establishing any higher reserves that the qualified actuary may deem necessary in order to render the opinion required by this subsection.

(C) Each opinion required by subparagraph (B) of this paragraph shall be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the Commissioner as specified by regulation, shall be prepared to support each actuarial opinion; and

(ii) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified by regulation or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commissioner.

(D) Every opinion required by this subsection shall be governed by the following provisions:

(i) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994;

(ii) The opinion shall apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the Commissioner as specified by regulation;

(iii) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the Commissioner may by regulation prescribe;

(iv) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(v) For the purposes of this subsection, the term "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in the regulation;

(vi) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion;

(vii) Disciplinary action by the Commissioner against the company or the qualified actuary shall be defined in regulations by the Commissioner;

(viii) Except as provided in divisions (xii), (xiii), and (xiv) of this subparagraph, documents, materials, or other information in the possession or control of the department that are a memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum, shall be confidential by law and privileged, shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties;

(ix) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to division (viii) of this subparagraph;

(x) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(I) May share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to division (viii) of this subparagraph, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, materials, or other information;

(II) May receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and

(III) May enter into agreements governing sharing and use of information consistent with divisions (viii) through (x) of this subparagraph;

(xi) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this subsection or as a result of sharing as authorized in division (x) of this subparagraph;

(xii) A memorandum in support of the opinion, and any other material provided by the company to the Commissioner in connection with the memorandum, may be subject to subpoena for the purpose of defending an action seeking damages from the actuary submitting the memorandum by reason of an action required by this subsection or by regulations promulgated hereunder;

(xiii) The memorandum or other material may otherwise be released by the Commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the Commissioner for preserving the confidentiality of the memorandum or other material; and

(xiv) Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before a

governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(2)(A) On and after the operative date of the valuation manual, every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the Commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion, including any items deemed to be necessary to its scope.

(B) Every company with outstanding life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and subject to regulation by the Commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subparagraph (A) of this paragraph an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(C) Each opinion required by subparagraph (B) of this paragraph shall be governed by the following provisions:

(i) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the Commissioner, shall be prepared to support each actuarial opinion; and

(ii) If the insurance company fails to provide a supporting memorandum at the request of the Commissioner within a period specified in the valuation manual or the Commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the Commissioner.

(D) Every opinion required by this paragraph shall be governed by the following provisions:

(i) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the Commissioner;

(ii) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual;

(iii) The opinion shall apply to all policies and contracts subject to subparagraph (B) of this paragraph, plus other actuarial liabilities as may be specified in the valuation manual;

(iv) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual;

(v) In the case of an opinion required to be submitted by a foreign or alien company, the Commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the Commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state;

(vi) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurance company and the Commissioner, for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion; and

(vii) Disciplinary action by the Commissioner against the company or the appointed actuary shall be defined in regulations by the Commissioner.

(e)(1) Except as otherwise provided in paragraph (2) of this subsection and subsection (f) of this Code section, the minimum standards for the valuation of all life insurance policies and annuity or pure endowment contracts issued on or after January 1, 1966, shall be the Commissioner's reserve valuation methods defined in subsections (g), (h), and (i) of this Code section and the following interest rates and tables:

(A) Three and one-half percent interest or, in the case of policies and contracts other than annuity and pure endowment contracts issued on or after July 1, 1973, 4 percent interest for such policies issued prior to July 1, 1979, 5 1/2 percent interest for single premium life insurance policies, and 4 1/2 percent interest for all other such policies issued on or after July 1, 1979;

(B) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the Commissioners 1958 Standard Ordinary Mortality Tables for such policies issued prior to the operative date of subsection (e) of Code Section 33-25-4 as amended, except that for any category of such policies issued on female risk modified net premiums and present values, referred to in subsection (g) of this Code section, may be calculated at the insurer's option and with the Commissioner's approval according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of subsection (e) of Code Section 33-25-4, (i) the Commissioners 1980 Standard Ordinary Mortality Table, or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or (iii) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies;

(C) For all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, the 1941 Standard Industrial Mortality Table; for such policies issued prior to the date on which the Commissioners 1961 Standard Industrial Mortality Table becomes applicable in accordance with subsection (d) of Code Section 33-25-4 and for such policies issued on or after such date the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies;

(D) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the insurer, the Annuity Mortality Table for 1949, ultimate, or any modification of either of these tables approved by the Commissioner;

(E) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such table approved by the Commissioner or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(F) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued prior to January 1, 1966, either such tables or, at the option of the insurer, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(G) For accidental death benefits in or supplementary to policies, for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such policies; for policies issued prior to January 1, 1966, either such table or, at the option of the insurer, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies; and

(H) For group life insurance, life insurance issued on the substandard basis, and other special benefits such tables or appropriate modifications of such tables as may be approved by the Commissioner as being sufficient with relation to the benefits provided by those policies.

(2) Except as provided in paragraphs (3) through (7) of this subsection, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this paragraph, as defined in this paragraph, and for all annuities and pure endowments purchased on or after the operative date under group annuity and pure endowment contracts, shall be the Commissioner's reserve valuation methods defined in subsections (g) and (h) of this Code section and the following tables and interest rates:

(A) For individual annuity and pure endowment contracts issued prior to July 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any modification of this table approved by the Commissioner and 6 percent interest for single premium immedi-

ate annuity contracts and 4 percent interest for all other individual annuity and pure endowment contracts;

(B) For individual single premium immediate annuity contracts issued on or after July 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such contracts or any modification of these tables approved by the Commissioner and 7 1/2 percent interest;

(C) For individual annuity and pure endowment contracts issued on or after July 1, 1979, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table or any individual annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such contracts or any modification of these tables approved by the Commissioner and 5 1/2 percent interest for single premium deferred annuity and pure endowment contracts and 4 1/2 percent interest for all other such individual annuity and pure endowment contracts;

(D) For all annuities and pure endowments purchased prior to July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any modification of this table approved by the Commissioner and 6 percent interest; and

(E) For all annuities and pure endowments purchased on or after July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table or any group annuity mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by regulation promulgated by the Commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments or any modification of these tables approved by the Commissioner and 7 1/2 percent interest.

After July 1, 1973, any insurer may file with the Commissioner a written notice of its election to comply with this paragraph after a specified date before January 1, 1979, which shall be the operative

date of this paragraph for such insurer, provided that if an insurer makes no such election, the operative date of this paragraph for such insurer shall be January 1, 1979.

(f)(1) The interest rates used in determining the minimum standard for the valuation of:

(A) All life insurance policies issued in a particular calendar year, on or after the operative date of subsection (e) of Code Section 33-25-4;

(B) All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1994;

(C) All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1994, under group annuity and pure endowment contracts; and

(D) The net increase, if any, in a particular calendar year after January 1, 1994, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in paragraphs (2) through (5) of this subsection.

(2) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of 1 percent:

(A) For life insurance:

$I = .03 + W(R1 - .03) + 1/2\ W(R2 - .09)$;

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$I = .03 + W(R - .03)$

where R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in paragraph (4) of this subsection, and W is the weighting factor defined in paragraph (3) of this subsection;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subparagraph (B) of this paragraph, the formula for life insurance stated in subparagraph (A) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply to annuities and

guaranteed interest contracts with guarantee duration of ten years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply; and

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply;

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of 1 percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when subsection (e) of Code Section 33-25-4 becomes operative.

(3) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting Factors for Life Insurance:

Guarantee Duration Years	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80; and

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (B) of this paragraph, shall be as specified in Tables I, II, and III of this subparagraph, according to the rules and definitions in IV, V, and VI of this subparagraph:

I. For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

II. For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Table I increased by:

Plan Type A	B	C
.15	.25	.05

III. For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in Table I or derived in Table II increased by:

Plan Type		
A	B	C
.05	.05	.05

IV. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence;

V. Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or (2) without such adjustment but in installments over five years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted;

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years;

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurer, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund;

VI. An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the

annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(4) The reference interest rate referred to in paragraph (2) of this subsection shall be defined as follows:

(A) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published in Moody's Investors Service, Inc.;

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subparagraph (B) of this paragraph, with guarantee duration in excess of ten years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.;

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subparagraph (B) of this paragraph, with guarantee duration of ten years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.;

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the

calendar year of issue or purchase, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.; and

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subparagraph (B) of this paragraph, the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's Corporate Bond Yield Average — Monthly Average Corporates, as published by Moody's Investors Service, Inc.

(5) In the event that Moody's Corporate Bond Yield Average — Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or, in the event that the National Association of Insurance Commissioners determines that Moody's Corporate Bond Yield Average — Monthly Average Corporates as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then the alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the Commissioner, may be substituted.

(g)(1) Except as otherwise provided in subsections (l) and (n) of this Code section, reserves according to the Commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value at the date of valuation of the future guaranteed benefits provided for by the policies over the then present value of any future modified net premiums therefor. The modified net premiums for the policy shall be the uniform percentage of the respective contract premiums for the benefits, excluding extra premiums on a substandard policy, that the present value at the date of issue of the policy of all the modified net premiums shall be equal to the sum of the then present value of the benefits provided for by the policy and the excess of subparagraph (A) of this paragraph over subparagraph (B) of this paragraph as follows:

(A) A net level annual premium equal to the present value at the date of issue of such benefits provided for after the first policy year, divided by the present value at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that the net level annual premium shall not exceed the net level annual premium on the 19 year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of the policy; and

(B) A net one-year term premium for the benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after the effective date of subsection (h) of Code Section 33-25-4 for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the Commissioner's reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined in this subsection as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (l) of this Code section, be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in that paragraph, but with (i) the value defined in subparagraph (A) of that paragraph being reduced by 15 percent of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison, the mortality and interest bases stated in subsections (e) and (f) of this Code section shall be used.

(2) Reserves according to the Commissioner's reserve valuation method for:

(A) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(B) Group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code as now or hereafter amended;

(C) Disability and accidental death benefits in all policies and contracts; and

(D) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of this subsection.

(h) This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code. Reserves according to the Commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, shall be the greatest of the respective excesses of the present values at the date of valuation of the future guaranteed benefits, including guaranteed nonforfeiture benefits provided for by the contracts at the end of each respective contract year, over the present value at the date of valuation of any future valuation considerations derived from future gross considerations required by the terms of the contract that become payable prior to the end of the respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(i) In no event shall an insurer's aggregate reserve for all life insurance policies, excluding disability and accidental death benefits issued on or after January 1, 1966, be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (g), (h), (l), and (m) of this Code section and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies. In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by subsection (d) of this Code section.

(j)(1) Reserves for all policies and contracts issued prior to January 1, 1966, may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all the policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date.

(2) For any category of policies, contracts, or benefits specified in subsection (e) of this Code section issued on or after January 1, 1966, reserves may be calculated, at the option of the insurer, according to any standard or standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard provided in this Code section; but the rate or rates of interest used for policies and contracts, other than annuity and pure

endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies and contracts.

(k) An insurer that at any time had adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided for in subsection (i) of this Code section may, with the approval of the Commissioner, adopt any lower standard of valuation but not lower than the minimum provided in this subsection; provided, however, that for the purposes of this subsection, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by subsection (d) of this Code section shall not be deemed to be the adoption of a higher standard of valuation.

(l) If in any contract year the gross premium charged by any life insurer on any policy or contract issued on or after January 1, 1966, is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract or the reserve calculated by the method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this Code section are those standards stated in subsections (e) and (f) of this Code section. Provided that for any life insurance policy issued on or after the effective date of subsection (h) of Code Section 33-25-4 for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides as an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (g) of this Code section, ignoring the second paragraph of paragraph (1) of subsection (g) of this Code section. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (g) of this Code section, including the second paragraph of paragraph (1) of subsection (g) of this Code section, and the minimum reserve calculated in accordance with this subsection.

(m) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by

the insurer based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (e), (g), (h), and (l) of this Code section, the reserves which are held under any such plan must:

(1) Be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(2) Be computed by a method which is consistent with the principles of this Code section, the "Standard Valuation Law,"

as determined by regulations promulgated by the Commissioner.

(n) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under paragraph (2) of subsection (c) of this Code section. For disability, accident and sickness, accident, and health insurance contracts issued prior to the operative date of the valuation manual, the minimum standard of valuation is the standard adopted by the Commissioner by regulation.

(o)(1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under paragraph (2) of subsection (c) of this Code section, except as provided under paragraphs (5) and (7) of this subsection.

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(A) The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater;

(B) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75 percent of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident, and health annual statements; health annual statements; or fraternal annual statements; and

(C) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: the 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when the change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(A) At least three-fourths of the members of the NAIC voting, but not less than a majority of the total membership; and

(B) Members of the NAIC representing jurisdictions totaling greater than 75 percent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subparagraph (A) of this paragraph: life, accident, and health annual statements, health annual statements, or fraternal annual statements.

(4) The valuation manual must specify all of the following:

(A) Minimum valuation standards for and definitions of the policies or contracts subject to paragraph (2) of subsection (c) of this Code section. Such minimum valuation standards shall be:

(i) The Commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to paragraph (2) of subsection (c) of this Code section;

(ii) The Commissioner's annuity reserve valuation method for annuity contracts subject to paragraph (2) of subsection (c) of this Code section; and

(iii) Minimum reserves for all other policies or contracts subject to paragraph (2) of subsection (c) of this Code section;

(B) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in paragraph (1) of subsection (p) of this Code section and the minimum valuation standards consistent with those requirements;

(C) For policies and contracts subject to a principle-based valuation under subsection (p) of this Code section:

(i) Requirements for the format of reports to the Commissioner under subparagraph (p)(2)(C) of this Code section and which shall include information necessary to determine if the valuation is appropriate and in compliance with this Code section;

(ii) Assumptions shall be prescribed for risks over which the company does not have significant control or influence; and

(iii) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures;

(D) For policies not subject to a principle-based valuation under subsection (p) of this Code section, the minimum valuation standard shall either:

(i) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(ii) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring;

(E) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(F) The data and form of the data required under subsection (q) of this Code section, with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(5) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the Commissioner, in compliance with this Code section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the Commissioner by regulation.

(6) The Commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this Code section. The Commissioner may rely upon the opinion, regarding provisions contained within this Code section, of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

(7) The Commissioner may require a company to change any assumption or method that in the opinion of the Commissioner is necessary in order to comply with the requirements of the valuation manual or this Code section; and the company shall adjust the reserves as required by the Commissioner. The Commissioner may take other disciplinary action as permitted pursuant to this title.

(p)(1) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(A) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts, and for policies or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

(B) Incorporate assumptions, risk analysis methods and financial models, and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(C) Incorporate assumptions that are derived in one of the following manners:

(i) The assumption is prescribed in the valuation manual; or

(ii) For assumptions that are not prescribed, the assumptions shall:

(I) Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

(II) To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience; and

(D) Provide margins for uncertainty, including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(2) A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual shall:

(A) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(B) Provide to the Commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accor-

dance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year; and

(C) Develop, and file with the Commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(3) A principle-based valuation may include a prescribed formulaic reserve component.

(q) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(r)(1) For purposes of this subsection, the term "confidential information" shall mean:

(A) A memorandum in support of an opinion submitted under subsection (d) of this Code section and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such memorandum;

(B) All documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in the course of an examination made under paragraph (6) of subsection (o) of this Code section; provided, however, that if an examination report or other material prepared in connection with an examination made under Chapter 2 of this title is not held as private and confidential information under Chapter 2 of this title, an examination report or other material prepared in connection with an examination made under paragraph (6) of subsection (o) of this Code section shall not be confidential information to the same extent as if such examination report or other material had been prepared under Chapter 2 of this title;

(C) Any reports, documents, materials, and other information developed by a company in support of, or in connection with, an annual certification by the company under subparagraph (p)(2)(B) of this Code section evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such reports, documents, materials, and other information;

(D) Any principle-based valuation report developed under subparagraph (p)(2)(C) of this Code section and any other documents, materials, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such report; and

(E) Any documents, materials, data, and other information submitted by a company under subsection (q) of this Code section (collectively, "experience data") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created or produced in connection with such experience data, in each case that include any potentially company-identifying or personally identifiable information, that is provided to or obtained by the Commissioner (together with any "experience data," the "experience materials") and any other documents, materials, data, and other information, including, but not limited to, all working papers, and copies thereof, created, produced, or obtained by or disclosed to the Commissioner or any other person in connection with such experience materials.

(2)(A) Except as provided in this subsection, a company's confidential information is confidential by law and privileged, and shall not be subject to Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action; provided, however, that the Commissioner is authorized to use the confidential information in the furtherance of any regulatory or legal action brought against the company as a part of the Commissioner's official duties.

(B) Neither the Commissioner nor any person who received confidential information while acting under the authority of the Commissioner shall be permitted or required to testify in any private civil action concerning any confidential information.

(C) In order to assist in the performance of the Commissioner's duties, the Commissioner may share confidential information (i) with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries, and (ii) in the case of confidential information specified in subparagraphs (A) and (D) of paragraph (1) of this subsection only, with the Actuarial Board for Counseling and Discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal, and international law enforcement officials; in the case of (i) and (ii), provided that such recipient agrees, and has the legal authority to agree, to maintain the confidentiality and privileged status of such documents, materials, data, and other information in

the same manner and to the same extent as required for the Commissioner.

(D) The Commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions, and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information.

(E) The Commissioner may enter into agreements governing sharing and use of information consistent with this paragraph.

(F) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the Commissioner under this subsection or as a result of sharing as authorized in subparagraph (C) of this paragraph.

(G) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this paragraph shall be available and enforced in any proceeding in, and in any court of, this state.

(H) In this subsection, the terms "regulatory agency," "law enforcement agency," and the "NAIC" include, but are not limited to, their employees, agents, consultants, and contractors.

(3) Notwithstanding this paragraph, any confidential information specified in subparagraphs (A) and (D) of paragraph (1) of this subsection:

(A) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under subsection (d) of this Code section or principle-based valuation report developed under subparagraph (p)(2)(C) of this Code section by reason of an action required by this Code section or by regulations promulgated hereunder;

(B) May otherwise be released by the Commissioner with the written consent of the company; and

(C) Once any portion of a memorandum in support of an opinion submitted under subsection (d) of this Code section or a principle-based valuation report developed under subparagraph

(p)(2)(C) of this Code section is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media, all portions of such memorandum or report shall no longer be confidential.

(s)(1) The Commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in this state from the requirements of subsection (o) of this Code section, provided that:

(A) The Commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(B) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the Commissioner and promulgated by regulation.

(2) For any company granted an exemption under this subsection, subsections (d) through (n) of this Code section shall be applicable. With respect to any company applying this exemption, any reference to subsection (o) of this Code section in subsections (d) through (n) of this Code section shall not be applicable.

(t)(1) An insurer that has less than $300 million of ordinary life premiums and that is licensed and doing business in this state and that is subject to the requirements of subsections (o) through (r) of this Code section may hold reserves based on the mortality tables and interest rates defined by the valuation manual for net premium reserves and using the methodologies described in subsections (g) through (m) of this Code section as they apply to ordinary life insurance in lieu of the reserves required by subsections (o) and (p) of this Code section, provided that:

(A) If the insurer is a member of a group of life insurers, the group has combined ordinary life premiums of less than $600 million;

(B) The insurer reported total adjusted capital of at least 450 percent of authorized control level risk based capital in the risk based capital report for the prior calendar year;

(C) The appointed actuary has provided an unqualified opinion on the reserves for the prior calendar year; and

(D) The insurer has provided a certification by a qualified actuary that any universal life policy with a secondary guarantee issued by the insurer after the operative date of the valuation

manual meets the definition of a nonmaterial secondary guarantee universal life product as defined in the valuation manual.

(2) For purposes of paragraph (1) of this subsection, ordinary life premiums are measured as direct premium plus reinsurance assumed from an unaffiliated company, as reported in the annual statement for the prior calendar year.

(3) A domestic company meeting all of the conditions provided in this subsection may file, prior to July 1 of the current calendar year, a statement with the Commissioner certifying that such conditions are met for the current calendar year based on premiums and other values from the financial statements for the prior calendar year. The Commissioner may reject such statement prior to September 1 and require a company to comply with the valuation manual requirements for life insurance reserves.

History. — Code 1981, § 33-10-13, enacted by Ga. L. 2015, p. 846, § 1/HB 185; Ga. L. 2016, p. 816, § 8/HB 883; Ga. L. 2016, p. 864, § 33/HB 737; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2019, p. 337, § 1-60/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (b), rewrote the introductory language, which read: "For the purposes of this Code section, the following definitions shall apply on or after the operative date of the valuation manual:", in paragraph (b)(1), substituted "'Accident" for "The term 'accident', in paragraph (b)(2), substituted "'Appointed" for "The term 'appointed', in paragraph (b)(3), substituted "'Company' means an entity, which:" for "The term 'company' mean an entity, which" in the introductory language, substituted "Has written" for "has written" at the beginning of subparagraphs (b)(3)(A) and (b)(3)(B), and added a semicolon following "or on claim" at the end of subparagraph (b)(3)(A), in paragraph (b)(4), substituted "'Deposit-type" for "The term 'deposit-type", in paragraph (b)(5), substituted "'Life" for "The term 'life", in paragraph (b)(6), deleted "The term" at the beginning, in paragraph (b)(7), substituted "'Policyholder" for "The term 'policyholder", in paragraph (b)(8), substituted "'Principle-based" for "The term 'principle-based", in paragraph (b)(9), substituted "'Qualified" for "The term 'qualified", in paragraph (b)(10), substituted "'Tail" for "The term 'tail", and, in paragraph (b)(11), substituted "'Valuation" for "The term 'valuation"; in subsection (i), substituted "this Code section" for "the Code section" at the end; and, in subparagraph (p)(1)(A), substituted "contracts, and for policies" for "contracts. For policies".

Cross references. — Admissibility of mortality tables as evidence of life expectancy, §§ 24-14-44 and 24-14-45.

Editor's notes. — This Code section formerly pertained to valuation of reserves. The former Code section was based on Code 1933, § 56-912, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 487, § 1; Ga. L. 1973, p. 617, § 1; Ga. L. 1979, p. 1407, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 650, § 1; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1993, p. 483, §§ 1-5 and was repealed by Ga. L. 2015, p. 846, § 1/HB 185, effective July 1, 2015.

Administrative rules and regulations. — Life and annuity tables, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-39.

Actuarial opinion and memorandum regulation, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-74.

Law reviews. — For article discussing the use of mortality tables in determining

the value of life earnings of the deceased in wrongful death actions, with emphasis on the Carlisle table, see 9 Ga. St. B.J. 293 (1973). For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

RESEARCH REFERENCES

C.J.S. — 46 C.J.S., Insurance, §§ 1586, 1718, 1719.

33-10-14. Valuation of investments.

The value or amount of investments, unless otherwise specified in this chapter, and excluding assets of separate accounts which are subject to Code Sections 33-11-65 through 33-11-67, shall be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

History. — Code 1933, § 56-913, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 7; Ga. L. 1999, p. 592, § 3.

33-10-15. Valuation of other securities; preferred or guaranteed stocks or shares; stock of subsidiary corporation.

Reserved. Repealed by Ga. L. 1999, p. 592, § 4, effective January 1, 2000.

Editor's notes. — This Code section was based on Code 1933, § 56-914, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2877, § 8.

33-10-16. Valuation of real and personal property reserves.

(a) Real property acquired under a mortgage loan or under a deed to secure debt or pursuant to a contract of sale, in the absence of a recent appraisal deemed by the Commissioner to be reliable, shall not be valued at an amount greater than the unpaid principal of the defaulted loan or contract at the date of such acquisition, together with any taxes and expenses paid or incurred in connection with such acquisition and the cost of improvements thereafter made by the insurer and any amounts thereafter paid by the insurer on assessments levied for improvements in connection with the property.

(b) Other real property held by an insurer shall not be valued at an amount in excess of fair value as determined by recent appraisal. If valuation is based on an appraisal more than three years old, the

Commissioner may at his discretion call for and require a new appraisal in order to determine fair value.

(c) Personal property acquired under a chattel mortgage made in accordance with Code Section 33-11-26 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition, together with taxes and expenses incurred in connection with the acquisition or the fair value of the property, whichever amount is the lesser.

History. — Code 1933, § 56-915, enacted by Ga. L. 1960, p. 289, § 1.

33-10-17. Valuation of mortgage reserves.

Mortgages on real property referred to in subsection (a) of Code Section 33-10-16 shall be valued in an amount not exceeding the acquisition cost of the real property covered thereby or 90 percent of the fair value of the real property, whichever is less.

History. — Code 1933, § 56-916, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-61/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Mortgages on real property" for "Purchase money mortgages on real property" at the beginning of this Code section.

CHAPTER 11

INVESTMENTS

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A repurchase agreement transaction can be an authorized investment of the Teachers Retirement System, Employees' Retirement System, and Georgia State Financing and Investment Commission, so long as the transaction is intended by the parties to be a sale and repurchase of securities on terms under which such securities might normally be sold, the documents supporting the transaction adequately record that intention of the parties, and the securities involved are those in which the state entity is otherwise authorized to invest. 1979 Op. Att'y Gen. No. 79-62.

ARTICLE 1

INVESTMENTS OF CERTAIN INSURERS

Editor's notes. — Ga. L. 1999, p. 592, § 6, effective January 1, 2000, designated the existing provisions of this chapter as Article 1 thereof.

33-11-1. Scope of article.

(a) With the exception of Code Section 33-11-42, this article shall apply to domestic insurers only.

(b) The provisions of this article shall apply only to those insurers that are not subject to Article 2 of this chapter.

History. — Code 1933, § 56-1001, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6, 7.

33-11-2. Eligible investments; investment limitations.

(a) Insurers shall invest in or lend their funds on the security of, and shall hold as invested assets, only eligible investments as prescribed in this article.

(b) Eligibility of an investment shall be determined as of the date of its making or acquisition.

(c) Any investment limitation based upon the amount of the insurer's assets or particular fund shall relate to such assets or funds as shown by the insurer's annual statement as of December 31 of the year preceding the date of acquisition of the investment by the insurer or as shown by a current financial statement resulting from merger of another insurer, bulk reinsurance, or change in capitalization.

History. — Code 1933, § 56-1002, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 58 et seq.

C.J.S. — 44 C.J.S., Insurance, § 82 et seq.

33-11-3. Acquisition of securities or investments by insurers generally.

(a) No security or investment, other than real and personal property acquired under Code Sections 33-11-28, 33-11-29, and 33-11-32 and cash and deposits under Code Section 33-11-6, shall be eligible for acquisition unless it is interest bearing or interest accruing or dividend or income paying, or it is not then in default in any respect, and the insurer is entitled to receive for its account and benefit the interest or income accruing thereon.

(b) No security or investment shall be eligible for purchase at a price above its market value.

(c) No provision of this article shall prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets or under a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment so acquired which is not otherwise eligible under this article shall be disposed of pursuant to Code Section 33-11-39 if real property, or pursuant to Code Section 33-11-40 if personal property or securities.

(d) Nothing in this Code section shall prohibit an insurer from acquiring control of another insurer subject to the approval of the Commissioner.

History. — Code 1933, § 56-1003, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

JUDICIAL DECISIONS

Cited in Georgia Power Co. v. Foster Wheeler Corp., 161 Ga. App. 641, 288 S.E.2d 720 (1982).

33-11-4. Authorization of loan or investment of insurer.

An insurer shall not make any investment or loan other than policy loans or annuity contract loans of a life insurer unless the same is authorized or approved by the insurer's board of directors or by a committee authorized by the board and charged with the supervision or making of the investment or loan. The minutes of the committee shall be recorded and regular reports of the committee shall be submitted to the board of directors.

History. — Code 1933, § 56-1004, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-5. Required investments; limitations.

An insurer shall invest in or hold as admitted assets categories of investments that fall within the applicable limits listed in paragraphs (1) through (3) of this Code section:

(1) **One person.** Any insurer shall not, except with the Commissioner's consent, have at any one time any combinations of investments in or loans upon the security of the obligations, property, or securities of any one person, institution, corporation, or municipal corporation, aggregating an amount in excess of 10 percent of the insurer's admitted assets. This restriction shall not apply as to general obligations of the United States of America or of the government of Canada or of any state, nor include policy loans under this article;

(2) **Voting stock.** An insurer shall not invest in or hold at any one time more than 10 percent of the outstanding voting stock of any corporation, except with the Commissioner's consent. This provision does not apply as to stock of a substantially wholly owned insurance subsidiary of the insurer, but the prior written consent of the Commissioner shall be required for investment in a subsidiary;

(3) **Minimum capital.** An insurer shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under this title of a domestic stock insurer transacting like kinds of insurance, only in the following:

(A) Cash;

(B) Certificates of deposit or similar certificates or evidences of deposit in banks and trust companies to the extent that the certificates or deposits are insured by the Federal Deposit Insurance Corporation;

(C) Savings accounts, certificates of deposit, or similar certificates or evidences of deposit in savings and loan associations and building and loan associations to the extent that the same are insured by the Federal Savings and Loan Insurance Corporation;

(D) The securities provided for under Code Section 33-11-9;

(E) The securities provided for under Code Section 33-11-11;

(F) The securities provided for under Code Section 33-11-12;

(G) The securities provided for under Code Section 33-11-13; and

(H) The securities provided for under Code Section 33-11-25;

(4) **Investment of reserves.** In addition to the investments in paragraph (3) of this Code section, an insurer shall invest and keep invested its funds in amounts not less than 100 percent of the reserves provided for by this title, in cash or the securities or investments authorized under this article; provided, however, that an amount equal to not less than 75 percent of the reserves shall be invested in securities other than common stocks;

(5) **Other specific limits.** Limits as to investments in the category of real estate shall be as provided in Code Sections 33-11-29 through 33-11-32; provided, however, that, except as authorized by subsection (b) of Code Section 33-11-29, all such investments shall not exceed the lesser of 10 percent of admitted assets or 50 percent of the policyholder's surplus; and other specific limits shall apply as stated in Code sections dealing with other respective kinds of investments.

History. — Code 1933, § 56-1005, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1966, p. 240, § 1; Ga. L. 1980, p. 1108, § 4; Ga. L. 1992, p. 2877, § 9; Ga. L. 1999, p. 592, §§ 5, 6.

Law reviews. — For article, "Why Captives, Lord, What Have They Ever Done?: The Georgia Captive Insurance Company Act," see 26 Ga. St. B.J. 119 (1990).

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"Admitted assets" is just another expression having the same meaning as "allowed assets," and both "admitted assets" and "allowed assets" mean those investments which come within the definition of assets considered in determining financial condition (see O.C.G.A. § 33-10-1) and not excluded therefrom either impliedly (see O.C.G.A. § 33-10-1) or expressly (see O.C.G.A. § 33-10-2). 1963-65 Op. Att'y Gen. p. 312.

A mutual insurance company may organize and capitalize a stock company as a subsidiary, provided the prior consent of the Commissioner is obtained and the conditions indicated in former Code 1933, § 56-1027 (see O.C.G.A. § 33-11-37) are complied with. 1962 Op. Att'y Gen. p. 294.

Federal National Mortgage Association participation certificates are authorized securities and may be accepted for deposit under former Code 1933, § 56-310 (see O.C.G.A. § 33-3-9). 1969 Op. Att'y Gen. No. 69-346.

Paragraph (3) applies to perpetual care trust funds. — The restrictions imposed by paragraph (3) of this section upon domestic insurers in the making of their investments apply to the investment of the assets of perpetual care trust funds. 1974 Op. Att'y Gen. No. 74-51 (minimum initial trust deposit equated with minimum capital of domestic stock insurer).

Clause making investments eligible if legal on date of title inapplicable to restriction in paragraph (4). — The drafters of this title did not intend that the provisions of former Code 1933, § 56-1002(2) (see O.C.G.A. § 33-11-2) should be applicable to the reserve distribution requirements of paragraph (4) of former Code 1933, § 56-1005 (see O.C.G.A. § 33-11-5); inasmuch as the legislature elsewhere authorized the holding of common stocks, subject to somewhat liberalized restrictions, in former Code 1933, § 56-1020 (see O.C.G.A. § 33-11-21), they clearly did not intend that the generalized "savings clause" contained in former Code 1933, § 56-1002(2), should apply to the specific quantitative restrictions on the holding of common stocks contained in the reserve distribution requirements of paragraph (4); stated differently, the legislature, while liberalizing the restrictions upon the quality of common stocks which could be held, on the one hand, imposed more rigid restrictions with respect to the quantitative portfolio distribution of such common stock holdings, on the other hand. 1971 Op. Att'y Gen. No. 71-170.

The proper application of the "savings clause" of former Code 1933, § 56-1002(2) (see O.C.G.A. § 33-11-2), was to that general group of assets, including common stock, which an insurer might lawfully hold, insofar as the qualitative restrictions contained in this title raised or altered the qualitative restrictions of the prior law; any attempt to apply the "savings clause" of former Code 1933, § 56-1002(2), to the reserve distribution requirements of paragraph (4) of former Code 1933, § 56-1005 (see O.C.G.A. § 33-11-5) rendered the latter section largely meaningless and was inconsistent with the general tenor of former Code 1933, § 56-1020 (see O.C.G.A. § 33-11-21). 1971 Op. Att'y Gen. No. 71-170.

33-11-6. Authorized investments generally; cash or deposits.

An insurer may have as assets cash or deposits in checking or savings accounts under certificates of deposit or in any other form in banks and trust companies and in savings accounts, certificates of deposit, or similar certificates or evidences of deposits in savings and loan associations and building and loan associations which have qualified for the insurance protection afforded by the Federal Deposit Insurance Corporation or the Federal Savings and Loan Insurance Corporation; pro-

vided, however, that an insurer may, upon approval of the Commissioner, have as assets cash or deposits in checking or savings accounts, or in any other form in banks, trust companies, or savings and loan associations which are not members of the Federal Deposit Insurance Corporation or Federal Savings and Loan Insurance Corporation.

History. — Code 1933, § 56-1006, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 5; Ga. L. 1999, p. 592, § 6.

Administrative rules and regulations. — Variable life insurance, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-32.

33-11-7. Securities of open-end management investment company or investment trust.

An insurer may invest in the securities of any open-end management type investment company or investment trust registered with the Federal Securities and Exchange Commission under the Investment Company Act of 1940, as from time to time amended, if such investment company or trust has been organized for not less than ten years or has assets of not less than $25 million at the date of investment by the insurer.

History. — Code 1933, § 56-1007, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

U.S. Code. — The Investment Company Act of 1940, referred to in this Code section, is codified as 15 U.S.C. § 80a-1 et seq.

33-11-8. Foreign securities.

An insurer authorized to transact insurance in a foreign country may make investments, in a manner consistent with the laws of such country, in securities or other investments within such foreign country which are similar in characteristics and quality to like investments required pursuant to this article for investments in the United States of America. The aggregate amount of the investments must not exceed the amount which is customary and necessary for the servicing of the insurance which the insurer has in force in the foreign country. Canadian securities eligible for investment under this article are not subject to this Code section.

History. — Code 1933, § 56-1021, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 6; Ga. L. 1999, p. 592, §§ 5, 6.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 58.

C.J.S. — 44 C.J.S., Insurance, § 134 et seq.

33-11-9. Obligations of government of United States generally.

An insurer may invest in bonds, notes, warrants, and other evidences of indebtedness which are direct obligations of the government of the United States of America or for which the full faith and credit of the government of the United States of America is pledged for the payment of principal and interest.

History. — Code 1933, § 56-1009, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

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Federal National Mortgage Association participation certificates are authorized securities and may be accepted for deposit under former Code 1933, § 56-310 (see O.C.G.A. § 33-3-9). 1969 Op. Att'y Gen. No. 69-346.

33-11-10. Securities which are not evidenced by certificates.

Notwithstanding any other provisions of this title which might be construed to the contrary, nothing contained in this title shall be deemed to prohibit an insurer from investing its funds in or holding or owning as admitted assets securities which are not evidenced by certificates or instruments and related records issued to the insurer if held in accordance with the rules and regulations prescribed by the Commissioner and such securities are otherwise eligible for investment under this title.

History. — Code 1933, § 56-1042, enacted by Ga. L. 1978, p. 1936, § 3; Ga. L. 1993, p. 1721, § 1; Ga. L. 1999, p. 592, § 6.

Editor's notes. — This Code section was originally enacted by the General Assembly as Code 1933, § 56-1042; however, Ga. L. 1978, p. 1639, had already designated a section as § 56-1042 (see § 33-11-36), hence this section was unofficially redesignated as Code 1933, § 56-1042.1.

33-11-11. Loans guaranteed by government of United States.

An insurer may invest in loans guaranteed as to principal and interest by the government of the United States of America, or by any agency or instrumentality of the government of the United States of America, to the extent of such guaranty.

History. — Code 1933, § 56-1010, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

OPINIONS OF THE ATTORNEY GENERAL

Federal National Mortgage Association participation certificates are authorized securities and may be accepted for deposit under former Code 1933, § 56-310 (see O.C.G.A. § 33-3-9). 1969 Op. Att'y Gen. No. 69-346.

33-11-12. Securities of states of United States, District of Columbia, or government of Canada.

An insurer may invest in bonds, notes, warrants, and other securities not in default which are the direct obligations of any state of the United States or of the District of Columbia, or of the government of Canada or any province of Canada, or for which the full faith and credit of such state, district, government, or province has been pledged for the payment of principal and interest.

History. — Code 1933, § 56-1011, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-12.1. Investment in direct obligations of foreign governments.

Subject to the restrictions and limitations provided in this title, an insurer may invest in bonds, notes, warrants, and other securities not in default which are the direct obligations of the government of any foreign country which the International Monetary Fund lists as an industrialized country and for which the full faith and credit of such government has been pledged for the payment of principal and interest, provided such securities are listed as investment grade by the Securities Valuation Office of the National Association of Insurance Commissioners (NAIC) or as investment grade by a securities rating organization accepted by the NAIC.

History. — Code 1981, § 33-11-12.1, enacted by Ga. L. 1997, p. 843, § 1; Ga. L. 1999, p. 592, § 6.

33-11-13. Obligations of political subdivisions or public authorities of states of United States, District of Columbia, or government of Canada.

An insurer may invest in the obligations of any county, any incorporated city, town, or village, any school district, water district, sewer district, road district, or any special district, or any other political subdivision or public authority of any state, territory, or insular possession of the United States, or of the District of Columbia, or of the Canadian cities that have a population of over 25,000 according to the most recent official Census of Canada, which has not defaulted for a

period of 120 days in the payment of interest upon, or for a period of more than one year in the payment of principal of, any of its bonds, notes, warrants, certificates of indebtedness, securities, or any other interest-bearing obligation during the five years immediately preceding the acquisition of the investment.

History. — Code 1933, § 56-1012, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6; Ga. L. 2006, p. 767, § 1/SB 385.

33-11-14. Industrial development obligations.

An insurer may invest in the bonds, notes, certificates of indebtedness, warrants, or other evidence of indebtedness which are valid obligations issued, assumed, or guaranteed by the United States of America or any state of the United States of America, or by any county, municipal corporation, district, or political subdivision, or civil division or public instrumentality of any such government or unit of such government, if by statute or other legal requirements such obligations are payable as to both principal and interest from revenues or earnings from the whole or any part of any utility supplying water, gas, sewage disposal facility, or electricity or any other public service, including but not limited to toll roads and toll bridges, and in revenue bonds issued by any political subdivision, authority, unit, or other corporate body created by the United States government or the government of any state, for the purpose of aiding in or promoting the industrial development of such state or political subdivisions.

History. — Code 1933, § 56-1013, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1961, p. 458, § 1; Ga. L. 1999, p. 592, § 6.

33-11-14.1. Securities of federal agencies.

An insurer may invest in bonds, debentures, or other securities issued or insured or guaranteed by any agency, authority, unit, or corporate body created by the government of the United States of America whether or not such obligations are guaranteed by the United States.

History. — Code 1933, § 56-1014, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-15. Securities of public housing authorities or agencies.

An insurer may invest in the bonds, debentures, or other securities of public housing authorities, issued under the act of Congress entitled the Housing Act of 1949 and approved July, 1949, the Municipal

Housing Commission Act, or the Rural Housing Commission Act, and any additional amendments issued by any other public housing authority or agency in the United States, if the bonds, debentures, or other securities are secured by a pledge of annual contributions to be paid by the United States or any agency of the United States.

History. — Code 1933, § 56-1015, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

Cross references. — Housing authorities generally, § 8-3-1 et seq.

U.S. Code. — The Housing Act of 1949, referred to in this Code section, is codified as 42 U.S.C. § 1441 et seq.

33-11-16. Obligations issued, assumed, or guaranteed by International Bank for Reconstruction and Development or International Finance Corporation.

An insurer may invest in obligations issued, assumed, or guaranteed by the International Bank for Reconstruction and Development or the International Finance Corporation. The investments authorized by this Code section shall not be counted as an investment of reserves under paragraph (4) of Code Section 33-11-5 at any one time in an amount greater than 5 percent of the insurer's admitted assets. Such investments shall be subject to all limitations and requirements of this article. In addition to authority contained in Code Section 33-11-8 and elsewhere in this title, an insurer may invest up to 10 percent of its admitted assets in securities or other investments within a foreign country which are similar in characteristics and quality to like investments authorized pursuant to this article for investments in the United States of America, including obligations of the government of such foreign country and its political subdivisions and instrumentalities, provided that the values of such securities or other investments shall be determined in accordance with the valuation methods then currently formulated or approved by the National Association of Insurance Commissioners or its successor organization.

History. — Code 1933, § 56-1008, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2389, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

Editor's notes. — Ga. L. 1992, p. 2389, § 2, effective April 20, 1992, not codified by the General Assembly, provides: "Notwithstanding any provision of this chapter to the contrary, a group policyholder may require an employee contribution or an additional contribution for spousal coverage where the spouse so covered is eligible to receive coverage under another group accident and sickness policy but declines such coverage." However, the reference to "this chapter" in the uncodified section is unclear since Ga. L. 1992, p. 2389, amended Code sections in both Chapter 7 and Chapter 11 of Title 33.

33-11-17. Obligations issued, assumed, or guaranteed by Asian Development Bank.

An insurer may invest in obligations issued, assumed, or guaranteed by the Asian Development Bank, in which bank the United States is a subscribing participant by virtue of an act of Congress approved March 16, 1966, entitled Asian Development Bank Act. The investments authorized by this Code section shall not be counted as an investment of reserves of paragraph (4) of Code Section 33-11-5 at any time in an amount greater than 5 percent of the insurer's admitted assets.

History. — Code 1933, § 56-1041, enacted by Ga. L. 1972, p. 295, § 1; Ga. L. 1999, p. 592, § 6.

U.S. Code. — The Asian Development Bank Act, referred to in this Code section, is codified as 22 U.S.C. § 285 et seq.

33-11-18. Obligations issued, assumed, or guaranteed by Inter-American Development Bank.

An insurer may invest in obligations issued, assumed, or guaranteed by the Inter-American Development Bank. The investments authorized by this Code section shall not be counted as an investment of reserves of paragraph (4) of Code Section 33-11-5 at any one time in an amount greater than 5 percent of the insurer's admitted assets.

History. — Code 1933, § 56-1018, enacted by Ga. L. 1962, p. 664, § 1; Ga. L. 1999, p. 592, § 6.

Editor's notes. — This Code section was originally enacted by the General Assembly as Code 1933, § 56-1018; however, Ga. L. 1960, p. 289, § 1, had already designated a section as § 56-1018 (see § 33-11-24). Hence, this section was unofficially redesignated as Code 1933, § 56-1037.

33-11-19. Loans guaranteed by Georgia Higher Education Assistance Corporation.

An insurer may make and invest in loans guaranteed as to principal and interest by the Georgia Higher Education Assistance Corporation, to the extent of such guaranty.

History. — Code 1933, § 56-1039, enacted by Ga. L. 1967, p. 460, § 1; Ga. L. 1999, p. 592, § 6.

Cross references. — Georgia Higher Education Assistance Corporation, § 20-3-260 et seq.

33-11-19.1. Obligations issued, assumed, or guaranteed by African Development Bank.

An insurer may invest in obligations issued, assumed, or guaranteed by the African Development Bank. The investments authorized by this Code section shall not be counted as an investment of reserves of

paragraph (4) of Code Section 33-11-5 at any one time in an amount greater than 5 percent of the insurer's admitted assets.

History. — Code 1981, § 33-11-19.1, enacted by Ga. L. 1985, p. 1104, § 1; Ga. L. 1999, p. 592, § 6.

33-11-19.2. Loans guaranteed by United Student Aid Funds, Inc.

An insurer may make and invest in loans guaranteed as to principal and interest by the United Student Aid Funds, Inc., to the extent of such guaranty.

History. — Code 1981, § 33-11-19.2, enacted by Ga. L. 1988, p. 1844, § 1; Ga. L. 1999, p. 592, § 6.

33-11-20. Obligations of corporations generally.

(a) An insurer may invest in bonds, debentures, notes, and other evidences of indebtedness issued, assumed, or guaranteed by any solvent institution existing under the laws of the United States of America or of Canada, or any state or province thereof, which are not in default as to principal or interest and which are secured by collateral worth at least 50 percent more than the par value of the entire issue of such obligations, but only if not more than one-third of the total value of the required collateral consists of common stocks.

(b) An insurer may invest in secured and unsecured obligations of such institutions other than obligations described in subsection (a) of this Code section bearing interest at a fixed rate, with mandatory principal and interest due at specified times, if the net earnings of the issuing, assuming, or guaranteeing institution available for its fixed charges for a period of five fiscal years next preceding date of acquisition by such insurer have averaged per year not less than one and one-half times its average annual fixed charges applicable to such period and if during either of the last two years of the period of such net earnings have been not less than one and one-half times its fixed charges for the year.

(c) An insurer may invest in bonds, debentures, notes, or other evidences of indebtedness of corporations existing under the laws of the United States of America or of Canada or any state or province thereof, which are secured by assignment of a lease or leases or the rentals payable under the leases of real or personal property or both to:

(1) The United States of America or any state thereof, or any county, city, town, village, municipality, or district therein or any political subdivision thereof or any civil division or public instrumentality of one or more of the foregoing; or

(2) One or more institutions created or existing under the laws of the United States of America or of Canada or of any state or province, provided that:

(A) The fixed rentals assigned shall be sufficient to repay the indebtedness within the unexpired term of the lease, exclusive of the term which may be provided by an enforceable option of renewal;

(B) No such lessee has defaulted in payment of interest or principal on any of its bonds, notes, debentures, or other evidences of indebtedness during the five fiscal years immediately preceding the date of the investment;

(C) The net earnings of each lessee under paragraph (2) of subsection (c) of this Code section available for its fixed charges for a period of five fiscal years next preceding the date of acquisition by the insurance company shall have averaged per year not less than one and one-half times its average annual fixed charges applicable to the period and during either of the last two years of the period the net earnings shall have been not less than one and one-half times its fixed charges for the year; and

(D) A first lien on the interest of the lessor in the unencumbered property so leased shall be obtained as additional security for the indebtedness.

(d) An insurer may invest in secured and unsecured obligations of such institutions or in portions thereof, other than the obligations described in subsections (a), (b), and (c) of this Code section, which do not bear interest at a fixed rate and which may or may not have a maturity date or be evidenced by a formal certificate. Such investments must:

(1) Consist of less than 100 percent of the total obligation issued;

(2) Be available for liquidation by the insurer within five days from the date of a request by the insurer for the liquidation of the investment; and

(3) Notwithstanding Code Section 33-11-37, as a total at any one time not exceed 5 percent of the insurer's admitted assets without the written approval of the Commissioner.

History. — Code 1933, § 56-1016, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1971, p. 629, § 1; Ga. L. 1978, p. 1936, § 2; Ga. L. 1996, p. 705, § 6; Ga. L. 1999, p. 592, § 6.

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This section must be satisfied for certain loans by Teachers Retirement System. — O.C.G.A. § 33-11-25 prevents the making of a loan secured by real estate by the Teachers Retirement System of Georgia where such loan represents more than 80 percent of the value of the real estate which stands as security for that loan unless such loan is guaranteed as to payment by a division of government or by a corporation satisfying the requirements of O.C.G.A. § 33-11-20. 1982 Op. Att'y Gen. No. U82-4.

Restrictions as to investing in notes apply to Teachers Retirement System. — The Teachers Retirement System of Georgia may invest in secured and unsecured notes subject to the same restrictions and safeguards that are applicable to investments of domestic life insurance companies. 1962 Op. Att'y Gen. p. 370.

33-11-21. Corporate stocks.

An insurer may invest in nonassessable dividend-paying stocks, common or preferred, of any solvent corporation other than a corporation engaged solely in the business of operating real estate or a corporation having substantially all of its assets invested in the shares of such corporation, created or existing under the laws of the United States of America or of any state or of the District of Columbia, provided cash dividends on the common stocks shall have been paid out of current earnings in at least three of the last five years preceding the purchase.

History. — Code 1933, § 56-1020, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

Cross references. — Securities regulation, T. 10, C. 5.

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Investment in Puerto Rican corporation not authorized. — An insurer would not be authorized under this section to invest in the corporate stock of a corporation organized under the laws of the Commonwealth of Puerto Rico. 1971 Op. Att'y Gen. No. 71-50.

Clause making investments eligible if legal on date of title inapplicable to reserve requirements. — The drafters of this title did not intend that the provisions of former Code 1933, § 56-1002(2) (see O.C.G.A. § 33-11-2), should be applicable to the reserve distribution requirements of former Code 1933, § 56-1005 (see O.C.G.A. § 33-11-5); inasmuch as the Legislature elsewhere authorized the holding of common stocks, subject to somewhat liberalized restrictions, by this section, they clearly did not intend that the generalized "savings clause" contained in former Code 1933 § 56-1002(2), apply to the specific quantitative restrictions on the holding of common stocks contained in the reserve distribution requirements of former Code 1933, § 56-1005; stated differently, the Legislature, while liberalizing the restrictions upon the quality of common stocks which could be held, on the one hand, imposed more rigid restrictions with respect to the quantitative portfolio distribution of such common stock holdings, on the other hand. 1971 Op. Att'y Gen. No. 71-170.

The proper application of the "savings clause" of former Code 1933, § 56-1002(2) (see O.C.G.A. § 33-11-2), was to that general group of assets, including common stock, which an insurer might lawfully hold, insofar as the qualitative restrictions contained in this title raised or altered the qualitative restric-

tions of the prior law; any attempt to apply the "savings clause" of former Code 1933, § 56-1002(2), to the reserve distribution requirements of former Code 1933, § 56-1005 (see O.C.G.A. § 33-11-5) rendered the latter section largely meaningless and was inconsistent with the general tenor of former Code 1933, § 56-1020 (see O.C.G.A. § 33-11-21). 1971 Op. Att'y Gen. No. 71-170.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 58.

33-11-22. Equipment trust obligations or certificates.

An insurer may invest in equipment trust obligations or certificates adequately secured and evidencing an interest in transportation equipment, wholly or in part within the United States of America, and the right to receive determined portions of rental, purchase, or other fixed obligatory payments for the use or purchase of the transportation equipment.

History. — Code 1933, § 56-1017, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-23. Loans secured by pledge of securities or by pledge or assignment of life insurance policies.

An insurer may invest in loans which are secured by pledge of securities eligible for investment under this article or by the pledge or assignment of life insurance policies issued by other insurers authorized to transact insurance in this state. On the date made, no loan shall exceed in amount 75 percent of the market value of the collateral pledged. The amount so loaned shall be included in the maximum percentage of funds permitted under this article to be invested in the kinds of securities or evidences of debt pledged.

History. — Code 1933, § 56-1019, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

33-11-24. Loans to policyholders secured by policy.

Reserved. Repealed by Ga. L. 1999, p. 592, § 8, effective January 1, 2000.

Editor's notes. — This Code section was based on Code 1933, § 56-1018, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-25. Obligations secured by first mortgage or deed of trust upon improved or income-producing real property in United States or Canada.

(a) An insurer may invest in:

(1) Bonds, notes, or other evidences of indebtedness, in addition to those eligible under Code Section 33-11-20 (corporate bonds and debentures) which are secured by first mortgage or deed of trust or deed to secure debt upon fee simple, unencumbered improved or income-producing real property located in the United States or Canada, including leasehold estates in such real estate:

(A) The loan or loans when made on a single-family residential dwelling shall not exceed 80 percent of the value of the real property or leasehold securing the real property; nor shall the loan or loans exceed 75 percent of the value of other real property, as determined by competent appraisers, unless guaranteed or insured by the secretary of veterans affairs or insured by the secretary of housing and urban development as provided in paragraphs (3) and (4) of this Code section;

(B) Unless the loan is guaranteed or insured by a governmental agency, as provided in subparagraph (A) of this paragraph, the appraisal must be certified by two or more company officers, or qualified employees, or by two independent appraisers;

(C) No loan made or acquired by an insurer which is a participation or a part of a series or issue secured by the same mortgage or deed to secure debt or deed of trust shall be a lawful investment under this Code section unless the entire series or issue which is secured by the same mortgage or deed to secure a debt or deed of trust is held by the insurer or unless the participation held by the insurer in the mortgage or deed to secure a debt or deed of trust gives the insurer substantially the rights of a first mortgagee and no other participant in such mortgage or deed to secure a debt or deed of trust holds a senior participation therein;

(D) All loans secured by leasehold must provide for amortization payments on principal at least once in each year in amounts sufficient to amortize completely the loan within a period of four-fifths of the term of the leasehold, inclusive of the term which may be provided by an enforceable option of renewal, but in no event exceeding 35 years;

(E) For the purposes of this Code section, real estate shall not be deemed to be encumbered by reason of the existence of taxes or assessments that are not delinquent, instruments creating or reserving mineral, oil, or timber rights, rights of way, joint drive-

ways, sewer rights, public utility easements, rights in walls, nor by reason of building restrictions or other restrictive covenants, nor when the real estate is subject to lease in whole or in part whereby rents or profits are reserved to the owner, provided that the security created by the mortgage or trust or security deed on the real estate is a first lien upon the real estate and that there is no condition or right of reentry or forfeiture under which the lien can be cut off, subordinated, or otherwise disturbed;

(2) Purchase money mortgages or like securities received upon the sale or exchange of real property acquired;

(3) Bonds, notes, or other evidences of indebtedness which are secured by mortgage or deed of trust or deed to secure debt on real estate or an interest in real estate in the United States, if payment of such indebtedness or part of such indebtedness is guaranteed or insured by the secretary of veterans affairs in accordance with the Servicemen's Readjustment Act of 1944, as amended;

(4)(A) Bonds, notes, or other evidences of indebtedness which are secured by mortgage or deed of trust or deed to secure debt insured in whole or in part by the secretary of housing and urban development under the terms of the National Housing Act, as amended, or any other loan guaranteed by the federal government or its instrumentalities.

(B) Any portion of a loan referred to in paragraph (3) or subparagraph (A) of this paragraph, which is neither insured by the secretary of housing and urban development nor guaranteed under the Servicemen's Readjustment Act, as amended, is subject to the same provisions as apply under this article to uninsured mortgage loans.

(b) Nothing in this Code section shall be deemed to prohibit an insurer from renewing or extending a loan for the original or a lesser amount where a shrinkage in value of the real estate securing the loan would cause its value to be less than the amount otherwise required in relation to the amount of the loan.

History. — Code 1933, § 56-1022, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1965, p. 409, § 1; Ga. L. 1966, p. 344, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 1999, p. 592, §§ 5, 6.

U.S. Code. — The Servicemen's Readjustment Act of 1944, referred to in paragraphs (a)(3) and (a)(4), is codified as 38 U.S.C. § 1801 et seq.

The National Housing Act, referred to in paragraph (a)(4), is codified as 12 U.S.C. § 1701 et seq.

JUDICIAL DECISIONS

Cited in Teachers Retirement Sys. v. City of Atlanta, 249 Ga. 196, 288 S.E.2d 200 (1982).

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Limitations section apply to Employee's Retirement System. — The Employee's Retirement System of Georgia, having the same investment powers as domestic insurers pursuant to Ga. L. 1963, p. 546, § 1 (see O.C.G.A. § 47-2-31), may make such loans (so long as the limitations of Ga. L. 1960, p. 289, § 1 (see subparagraph (a)(1)(D) of O.C.G.A. § 33-11-25) are observed, should the board of trustees so desire. 1963-65 Op. Att'y Gen. p. 385.

O.C.G.A. § 33-11-20 must be satisfied for certain loans by Teachers Retirement System. — This section prevents the making of a loan secured by real estate by the Teachers Retirement System of Georgia where such loan represents more than 80 percent of the value of the real estate which stands as security for that loan unless such loan is guaranteed as to payment by a division of government or by a corporation satisfying the requirements of § 33-11-20. 1982 Op. Att'y Gen. No. U82-4.

Each appraiser must make separate appraisal. — The fact that two officers (or independent appraisers) are required to certify as to the appraisal (see subparagraph (a)(1)(B) of O.C.G.A. § 33-11-25) implies that each of the two officers or employees (or independent appraisers) shall make an independent and separate appraisal of the real estate. 1960-61 Op. Att'y Gen. p. 268.

The two independent appraisers may be members of the same appraisal firm, so long as each independent appraiser is competent and qualified to fix a fair and reasonable value of the security real estate. 1960-61 Op. Att'y Gen. p. 268.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 58.

C.J.S. — 44 C.J.S., Insurance, § 72 et seq.

ALR. — Construction mortgagee-lender's duty to protect interest of subordinated purchase-money mortgagee, 13 A.L.R.5th 684.

33-11-25.1. Security representing interest in pool of loans secured by mortgage or deed of trust upon property in United States or Canada.

(a) In addition to the investment authority granted to insurers under Code Sections 33-11-20, 33-11-21, and other applicable provisions of this title, an insurer authorized to transact insurance in this state, other than an insurer authorized to transact mortgage guaranty insurance, may invest in, purchase, or hold a mortgage or a mortgage participation, pass-through, conventional pass-through, trust certificate, or other similar security which represents an undivided, beneficial interest in a pool of loans secured by first mortgages, deeds of trust, or deeds to secure debt upon fee simple, unencumbered, improved, or income-producing real property located in the United States or Canada, which is improved with a residential building or a condominium unit or

buildings designed for occupancy by not more than four families, including leasehold estates in such real estate if such first mortgages, deeds of trust, or deeds to secure debt are fully guaranteed or insured by the Federal Housing Administration, the United States Department of Veterans Affairs, the Farmers Home Administration, the Federal Home Loan Mortgage Corporation, the Government National Mortgage Association, the Federal National Mortgage Association, or any other similar governmental entity or instrumentality or by an insurer authorized to transact mortgage guaranty insurance in this state in accordance with such rules and regulations as may be promulgated by the Commissioner after due notice and hearing.

(b) Notwithstanding any provisions of this title which might be construed to the contrary, the Commissioner may, in his discretion, grant, deny, or revoke the authority of any authorized insurer to invest in or to continue to hold its investment in such securities if, after due notice and hearing, he shall determine that such continued investments would be hazardous to such insurer's policyholders or to the public. In such event, the Commissioner shall give such company a reasonable period of time, not to exceed three years, to dispose of such investments as otherwise provided for in this title, subject to such extensions of time or exceptions as the Commissioner, in his discretion, may grant.

History. — Code 1933, § 56-1022.1, enacted by Ga. L. 1982, p. 1217, § 1; Code 1981, § 33-11-25.1, enacted by Ga. L. 1982, p. 1217, § 2; Ga. L. 1990, p. 45, § 1; Ga. L. 1999, p. 592, § 6.

33-11-26. Chattel mortgage loans.

(a) In connection with a loan on the security of real estate designed and used primarily for residential purposes only, which loan was acquired pursuant to Code Section 33-11-25, an insurer may lend or invest an amount not exceeding 20 percent of the amount loaned on or invested in the real estate mortgage or loan deed on the security of a chattel mortgage to be amortized by regular periodic payments within a term of not more than five years, and representing a first and prior lien, except for taxes not then delinquent, on personal property constituting durable equipment owned by the mortgagor or security grantor and kept and used in the mortgaged premises.

(b) For the purpose of this Code section, the term "durable equipment" shall include only mechanical refrigerators, air-conditioning equipment, mechanical laundering machines, heating and cooking stoves and ranges, and, in addition, in the case of apartment houses and hotels, room furniture and furnishings.

(c) Prior to the acquisition of a chattel mortgage as prescribed by this Code section, items of property to be included in such mortgage shall be

separately appraised by a qualified appraiser and the fair market value of such items of property determined. No chattel mortgage loan shall exceed in amount the same ratio of loan to the value of the property as is applicable to the companion loan on the real property.

(d) This Code section shall not prohibit an insurer from taking liens on personal property as additional security for any investment otherwise eligible under this article.

History. — Code 1933, § 56-1025, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

Cross references. — Mortgages, § 44-14-30 et seq. Security deeds, § 44-14-60 et seq.

33-11-27. Abstract plant and equipment and stocks of abstract companies.

(a) In addition to other investments eligible under this article, a title insurer may invest and have invested an amount not exceeding 50 percent of its paid-in capital stock in its abstract plant and equipment and, with the Commissioner's consent, in stocks of abstract companies.

(b) Investments authorized by this Code section shall not be credited against the insurer's required unearned premium or guaranty fund reserve provided for under Code Section 33-10-10.

History. — Code 1933, § 56-1026, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

33-11-28. Investments incidental to preservation or enhancement of earnings of real property securing evidence of indebtedness held by insurer.

(a) If real property securing any evidence of indebtedness held by an insurer is used for agricultural purposes and a proceeding to foreclose the security instrument or an insolvency proceeding relating to the mortgagor has been commenced or, if the mortgagor has made an assignment for the benefit of creditors, the insurer may, for the purpose of preserving or enhancing the earnings of the property:

(1) Purchase agricultural livestock or equipment and utilize the same or cause the same to be utilized in the operation of the property by the mortgagor, or a receiver or trustee, or by the insurer-creditor; or

(2) Lend up to the value of any agricultural equipment or livestock which may be used in the operation of the property, on the security of a first lien on the equipment and livestock.

(b) Nothing in this Code section shall be deemed to limit any right which the insurer may otherwise have under or with respect to any loan, mortgage, or investment.

History. — Code 1933, § 56-1023, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-29. Acquisition or holding of real property generally.

(a) An insurer shall not directly or indirectly acquire or hold real estate except as authorized in this Code section and in Code Sections 33-11-30 through 33-11-32. An insurer may acquire and hold:

(1) Land and buildings on such land used or acquired for use as its principal home office and branch offices for the convenient transaction of its own business; portions of such buildings not used for its own business may be rented by the insurer to others;

(2) Real property acquired in satisfaction in whole or in part of loans, mortgages, liens, judgments, decrees, or debts previously owing to the insurer in the course of its business;

(3) Real property acquired in part payment of the consideration on the sale of other real property owned by it if such transaction effects a net reduction in the insurer's investment in real estate;

(4) Real property acquired by gift or devise, or through merger, consolidation, or bulk reinsurance of another insurer under this title; or

(5) Additional real property and equipment incident to real property if necessary or convenient for the enhancement of the marketability or sale value of real property previously acquired or held by it under paragraphs (2) through (4) of this subsection, but subject to the prior written approval of the Commissioner.

(b) The amount invested by an insurer in home office and branch office property under paragraph (1) of subsection (a) of this Code section shall not exceed 10 percent of the insurer's admitted assets, but the Commissioner may grant permission to the insurer to invest in real property for that purpose in an increased amount not to exceed 25 percent of admitted assets.

History. — Code 1933, § 56-1028, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6; Ga. L. 2000, p. 136, § 33.

OPINIONS OF THE ATTORNEY GENERAL

Foreign insurer's investments not limited. — The "quality" clause of former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42(a)) does not limit a foreign

insurer's investments to only those investments specifically permitted for domestic insurers under former Code 1933, §§ 56-1028 through 56-1031 (see O.C.G.A. §§ 33-11-29 through 33-11-32). 1970 Op. Att'y Gen. No. 70-180.

Firemen's Pension Fund may invest in land and buildings used for home office. — The Board of Trustees of the Georgia Firemen's Pension Fund has power to invest funds in such land and buildings thereon as are used for its principal home office. 1969 Op. Att'y Gen. No. 69-377.

33-11-30. Investment of assets in real estate acquired for purposes of leasing.

(a) **Authority to make; terms and conditions.** Every insurance company organized and doing business by virtue of the laws of this state shall have authority, in addition to all other investments authorized by law, to invest assets in real estate acquired for the purpose of leasing the same to any person, firm, or corporation, or in real estate already leased to any person, firm, or corporation, under the following terms and conditions:

(1) That the lessee shall at his own cost erect, or that there has already been erected on such real estate, free of liens, a building or other improvements costing an amount at least equal to the value of the said real estate exclusive of improvements; but, if the lease is entered into simultaneously with the purchase of the real estate, the lessor may agree to erect such improvements on the real estate;

(2) That the said improvements shall remain on the said property during the period of the lease with provisions when such improvements are put upon the said property at the cost of the lessee that at the termination of the lease the ownership of the improvements free of liens shall vest in the owner of the real estate;

(3) That the lessee shall during the term of the lease, or the unexpired period of the lease if the property is bought subject to the lease, pay to the owner of the real estate rent in such amount as will enable the owner to amortize completely the improvements put upon the real estate according to a standard amortization table then in use at or before the end of the normal termination of the lease or at the end of 30 years should the lease, or the unexpired period of the lease, be for a longer period than 30 years; and

(4) That during the term of the lease the tenant shall pay all taxes and assessments levied on or against the said real estate, including improvements, shall keep and maintain the said improvements in good repair, and shall provide and maintain for the benefit of the lessor fire and extended coverage insurance on such improvements at least equal to the then current insurable value of the improvements.

(b) **Lease and improvements as prerequisites to treatment as investment.** Real estate acquired pursuant to this article shall not be treated as an investment unless and until the improvements required under subsection (a) of this Code section have been constructed and the lease agreement entered into in accordance with the terms of this Code section, but if the lessee is a corporation, the bonds, debentures, notes, or preferred stock of which are eligible as investments under the laws of this state, the requirements of this Code section as to the erection of improvements by the lessee, the cost of the improvements, and the vesting of ownership of the improvements in the owner of the real estate shall not be applicable.

(c) **Treatment as admitted asset.** Real estate acquired under authority of this Code section shall not be treated as an admitted asset in an amount in excess of the actual investment reduced each year by decrements out of the income from said property sufficient to write off completely, based on standard amortization tables in general use, the improvements at the normal termination of the lease or at the end of 30 years should the term of the lease, or the unexpired period of the lease, be for a longer period than 30 years.

(d) **Limitation of amount.** The total investment of any company under this Code section shall not exceed 5 percent of its admitted assets. No investment shall be made by any company pursuant to this Code section which will cause the company's investment in all real property owned by it to exceed 25 percent of its admitted assets or when all real property owned by the company equals or exceeds 25 percent of its admitted assets.

History. — Code 1933, § 56-1029, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

OPINIONS OF THE ATTORNEY GENERAL

Foreign insurer's investments not limited. — The "quality" clause of former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42(a)) does not limit a foreign insurer's investments to only those investments specifically permitted for domestic insurers under former Code 1933, §§ 56-1028 through 56-1031 (see O.C.G.A. §§ 33-11-29 through 33-11-32). 1970 Op. Att'y Gen. No. 70-180.

33-11-31. Acquisition and holding of real property for recreation, hospitalization, convalescence, and retirement of employees.

Subject to prior approval of the Commissioner, an insurer may acquire and hold real property for recreation, hospitalization, convalescence, and retirement purposes of its employees. All investments under this Code section shall not exceed 5 percent of the insurer's surplus; or,

if a mutual or reciprocal insurer, all of those investments shall not exceed 5 percent of the insurer's surplus in excess of the surplus required to be maintained under this title for its authority to transact insurance.

History. — Code 1933, § 56-1030, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

OPINIONS OF THE ATTORNEY GENERAL

Foreign insurer's investments not limited. — The "quality" clause of former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42(a)) does not limit a foreign insurer's investments to only those investments specifically permitted for domestic insurers under former Code 1933, §§ 56-1028 through 56-1031 (see O.C.G.A. §§ 33-11-29 through 33-11-32). 1970 Op. Att'y Gen. No. 70-180.

33-11-32. Limitation on investments pursuant to Code Sections 33-11-30 or 33-11-31.

No investment in real property shall be made by any insurer pursuant to Code Section 33-11-30 or 33-11-31 which will cause the insurer's investment in all real property owned or held by it directly or indirectly to exceed 25 percent of its admitted assets.

History. — Code 1933, § 56-1031, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

OPINIONS OF THE ATTORNEY GENERAL

Foreign insurer's investments not limited. — The "quality" clause of former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42(a)) does not limit a foreign insurer's investments to only those investments specifically permitted for domestic insurers under former Code 1933, §§ 56-1028 through 56-1031 (see O.C.G.A. §§ 33-11-29 through 33-11-32). 1970 Op. Att'y Gen. No. 70-180.

33-11-33. Prohibited investments; underwriting of offering of securities or property by other persons.

(a) In addition to investments excluded pursuant to other provisions of this title, an insurer shall not directly or indirectly invest in or lend its funds upon the security of:

(1) Any investment or security which is found by the Commissioner to be designed to evade any prohibition of this title;

(2) Issued shares of its own capital stock, except for the purpose of mutualization under Chapter 14 of this title or in connection with a plan approved by the Commissioner for purchase of the shares by the insurer's employees or agents;

(3) Except with the advance consent of the Commissioner, securities issued by any corporation or enterprise the controlling interest of which is, or will after acquisition by the insurer be, held directly or indirectly by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries, or controlling stockholders. Investments in subsidiaries, to the extent otherwise authorized by this article, shall not be subject to this provision; or

(4) Any note or other evidence of indebtedness of any director, officer, or controlling stockholder of the insurer.

(b) No insurer shall underwrite or participate in the underwriting of an offering of securities or property by any other person.

History. — Code 1933, § 56-1035, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, §§ 5, 6; Ga. L. 2000, p. 136, § 33.

OPINIONS OF THE ATTORNEY GENERAL

Loans to parent corporation. — A domestic insurance company is prohibited under paragraph (a)(4) of O.C.G.A. § 33-11-33 from loaning funds to a parent corporation which is the controlling stockholder of the domestic insurance company, when that debt is secured by any note or other evidence of indebtedness issued by the controlling stockholder-parent corporation. 1990 Op. Att'y Gen. No. 90-34.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 58.

33-11-34. Separate accounts for funds received in connection with pension, retirement, and profit-sharing plans; investment of funds; issuance of contracts.

Reserved. Repealed by Ga. L. 1999, p. 592, § 9, effective January 1, 2000.

Editor's notes. — This Code section was based on Code 1933, § 56-1038, enacted by Ga. L. 1966, p. 57, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1989, p. 1120, § 1.

33-11-35. Separate accounts for variable annuity contracts; investment of funds; issuance and sale of contracts.

Reserved. Repealed by Ga. L. 1999, p. 592, § 10, effective January 1, 2000.

Editor's notes. — This Code section was based on Code 1933, § 56-1040, enacted by Ga. L. 1969, p. 723, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1992, p. 6, § 33.

33-11-36. Separate accounts for variable life insurance policies; investment of funds; issuance and sale of policies.

Reserved. Repealed by Ga. L. 1999, p. 592, § 11, effective January 1, 2000.

Editor's notes. — This Code section was based on Code 1933, § 56-1042, enacted by Ga. L. 1978, p. 1639, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 1199, § 6; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1992, p. 6, § 33.

33-11-37. Investment of funds in excess of reserve and capital, or surplus, in authorized and approved investments.

After satisfying requirements of this article, any funds of any domestic insurer in excess of its reserve and capital, if a stock insurer, or surplus, if a mutual or reciprocal insurer, required to be maintained may be invested without limitation in any investments otherwise authorized by this title, and, in addition, in the other investments, notwithstanding any prohibition contained in Code Section 33-11-29, as may be approved by the Commissioner; provided, however, that approval of the Commissioner is not required except to the extent the investments constitute more than 5 percent of the total assets of an insurer.

History. — Code 1933, § 56-1027, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1969, p. 23, § 1; Ga. L. 1999, p. 592, §§ 5, 6.

OPINIONS OF THE ATTORNEY GENERAL

Two types of investments are specified in this section; the first is investments authorized by this title and specifically set forth in former Code 1933, §§ 56-1002 through 56-1023 (see O.C.G.A. §§ 33-11-2 through 33-11-28); the second is investments as may be approved by the Commissioner and, of course, encompasses investments not specified in the foregoing sections; to this second category is added the proviso that "approval of the Commissioner is not required to the extent that such investments constitute more than five percent of the total assets of the insurer." 1963-65 Op. Att'y Gen. p. 284.

Excess funds may be invested at discretion without approval up to five percent limit. — When the conditions set out in this section have been met, an insurer may then invest five percent of its total assets in investments which are not specifically recognized as eligible investments and in investments which have not been approved by the Commissioner. 1963-65 Op. Att'y Gen. p. 312.

Assuming compliance with other provisions of the law, a domestic insurer would be entitled under this section to invest the funds required to be maintained, which funds do not exceed five percent of the total assets, at its discretion; such investment would not require the Commissioner's approval. 1963-65 Op. Att'y Gen. p. 284.

In loan to finance company secured by pledge of consumer loans. — A stock insurance company, after having invested sums equivalent to the amount of its capital stock and required reserves in the securities required by law, may participate in a loan to a finance company secured by pledge of its consumer loans without first obtaining the Commission-

er's consent, provided that the amount of the insurer's participation is less than five percent of its total assets. 1963-65 Op. Att'y Gen. p. 312.

Investments are admitted or allowed assets. — Investments made under the "provided clause" of this section are admitted assets or allowed assets. 1963-65 Op. Att'y Gen. p. 312.

A mutual insurance company may organize and capitalize a stock company as a subsidiary, provided the prior consent of the Commissioner is obtained and the conditions indicated in this section are complied with. 1962 Op. Att'y Gen. p. 294.

33-11-38. Authority of insurers to convey property or securities in which moneys or assets invested or upon which loans made.

Insurance companies organized and doing business by virtue of the laws of this state may sell, assign, transfer, and convey, either with or without warranty, or either with or without recourse upon it, as it may prefer, any real estate, personal property, bond, note, mortgage, deed of trust, deed to secure debt, or other form of property or securities in which it may have invested its money or its assets or on which it may have made loans as allowed by law and may also buy and sell any realty that may be necessary for the protection of any loan such insurance company may lawfully make.

History. — Code 1933, § 56-1024, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-39. Time limit for disposal by insurer of real estate.

(a) Except as provided in subsection (d) of this Code section, an insurer shall dispose of real property within time limits as follows:

(1) If acquired under paragraph (1) of subsection (a) of Code Section 33-11-29 or Code Section 33-11-31, the insurer shall sell the property within five years after it ceased to be used or to be necessary for the purposes stated in paragraph (1) of subsection (a) of Code Section 33-11-29 or Code Section 33-11-31;

(2) If acquired under paragraph (2), (3), or (4) of subsection (a) of Code Section 33-11-29, the insurer shall sell the property within five years after the insurer acquired title to the property;

(3) If acquired under paragraph (5) of subsection (a) of Code Section 33-11-29, the insurer shall sell the property within five years after the date of acquisition by the insurer of the real property the marketability or sales price of which was so enhanced; and

(4) If acquired under Code Section 33-11-30, the insurer shall within five years after the termination or expiration of the lease sell

the property or re-lease the property for an additional term under the same conditions provided for in Code Section 33-11-30 as for an original leasing.

(b) Any real property otherwise subject to disposal under paragraphs (2) through (4) of subsection (a) of this Code section may be retained by the insurer for home office or branch office purposes for so long as so used, provided that retention of the real property is in compliance with any other provisions of this article applicable to the home office and branch office property (real property leasing).

(c) Any real property otherwise subject to disposal under paragraph (1), (2), or (3) of subsection (a) of this Code section may be retained by the insurer for leasing under Code Section 33-11-30 for so long as so used and subject to provisions otherwise applicable to such real property for leasing.

(d) Upon proof satisfactory to him that the interests of the insurer will suffer materially by the forced sale of such real property, the Commissioner may by certificate grant a reasonable additional period, as specified in the certificate, within which the insurer shall dispose of any particular parcel of real property.

(e) Nothing contained in this Code section shall prevent any insurer from improving or conveying its real property, notwithstanding the lapse of five years without having procured a certificate from the Commissioner.

History. — Code 1933, § 56-1032, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1999, p. 592, §§ 5, 6.

33-11-40. Time limit for disposal by insurer of personal property or securities deemed unauthorized investments.

Any personal property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at the time of the acquisition shall be disposed of within three years from date of acquisition unless within that period the security has attained to the standard of eligibility. However, any security or personal property acquired under any agreement of bulk reinsurance, merger, or consolidation may be retained for a longer period if so provided in the plan for the reinsurance, merger, or consolidation as approved by the Commissioner under Chapter 14 of this title. Upon application by the insurer and proof that forced sale of any of the property or security would materially injure the interests of the insurer, the Commissioner may extend the disposal period for an additional reasonable time.

History. — Code 1933, § 56-1033, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-41. Effect of failure of insurer to dispose of real estate, personal property, or securities.

(a) Any real estate, personal property, or securities lawfully acquired and held by an insurer after expiration of the period for disposal of such real estate, personal property, or securities or any extension of the period granted by the Commissioner, as provided in Code Section 33-11-39 or 33-11-40, shall not be allowed as an asset of the insurer.

(b) The insurer shall immediately dispose of any ineligible investment unlawfully acquired by it, and the Commissioner may suspend or revoke the insurer's certificate of authority if the insurer fails to dispose of the investment within a reasonable time as the Commissioner may, by his order, specify.

History. — Code 1933, § 56-1034, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 592, § 6.

33-11-42. Investments of foreign and alien insurers; place of domicile.

(a) The investments of foreign and alien insurers shall be as permitted by the laws of their domicile but shall be of a quality substantially as high as those required under this article for similar funds of like domestic insurers.

(b) For the purposes of this Code section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the Commissioner at time of admission to this state and may be any one of the following states:

(1) This state if the insurer is entering through this state to transact insurance in the United States through a United States branch;

(2) That in which the insurer was first authorized to transact insurance;

(3) That in which is located the insurer's principal place of business in the United States; or

(4) That in which is held the larger deposits of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

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

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

History. — Code 1933, § 56-1036, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 584, § 5; Ga. L. 1999, p. 592, §§ 5, 6.

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Section gives Commissioner discretion in evaluating deposits by foreign and alien insurers. — Former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42) vests in the Insurance Commissioner the discretionary determination whether securities deposited in this state by foreign or alien insurers are "of a quality substantially as high" as those required of domestic insurers under former Code 1933, § 56-309 (see O.C.G.A. § 33-3-8), as construed in conjunction with former Code 1933, § 56-1002(2) (see O.C.G.A. § 33-11-2), and this is true even though such securities may not meet the specific qualitative restrictions contained in this title, provided such securities are authorized by the law of the insurer's domicile. 1971 Op. Att'y Gen. No. 71-170.

Foreign insurers not limited to specific real estate investments permitted domestic insurers. — The "quality" clause of subsection (a) of former Code 1933, § 56-1036 (see O.C.G.A. § 33-11-42) did not limit a foreign insurer's investments to only those investments specifically permitted for domestic insurers under former Code 1933, §§ 56-1028 through 56-1031 (see O.C.G.A. §§ 33-11-29 through 33-11-32). 1970 Op. Att'y Gen. No. 70-180.

33-11-43. Compliance with Secondary Mortgage Market Enhancement Act.

Notwithstanding any provision of the federal Secondary Mortgage Market Enhancement Act of 1984, 15 U.S.C. Section 77r-1, to the contrary, any insurer subject to the provisions of this title shall comply with all provisions, restrictions, and limitations concerning investments provided in this article.

History. — Code 1981, § 33-11-43, enacted by Ga. L. 1991, p. 1424, § 4; Ga. L. 1999, p. 592, §§ 5, 6.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2000, "of 1984" was inserted following "Enhancement Act".

Editor's notes. — Ga. L. 1991, p. 1424, § 9, not codified by the General Assembly, contained inconsistencies in references to the sections of the bill due to differences in the section numbers contained in the Senate version of the bill and the final version of the bill. Subsection (c) of Section 9 refers to Code Sections 33-13-3.1 and 33-13-5 in the Senate version of Ga. L. 1991, p. 1424.

Ga. L. 1991, p. 1424, § 9(c), not codified by the General Assembly, provides that this Code section is applicable to transactions between affiliates or subsidiaries taking place on or after July 1, 1991.

Law reviews. — For note on 1991 enactment of this Code section, see 8 Ga. St. U.L. Rev. 89 (1992).

ARTICLE 2

INVESTMENTS OF LIFE, ACCIDENT AND SICKNESS, PROPERTY, AND CASUALTY INSURERS

33-11-50. Legislative purpose; application of article; separate accounts.

(a) The purpose of this article is to protect and to further the interests of insureds, creditors, and the general public. This objective will be met by the establishment of:

(1) Prudent standards by which an insurer shall develop its investment policy and investment portfolio;

(2) A minimum financial security benchmark and a minimum asset requirement, each of which shall be supported by classes of investments and, as applicable, noninvested assets, described in this article;

(3) A level of investment discretion whereby the regulation of an insurer's investment practices has minimum interference with management initiative and judgment; and

(4) A prescribed process for actions by the Commissioner to address situations where an insurer's investment policy or investment portfolio is not prudent under prevailing circumstances.

(b) This article and the regulations adopted to interpret and implement it shall apply only to domestic life, accident and sickness, property, and casualty insurers licensed pursuant to Code Section 33-3-2 to transact the classes of business described in paragraphs (1) through (5) of Code Section 33-3-5 and United States branches of similar alien insurers entered through this state if such entry is otherwise permitted by law.

(c) Separate accounts established in accordance with Code Sections 33-11-65 through 33-11-67 shall be governed pursuant to those Code sections.

History. — Code 1981, § 33-11-50, enacted by Ga. L. 1999, p. 592, § 12.

33-11-51. Definitions.

For purposes of this article, the term:

(1) "Admitted assets" means assets permitted to be reported as admitted assets on the statutory financial statement of the insurer most recently required to be filed with the Commissioner.

(2) "Asset-backed/mortgage-backed securities" shall include single-class mortgage-backed/asset-backed securities, multiclass residential mortgage-backed securities, and multiclass commercial mortgage-backed/asset-backed securities.

(3) "Asset-valuation reserve" means the reserve required to be computed and reported in the annual and quarterly financial statements, adopted for use by the Commissioner, which is designed to address the credit related and equity risks of a domestic life or accident and sickness insurer's assets.

(4) "Cap" means an option contract in which the cap writer (seller), in return for a premium, agrees to limit, or cap, the cap holder's (purchaser's) risk associated with an increase in a reference rate or index.

(5) "Collar" means a combination of a cap and a floor (one purchased and one written). A collar fixes the rate between two levels (the strike prices of the cap and the floor).

(6) "Counterparty exposure amount" means:

(A) The net amount of credit risk attributable to an over-the-counter derivative instrument. The amount of credit risk equals:

(i) The market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(ii) Zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer;

(B) If over-the-counter derivative instruments are entered into under a written master agreement which provides for netting of payments owed by the respective parties and the domiciliary jurisdiction of the counterparty is either within the United States or, if not within the United States, within a foreign jurisdiction listed in the *Purposes and Procedures Manual of the NAIC Securities Valuation Office* as eligible for netting in accordance with procedures adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner, the net amount of credit risk shall be the greater of zero or the net sum of:

(i) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(ii) The market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of

which would result in a final cash payment by the insurer to the business entity; and

(C) For open transactions, market value shall be determined at the end of the most recent quarter of the insurer's fiscal year and shall be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

(7) "Debt-like preferred stock" means an investment with the structure of a preferred stock that has the cash flow characteristics of a debt instrument.

(8) "Derivative instrument" means a cap, collar, floor, forward, future, option, swap, or warrant.

(9) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(10) "Domestic jurisdiction" means the United States, Canada, any state, any province of Canada, or any political subdivision of any of the foregoing.

(11) "Equity-like preferred stock" means an investment with the structure of a preferred stock that has the characteristics of an equity instrument.

(12) "Floor" means an option contract in which the floor writer (seller), in return for a premium, agrees to limit the risk associated with a decline in a reference rate or index.

(13) "Forward" means a contract in which there is an agreement (other than a futures) between two parties that commits one party to purchase and the other to sell the instrument or commodity underlying the contract at a specified future date.

(14) "Future" means a standardized forward contract traded on organized exchanges. Each exchange specifies the standard terms of futures contracts it sponsors. Futures contracts are available for a wide variety of underlying instruments, including insurance, agricultural commodities, minerals, debt instruments (such as United States Treasury bonds and bills), composite stock indices, and foreign currencies.

(15) "Government sponsored enterprise" means a:

(A) Governmental agency; or

(B) Corporation, limited liability company, association, partnership, joint-stock company, joint venture, trust, or other entity or instrumentality organized under the laws of any domestic jurisdiction to accomplish a public policy or other governmental purpose.

(16) "Hedging transaction" means a derivative transaction which is entered into and maintained to reduce or manage:

(A) The risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities which the insurer has acquired or incurred or anticipates acquiring or incurring; or

(B) The currency exchange rate risk or the degree of exposure as to assets or liabilities which an insurer has acquired or incurred or anticipates acquiring or incurring.

(17) "High-grade investment" means an investment rated 1 or 2 by the Securities Valuation Office or any successor office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(18) "Lower grade investment" means an investment rated 4, 5, or 6 by the Securities Valuation Office or any successor office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(19) "Medium grade investment" means an investment rated 3 by the Securities Valuation Office or any successor office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(20) "Minimum asset requirement" means the sum of an insurer's liabilities and its minimum financial security benchmark.

(21) "Minimum financial security benchmark" means the amount an insurer is required to maintain under Code Section 33-11-52.

(22) "Multiclass commercial mortgage-backed/asset-backed securities" means securities which have been divided into two or more classes, which do not receive proportionate payments of principal and interest, each of which represents an ownership interest in instruments or cash flows, but not including those secured by liens on one-family to four-family residential properties, including:

(A) Defined multiclass commercial mortgage-backed securities which have been divided into two or more classes, which do not receive proportionate payments of principal and interest, each of which represents an ownership interest in instruments, directly or indirectly secured by a first lien on one or more parcels of real

estate upon which is located one or more commercial structures, and rated in one of the two highest generic rating categories established by a nationally recognized statistical rating organization that is recognized by the Securities Valuation Office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner; and

(B) Other multiclass commercial mortgage-backed/asset-backed securities which have been divided into two or more classes, which do not receive proportionate payments of principal and interest, each of which represents an ownership interest in instruments or cash flows, including, but not limited to, instruments secured by liens on one or more parcels of real estate upon which is located one or more commercial structures that are not first liens or, if secured by first liens, the securities are rated below the two highest generic rating categories established by a nationally recognized statistical rating organization that is recognized by the Securities Valuation Office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(23) "Multiclass residential mortgage-backed securities" means mortgage-backed securities which have been divided into two or more classes, which do not receive proportionate payments of principal and interest, each of which represents an ownership interest in instruments which are directly or indirectly secured by liens on one-family to four-family residential properties, including:

(A) Defined multiclass residential mortgage-backed securities which are first liens and are rated in one of the two highest generic rating categories established by a nationally recognized statistical rating organization that is recognized by the Securities Valuation Office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner; and

(B) Other multiclass residential mortgage-backed securities which are not first liens or, if secured by first liens, are rated below the two highest generic rating categories established by a nationally recognized statistical rating organization that is recognized by the Securities Valuation Office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(24) "Option" means a contract that gives the option holder (purchaser of the option rights) the right, but not the obligation, to enter into a transaction with the option writer (seller of the option rights) on terms specified in the contract. A call option allows the holder to buy the underlying instrument, while a put option allows the holder to sell the underlying instrument.

(25) "Over-the-counter derivative instrument" means a derivative instrument entered into with a business entity other than through a qualified exchange, qualified foreign exchange, or cleared through a qualified clearing-house.

(26) "Potential exposure" means the amount determined in accordance with the *Annual Statement Instructions* adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(27) "Replication" means a derivative transaction involving one or more derivative instruments being used to modify the cash flow characteristics of one or more investments held by an insurer in a manner so that the aggregate cash flows of the derivative instruments and investments reproduce the cash flows of another investment having a higher risk-based capital charge than the risk-based capital charge of the original investments or investments.

(28) "Single-class mortgage-backed/asset-backed securities" means pass-through certificates and other securitized loans issued using only one class where the payment of interest or principal or both of the security is directly proportional to interest or principal or both received by the business entity from the loans supporting the security.

(29) "Special rated credit instrument" means an asset-backed/mortgage-backed security authorized by paragraph (2) of subsection (a) of Code Section 33-11-55 where the investment is structured such that:

(A) The payments are the interest only portion of the underlying collateral;

(B) Such payments are reduced as the balance of the underlying collateral is reduced; and

(C) Such reduction may cause a significant loss of the original investment. For purposes of this subparagraph, "significant" shall mean a loss of 15 percent or more.

(30) "SVO listed mutual fund" means a money market mutual fund or short-term bond fund that is registered with the United States

Securities and Exchange Commission under the Investment Company Act of 1940 and that has been determined by the Securities Valuation Office or any successor office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner to be eligible for special reserve and reporting treatment other than as common stock.

(31) "Swap" means a contract to exchange, for a period of time, the investment performance of one underlying instrument for the investment performance of another underlying instrument, typically without exchanging the instruments themselves. An interest rate swap is a contractual agreement between two parties to exchange interest rate payments (usually fixed for variable) based on a specified amount of underlying assets or liabilities (known as the notional amount) for a specified period. The swap does not involve an exchange of principal. The result of these transactions is to transform payments from a variable rate to a fixed rate, from a fixed rate to a variable rate, or from one variable rate index to another variable rate index.

(32) "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement.

History. — Code 1981, § 33-11-51, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2000, p. 136, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2000, "asset-backed" was substituted for "asset backed" near the end of paragraph (2).

33-11-52. Determining minimum financial security benchmark.

(a)(1) Unless otherwise established in accordance with paragraphs (2) and (3) of this subsection, the amount of the minimum financial security benchmark for an insurer shall be the greater of:

(A) The authorized control level risk-based capital applicable to the insurer as set forth by Code Section 33-56-3 less the asset valuation reserve and voluntary investment reserves as defined by the valuation procedures in Code Section 33-10-14; or

(B) The minimum capital and surplus required by this title for maintenance of an insurer's certificate of authority.

(2) The Commissioner may, in accordance with the factors in paragraph (2) of subsection (b) of this Code section, establish by order a minimum financial security benchmark to apply to a specific

insurer provided it is not less than the amount determined by paragraph (1) of this subsection.

(3) The Commissioner may establish by regulation a minimum financial security benchmark that is a multiple of authorized control level risk-based capital to apply to any class of insurers provided the amount established by the regulation is not less than the amount determined in paragraph (1) of this subsection.

(b) The Commissioner shall determine the amount of surplus that shall constitute an insurer's minimum financial security benchmark, as an amount that will provide reasonable security against contingencies affecting the insurer's financial position that are not fully covered by reserves or by reinsurance.

(1) The Commissioner shall consider the risks of the following types of contingencies:

(A) Increases in the frequency or severity of losses beyond the levels contemplated by the rates charged;

(B) Increases in expenses beyond those contemplated by the rates charged;

(C) Decreases in the value of or the return on invested assets below those planned on;

(D) Changes in economic conditions that would make liquidity more important than contemplated and would force untimely sale of assets or prevent timely investments;

(E) Currency devaluation to which the insurer may be subject; and

(F) Any other contingencies the Commissioner can identify that may affect the insurer's operations.

(2) In determining an insurer's minimum financial security benchmark under this subsection, the Commissioner shall take into account the following factors:

(A) The most reliable information available as to the magnitude of the various risks under paragraph (1) of this subsection;

(B) The extent to which the risks in paragraph (1) of this subsection are independent of each other or are related, and whether any dependency is direct or inverse;

(C) The insurer's recent history of profits or losses;

(D) The extent to which the insurer has provided protection against the contingencies in other ways than the establishment of surplus, including redundancy of premiums, adjustability of con-

tracts under their terms, investment valuation reserves whether voluntary or mandatory, appropriate reinsurance, the use of conservative actuarial assumptions to provide a margin of security, reserve adjustments in recognition of previous rate inadequacies, contingency or catastrophe reserves, diversification of assets and underwriting risks;

(E) Independent judgments of the soundness of the insurer's operations, as evidenced by the ratings of reliable professional financial reporting services; and

(F) Any other relevant factors.

(3) An insurer subject to the provisions of this article shall invest and maintain invested funds not less in amount than the minimum financial security benchmark only in the following:

(A) Cash;

(B) Certificates of deposit or similar certificates or evidences of deposit in banks and trust companies to the extent that the certificates or deposits are insured by the Federal Deposit Insurance Corporation;

(C) Savings accounts, certificates of deposit, or similar certificates or evidences of deposit in savings and loan associations and building and loan associations to the extent that the same are insured by the Savings Association Insurance Fund of the Federal Deposit Insurance Corporation;

(D) Bonds, notes, warrants, and other evidences of indebtedness which are direct obligations of the government of the United States of America or for which the full faith and credit of the government of the United States of America is pledged for the payment of principal and interest;

(E) Loans guaranteed as to principal and interest by the government of the United States of America, or by any agency or instrumentality of the government of the United States of America, to the extent of such guaranty;

(F) Bonds, notes, warrants, and other securities not in default which are the direct obligations of any domestic jurisdiction, or for which the full faith and credit of such domestic jurisdiction has been pledged for the payment of principal and interest;

(G) The obligations of any county, any incorporated city, town, or village, any school district, water district, sewer district, road district, or any special district, or any other political subdivision or public authority of any state, territory, or insular possession of the United States, or of the District of Columbia, or of the Canadian

cities having a population of over 25,000 according to the most recent official census, which has not defaulted for a period of 120 days in the payment of interest upon, or for a period of more than one year in the payment of principal of, any of its bonds, notes, warrants, certificates of indebtedness, securities, or any other interest-bearing obligation during the five years immediately preceding the acquisition of the investment;

(H) Bonds, notes, or other evidences of indebtedness, in addition to those eligible corporate bonds and debentures, which are secured by first mortgages on real estate situated within a domestic jurisdiction, or purchase money mortgages or like securities received upon the sale or exchange of real property acquired; provided, however, that not more than 45 percent in the case of life insurers, and not more than 25 percent in the case of nonlife insurers, of the minimum financial security benchmark may be made up of such investments;

(I) High-grade investments in corporate bonds and debentures having a remaining maturity of five years or less; and

(J) Any other investment not otherwise prohibited by this article that is considered exempt from risk-based capital requirements pursuant to Code Section 33-56-2 in accordance with risk-based capital instructions adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

History. — Code 1981, § 33-11-52, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2000, p. 136, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, a comma was substituted for a semicolon in subparagraph (b)(2)(D), "and" was inserted between "building" and "loan" in subparagraph (b)(3)(C), and "risk-based" was substituted for "risk based" in subparagraph (b)(3)(J).

33-11-53. Factors to be considered in determining prudence.

The following factors shall be evaluated by the insurer and considered along with its business in determining whether an investment portfolio or investment policy is prudent, and the Commissioner shall consider the following factors prior to making a determination that an insurer's investment portfolio or investment policy is not prudent:

(1) General economic conditions;

(2) The possible effect of inflation or deflation;

(3) The expected tax consequences of investment decisions or strategies;

(4) The fairness and reasonableness of the terms of an investment considering its probable risk and reward characteristics and relationship to the investment portfolio as a whole;

(5) The extent of the diversification of the insurer's investments among:

(A) Individual investments;

(B) Classes of investments;

(C) Industry concentrations;

(D) Dates of maturity; and

(E) Geographic areas;

(6) The quality and liquidity of investments in affiliates;

(7) The investment exposure to the following risks, quantified in a manner consistent with the insurer's acceptable risk level appropriate for the insurer given the level of capitalization and expertise available to the insurer:

(A) Liquidity;

(B) Credit and default;

(C) Systemic (market);

(D) Interest rate;

(E) Call, prepayment, and extension;

(F) Currency; and

(G) Foreign sovereign, political subdivision, and corporate;

(8) The amount of the insurer's assets, capital and surplus, premium writings, insurance in force, and other appropriate characteristics;

(9) The amount and adequacy of the insurer's reported liabilities;

(10) The relationship of the expected cash flows of the insurer's assets and liabilities and the risk of adverse changes in the insurer's assets and liabilities;

(11) The adequacy of the insurer's capital and surplus to secure the risks and liabilities of the insurer; and

(12) Any other factors appropriate for consideration and relevant to whether an investment is prudent.

History. — Code 1981, § 33-11-53, enacted by Ga. L. 1999, p. 592, § 12.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, a comma

was inserted following "prepayment" in subparagraph (7)(E) and a comma was deleted following "liabilities" in paragraph (10).

33-11-54. Written plan and policy; duty of board of directors.

(a) An insurer's board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity, and diversification of investments and other specifications, including investment strategies intended to assure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus. The board shall review and assess the insurer's technical investment and administrative capabilities and expertise before adopting a written plan concerning an investment strategy or investment practice.

(b) Investments acquired and held under this article shall be acquired and held under the supervision and direction of the board of directors of the insurer. The board of directors shall evidence by formal resolution, at least annually, that it has determined whether all investments have been made in accordance with delegations, standards, limitations, and investment objectives prescribed by the board or a committee of the board charged with the responsibility to direct its investments.

(c) On no less than a quarterly basis, and more often if deemed appropriate, an insurer's board of directors or committee of the board of directors shall:

(1) Receive and review a summary report on the insurer's investment portfolio, its investment activities, and investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan; and

(2) Review and revise, as appropriate, the written plan.

(d) In discharging its duties under this Code section, the board of directors shall require that records of any authorizations or approvals, other documentation as the board may require, and reports of any action taken under authority delegated under the plan referred to in subsection (a) of this Code section shall be made available on a regular basis to the board of directors.

(e) If an insurer does not have a board of directors, all references to the board of directors in this article shall be deemed to be references to the governing body of the insurer having authority equivalent to that of a board of directors.

(f) In discharging their duties under this Code section, the directors of an insurer shall perform their duties to the same degree required by Code Section 14-2-830.

History. — Code 1981, § 33-11-54, enacted by Ga. L. 1999, p. 592, § 12.

33-11-55. Investments eligible for support of outstanding liabilities.

(a) The following classes of investments are eligible for support of an insurer's outstanding liabilities, whether they are made directly or through limited partnership interests, joint ventures, stock of an investment subsidiary or membership interests in a limited liability company, trust certificates, participation certificates, or other similar instruments and, with the prior written approval of the Commissioner, general partnership interests:

(1) Cash;

(2) Bonds, investment pools, trust certificates, asset-backed/mortgage-backed securities, SVO listed mutual funds, debt-like preferred stock, or evidences of indebtedness of governmental units or government sponsored enterprises of a domestic jurisdiction, or private business entities domiciled in a domestic jurisdiction;

(3)(A) Obligations secured by mortgages on real estate situated within a domestic jurisdiction, in an aggregate amount which, together with those investments made pursuant to paragraph (6) of this subsection, does not exceed 45 percent of admitted assets in the case of life insurers and 25 percent in the case of nonlife insurers; but a mortgage loan which is secured by other than a first lien may only be acquired when:

(i) The insurer is the holder of the first lien; or

(ii) No senior loan is cross-collateralized or cross-defaulted with another mortgage loan secured by real estate, and the insurer has the right to cure a default on any senior loans.

(B) The obligations held by the insurer and any obligations with an equal lien priority shall not, at the time of acquisition of the obligation, exceed:

(i) Ninety percent of the fair market value of the real estate, if the mortgage loan is secured by a purchase money mortgage or like security received by the insurer upon disposition of the real estate;

(ii) Eighty percent of the fair market value of the real estate, if the mortgage loan requires immediate scheduled payment in

periodic installments of principal and interest, has an amortization period of 30 years or less, and has periodic payments made no less frequently than annually. Each periodic payment shall be sufficient to assure that at all times the outstanding principal balance of the mortgage loan shall be not greater than the outstanding principal balance that would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this subsection are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. For residential mortgage loans, the 80 percent limitation may be increased to 97 percent if acceptable private mortgage insurance has been obtained; or

(iii) Seventy-five percent of the fair market value of the real estate for mortgage loans that do not meet the requirements of division (i) or (ii) of this subparagraph.

(C) For purposes of subparagraph (A) of this paragraph, the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the Federal Housing Administration or guaranteed by the United States Department of Veterans Affairs, or their successors.

(D) Subject to the limitations of Code Section 33-11-58, credit tenant loans with the following characteristics shall be exempt from the provisions of subparagraph (B) of this paragraph:

(i) The loan amortizes over the initial fixed lease term at least in an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate;

(ii) The lease payments cover or exceed the total debt service over the life of the loan;

(iii) A tenant or its affiliated entity whose outstanding obligations have a high-grade designation or a comparable rating from a nationally recognized statistical rating organization recognized by the Securities Valuation Office or any successor office in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner and where the tenant or its affiliated entity has a full faith and credit obligation to make the lease payments;

(iv) The insurer holds or is the beneficial holder of a first lien mortgage on the real estate;

(v) The expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking, and heating, ventilation, and air conditioning replacement expenses, unless annual escrow contributions from cash flows derived from the lease payments cover the expense shortfall; and

(vi) There is a perfected assignment of the rents due pursuant to the lease to, or for the benefit of, the insurer.

(E) An insurer shall not acquire an investment under this paragraph if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this paragraph would exceed:

(i) Four percent of its admitted assets in mortgage loans covering any one secured location;

(ii) One percent of its admitted assets in construction loans covering any one secured location; or

(iii) Eight percent of its admitted assets in construction loans in the aggregate;

(4) Common stock or equity-like preferred stock or equity interests in any business entity in a domestic jurisdiction, or shares of mutual funds registered with the Securities and Exchange Commission of the United States under the Investment Company Act of 1940, other than Securities Valuation Office listed mutual funds, in an amount not exceeding 20 percent of admitted assets in the case of life insurers, and 25 percent in the case of nonlife insurers;

(5) Real property for the convenient accommodation of the insurer's (which may include its affiliates) business operations, including home office, branch office, and field office operations, in an amount not exceeding 10 percent of admitted assets;

(A) Real estate acquired under this paragraph may include excess space for rent to others, if the excess space, valued at its fair market value, would otherwise be a permitted investment under paragraph (6) of this subsection and is so qualified by the insurer;

(B) The real estate acquired under this paragraph may be subject to one or more mortgages, liens, or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with this Code section; and

(C) For purposes of this paragraph, business operations shall not include that portion of real estate used for the direct provision of health care services by an accident and sickness insurer for its insureds. An insurer may acquire real estate used for these purposes under paragraph (6) of this subsection;

(6) Real property, together with the fixtures, furniture, furnishings, and equipment pertaining thereto situated in a domestic jurisdiction, in an amount not exceeding 20 percent of admitted assets in the case of life insurers, and 10 percent in the case of nonlife insurers. Real estate acquired under this paragraph:

(A) Shall be income producing or intended for improvement or development for investment purposes under an existing program (in which case the real estate shall be deemed to be income producing);

(B) May be subject to mortgages, liens, or other encumbrances, the amount of which shall, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subparagraph (C) of this paragraph; and

(C) An insurer shall not acquire an investment under this paragraph if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under this paragraph plus the guarantees then outstanding would exceed:

(i) Four percent of its admitted assets in one parcel or group of contiguous parcels of real estate, except that this limitation shall not apply to that portion of real estate used for the direct provision of health care services by an accident and sickness insurer for its insureds, such as hospitals, medical clinics, medical professional buildings, or other health facilities used for the purpose of providing health services; or

(ii) Fifteen percent of its admitted assets in the aggregate;

(7) Loans, securities, or other investments of the types described in paragraphs (1) through (6) of this subsection in countries other than the United States and Canada, provided that the aggregate amount of investments shall not exceed 20 percent of admitted assets;

(8) Bonds or other evidences of indebtedness of international development organizations of which the United States is a member,

in an amount not exceeding 5 percent of admitted assets in each organization;

(9) Loans upon the security of the insurer's own policies in amounts that are adequately secured by the policies and that in no case exceed the surrender values of the policies;

(10) Tangible personal property under contract of sale or lease under which contractual payments may reasonably be expected to return the principal of and provide earnings on the investment within its anticipated useful life, in an amount not exceeding 2 percent of admitted assets;

(11) Loans guaranteed as to principal and interest by the Georgia Higher Education Assistance Corporation, to the extent of such guaranty;

(12) Chattel mortgage loans as follows:

(A) In connection with a loan on the security of real estate designed and used primarily for residential purposes only, which loan was acquired in accordance with paragraph (3) of subsection (a) of this Code section, an insurer may lend or invest an amount not exceeding 20 percent of the amount loaned on a chattel mortgage to be amortized by regular periodic payments within a term of not more than five years, and representing a first and prior lien, except for taxes not then delinquent, on personal property constituting durable equipment owned by the mortgagor or security grantor and kept and used in the mortgaged premises;

(B) For the purpose of this paragraph, the term "durable equipment" shall include only mechanical refrigerators, air-conditioning equipment, mechanical laundering machines, heating and cooking stoves and ranges, and in addition, in the case of apartment houses and hotels, room furniture and furnishings;

(C) Prior to the acquisition of a chattel mortgage as prescribed by this Code section, items of property to be included in such mortgage shall be separately appraised by a qualified appraiser and the fair market value of such items of property determined. No chattel mortgage loan shall exceed in amount the same ratio of loan to the value of the property as is applicable to the companion loan on the real property; and

(D) This paragraph shall not prohibit an insurer from taking liens on personal property as additional security for any investment otherwise eligible under this article;

(13)(A) If real property securing any evidence of indebtedness held by an insurer is used for agricultural purposes and a proceeding to

foreclose the security instrument or an insolvency proceeding relating to the mortgagor has been commenced or, if the mortgagor has made an assignment for the benefit of creditors, the insurer may, for the purpose of preserving or enhancing the earnings of the property:

(i) Purchase agricultural livestock or equipment and utilize the same or cause the same to be utilized in the operation of the property by the mortgagor, or a receiver or trustee, or by the insurer-creditor; or

(ii) Lend up to the value of any agricultural equipment or livestock which may be used in the operation of the property, on the security of a first lien on the equipment and livestock.

(B) Nothing in this Code section shall be deemed to limit any right which the insurer may otherwise have under or with respect to any loan, mortgage, or investment;

(14) Subject to prior approval of the Commissioner, an insurer may acquire and hold real property for recreation, hospitalization, convalescence, and retirement purposes of its employees. All investments under this paragraph shall not exceed 5 percent of the insurer's surplus; or, if a mutual or reciprocal insurer, all of those investments shall not exceed 5 percent of the insurer's surplus in excess of the surplus required to be maintained under this title for its authority to transact insurance;

(15) Other investments the Commissioner authorizes by regulation; and

(16) Investments not otherwise expressly permitted by this Code section but not specifically prohibited by statute, to the extent of not more than 10 percent of the insurer's admitted assets.

(b) An insurer may exceed the aggregate limitation contained in paragraph (3) of subsection (a) of this Code section by no more than 30 percent of its admitted assets if:

(1) This increased amount is invested only in residential mortgage loans;

(2) The insurer has no more than 10 percent of its admitted assets invested in mortgage loans other than residential mortgage loans;

(3) The loan-to-value ratio of each residential mortgage loan does not exceed 60 percent at the time the mortgage loan is qualified under this increased authority, and the fair market value is supported by an appraisal no more than two years old, prepared by an independent appraiser; and

(4) A single mortgage loan qualified under this increased authority shall not exceed 0.5 percent of its admitted assets.

(c) With the permission of the Commissioner, additional amounts of real estate may be acquired under paragraph (5) of subsection (a) of this Code section.

History. — Code 1981, § 33-11-55, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2000, p. 136, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "nationally recognized statistical rating organization" was substituted for "Nationally Recognized Statistical Rating Organization" in division (a)(3)(D)(iii) and a comma was substituted for a semicolon following "Canada" in paragraph (a)(7).

33-11-56. Conditions for engaging in derivative transactions.

(a) An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this article under the following conditions:

(1) An insurer may use derivative instruments under this Code section to engage in hedging transactions which manage risk and certain income generation transactions, as these terms may be further defined in regulation promulgated by the Commissioner;

(2) An insurer shall be able to demonstrate to the Commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses;

(3) An insurer may enter into hedging transactions under this Code section if, as a result of and after giving effect to the transaction:

(A) The aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed 7.5 percent of its admitted assets;

(B) The aggregate statement value of options, caps, and floors written in hedging transactions does not exceed 3 percent of its admitted assets; and

(C) The aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed 6.5 percent of its admitted assets;

(4) An insurer may only enter into the types of income generation transactions described in subparagraphs (A) through (D) of this paragraph if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed income assets that are subject to call or that generate the cash flows for payments under the

caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the puts, does not exceed 10 percent of its admitted assets:

(A) Sales of covered call options on noncallable fixed income securities, callable fixed income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed income securities;

(B) Sales of covered call options on equity securities, if the insurer holds in its portfolio, or can immediately acquire through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(C) Sales of covered puts on investments that the insurer is permitted to acquire under this article, if the insurer has escrowed, or entered into a custodian agreement segregating, cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put during the complete term of the put option sold; or

(D) Sales of covered caps or floors, if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding; and

(5) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of this article.

(b) The Commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of this Code section or for other risk management purposes under regulations promulgated by the Commissioner.

History. — Code 1981, § 33-11-56, enacted by Ga. L. 1999, p. 592, § 12.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, in subsection (a), a semicolon was substituted for a period at the end of paragraph (2) and a comma was inserted following "floors" in subparagraph (3)(A).

33-11-57. Requirements regarding admitted assets at time of acquisition; nonadmitted assets; relation of investment limitation; qualification of investments; documentation; authority of Commissioner; insurance futures.

(a) Investments not conforming to this article shall not be admitted assets.

(b) Subject to subsection (c) of this Code section, an insurer shall not acquire or hold an investment as an admitted asset unless at the time of acquisition it is:

(1) Eligible for the payment or accrual of interest or discount (whether in cash or other forms of income or securities), eligible to receive dividends or other distributions, or is otherwise income producing;

(2) Acquired under Code Section 33-11-55, 33-11-56, or 33-11-63 as a result of securities lending, repurchase, reverse repurchase, dollar roll transactions or, if a life insurer, the administration of policy loans; or

(3) Under the authority of provisions of this chapter other than this article.

(c) An insurer may acquire or hold as admitted assets investments that do not otherwise qualify as provided in this article if the insurer has not acquired them for the purpose of circumventing any limitations contained in this article, the insurer complies with the provisions of Code Section 33-11-60 and values such investments in accordance with Code Section 33-10-14, and if the insurer acquires the investments in the following circumstances:

(1) As payment on account of existing indebtedness or in connection with the refinancing, restructuring, or workout of existing indebtedness, if taken to protect the insurer's interest in that investment;

(2) As realization on collateral for an obligation;

(3) In connection with an otherwise qualified investment or investment practice, as interest on or a dividend or other distribution related to the investment or investment practice or in connection with the refinancing of the investment, in each case for no additional or only nominal consideration;

(4) Under a lawful and bona fide agreement of recapitalization or voluntary or involuntary reorganization in connection with an investment held by the insurer; or

(5) Under a bulk reinsurance, merger, or consolidation transaction approved by the Commissioner if the assets constitute admissible investments for the ceding, merged, or consolidated companies.

(d) An investment or portion of an investment acquired by an insurer under subsection (c) of this Code section shall become a nonadmitted asset three years (or five years in the case of mortgage loans and real estate) from the date of its acquisition, unless within that period the investment has become a qualified investment under a provision of this

article other than subsection (c) of this Code section, but an investment acquired under an agreement of bulk reinsurance, merger, or consolidation may be qualified for a longer period if so provided in the plan for reinsurance, merger, or consolidation as approved by the Commissioner. Upon application by the insurer and a showing that the nonadmission of an asset held under subsection (c) of this Code section would materially injure the interests of the insurer, the Commissioner may extend the period for admissibility for an additional reasonable period of time.

(e) Except as provided in subsections (f) and (h) of this Code section, an investment acquired or committed to be acquired prior to January 1, 2000, shall qualify under this article if, on the date the insurer committed to acquire the investment or on the date of its acquisition, it would have qualified under provisions of this chapter then in effect. For the purposes of determining limitations contained in this article, an insurer shall give appropriate recognition to any commitments to acquire investments.

(f)(1) Each specific transaction constituting an investment practice of the type described in this article that was lawfully entered into by an insurer and was in effect on January 1, 2000, shall continue to be permitted under this article until its expiration or termination under its terms.

(2) A mortgage made pursuant to Code Section 33-11-55 or held as an admitted asset pursuant to paragraph (1) of this subsection shall remain qualified as an admitted asset regardless of any refinancing, modification, or extension of such mortgage loan.

(g) Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the Commissioner.

(h) An investment qualified, in whole or in part, for acquisition or holding as an admitted asset may be qualified or requalified at the time of acquisition or a later date, in whole or in part, under any other provision of this article, if the relevant conditions contained in such other provision are satisfied at the time of qualification or requalification.

(i) An insurer shall maintain documentation demonstrating that investments were acquired in accordance with this article and specifying the Code section under which they were acquired.

(j) An insurer shall not enter into an agreement to purchase securities in advance of their issuance for resale to the public as part of a

distribution of the securities by the issuer or otherwise guarantee the distribution, except that an insurer may acquire privately placed securities with registration rights.

(k) Notwithstanding the provisions of this article, the Commissioner, for good cause, may order an insurer to nonadmit, limit, dispose of, withdraw from, or discontinue an investment or investment practice. The authority of the Commissioner under this subsection is in addition to any other authority of the Commissioner.

(l) Insurance futures and insurance futures options are not considered investments or investment practices for purposes of this article.

History. — Code 1981, § 33-11-57, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2000, p. 136, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999 and in 2000, "Code Section" was deleted twice and the comma following "33-11-63" was deleted in paragraph (b)(2), "January 1, 2000," was substituted for "the effective date of this article" in subsection (e) and paragraph (f)(1) and "under" was deleted following "order" in subsection (k).

33-11-58. Percentage of securities from single issuer; assignment of excesses; compliance; investment in government obligations.

(a)(1) For purposes of determining compliance with Code Section 33-11-61, securities of a single issuer and its affiliates, other than:

(A) The government of the United States; or

(B) Government sponsored enterprises,

shall not exceed 10 percent of admitted assets.

(2) This limitation shall not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(b) For the purpose of determining compliance with the limitations of this Code section, the admitted portion of assets of subsidiaries authorized under Code Section 33-13-2 shall be deemed to be owned directly by the insurer and any other investors in proportion to the market value or, if there is no market, the reasonable value of their interest in the subsidiaries.

(c) To the extent that investments exceed the limitations specified in subsections (a) and (b) of this Code section, the excess may be assigned to the investment class authorized in paragraph (15) of Code Section 33-11-55, until that limit is exhausted.

(d) Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus shall

relate to the amount required to be shown on the statutory balance sheet of the insurer most recently required to be filed with the Commissioner.

(e) Notwithstanding any provision of the federal Secondary Mortgage Enhancement Act, 15 U.S.C. Section 77r-1, to the contrary, any insurer subject to the provisions of this article shall comply with all restrictions and limitations concerning investments provided in this article.

(f) Notwithstanding any other provision of this article, an insurer authorized to transact insurance in a foreign country may make investments, in a manner consistent with the laws of such country, in securities or other investments which are similar in characteristics and quality to like investments required pursuant to this chapter for investments in the United States of America. The aggregate amount of the investments must not exceed the amount which is customary and necessary for the servicing of the insurance which the insurer has in force in the foreign country.

(g) Subject to the restrictions and limitations provided in this article, an insurer may invest in bonds, notes, warrants, and other securities not in default which are the direct obligations of the government of any foreign country for which the full faith and credit of such government has been pledged for the payment of principal and interest, provided such securities are listed as high by a securities rating organization accepted by the National Association of Insurance Commissioners in accordance with valuation standards adopted by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

History. — Code 1981, § 33-11-58, enacted by Ga. L. 1999, p. 592, § 12.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, minor capitalization changes were made to paragraph (a)(2) and a comma was deleted following "the reasonable value" in subsection (b).

33-11-59. Obligations in different currencies.

An insurer doing business that requires it to make payment in different currencies shall have investments in securities in each of these currencies in an amount that independently of all other investments meets the requirements of this article as applied separately to the insurer's obligations in each currency. The Commissioner may by order exempt an insurer, or by regulation a class of insurers, from this requirement if the obligations in other currencies are small enough that no significant problem for financial solidity would be created by substantial fluctuations in relative currency values.

History. — Code 1981, § 33-11-59, enacted by Ga. L. 1999, p. 592, § 12.

33-11-60. Prohibited investments and activities.

In addition to investments excluded or prohibited pursuant to other provisions of this article, an insurer shall not, directly or indirectly:

(1) Engage on its own behalf or through one or more affiliates in a transaction or series of transactions designed to evade the prohibitions of this article; or

(2) Invest in or lend its funds upon the security of shares of its own stock, except that an insurer may acquire shares of its own stock for the following purposes, but the shares shall not be admitted assets of the insurer:

(A) Conversion of a stock insurer into a mutual or reciprocal insurer or a mutual or reciprocal insurer into a stock insurer;

(B) Issuance to the insurer's officers, employees, or agents in connection with a plan approved by the Commissioner for converting a publicly held insurer into a privately held insurer or in connection with other stock option and employee benefit plans; or

(C) In accordance with any other plan approved by the Commissioner.

History. — Code 1981, § 33-11-60, enacted by Ga. L. 1999, p. 592, § 12.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, a comma was inserted following "employees" in subparagraph (2)(B).

33-11-61. Using investment assets to satisfy minimum assets requirements; qualification of admitted assets; determining financially hazardous insurer.

(a) Invested assets may be counted toward satisfaction of the minimum asset requirement only so far as they are invested in compliance with this article and applicable regulations promulgated and orders issued by the Commissioner pursuant to this article. Assets other than invested assets may be counted toward satisfaction of the minimum asset requirement at admitted annual statement value.

(b) An investment held as an admitted asset by an insurer on January 1, 2000, which qualified under Article 1 of this chapter shall remain qualified as an admitted asset under this article.

(c) If an insurer does not own, or is unable to apply toward compliance with this article, an amount of assets equal to its minimum asset requirement, the Commissioner may deem it to be financially hazardous under Chapter 37 of this title.

History. — Code 1981, § 33-11-61, enacted by Ga. L. 1999, p. 592, § 12.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "January 1, 2000," was substituted for "the effective date of this article" in subsection (b).

33-11-62. Retention of personnel to assist Commissioner; confidentiality.

(a) The Commissioner may retain at the insurer's expense attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist in reviewing the insurer's investments. Persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(b) The investment policy or information related to the investment policy provided to the Commissioner for review under this article shall be considered confidential and shall not be a public record for purposes of Article 4 of Chapter 18 of Title 50 or subject to subpoena, and shall be subject to disclosure only as required for purposes of and in accordance with this title.

History. — Code 1981, § 33-11-62, enacted by Ga. L. 1999, p. 592, § 12.

33-11-63. Determination by Commissioner of noncompliance; reasonable additional restrictions; consideration of other assets by Commissioner.

(a) If the Commissioner determines that an insurer's investment practices do not meet the provisions of this article, the Commissioner may, after notification to the insurer of the Commissioner's findings, order the insurer to make changes necessary to comply with the provisions of this article.

(b) If the Commissioner determines that by reason of the financial condition, current investment practice, or current investment plan of an insurer, the interests of insureds, creditors, or the general public are or may be endangered, the Commissioner may impose reasonable additional restrictions upon the admissibility or valuation of investments or may impose restrictions on the investment practices of an insurer, including prohibition or divestment.

(c) If the Commissioner is satisfied by evidence of an insurer's financial strength and the competence of management and its investment advisers, the Commissioner may count toward satisfaction of the minimum asset requirement any other investment not specifically prohibited by this article to the extent that the Commissioner is satisfied that the interests of insureds, creditors, and the general public of this state are protected.

History. — Code 1981, § 33-11-63, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2000, p. 136, § 33.

33-11-64. Conditions under which insurer shall not acquire an investment; special rated credit instruments.

(a) An insurer shall not acquire an investment under this article if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this article would exceed:

(1) For medium and lower grade investments, 20 percent of admitted assets;

(2) For lower grade investments, 10 percent of admitted assets;

(3) For investments rated 5 or 6 by the Securities Valuation Office or any successor office pursuant to the valuation procedures of Code Section 33-10-14, 5 percent of admitted assets; or

(4) For investments rated 6 by the Securities Valuation Office or any successor office pursuant to the valuation procedures of Code Section 33-10-14, 1 percent of admitted assets.

(b) The aggregate amount of special rated credit instruments held by an insurer pursuant to the valuation procedures of Code Section 33-10-14 shall not exceed 10 percent of admitted assets.

History. — Code 1981, § 33-11-64, enacted by Ga. L. 1999, p. 592, § 12.

33-11-65. Establishment of separate accounts by domestic life insurance companies.

(a) Any domestic life insurance company may establish one or more separate accounts and may allocate to such separate account or accounts, in accordance with the terms of a written agreement, any amounts paid to the company in connection with a pension, retirement, or profit-sharing plan, which is established by or in behalf of any group listed in Code Section 33-27-1, which are to be applied to provide benefits payable in fixed or variable dollar amounts.

(b) The amounts allocated to each account and accumulations thereon may be invested and reinvested in any class of investments which may be authorized in the written agreement without regard to any requirements or limitations prescribed by the laws of this state governing the investments of domestic life insurance companies, provided that, to the extent that the company's reserve liability with regard to benefits guaranteed as to amount and duration and funds

guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be invested in accordance with the laws of this state governing the investment of reserves of domestic life insurance companies, as set forth in this article. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company.

(c) The income, if any, and gains and losses realized or unrealized on each account shall be credited to or charged against the amounts allocated to the account in accordance with the written agreement, without regard to other income, gains, or losses of the company.

(d) Assets allocated to a separate account shall be valued at their market value on the date of valuation or, if there is no readily available market, in accordance with the terms of the applicable written agreement, provided that the portion of the assets of such separate account at least equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subsection (b) of this Code section, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

(e) Amounts allocated to a separate account in the exercise of the power granted by this Code section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to those amounts.

(f) If the agreement provides for payment of benefits in variable amounts, any contract entered into pursuant to this chapter and delivered in this state providing for such variable benefits shall be a group annuity contract. Such contract shall:

(1) Cover at least ten persons at the time it is entered into;

(2) Be for the purpose of funding a pension, retirement, or profit-sharing plan or agreement which meets the requirements for qualification under Section 401, 403, or 414 of the United States Internal Revenue Code, as now or hereafter amended, or any corresponding provisions of prior or subsequent United States revenue laws; and

(3) Prohibit the allocation to the separate account of any payment or contribution made by any employee.

The contract shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amounts of such variable benefits. The contract and any group certificate issued under the contract shall state that such dollar amounts may decrease or increase and shall contain on its first page, in a prominent

position, a statement that the benefits under the contract are on a variable basis.

(g) No domestic life insurance company and no foreign or Canadian life insurance company admitted to transact business in this state shall be authorized to deliver within this state any contract entered into pursuant to this article and providing benefits in variable amounts until said company has satisfied the Commissioner that its condition or methods of operation in connection with the issuance of such contracts will not be such as would render its operation hazardous to the public or its policyholders in this state. In determining the qualification of a company requesting authority to deliver the contracts in this state, the Commissioner shall consider, among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility, and general fitness of the officers and directors of the company; and

(3) In the case of a foreign or Canadian company, whether the regulations provided by the state of its domicile or that province in which its head office is located provides a degree of protection to policyholders and the public which is substantially equal to that provided by this Code section and the rules and regulations issued thereunder.

(h) Notwithstanding any other provisions of law, the Commissioner shall have sole authority to issue such reasonable rules and regulations as may be necessary to carry out the purposes of this Code section.

(i) Nothing in this Code section shall be deemed to repeal any provision of Code Section 33-25-9 and no contract or agreement made pursuant to this Code section, or policy or certificate issued under this Code section, shall be construed to violate Code Section 33-25-9.

History. — Code 1981, § 33-11-65, enacted by Ga. L. 1999, p. 592, § 12.

33-11-66. Cumulative nature of Code section; variable annuity contract; separate accounts; conduct of business; licensed or organized to do business in state; Commissioner's role.

(a) This Code section is cumulative of and in addition to the authority granted by any other law of this state relating to separate accounts for insurance companies or to annuity contracts on a variable basis and shall not be deemed to repeal or affect the provisions of Code Section 33-11-65 dealing with the group variable annuity contracts referred to in subsection (f) of Code Section 33-11-65.

(b) When used in this Code section, the term "variable annuity contract" shall mean any individual or group contract issued by an insurance company or annuity company providing for annuity benefits and incidental contractual payments or values which vary in whole or in part so as to reflect investment results of any segregated portfolio of investments or of a designated separate account or accounts in which amounts received or retained in connection with any of the contracts have been placed.

(c) Any domestic life insurance company may establish one or more separate accounts and may allocate to those accounts amounts to provide for annuities (and benefits incidental thereto) payable in fixed or variable amounts or both.

(d) Except as provided in subsection (f) of this Code section, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of domestic life insurance companies, provided that, to the extent that the company's reserve liability with regard to benefits guaranteed as to amount and duration and funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to the reserve liability shall be invested in accordance with the laws of this state governing the investment of reserves of life insurance companies. The investments in the separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company.

(e) To the extent any such domestic company deems it necessary to comply with any applicable federal or state laws, the company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest in such separate account appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of the account. This subsection shall not affect existing laws pertaining to the voting rights of the life insurance company's stockholders or policyholders except as provided in this Code section.

(f) No domestic company shall, for any separate account, purchase the voting securities of a single issuer if such purchase would result in such company, and all domestic insurance companies, directly or indirectly controlling, controlled by, or under common control with the

company and holding in the company's or companies' separate account or accounts an amount in excess of 10 percent of the total issued and outstanding voting securities of the issuer, provided that this limitation shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable in accordance with instructions from persons having interests in such accounts. This limitation shall not apply to the investment for a separate account in the securities of an investment company registered under the Investment Company Act of 1940.

(g) No sale, exchange, or other transfer of assets may be made by any domestic company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made and unless the transfer, whether into or from a separate account, is made by transfer of cash or by a transfer of securities having a readily determinable market value, provided that transfer of securities is approved by the Commissioner. The Commissioner may approve other transfers among such accounts if, in his or her opinion, the transfers would not be inequitable.

(h) The income, if any, and gains and losses, realized or unrealized, from assets allocated to each account shall be credited to or charged against the account without regard to income, gains, or losses of the company.

(i) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation or, if there is no readily available market, as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided that the portion of the assets of the separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in subsection (d) of this Code section, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets. The reserve liability for variable annuity contracts shall be determined in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(j) The amounts held in any separate account shall not be chargeable with liabilities arising out of any other business the company may conduct but shall be held and applied exclusively for the benefit of the owners or beneficiaries of the variable annuity contracts applicable thereto.

(k) Each domestic life insurance company shall have the power within the limits of its corporate charter to do all things necessary

under any applicable state or federal law in order that variable annuity contracts may be lawfully sold or offered for sale including, without limitation, the power to provide for management of a separate account by persons who may otherwise be unaffiliated with the life insurance company and the power to grant in connection with such contracts such voting rights as are set forth in subsection (e) of this Code section. Each domestic life insurance company may allocate from its general accounts to each separate account established under this Code section an initial cash amount necessary to meet minimum capitalization requirements for such account as prescribed by the Securities and Exchange Commission, provided that the total of all such allocations shall not exceed 10 percent of the company's assets or $1 million, whichever is less. Any allocation may be withdrawn when sufficient amounts have been received by the company in connection with variable annuity contracts and allocated to a separate account to meet the minimum capitalization requirement.

(l) Amounts allocated to a separate account in the exercise of the power granted by this Code section shall be owned by the company, and the company shall not be, or hold itself out to be, a trustee with respect to such amounts.

(m) Any variable annuity contract providing benefits payable in variable amounts issued under this Code section shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amount of such variable benefits. Any contract, including a group contract and certificate in evidence or variable benefits issued under such contract, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that benefits under the contract are on a variable basis.

(n) No company shall deliver or issue for delivery variable annuity contracts within this state unless it is licensed or organized to do a life insurance or annuity business in this state or is organized as a nonprofit educational corporation in its state of domicile and issues variable annuity contracts solely for the purpose of aiding and strengthening nonproprietary and nonprofit-making colleges, universities, and other institutions engaged primarily in education or research and the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The character, responsibility, and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

(o) The Commissioner shall have sole and exclusive authority to regulate the issuance or sale of the contracts and to issue such reasonable rules and regulations as may be necessary to carry out the purposes and provisions of this Code section; and the contracts, the companies which issue them, and the agents or other persons who sell them shall not be subject to Chapter 5 of Title 10, the "Georgia Uniform Securities Act of 2008," in the sale of the contracts.

(p) Notwithstanding any other laws of this state, no individual shall, within this state, sell or offer for sale variable annuity contracts as defined in this Code section unless the individual shall have both a valid and current life insurance license and variable contract license issued by the Commissioner. No license shall be issued unless and until the Commissioner is satisfied, after examination, except as provided for in Code Section 33-23-16, that the person is by training, knowledge, ability, and character qualified to act as such a variable annuity agent. The Commissioner may reject any application or suspend or revoke or refuse to renew any variable contract agent's license upon any ground that would bar the applicant or the agent from being licensed to sell life insurance contracts in this state or for the violation of any federal or state securities laws or regulations. The rules governing any proceedings relating to the suspension or revocation of a life insurance agent's license shall also govern any proceedings for the suspension or revocation of a variable contract agent's license. Renewal of a variable contract agent's license shall follow the same procedure established for renewal of an agent's license to sell life insurance contracts in this state.

(q) No contract or agreement made pursuant to this Code section or policy or certificate issued under this Code section shall be construed to violate Code Section 33-25-9, and the sale or offer of any policy or certificate shall not be deemed an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of paragraph (7) of subsection (b) and subparagraphs (b)(8)(B) and (b)(8)(C) of Code Section 33-6-4.

(r) Except for paragraphs (1), (5), and (6) of subsection (b) of Code Section 33-28-2 and except as otherwise provided in this Code section, all pertinent provisions of this title shall apply to separate accounts and variable annuity contracts relating thereto. The Commissioner, by regulation, may require that any individual variable annuity contract delivered or issued for delivery in this state contain provisions as to grace period and reinstatement appropriate for a variable annuity contract.

History. — Code 1981, § 33-11-66, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2001, p. 925, § 3; Ga. L. 2008, p. 381, § 10/SB 358; Ga. L. 2018, p. 1112, § 33/SB 365.

The 2018 amendment, effective May 8, 2018, part of an Act to revise, modernize, and correct the Code, substituted "paragraph (7) of subsection (b) and subparagraphs (b)(8)(B) and (b)(8)(C)" for "paragraph (7) and subparagraphs (B) and (C) of paragraph (8)" near the end of subsection (q).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "agents" was substituted for "agent" in subsection (o).

33-11-67. Variable contract insurance policies; separate accounts; power of company; statement of essential features in determining benefits; certificate of authority; Commissioner's role; insurance license required.

(a) As used in this Code section, "variable life insurance policy" means any individual or group policy issued by an insurance company providing for life insurance and benefits incidental thereto, under which payments or values may vary in whole or in part so as to reflect investment results of any segregated portfolio of investments or of a designated separate account or accounts in which amounts received or retained in connection with any of such policies have been placed.

(b) A domestic life insurance company may establish one or more separate accounts and may allocate to the accounts amounts including without limitation proceeds applied under optional modes of settlement or under dividend options to provide for life insurance and benefits incidental thereto, payable in variable amounts, subject to the following:

(1) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the company;

(2) Except as provided in paragraph (4) of this subsection, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of domestic life insurance companies, provided that, to the extent that the company's reserve liability with regard to benefits guaranteed as to amount and duration and funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of the separate account at least equal to the reserve liability shall be invested in accordance with the laws of this state governing the investment of reserves of life insurance companies. The investments in the separate account or accounts shall not be taken into account in applying the investment limitations applicable to other investments of the company;

(3) To the extent any domestic company deems it necessary to comply with any applicable federal or state laws, the company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with the company, to manage the business of such account. This paragraph shall not affect existing laws pertaining to the voting rights of the life insurance company's stockholders or policyholders except as provided in paragraph (4) of this subsection;

(4) No domestic company shall, for any separate account, purchase the voting securities of a single issuer if the purchase would result in the company and all domestic insurance companies directly or indirectly controlling, controlled by, or under common control with the company and holding in the company's or companies' separate account or accounts an amount in excess of 10 percent of the total issued and outstanding voting securities of the issuer, provided that this limitation shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable in accordance with instructions from persons having interest in the accounts. This limitation shall not apply to the investment for a separate account in the securities of an investment company registered under the Investment Company Act of 1940;

(5) Unless otherwise approved by the Commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation or, if there is no readily available market, as provided under the terms of the policy or the rules or other written agreement applicable to the separate account, provided that, unless otherwise approved by the Commissioner, the portion, if any, of the assets of such separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in paragraph (2) of this subsection shall be valued in accordance with the rules otherwise applicable to the company's assets;

(6) Amounts allocated to a separate account in the exercise of the power granted by this Code section shall be owned by the company, and the company shall not be, nor hold itself out to be, a trustee with respect to such amounts. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with

respect to the account shall not be chargeable with liabilities arising out of any other business the company may conduct; and

(7) No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the policies with respect to the separate account to which the transfer is made and unless the transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value, provided that the transfer of securities is approved by the Commissioner. The Commissioner may approve other transfers among the accounts if, in his or her opinion, the transfers would not be inequitable.

(c) Each domestic life insurance company shall have the power within the limits of its corporate charter to do all things necessary under any applicable state or federal law in order that variable life insurance policies may be lawfully sold or offered for sale including, without limitation, the power to provide for management of a separate account by persons who may otherwise be unaffiliated with the life insurance company and the power to grant in connection with the policies such voting rights as are set forth in paragraph (3) of subsection (b) of this Code section. Each domestic life insurance company may allocate from its general accounts to each separate account established under this Code section an initial cash amount necessary to meet minimum capitalization requirements for such account as prescribed by the Securities and Exchange Commission, provided that the total of all of the allocations shall not exceed 10 percent of the company's assets or $1 million, whichever is less. Any allocation may be withdrawn when sufficient amounts have been received by the company in connection with variable life insurance policies and allocated to a separate account to meet the minimum capitalization requirement.

(d) Any variable life insurance policy issued under this Code section shall contain a statement of the essential features of the procedure to be followed by the company in determining the dollar amount of variable benefits provided under such policy. Any policy, including a group contract and certificates in evidence of variable benefits issued thereunder, shall state that the dollar amount will vary to reflect investment experience and shall contain on its first page a statement to the effect that benefits under such policy are on a variable basis.

(e) No company shall deliver or issue for delivery variable life insurance policies within this state unless it has a current certificate of authority to transact life insurance in this state and the Commissioner is satisfied that its condition or method of operations in connection with

the issuance of such policies will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things:

(1) The history and financial condition of the company;

(2) The experience, character, responsibility, and fitness of the officers and directors of the company; and

(3) The law and regulation under which the company is authorized in the state of domicile to issue variable life insurance policies.

(f) The Commissioner shall have sole and exclusive authority to regulate the solicitation, sale, and issuance of variable life insurance policies and to issue any reasonable rules and regulations as may be necessary to carry out the purposes and provisions of this Code section; and the policies, the companies which issue them, and the agents or other persons who sell them shall not be subject to Chapter 5 of Title 10, the "Georgia Uniform Securities Act of 2008," in the sale of the policies.

(g) Notwithstanding any other laws of this state, no individual shall, within this state, sell or offer for sale variable life insurance contracts as defined in this Code section unless such individual shall have both a valid and current life insurance license and variable contract insurance license issued by the Commissioner. No license shall be issued unless and until the Commissioner is satisfied, after examination, except as provided for in Code Section 33-23-16, that the individual is by training, knowledge, ability, and character qualified to act as such a variable contract insurance agent. The Commissioner may reject any application or suspend or revoke or refuse to renew any variable contract insurance agent's license upon any ground that would bar the applicant or the agent from being licensed to sell life insurance contracts in this state or for the violation of any federal or state securities laws or regulations. The rules governing any proceedings relating to the suspension or revocation of a life insurance agent's license shall also govern any proceedings for the suspension or revocation of a variable contract insurance agent's license. Renewal of a variable contract insurance agent's license shall follow the same procedure established for renewal of an agent's license to sell life insurance contracts in this state.

(h) No variable life insurance policy or certificate issued pursuant to this Code section shall be construed to violate Code Section 33-25-9, and the sale or offer of any such policy or certificate shall not be deemed an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of paragraph (7) and subparagraphs (B) and (C) of paragraph (8) of subsection (b) of Code Section 33-6-4.

(i)(1) Except for paragraphs (1), (5), (6), (7), and (8) of subsection (a) of Code Section 33-25-3, Code Section 33-25-4, and paragraph (1) of

Code Section 33-27-3 and except as otherwise provided in this Code section, all pertinent provisions of this title shall apply to separate accounts and variable life insurance policies relating to such accounts. The Commissioner, by regulation, may require that any individual variable life insurance policy delivered or issued for delivery in this state contain provisions as to grace, reinstatement, and nonforfeiture appropriate for that policy; and any such group variable life insurance policy shall contain a provision for grace and nonforfeiture appropriate to that policy.

(2) The reserve liability for variable life insurance policies shall be determined in accordance with actuarial procedures approved by the Commissioner that recognize the variable nature of the benefits provided and any mortality guarantees.

History. — Code 1981, § 33-11-67, enacted by Ga. L. 1999, p. 592, § 12; Ga. L. 2001, p. 925, § 4; Ga. L. 2008, p. 381, § 10/SB 358.

ARTICLE 3

INVESTMENT POOLS

Editor's notes. — Ga. L. 1999, p. 592, § 15, effective January 1, 2000, designated the existing provisions of Chapter 11A of this title, which became effective April 22, 1997, as Article 3 of Chapter 11 and redesignated Code Sections 33-11A-1 through 33-11A-10 as Code Sections 33-11-80 through 33-11-89, respectively.

33-11-80. Short title.

This article shall be known and may be cited as the "Investment Pool Act of 1997."

History. — Code 1981, § 33-11A-1, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-80, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

33-11-81. Applicability.

This article shall apply to domestic insurers only.

History. — Code 1981, § 33-11A-2, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-81, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

33-11-82. Definitions.

As used in this article, the term:

(1) "Business entity" means a corporation, limited liability company, association, partnership, joint-stock company, joint venture, mutual fund trust, or other similar form of business organization, whether organized for profit or not for profit.

(2) "Class one money market mutual fund" means a mutual fund that at all times qualifies for investment using the bond class one reserve factor under the *Purposes and Procedures* of the SVO or any successor publication.

(3) "Government money market mutual fund" means a money market mutual fund that at all times:

(A) Invests only in obligations issued, guaranteed, or insured by the government of the United States or collateralized repurchase agreements composed of such obligations; and

(B) Qualifies for investment without a reserve under the *Purposes and Procedures* of the SVO or any successor publication.

(4) "Money market mutual fund" means a mutual fund that meets the conditions of 17 C.F.R. 270.2a-7, under the Investment Company Act of 1940, 15 U.S.C. Section 80a-1, et seq., as amended.

(5) "Obligation" means a bond, note, debenture, or trust certificate, including equipment certificate, production payment, negotiable bank certificate of deposit, banker's acceptance, credit tenant loan, loan secured by financing net leases, and other evidence of indebtedness for the payment of money, or participation, certificates, or other evidences of an interest in any of the foregoing, whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.

(6) "Qualified bank" means a national bank, state bank, or trust company that at all times is no less than adequately capitalized as determined by the standards provided by federal banking regulations and that is either regulated by state banking laws or is a member of the Federal Reserve System.

(7) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(8) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(9) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(10) "SVO" means the Securities Valuation Office of the National Association of Insurance Commissioners.

History. — Code 1981, § 33-11A-3, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-82, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

33-11-83. Authorization and requirements for insurers acquiring investments in investment pools.

(a) Notwithstanding any provisions of Article 1 or Article 2 of this chapter to the contrary, an insurer may under this article acquire investments in investments pools that:

(1) Invest only in:

(A) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating by a nationally recognized statistical rating organization recognized by the SVO or, in the absence of an SVO 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 rating or equivalent rating by a nationally recognized statistical rating organization recognized by the SVO and which have:

(i) A remaining maturity of 397 days or less or a put that entitles the holder to receive the principal amount of the obligation, which put may be exercised through maturity at specified intervals not exceeding 397 days; or

(ii) A remaining maturity of three years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index, including federal funds, prime rate, treasury bills, London InterBank Offered Rate (LIBOR), or commercial paper, and is subject to no maximum limit, if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(B) Government money market mutual funds or class one money market mutual funds; or

(C) Securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of Code Section 33-11-7; or

(2) Invest only in investments which an insurer may acquire under this title, if the insurer's proportionate interest in the amount invested in such investments does not exceed the applicable limits of this title.

History. — Code 1981, § 33-11A-4, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-83, as redesignated by Ga. L. 1999, p. 592, §§ 14, 15.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "this article" was substituted for "this chapter" in subsection (a).

33-11-84. Qualification in investment pool.

For an investment in an investment pool to be qualified under this article, the investment pool shall not:

(1) Acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer;

(2) Borrow or incur an indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of this article; or

(3) Permit the aggregate value of securities then loaned or sold to, purchased from, or invested in any one business entity under this article to exceed 10 percent of the total assets of the investment pool.

History. — Code 1981, § 33-11A-5, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-84, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

33-11-85. Limitations to insurer's investment.

The limitations of paragraphs (1) and (2) of Code Section 33-11-5 shall not apply to an insurer's investment in an investment pool; provided, however, that an insurer shall not acquire an investment in an investment pool under this article if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this article:

(1) In any one investment pool would exceed 10 percent of its admitted assets;

(2) In all investment pools investing in investments permitted under paragraph (2) of subsection (a) of Code Section 33-11-83 would exceed 25 percent of its admitted assets; or

(3) In all investment pools would exceed 35 percent of its admitted assets.

History. — Code 1981, § 33-11A-6, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-85, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "Code Section 33-11-83" was substituted for "Code Section 33-11A-4" in paragraph (2).

33-11-86. Management of investment pool.

For an investment in an investment pool to be qualified under this article, the manager of the investment pool shall:

(1) Be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(2) Be the insurer, an affiliated insurer or a business entity affiliated with the insurer, a qualified bank, or a business entity registered under the Investment Advisors Act of 1940, 15 U.S.C. Section 80b-1, et seq., as amended; or, in the case of a reciprocal insurer or interinsurance exchange, be its attorney in fact; or, in cases of a United States branch of an alien insurer, be its United States manager or affiliates or subsidiaries of its United States manager;

(3) Compile and maintain detailed accounting records setting forth:

(A) The cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(B) A complete description of all underlying assets of the investment pool, including amount, interest rate, any maturity date, and other appropriate designations; and

(C) Such other records which, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(4) Maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custodial agreement compliant with this title with a qualified bank. The custodial agreement shall include but not be limited to:

(A) A statement and recognition of the claims and rights of each participant;

(B) An acknowledgment that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(C) An agreement that the underlying assets of the investment pool shall not be commingled with the general assets of the custodian qualified bank or any other person.

History. — Code 1981, § 33-11A-7, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-86, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

33-11-87. Notification to Commissioner; ownership; inspection.

A pooling agreement under this article may not be entered into unless the insurer has notified the Commissioner in writing of the pooling agreement at least 30 days prior to entering into the pooling agreement and the Commissioner has not disapproved it within such period. The

pooling agreement for each investment pool shall be in writing and shall provide that:

(1) An insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under paragraph (1) of subsection (a) of Code Section 33-11-83, the insurer and its subsidiaries, affiliates, or any pension or profit-sharing plan of the insurer, its subsidiaries and affiliates, or, in the case of a United States branch of an alien insurer, affiliates or subsidiaries of its United States manager, shall, at all times, hold 100 percent of the interests in the investments pool;

(2) The underlying assets of the investment pool shall not be commingled with the general assets of the pool manager or any other person;

(3) In proportion to the aggregate amount of each pool participant's interest in the investment pool:

(A) Each participant owns an undivided interest in the underlying assets of the investment pool; and

(B) The underlying assets of the investment pool are held solely for the benefit of each participant;

(4) A participant, or in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, or other successor in interest, may withdraw all or any portion of its investment from the pool under the terms of the pooling agreement;

(5) Withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds shall occur within a reasonable and customary period thereafter not to exceed five business days. Distributions under this paragraph shall be calculated in each case net of all then applicable fees and expenses of the investment pool. The pooling agreement shall provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(A) In cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(B) In kind, a pro rata share of each underlying asset; or

(C) In a combination of cash and in kind distributions, a pro rata share of each underlying asset; and

(6) The pool manager shall make the records of the investment pool available for inspection by the Commissioner.

History. — Code 1981, § 33-11A-8, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-87, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "Code Section 33-11-83" was substituted for "Code Section 33-11A-4" in paragraph (1).

33-11-88. Business entity requirement.

An investment pool authorized under this article must be a business entity.

History. — Code 1981, § 33-11A-9, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-88, as redesignated by Ga. L. 1999, p. 592, §§ 13, 15.

33-11-89. Standards not applicable; reporting.

Transactions between an investment pool and its participants shall not be subject to the provisions of Code Section 33-13-5. Investment activities of an investment pool and transactions between such pools and pool participants shall be reported annually in the registration statement required by Code Section 33-13-4.

History. — Code 1981, § 33-11A-10, enacted by Ga. L. 1997, p. 1042, § 1; Code 1981, § 33-11-89, as redesignated by Ga. L. 1999, p. 592, § 15.

CHAPTER 11A

INVESTMENT POOLS [REDESIGNATED]

Sec.
33-11A-1 through 33-11A-10. Redesignated.

33-11A-1 through 33-11A-10.

Editor's notes. — Ga. L. 1999, p. 592, § 15, effective January 1, 2000, redesignated the former provisions of this chapter, relating to investment pools and which became effective April 22, 1997, as Article 3 of Chapter 11 and redesignated Code Sections 33-11A-1 through 33-11A-10 as Code Sections 33-11-80 through 33-11-89, respectively.

CHAPTER 12

ADMINISTRATION OF DEPOSITS

Sec.
33-12-1. Persons with whom required deposit to be made; acceptance and holding in trust of deposits generally.
33-12-2. Purposes for which deposits to be held.
33-12-3. Assets deemed eligible for deposit.
33-12-4. Designation of state depositories; responsibility for safekeeping of deposits; acceptance of book-entry securities as securities.
33-12-5. Rights of insurers as to recovery, exchange, and inspection of deposits generally.
33-12-6. Deposit of securities in amounts exceeding required or permitted deposit.
33-12-7. Procedure upon occurrence of deficiencies in deposits of insurers generally.
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33-12-10. Levy upon deposits by claimants.
33-12-11. Retention of amount to pay judgment in event of occurrence of loss by insured; application for appointment of receiver.
33-12-12. Proceedings upon appointment of receiver generally.
33-12-13. Proceedings upon appointment of receivers for satisfaction of multiple claims.
33-12-14. Proceeding by Commissioner upon reduction in amount of deposit resulting from occurrence or loss by insured; effect of failure to deposit additional securities.
33-12-15. Limitation period for settlement or renewal of claims against deposits of insurers; procedure upon settlement of claims.
33-12-16. Effect of order of general receivership.
33-12-17. Withdrawal of deposit.

Cross references. — Requirement of deposits, §§ 33-3-8 et seq., and 33-3-25.

Administrative rules and regulations. — Business requirements, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-18.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Code 1933 §§ 22-1210 and 56-301 et seq. are included in the annotations for this Code section.

Chapter part of general scheme to protect Georgia citizens. — Former statute as to the depositing of bonds and retaining them so long as there is a pending claim in the state (see this chapter and §§ 33-3-8 to 33-3-10), and the former statute providing for the prosecution of pending suits after the dissolution of a foreign corporation (see T. 14, C. 2), are a part of the general scheme of the Georgia law to protect Georgia citizens in the collection of just claims against foreign corporations which are dissolved and which have their principal assets in another state. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933 §§ 22-1210 and 56-301 et seq.).

Cited in Preferred Ins. Co. v. Bentley, 223 Ga. 735, 157 S.E.2d 737 (1967).

RESEARCH REFERENCES

ALR. — Allocation, as between special fund created pursuant to statute for benefit of certain class of creditors and general assets of insolvent, of payment on claim having priority as to both the special fund and general assets, 106 A.L.R. 713.

33-12-1. Persons with whom required deposit to be made; acceptance and holding in trust of deposits generally.

(a) Deposits required or permitted by law to be made by domestic life insurers and all other insurers shall be made with the Commissioner or with some strong corporation approved by the Commissioner.

(b) The Commissioner shall accept and hold in trust deposits of securities or funds by insurers as follows:

(1) Deposits required for authority to transact insurance in this state;

(2) Deposits of domestic, foreign, or alien insurers when made pursuant to the laws of other states, provinces, and countries as prerequisite for authority to transact insurance in such state, province, or country; or

(3) Deposits in such additional amounts as are permitted to be made by Code Section 33-12-6.

History. — Ga. L. 1887, p. 113, §§ 4, 5; Civil Code 1895, §§ 2036, 2042; Civil Code 1910, §§ 2420, 2426; Ga. L. 1922, p. 122, § 2; Code 1933, §§ 56-302, 56-314, 56-316; Code 1933, § 56-1101, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 1015, § 14; Ga. L. 1982, p. 3, § 33.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 37.

33-12-2. Purposes for which deposits to be held.

Deposits shall be held as follows:

(1) When the deposit is required for authority to transact insurance in this state, the deposit shall be held for the protection of all the insurer's policyholders or others entitled to the proceeds of policies within the United States, provided that this paragraph shall not apply to a deposit made under Code Section 33-3-9;

(2) When the deposit is required pursuant to the laws of another state, commonwealth, territory, district of the United States, province, or country, the deposit shall be held for such purposes as are required by such laws and as specified by the Commissioner at the time the deposit is made; or

(3) When the deposit is required pursuant to the retaliatory provision, Code Section 33-3-26, the deposit shall be held for purposes as specified in the Commissioner's order requiring the deposit.

History. — Ga. L. 1887, p. 113, § 12; Civil Code 1895, § 2060; Civil Code 1910, § 2449; Code 1933, § 56-315; Code 1933, § 56-1102, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Code 1895, §§ 2035 to 2043 and former Code 1933, §§ 22-1210 and 56-301 et seq. are included in the annotations for this Code section.

Deposit is to prevent action against dissolved corporation being futile. — The bonds which a foreign insurance corporation doing business in this state is required to deposit are to prevent an action against a dissolved corporation from being futile and unavailing. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938) (decided under former Code 1933, §§ 22-1210 and 56-301 et seq.).

Deposits primary purpose to secure payment of losses. — The primary purpose of the deposit is to secure the payment of fire losses, which are the only losses insured against, although it also secures, secondarily, other claims arising on policies, such as the repayment, after the termination of the risk, of unearned premiums paid; even when a company becomes insolvent and the deposit is brought into a court of equity for distribution, fire losses are entitled to priority of payment from the fund over claims for unearned premiums. Kelsey v. Cogswell, 112 F. 599 (N.D. Ga. 1901) (decided under former Code 1895, §§ 2035 to 2043); Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 37.

C.J.S. — 44 C.J.S., Insurance, § 77.

33-12-3. Assets deemed eligible for deposit.

(a) All deposits required for authority to transact insurance in this state shall consist of any combination of the securities eligible for the investment of capital funds of domestic insurers as enumerated and described in paragraph (3) of Code Section 33-11-5, except real estate, notes secured by real estate, stocks, or investment trust or investment company shares.

(b) All deposits required pursuant to the laws of another state, province, or country or pursuant to the retaliatory provisions of Code Section 33-3-26 shall consist of those assets as are required or permitted by law or as are required pursuant to a retaliatory provision.

History. — Ga. L. 1887, p. 124, §§ 12, 13; Civil Code 1895, §§ 2060, 2061; Ga. L. 1900, p. 47, § 1; Ga. L. 1901, p. 33, § 1; Ga. L. 1905, p. 77, § 1; Civil Code 1910, §§ 2449, 2450; Ga. L. 1912, p. 119, §§ 14, 27, 39; Ga. L. 1924, p. 121, § 1; Code 1933, §§ 56-311, 56-312, 56-315, 56-320, 56-321, 56-322; Code 1933, § 56-1103, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1974, p. 464, § 4; Ga. L. 1975, p. 1232, § 2; Ga. L. 1983, p. 3, § 24.

33-12-4. Designation of state depositories; responsibility for safekeeping of deposits; acceptance of book-entry securities as securities.

(a) The Commissioner may designate any regularly constituted state depository having trust powers domiciled in this state as a depository to receive and hold deposit. A deposit so held shall be at the expense of the insurer. A depository shall give to the Commissioner proper trust and safekeeping, receipt upon which the Commissioner shall give official receipt to the insurer.

(b) The Commissioner shall be responsible for the safekeeping and return of all securities deposited pursuant to this title with the Commissioner or in any depository so designated.

(c) The Commissioner may by rule or regulation prescribe the methods by which book-entry securities may be accepted as securities required or permitted by law.

History. — Code 1933, § 56-1104, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1993, p. 1721, § 2.

Cross references. — State depositories, § 50-17-50 et seq.

33-12-5. Rights of insurers as to recovery, exchange, and inspection of deposits generally.

So long as the insurer remains solvent and complies with this title it may:

(1) Demand, receive, institute an action for, and recover the income from the securities deposited;

(2) Exchange and substitute for the deposited securities or any part thereof, with the approval of the Commissioner, eligible securities of equivalent or greater value; and

(3) Inspect at reasonable times any deposit.

History. — Ga. L. 1887, p. 113, § 5; Civil Code 1895, § 2043; Ga. L. 1905, p. 76, § 1; Ga. L. 1906, p. 107, §§ 4, 5; Civil Code 1910, §§ 2427, 2431, 2432; Code 1933, §§ 56-309, 56-310, 56-317; Code 1933, § 56-1105, enacted by Ga. L. 1960, p. 289, § 1.

33-12-6. Deposit of securities in amounts exceeding required or permitted deposit.

An insurer may deposit eligible securities in an amount exceeding its deposit required or otherwise permitted under this title by not more than $100,000.00 for the purpose of absorbing fluctuations in the value of securities held in its deposit and to facilitate the exchange and substitution of securities deposited. During the solvency of the insurer any excess deposit or part thereof shall be released to the insurer upon its request, subject to Code Section 33-12-9. During the insolvency of the insurer the excess deposit shall be released only as provided in Code Section 33-12-8.

History. — Ga. L. 1899, p. 54, § 1; Civil Code 1910, § 2560; Code 1933, § 56-1110; Code 1933, § 56-1106, enacted by Ga. L. 1960, p. 289, § 1.

33-12-7. Procedure upon occurrence of deficiencies in deposits of insurers generally.

If for any reason the market value of assets and securities of an insurer held on deposit in this state under this title falls below the amount so required, the insurer shall promptly deposit other or additional assets or securities eligible for deposit sufficient to cure the deficiency. If the insurer has failed to cure the deficiency within 30 days after receipt of notice to deposit other or additional assets or securities by registered or certified mail or statutory overnight delivery from the Commissioner, the Commissioner shall revoke the insurer's certificate of authority.

History. — Ga. L. 1887, p. 113, § 4; Civil Code 1895, § 2040; Civil Code 1910, § 2424; Code 1933, § 56-305; Code 1933, § 56-1107, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 1589, § 3.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

33-12-8. Release of deposits generally.

Any deposit made in this state under this title shall be released:

(1) To the insurer upon extinguishment by reinsurance or otherwise of all liability of the insurer for the security of which the deposit is held;

(2) To the insurer to the extent such deposit is in excess of the amount required; or

(3) Upon proper order of a court of competent jurisdiction, to the receiver, conservator, rehabilitator, or liquidator of the insurer or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

History. — Ga. L. 1887, p. 113, § 4; Civil Code 1895, §§ 2039, 2041; Civil Code 1910, §§ 2423, 2425; Code 1933, §§ 56-323, 56-324; Code 1933, § 56-1108, enacted by Ga. L. 1960, p. 289, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Paragraph (1) of former Code 1933, § 56-1108 (see O.C.G.A. § 33-12-8) and former Code 1933, § 56-310 (see O.C.G.A. 33-3-9) are part of the general scheme of Georgia law to protect Georgia citizens in the collection of just claims against foreign corporations which are dissolved and which have their principal assets in other states. 1965-66 Op. Att'y Gen. 66-25.

Paragraph (1) requires insurer to extinguish liability which may be done by reinsurance. — Paragraph (1) of this section was intended to mean that an insurer, before being allowed to take down its deposits, must extinguish, that is, put an end to all of its liability for the security of which the deposit is held and that, in addition to any other means by which this might be accomplished, it could also be accomplished by the means of reinsurance; to be accomplished by reinsurance would require a reinsurance contract whereby a second insurer is substituted for the first or withdrawing insurer, with the consent of the insured, which, of course, would release the first insurer from all liability to the insured. 1965-66 Op. Att'y Gen. No. 66-25.

If surviving corporation has required amounts on deposit, acquired company's deposits may be released. — Where the surviving company under a merger agreement has on deposit the amounts required by statute for the various classes of insurance which it is licensed to write, the deposit of the acquired company becomes a surplus deposit which is no longer required and may be released. 1958-59 Op. Att'y Gen. p. 198.

33-12-9. Requirement of application and order for release of deposits; liability of Commissioner for release.

No release of deposited funds shall be made except upon application to and the written order of the Commissioner. The Commissioner shall have no liability for any release of any deposit or part of a deposit so made by him in good faith.

History. — Ga. L. 1916, p. 129, § 2; Code 1933, § 56-1113; Code 1933, § 56-1109, enacted by Ga. L. 1960, p. 289, § 1.

33-12-10. Levy upon deposits by claimants.

No judgment creditor or other claimant of an insurer shall levy upon any deposit held pursuant to this title or upon any part of a deposit, except that such levy may be permitted if so specified in the Commis-

sioner's order requiring the deposit pursuant to the retaliatory provision of Code Section 33-3-26.

History. — Code 1933, § 56-1110, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1983, p. 3, § 24.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 29, 103.

33-12-11. Retention of amount to pay judgment in event of occurrence of loss by insured; application for appointment of receiver.

Whenever any loss insured against shall occur, the insured or other person entitled to the proceeds of the policy, by judgment or otherwise, in order to secure his recovery, may give notice to the Commissioner of the occurrence of said loss and of the amount claimed, after which notice the Commissioner shall be bound to retain, subject to the order of a court of competent jurisdiction trying any action that may be brought for the recovery of the loss or any action which may be brought upon any judgment obtained in the courts of another state or the courts of the United States on account of the loss, a sufficient amount to pay the judgment in said case in event of recovery; and, if the amount for which the depositing insurer is liable shall not be paid within 30 days, said plaintiff may file an application with the judge of the superior court of the county where the case was tried for appointment of the Commissioner as receiver to take charge of as many securities as shall be necessary to satisfy the aforesaid judgment.

History. — Ga. L. 1887, p. 113, § 4; Civil Code 1895, § 2036; Ga. L. 1896, p. 58, § 3; Civil Code 1910, §§ 2420, 2559; Code 1933, §§ 56-302, 56-1109; Code 1933, § 56-1111, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Local action necessary for appropriation of deposit. — An action brought in a local court is a condition precedent to the appropriation of the bonds deposited by a foreign insurance corporation to the payment of a fire loss. Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938).

Judgment for loss required to have receiver appointed. — Where one plaintiff had no judgment against an indemnity insurance association doing business in this state, but claimed merely that a judgment had been rendered against the plaintiff for a stated sum and that, although the plaintiff held a policy of insurance issued by the defendant covering such liability, the defendant would not and could not, because of its insolvency, pay the judgment after demand therefor was made, and the other plaintiff had only a judgment against the defendant for legal services rendered, which for a like

reason had not been paid, neither of the plaintiffs was entitled to appointment of a receiver for the defendant, or to a court order requiring all persons claiming under and by reason of policies of indemnity issued by the defendant to intervene in the consolidated cases made by the two plaintiffs, or to an order enjoining all such claimants from prosecuting their claims in any other case or court in this state; accordingly, it was erroneous for the court to deny a motion to modify these restraining orders and permit two other individuals to prosecute their actions against the company which were about to be reached in city court. Carter v. Moyd, 188 Ga. 753, 4 S.E.2d 837 (1939).

Appointment of receiver under section is not suit in equity and does not involve extraordinary remedy. Albright v. American Cent. Ins. Co., 147 Ga. 492, 94 S.E. 561 (1917), later appeal, 21 Ga. App. 583, 94 S.E. 813 (1918).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 107.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

ALR. — Effect of failure to give notice, or delay in giving notice or filing of proofs of loss, upon fidelity bond or insurance, 23 A.L.R.2d 1065.

33-12-12. Proceedings upon appointment of receiver generally.

The Commissioner in his capacity as receiver shall apply to the judge of the superior court for an order of sale and in pursuance of said order shall sell said securities. After deducting any expenses as shall be allowed by the court, he shall pay over to the plaintiff or his attorney a sufficient amount to satisfy the judgment; and, if there shall remain any residue in the hands of the receiver, he shall pay over the same to the agent of the depositing company taking his receipt for the same, which shall be filed and recorded with the other papers in the case. The receipt shall be a complete discharge to the Commissioner.

History. — Ga. L. 1887, p. 113, § 4; Civil Code 1895, § 2037; Civil Code 1910, § 2421; Code 1933, § 56-303; Code 1933, § 56-1112, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

33-12-13. Proceedings upon appointment of receivers for satisfaction of multiple claims.

If receiverships are ordered for the purpose of holding securities for the future satisfaction of more than one claim, the Commissioner shall retain securities deposited by the insurer and apply the securities to the judgments in the order of his appointments as receiver as provided in Code Section 33-12-11. If the receiver determines that the securities the insurer has on deposit are insufficient to cover the claim and if there is another receivership or there are other receiverships in this state

against the same insurer in which distribution has not been completed, the Commissioner shall institute proceedings for a general receivership under Chapter 37 of this title.

History. — Ga. L. 1887, p. 113, § 4; Civil Code 1895, § 2038; Ga. L. 1896, p. 58, § 3; Civil Code 1910, §§ 2422, 2559; Code 1933, §§ 56-304, 56-1109; Code 1933, § 56-1113, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Code 1895, §§ 2035 to 2043 are included in the annotations for this Code section.

Deposit is primarily to secure payment of losses, which have priority. — The primary purpose of the deposit is to secure the payment of fire losses, which are the only losses "insured against," although it also secures, secondarily, other claims arising on policies, such as the repayment, after the termination of the risk, of unearned premiums paid; even when a company becomes insolvent and the deposit is brought into a court of equity for distribution, fire losses are entitled to priority of payment from the fund over claims for unearned premiums. Kelsey v. Cogswell, 112 F. 599 (N.D. Ga. 1901) (decided under former Code 1895, §§ 2035 to 2043); Manufacturing Lumbermen's Underwriters v. South Ga. Ry., 57 Ga. App. 699, 196 S.E. 244 (1938).

33-12-14. Proceeding by Commissioner upon reduction in amount of deposit resulting from occurrence or loss by insured; effect of failure to deposit additional securities.

Whenever, by means of Code Sections 33-12-11 through 33-12-13, the amount of securities so deposited shall be reduced, the Commissioner shall give notice to the insurer depositing and require more securities to be deposited so as always to maintain the original amount; and if the company so notified by the Commissioner shall fail to comply within 30 days, its certificate of authority to do business in this state shall be revoked, and the Commissioner shall at the same time give notice by publication of display advertising in bold type in a newspaper of general circulation throughout the state of the fact of the failure and revocation of certificate of authority. The cost of this publication shall be paid by the company failing to comply with this Code section.

History. — Ga. L. 1887, p. 113, § 4; Civil Code 1895, § 2040; Ga. L. 1896, p. 58, § 3; Civil Code 1910, §§ 2424, 2562; Code 1933, §§ 56-305, 56-1115; Code 1933, § 56-1114, enacted by Ga. L. 1960, p. 289, § 1.

33-12-15. Limitation period for settlement or renewal of claims against deposits of insurers; procedure upon settlement of claims.

Whenever a notice of claim is filed with the Commissioner as provided by law against the deposit of any insurance company doing

business in Georgia and said claim has not been withdrawn at the expiration of seven years from the date of the notice of claim, the Commissioner is authorized to treat the notice as void and not binding unless the notice of claim is renewed within said seven-year period. In the event the Commissioner determines that a claim on which notice has been filed and not released by claimant has been settled or disposed of in any manner, it is authorized to proceed as if the notice of claim had never been filed.

History. — Code 1933, § 56-1115, enacted by Ga. L. 1960, p. 289, § 1.

33-12-16. Effect of order of general receivership.

Whenever a general receivership under Chapter 37 of this title is ordered by a court of this state, it shall supersede receiverships created under Code Sections 33-12-11 through 33-12-13.

History. — Code 1933, § 56-1116, enacted by Ga. L. 1960, p. 289, § 1.

33-12-17. Withdrawal of deposit.

When any depositing company shall desire to withdraw any deposit made with the Commissioner as provided by Code Section 33-12-1, and the Commissioner shall find that the deposit is no longer required, in whole or in part, in order to comply with the laws of this or any other state, he may to that extent release the deposit, and his certificate to that effect shall authorize the state to return the deposit so released to the depositing company. A certificate from the Commissioner or other official authorized to administer the insurance laws of any other state or states showing that the depositing company has fully satisfied or made provision for the full payment and satisfaction of all policy obligations in the other state or states or that such policy obligations in such other state or states have been otherwise adequately provided for shall be sufficient evidence that the deposit is no longer required by the laws of such other state or states; provided, however, that any notice of loss theretofore given in conformity with this law shall remain effective, and the Commissioner shall nevertheless retain securities in an amount sufficient to meet the requirements of Code Sections 33-12-11 and 33-12-12.

History. — Ga. L. 1896, p. 58, § 3; Civil Code 1910, § 2561; Ga. L. 1916, p. 129, § 1; Code 1933, §§ 56-1111, 56-1112; Code 1933, § 56-1117, enacted by Ga. L. 1960, p. 289, § 1.

CHAPTER 13

INSURANCE HOLDING COMPANY SYSTEMS

Article 1

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ARTICLE 1

GENERAL PROVISIONS

Editor's notes. — Ga. L. 2015, p. 608, § 1/SB 108, designated §§ 33-13-1 through 33-13-15 as Article 1.

33-13-1. Definitions.

As used in this article, the term:

(1) "Affiliate," including the term "affiliate of" or "person affiliated with" a specific person, means a person who directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with the person specified.

(2) "Commissioner" means the Commissioner of Insurance, the Commissioner's deputies, or the Department of Insurance, as appropriate.

(3) "Control," including the terms "controlling," "controlled by," and "under common control with," means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position or corporate office held by the person. Control shall be presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by subsection (k) of Code Section 33-13-4 that control does not exist in fact. The Commissioner may determine after furnishing all persons in interest notice and opportunity to be heard and after making specific findings of fact to support such determination that control exists in fact, notwithstanding the absence of a presumption to that effect.

(4) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in Chapter 56 of this title or

would cause the insurer to be in hazardous financial condition based on the standards prescribed by the Commissioner's rules and regulations.

(4.1) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the Commissioner under Code Section 33-13-7.1 to have sufficient significant contacts with an internationally active insurance group.

(5) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

(6) "Insurer" shall have the same meaning as set forth in Code Section 33-1-2, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(6.1) "Internationally active insurance group" means an insurance holding company system that includes an insurer registered under Code Section 33-13-4 and that meets the following criteria:

(A) Premiums written in at least three countries;

(B) The percentage of gross premiums written outside the United States is at least 10 percent of the insurance holding company system's total gross written premiums; and

(C) Based on a three-year rolling average, the total assets of the insurance holding company system are at least $50 billion or the total gross written premiums of the insurance holding company system are at least $10 billion.

(7) "Person" means an individual, a corporation, a limited liability company, a partnership, an association, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert, but shall not include any joint venture partnership exclusively engaged in owning, managing, leasing, or developing real or tangible personal property.

(8) "Subsidiary" means an affiliate controlled by a specified person directly or indirectly through one or more intermediaries.

(9) "Voting security" shall include any security convertible into or evidencing a right to acquire a voting security.

History. — Code 1933, § 56-3401, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108; Ga. L. 2019, p. 337, §§ 1-62, 1-93/SB 132; Ga. L. 2019, p. 1045, § 1/HB 491.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for

"Insurance Department" in paragraph (2); and deleted "Chapter 120-2-54 of" following "standards prescribed by" near the end of paragraph (4). The second 2019 amendment, effective July 1, 2019, added paragraphs (4.1) and (6.1).

33-13-2. Acquisition or organization of subsidiaries by domestic insurers; conduct of business by subsidiaries; investment by insurers in securities of subsidiaries.

(a) Any domestic insurer either by itself or in cooperation with one or more persons may organize or acquire one or more subsidiaries. The subsidiaries may conduct any kind of business or businesses permitted by the Constitution and laws of this state; and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under all other Code sections of this title, a domestic insurer may also:

(1) Invest in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries amounts which do not exceed the lesser of 10 percent of the insurer's assets or 50 percent of the insurer's surplus as regards policyholders, provided that after the investments the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(A) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and

(B) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation;

(2) Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, provided that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations applicable to the insurer as specified in Chapter 11 of this title. For the purpose of this paragraph, "the total investment of the insurer" shall include:

(A) Any direct investment by the insurer in an asset; and

(B) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership of such subsidiary; and

(3) Invest any amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries with the approval of the Commissioner, provided that after the investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(c) Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made pursuant to subsection (b) of this Code section shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in this title applicable to the investments of insurers.

(d) Whether any investment pursuant to subsection (b) of this Code section meets the applicable requirements of that subsection is to be determined before the investment is made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(e) If an insurer ceases to control a subsidiary, it shall dispose of any investment in the subsidiary made pursuant to this Code section within three years from the time of the cessation of control or within any further time as the Commissioner may prescribe unless at any time after the investment shall have been made the investment shall have met the requirements for investment under any other Code section of this title and the insurer notifies the Commissioner that the requirement has been met.

History. — Code 1933, § 56-3402, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 136, § 33; Ga. L. 2013, p. 802, § 1/HB 312.

JUDICIAL DECISIONS

Cited in Hill v. Nelson, 676 F.2d 1371 (11th Cir. 1982).

33-13-3. Acquisition of control of or merger with domestic insurer.

(a) **Filing requirements.**

(1) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if after the consummation of the agreement the person would directly or indirectly or by conversion or by exercise of any right to acquire be in control of the insurer; and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless at the time the offer, request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the Commissioner and has sent to the insurer a statement containing the information required by this Code section and the offer, request, invitation, agreement, or acquisition has been approved by the Commissioner in the manner prescribed in subsection (d) of this Code section.

(2) For the purposes of this Code section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the Commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least 30 days prior to the cessation of control. The Commissioner shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the Commissioner, in his or her discretion, determines that confidential treatment will interfere with enforcement of this Code section. If the statement referred to in paragraph (1) of this subsection is otherwise filed, this paragraph shall not apply.

(3) With respect to a transaction subject to this Code section, the acquiring person must also file a preacquisition notification with the Commissioner, which shall contain the information set forth in paragraph (1) of subsection (c) of Code Section 33-13-3.1. A failure to file the notification may be subject to penalties specified in paragraph (3) of subsection (e) of Code Section 33-13-3.1.

(4) For purposes of this Code section, a "domestic insurer" shall include any person controlling a domestic insurer unless the person, as determined by the Commissioner, is either directly or through its affiliates primarily engaged in business other than the business of insurance. For the purposes of this Code section, "person" shall not

include any securities broker holding, in the usual and customary broker's function, less than 20 percent of the voting securities of an insurance company or of any person which controls an insurance company.

(b) **Execution and content of statement.** The statement to be filed with the Commissioner in accordance with this Code section shall be made under oath or affirmation and shall contain the following information:

(1) The name and address of each person, hereinafter called "acquiring party," by whom or on whose behalf the merger or other acquisition of control referred to in subsection (a) of this Code section is to be effected and:

(A) If the person is an individual, his or her principal occupation and all offices and positions held during the past five years and any conviction of crimes other than minor traffic violations during the past ten years; and

(B) If the person is not an individual, a report of the nature of its business operations during the past five years or for any lesser periods as the person and any predecessors of such person shall have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to the positions. The list shall include for each individual the information required by subparagraph (A) of this paragraph;

(2) The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for that purpose, including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing the consideration; provided, however, that where a source of the consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing the statement so requests;

(3) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each acquiring party or for any lesser period as the acquiring party and any predecessors of the acquiring party shall have been in existence and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement;

(4) Any plans or proposals which each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with

any person, or to make any other material change in its business or corporate structure or management;

(5) The number of shares of any security referred to in subsection (a) of this Code section which each acquiring party proposes to acquire and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (a) of this Code section and a statement as to the method by which the fairness of the proposal was arrived at;

(6) The amount of each class of any security referred to in subsection (a) of this Code section which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(7) A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (a) of this Code section in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies; and the description shall identify the persons with whom the contracts, arrangements, or understandings have been entered into;

(8) A description of the purchase by any acquiring party of any security referred to in subsection (a) of this Code section during the 12 calendar months preceding the filing of the statement by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid;

(9) A description of any recommendations to purchase any security referred to in subsection (a) of this Code section made during the 12 calendar months preceding the filing of the statement by any acquiring party or by anyone based upon interviews or at the suggestion of the acquiring party;

(10) Copies of all tender offers for, requests or invitations for tenders of exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (a) of this Code section and, if distributed, of additional soliciting material relating thereto;

(11) The terms of any agreement, contract, or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) of this Code section for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to the agreement, contract, or understanding;

(12) An agreement by the person required to file the statement referred to in subsection (a) of this Code section that it will provide

the annual report, specified in subsection (l) of Code Section 33-13-4, for so long as control exists;

(13) An acknowledgment by the person required to file the statement referred to in subsection (a) of this Code section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the Commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(14) Any additional information as the Commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (a) of this Code section is a partnership, limited partnership, syndicate, or other group, the Commissioner may require that the information called for by paragraphs (1) through (14) of this subsection shall be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection (a) of this Code section is a corporation, the Commissioner may require that the information called for by paragraphs (1) through (14) of this subsection shall be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation. If any material change occurs in the facts set forth in the statement filed with the Commissioner and sent to the insurer pursuant to this Code section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the Commissioner and sent to the insurer within two business days after the person learns of the change.

(c) **Alternate filing materials.** If any offer, request, invitation, agreement, or acquisition referred to in subsection (a) of this Code section is proposed to be made by means of a registration statement under the Securities Act of 1933, in circumstances requiring the disclosure of similar information, under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (a) of this Code section may utilize the documents in furnishing the information called for by that statement.

(d) **Approval or disapproval by Commissioner; hearings.**

(1) The Commissioner shall approve any merger or other acquisition of control referred to in subsection (a) of this Code section unless, after a public hearing thereon, he or she finds that:

(A) After the change of control the domestic insurer referred to in subsection (a) of this Code section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(B) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly. In applying the competitive standard in this subparagraph:

(i) The informational requirements of paragraph (1) of subsection (c) of Code Section 33-13-3.1 and the standards of paragraph (2) of subsection (d) of Code Section 33-13-3.1 shall apply;

(ii) The merger or other acquisition shall not be disapproved if the Commissioner finds that any of the situations meeting the criteria provided by paragraph (3) of subsection (d) of Code Section 33-13-3.1 exist; and

(iii) The Commissioner may condition the approval of the merger or other acquisition on the removal of the basis of disapproval within a specified period of time;

(C) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer or prejudice the interest of its policyholders;

(D) The plans or proposals which the acquiring party has to liquidate the insurer, to sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(E) The competence, experience, and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(F) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(2) The public hearing referred to in paragraph (1) of this subsection shall be held within 30 days after the statement required by subsection (a) of this Code section is filed; and at least 20 days' notice of the public hearing shall be given by the Commissioner to the person filing the statement. Not less than seven days' notice of the public hearing shall be given by the person filing the statement to the insurer and to any other persons as may be designated by the Commissioner. The Commissioner shall make a determination within

the 60 day period preceding the effective date of the proposed transaction. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in the superior courts of this state. All discovery proceedings shall be concluded not later than three days prior to the commencement of the public hearing.

(3) If the proposed acquisition of control will require the approval of more than one commissioner, the public hearing referred to in paragraph (2) of this subsection may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a) of this Code section. Such person shall file the statement referred to in subsection (a) of this Code section with the National Association of Insurance Commissioners within five days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing and shall provide notice to the applicant of the opt-out within ten days of the receipt of the statement referred to in subsection (a) of this Code section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

(4) In connection with a change of control of a domestic insurer, any determination by the Commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than 60 days after the date of notification of the change in control submitted pursuant to paragraph (1) of subsection (a) of this Code section.

(5) The Commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing the proposed acquisition of control.

(e) **Exemptions.** This Code section shall not apply to any offer, request, invitation, agreement, or acquisition which the Commissioner by order shall exempt from this Code section as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer or as otherwise not comprehended within the purposes of this Code section.

(f) **Violations.** The following shall be violations of this Code section:

(1) The failure to file any statement, amendment, or other material required to be filed pursuant to subsection (a) or (b) of this Code section; or

(2) The effectuation or any attempt to effectuate an acquisition of control of or merger with a domestic insurer unless the Commissioner has given approval to the acquisition of control or merger.

(g) **Jurisdiction; service of process.** The courts of this state are vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the Commissioner under this Code section and over all actions involving that person arising out of violations of this Code section; and each person shall be deemed to have performed acts equivalent to and constituting an appointment by that person of the Commissioner to be his or her true and lawful attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this Code section. Copies of all lawful process shall be served on the Commissioner and transmitted by registered or certified mail or statutory overnight delivery by the Commissioner to the person at his or her last known address.

History. — Code 1933, § 56-3403, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1989, p. 74, §§ 1, 2; Ga. L. 2000, p. 1589, § 3; Ga. L. 2013, p. 802, § 1/HB 312.

Cross references. — Merger and consolidation of corporations generally, §§ 14-2-1101 et seq., 14-3-170 et seq.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1989, a comma was inserted following "agreement is involved" in paragraph (a)(1) and "to" was inserted preceding "sell its assets" in subparagraph (f)(1)(E) (now subparagraph (d)(1)(D)).

Pursuant to Code Section 28-9-5, in 2000, "the" was inserted following "any predecessors of" in paragraph (b)(3).

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

U.S. Code. — The Securities Act of 1933, referred to in subsection (c) of this Code section, is codified as 15 U.S.C. § 77a et seq.

The Securities Exchange Act of 1934, referred to in subsection (c) of this Code section, is codified as 15 U.S.C. § 78a et seq.

OPINIONS OF THE ATTORNEY GENERAL

Statement required upon acquisition of foreign insurer with Georgia subsidiary. — Even if the target parent is determined not to be a domestic insurer, the buyer must file a statement as to the Georgia insurer subsidiary. 1984 Op. Att'y Gen. No. 84-65.

Exemption from filing and approval requirements. — When 86 percent of the total revenues of the target parent's business is in noninsurance related fields, the target parent is not a domestic insurer within the meaning of paragraph (a)(2) of O.C.G.A. § 33-13-3 since it is primarily engaged in business other than the business of insurance and therefore buyer would not be required to file information and seek prior approval

pursuant to paragraph (a)(1) on the target parent. 1984 Op. Att'y Gen. No. 84-65.

"Domestic insurer." — Paragraph (a)(2) of O.C.G.A. § 33-13-3 does not provide an exemption from the filing and approval requirements of paragraph (a)(1). It does not authorize exemptions of any kind but is merely a definitional provision which expands the class of potential domestic insurers subject to the filing and approval requirements of paragraph (a)(1). 1984 Op. Att'y Gen. No. 84-65.

33-13-3.1. Acquisition of insurer; effect on competition.

(a) As used in this Code section, the term:

(1) "Acquisition" means any agreement, arrangement, or activity, the consummation of which results in a person acquiring directly or indirectly the control of another person and, includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance, and mergers.

(2) "Involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

(b)(1) Except as exempted in paragraph (2) of this subsection, this Code section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state.

(2) This Code section shall not apply to the following:

(A) A purchase of securities solely for investment purposes so long as such securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under paragraph (3) of Code Section 33-13-1, it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and such disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the Commissioner of this state;

(B) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the Commissioner in accordance with paragraph (1) of subsection (c) of this Code section 30 days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this Code section if the acquisition would otherwise be excluded from this Code section by any other subparagraph of this paragraph;

(C) The acquisition of already affiliated persons;

(D) An acquisition if, as an immediate result of the acquisition:

(i) In no market would the combined market share of the involved insurers exceed 5 percent of the total market;

(ii) There would be no increase in any market share; or

(iii) In no market would:

(I) The combined market share of the involved insurers exceed 12 percent of the total market; and

(II) The market share increase by more than 2 percent of the total market.

For the purpose of this subparagraph, the term "market" means a direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(E) An acquisition for which a preacquisition notification would be required pursuant to this Code section due solely to the resulting effect on the ocean marine insurance line of business; or

(F) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that such insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving such insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and such findings are communicated by the domiciliary commissioner to the Commissioner of this state.

(c) An acquisition covered by subsection (b) of this Code section may be subject to an order pursuant to subsection (e) of this Code section unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The Commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in Code Section 33-13-8:

(1) The preacquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner relating to those markets which, under subparagraph (b)(2)(D) of this Code section, cause the acquisition not to be exempted from the provisions of this Code section. The Commissioner may require such additional material and information as he or she deems necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (d) of this Code section. The required information may include an opinion of an economist as to the competitive impact of the

acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion; and

(2) The waiting period required shall begin on the date of receipt of the Commissioner of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of such receipt or termination of the waiting period by the Commissioner. Prior to the end of the waiting period, the Commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of such additional information by the Commissioner or termination of the waiting period by the Commissioner.

(d)(1) The Commissioner may enter an order under paragraph (1) of subsection (e) of this Code section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein or if the insurer fails to file adequate information in compliance with subsection (c) of this Code section.

(2) In determining whether a proposed acquisition would violate the competitive standard of paragraph (1) of this subsection, the Commissioner shall consider the following:

(A) Any acquisition covered under subsection (b) of this Code section involving two or more insurers competing in the same market is prima-facie evidence of violation of the competitive standards:

(i) If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4 percent	4 percent or more
10 percent	2 percent or more
15 percent	1 percent or more; or

(ii) If the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5 percent	5 percent or more
10 percent	4 percent or more
15 percent	3 percent or more
19 percent	1 percent or more

A highly concentrated market is one in which the share of the four largest insurers is 75 percent or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two insurers are involved, exceeding the total of the two columns in the table is prima-facie evidence of violation of the competitive standard in paragraph (1) of this subsection. For the purpose of this subparagraph, the insurer with the largest share of the market shall be deemed to be Insurer A;

(B) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by 7 percent or more of the market over a period of time extending from any base year five to ten years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection (b) of this Code section involving two or more insurers competing in the same market is prima-facie evidence of violation of the competitive standard in paragraph (1) of this subsection if:

(i) There is a significant trend toward increased concentration in the market;

(ii) One of the insurers involved is one of the insurers in a grouping of such large insurers showing the requisite increase in the market share; and

(iii) Another involved insurer's market is 2 percent or more;

(C) For the purposes of this paragraph:

(i) The term "insurer" includes any company or group of companies under common management, ownership, or control;

(ii) The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the Commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the National Association of Insurance Commissioners and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state; and

(iii) The burden of showing prima-facie evidence of violation of the competitive standard rests upon the Commissioner; and

(D) Even though an acquisition is not prima-facie violative of the competitive standard under subparagraphs (A) and (B) of this paragraph, the Commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima-facie violative of the competitive standard under subparagraphs (A) and (B) of this paragraph, a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this paragraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry into the market and exit from the market.

(3) An order may not be entered under paragraph (1) of subsection (e) of this Code section if:

(A) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(B) The acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

(e)(1)(A) If an acquisition violates the standards of this Code section, the Commissioner may enter an order:

(i) Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

(ii) Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(B) Such an order shall not be entered unless:

(i) There is a hearing;

(ii) Notice of such hearing is issued prior to the end of the waiting period and not less than 15 days prior to the hearing; and

(iii) The hearing is concluded and the order is issued no later than 60 days after the end of the waiting period. Every order shall be accompanied by a written decision of the Commissioner setting forth his or her findings of fact and conclusions of law.

(C) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(2) Any person who violates a cease and desist order of the Commissioner under paragraph (1) of this subsection and while such order is in effect may after notice and hearing and upon order of the Commissioner, be subject, at the discretion of the Commissioner, to any one or more of the following:

(A) A monetary penalty of not more than $10,000.00 for every day of violation; or

(B) Suspension or revocation of such person's license.

(3) Any insurer or other person who fails to make any filing required by this subsection and who also fails to demonstrate a good faith effort to comply with any such filing requirement shall be subject to a fine of not more than $50,000.00.

(f) Subsections (b) and (c) of Code Section 33-13-10 and Code Section 33-13-12 shall not apply to acquisitions covered under this Code section.

History. — Code 1981, § 33-13-3.1, enacted by Ga. L. 1991, p. 1424, § 5; Ga. L. 2000, p. 136, § 33; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2019, p. 337, § 1-64/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner" in the first sentence of paragraph (c)(1).

Editor's notes. — Ga. L. 1991, p. 1424, § 9/SB 347, not codified by the General Assembly, contained inconsistencies in references to the sections of the bill due to differences in the section numbers contained in the Senate version of the bill and the final version of the bill. Subsection (c) of Section 9 referred to this Code section in the Senate version of SB 347 and provides as follows: "Section 3 and 4 of this Act shall apply to transactions between affiliates or subsidiaries taking place on or after July 1, 1991."

Law reviews. — For note on 1991 enactment of this Code section, see 8 Ga. St. U.L. Rev. 89 (1992).

33-13-4. Registration of insurers belonging to holding company systems.

(a) **Requirement of registration generally.** Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the Commissioner, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained:

(1) In this Code section;

(2) In paragraph (1) of subsection (a), subsection (b), and subsection (d) of Code Section 33-13-5; and

(3) In either paragraph (2) of subsection (a) of Code Section 33-13-5 or a provision such as the following: "Each registered insurer shall keep current the information required to be disclosed in its registra-

tion statement by reporting all material changes or additions within 15 days after the end of the month in which it learns of each change or addition."

Any insurer which is subject to registration under this Code section shall register within 15 days after it becomes subject to registration and annually thereafter by April 30 of each year for the previous calendar year, unless the Commissioner for good cause shown extends the time for registration, and then within the extended time. The Commissioner may require any insurer authorized to do business in this state which is a member of an insurance holding company system, and which is not subject to registration under this Code section, to furnish a copy of the registration statement, the summary specified in subsection (c) of this Code section, or other information filed by the insurance company with the insurance regulatory authority of its domiciliary jurisdiction.

(b) **Contents of registration statement.** Every insurer subject to registration shall file a registration statement with the Commissioner on a form and in a format prescribed by the National Association of Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner, which statement shall contain current information about:

(1) The capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(2) The identity of every member of the insurance holding company system;

(3) The following agreements in force, relationships subsisting, and transactions outstanding between such insurer and its affiliates:

(A) Loans, other investments, or purchases, sales, or exchanges of the affiliates by the insurer or of the insurer by its affiliates;

(B) Purchases, sales, or exchanges of assets;

(C) Transactions not in the ordinary course of business;

(D) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) All management and service contracts and all cost-sharing arrangements;

(F) Reinsurance agreements;

(G) Dividends and other distributions to shareholders; and

(H) Consolidated tax allocation agreements;

(4) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(5) If requested by the Commissioner, financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the federal Securities and Exchange Commission pursuant to the federal Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the Commissioner with the most recently filed parent corporation financial statements filed with the Securities and Exchange Commission;

(6) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the Commissioner;

(7) Statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures; and

(8) Any other information required by the Commissioner by rule or regulation.

(c) **Summary of changes to registration statement.** All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(d) **Disclosure of nonmaterial information.** No information need be disclosed on the registration statement filed pursuant to subsection (b) of this Code section if the information is not material for the purposes of this Code section. Unless the Commissioner by rule, regulation, or order provides otherwise, sales, purchases, exchanges, loans, extensions of credit, or investments involving one-half of 1 percent or less of an insurer's admitted assets as of December 31 of the preceding year shall not be deemed material for purposes of this Code section.

(e) **Reporting dividends to shareholders.** Subject to subsection (b) of Code Section 33-13-5, each registered insurer shall report to the Commissioner all dividends and other distributions to shareholders within 15 business days following the declaration thereof.

(f) **Information of insurers.** Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this article.

(g) **Termination of registration.** The Commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(h) **Filing of consolidated registration.** The Commissioner may require or allow two or more affiliated insurers subject to registration under this Code section to file a consolidated registration statement.

(i) **Filing of registration for affiliated insurer.** The Commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (a) of this Code section and to file all information and material required to be filed under this Code section.

(j) **Exemptions.** This Code section shall not apply to any insurer, information, or transaction if and to the extent that the Commissioner by rule, regulation, or order shall exempt the same from this Code section.

(k) **Filing of disclaimer.** Any person may file with the Commissioner a disclaimer of affiliation with any authorized insurer or the disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the persons and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the Commissioner, within 30 days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this Code section if approval of the disclaimer has been granted by the Commissioner, or if the disclaimer is deemed to have been approved.

(l) **Enterprise risk filing.** The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of

Insurance Commissioners and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner.

(m) **Violations.** The failure to file a registration statement or any amendment to the registration statement required by this Code section within the time specified for the filing shall be a violation of this Code section.

History. — Code 1933, § 56-3404, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1993, p. 625, § 1; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108; Ga. L. 2019, p. 337, § 1-65/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (b), inserted "and adopted by regulation promulgated by the Commissioner or as otherwise prescribed by regulation promulgated by the Commissioner" in the introductory paragraph, deleted "currently" following "and transactions" in the introductory language of paragraph (b)(3), and, in paragraph (b)(5), inserted a comma following "may include" and following "not limited to" in the first sentence and deleted "that have been" following "corporation financial statements" in the last sentence; and added the language following "National Association of Insurance Commissioners" at the end of subsection (l).

33-13-5. Standards governing transactions by registered insurers with affiliates generally; extraordinary distributions; adequacy of surplus.

(a)(1) Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(A) The terms shall be fair and reasonable;

(B) Agreements for cost sharing services and management shall include such provisions as required by the Commissioner by rule or regulation;

(C) Charges or fees for services performed shall be reasonable;

(D) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(E) The books, accounts, and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(F) The insurer's surplus with regard to policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions involving a domestic insurer and any person in its holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this Code section, which are subject to any materiality standards contained in subparagraphs (A) through (G) of this paragraph, may not be entered into unless the insurer has notified the Commissioner in writing of its intention to enter into such transaction at least 30 days prior thereto, or such shorter period as the Commissioner may permit, and the Commissioner has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within 30 days after a termination of a previously filed agreement, to the Commissioner for determination of the type of filing required, if any:

(A) Sales, purchases, exchanges, loans or extensions of credit, guarantees, or investments, provided such transactions are equal to or exceed: with respect to nonlife insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders; or with respect to life insurers, 3 percent of the insurer's admitted assets; each as of December 31 next preceding;

(B) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extensions of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in any affiliate of the insurer making such loans or extensions of credit to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit, provided such transactions are equal to or exceed: with respect to nonlife insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus with regard to policyholders; or with respect to life insurers, 3 percent of the insurer's admitted assets; each as of December 31 next preceding;

(C) Reinsurance agreements or modifications thereto, including:

(i) All reinsurance pooling agreements; and

(ii) Agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three years, equals or exceeds 5 percent of the insurer's surplus with regard to policyholders, as of December 31 next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and

nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(D) All management agreements, service contracts, tax allocation agreements, guarantees, and all cost-sharing agreements;

(E) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of 1 percent of the insurer's admitted assets or 10 percent of surplus as regards policyholders as of December 31 next preceding. Further, all guarantees which are not quantifiable as to amount are subject to the notice requirements of this paragraph;

(F) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an agreement which, together with its present holdings in such investments, exceeds 2 1/2 percent of the insurer's surplus to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Code Section 33-13-2 or authorized under any other Code section of this title, or in nonsubsidiary insurance affiliates that are subject to the provisions of this article, are exempt from this requirement; and

(G) Any material transactions, specified by regulation, which the Commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing contained in this paragraph shall be deemed to authorize or permit any transactions which, in the case of an insurer that is not a member of the same holding company system, would be otherwise contrary to law.

(3) A domestic insurer may not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would occur otherwise. If the Commissioner determines that such separate transactions were entered into over any 12 month period for such purpose, the Commissioner may exercise his or her authority under Code Section 33-13-11.

(4) The Commissioner, in reviewing transactions pursuant to paragraph (2) of this subsection, shall consider whether the transactions comply with the standards set forth in paragraph (1) of this subsection and whether they may adversely affect the interests of policyholders.

(5) The Commissioner shall be notified within 30 days of any investment of the domestic insurer in any one corporation if the total

investment in such corporation by the insurance holding company system exceeds 10 percent of such corporation's voting securities.

(b)(1) No domestic insurer shall apply any extraordinary dividend or make any other extraordinary distribution to its shareholders until 30 days after the Commissioner has received notice of the declaration thereof and has not within such period disapproved such payment, or until the Commissioner has approved such payment within such 30 day period.

(2) For the purposes of this subsection, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the greater of 10 percent of such insurer's surplus with regard to policyholders as of December 31 next preceding, or the net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the 12 month period ending December 31 next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

(3) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(4) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the Commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until the Commissioner has approved the payment of such a dividend or distribution or the Commissioner has not disapproved such payment within the 30 day period referred to in paragraph (1) of this subsection.

(c) For purposes of this article, in determining whether an insurer's surplus with regard to policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(1) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(2) The extent to which the insurer's business is diversified among the several lines of insurance;

(3) The number and size of risks insured in each line of business;

(4) The extent of the geographical dispersion of the insurer's insured risks;

(5) The nature and extent of the insurer's reinsurance program;

(6) The quality, diversification, and liquidity of the insurer's investment portfolio;

(7) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(8) The surplus with regard to policyholders maintained by other comparable insurers;

(9) The adequacy of the insurer's reserves; and

(10) The quality and liquidity of investments in affiliates. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus with regard to policyholders whenever in the judgment of the Commissioner the investment so warrants.

History. — Code 1933, § 56-3405, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1975, p. 1238, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1991, p. 1424, § 6; Ga. L. 1993, p. 625, § 2; Ga. L. 2000, p. 136, § 33; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108; Ga. L. 2019, p. 869, § 3/HB 277.

The 2019 amendment, effective July 1, 2019, substituted "exceeds the greater" for "exceeds the lesser" in the middle of paragraph (b)(2).

Editor's notes. — Ga. L. 1991, p. 1424, § 9/SB 397, not codified by the General Assembly, contained inconsistencies in references to the sections of the bill due to differences in the section numbers contained in the Senate version of the bill and the final version of the bill. Subsection (d) of Section 9 refers to Chapters 47, 48, and 49 of Title 33 in the Senate version of SB 347. Subsection (c) of Section 9 refers to Code Section 33-13-3.1 and this Code section in the Senate version of SB 347 and provides as follows: "Sections 3 and 4 of this Act shall apply to transactions between affiliates or subsidiaries taking place on or after July 1, 1991."

Law reviews. — For note on 1991 amendment of this Code section, see 8 Ga. St. U.L. Rev. 89 (1992).

JUDICIAL DECISIONS

Cited in State Farm Mut. Auto. Ins. Co. v. Hubbell Metals, Inc., 161 Ga. App. 275, 287 S.E.2d 726 (1982); Georgia Farm Bureau Mut. Ins. Co. v. Alterman Foods, Inc., 161 Ga. App. 695, 289 S.E.2d 537 (1982).

33-13-6. Powers of Commissioner to examine insurers; access to books and records; use of experts and consultants; payment of expenses; compelling production.

(a) **Powers of Commissioner.** Subject to the limitation contained in this Code section and in addition to the powers which the Commissioner has under this title relating to the examination of insurers, the

Commissioner shall have the power to examine any insurer registered under Code Section 33-13-4 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(b) **Access to books and records.**

(1) The Commissioner may order any insurer registered under Code Section 33-13-4 to produce such records, books, or other information in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this article.

(2) To determine compliance with this article, the Commissioner may order any insurer registered under Code Section 33-13-4 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the Commissioner, the insurer shall provide the Commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the Commissioner that the detailed explanation is without merit, the Commissioner may require, after notice and hearing, the insurer to pay a penalty of $1,000.00 for each day's delay, or may suspend or revoke the insurer's license.

(c) **Use of consultants.** The Commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as shall be reasonably necessary to assist in the conduct of the examination under subsection (a) of this Code section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(d) **Expenses.** Each registered insurer producing for examination records, books, and papers pursuant to subsection (a) of this Code section shall be liable for and shall pay the expense of the examination in accordance with Code Section 33-2-15.

(e) **Compelling production.** In the event the insurer fails to comply with an order, the Commissioner shall have the power to examine the affiliates to obtain the information. The Commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this subsection. Upon the failure or refusal of any person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order

compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in superior court, which fees, mileage, and actual expense, if any, necessarily incurred in securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

History. — Code 1933, § 56-3406, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1992, p. 2725, § 18; Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

33-13-7. Power of Commissioner to participate in supervisory college; payment of expenses associated with participation in supervisory college.

(a) **Power of Commissioner.** With respect to any insurer registered under Code Section 33-13-4, and in accordance with subsection (c) of this Code section, the Commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this title. For purposes of this chapter, "supervisory colleges" means a forum for cooperation and communication between the involved supervisors established for the fundamental purpose of facilitating the effectiveness of the supervision of entities belonging to an insurance group. The powers of the Commissioner with respect to supervisory colleges include, but are not limited to, the following:

(1) Initiating the establishment of a supervisory college;

(2) Clarifying the membership and participation of other supervisors in the supervisory college;

(3) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(4) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(5) Establishing a crisis management plan.

(b) **Expenses.** Each registered insurer subject to this Code section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in a supervisory college in accordance with subsection (c) of this Code section, including reasonable travel

expenses. For purposes of this Code section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the Commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(c) **Supervisory college.** In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Code Section 33-13-6, the Commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal, and international regulatory agencies. The Commissioner may enter into agreements in accordance with subsection (c) of Code Section 33-13-8 providing the basis for cooperation between the Commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this Code section shall delegate to the supervisory college the authority of the Commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

History. — Code 1981, § 33-13-7, enacted by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2019, p. 337, § 1-66/SB 132.

The 2019 amendment, effective July 1, 2019, added the second sentence in subsection (a).

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-7 as present Code Section 33-13-8.

33-13-7.1. Supervisors for internationally active insurance group; activities of supervisors; cooperation; entering into agreements; obtaining documentation; regulatory authority; payment of expenses.

(a) The Commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this Code section. However, the Commissioner may acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(1) Does not have substantial insurance operations in the United States;

(2) Has substantial insurance operations in the United States but not in this state; or

(3) Has substantial insurance operations in the United States and this state, but the Commissioner has determined pursuant to the factors set forth in subsections (b) and (f) of this Code section that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the Commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this Code section.

(b) In cooperation with other state, federal, and international regulatory agencies, the Commissioner shall identify a single group-wide supervisor for an internationally active insurance group. The Commissioner may determine that he or she is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the Commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for an internationally active insurance group. The Commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

(1) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(2) The place of domicile of the top-tiered insurer or insurers in the insurance holding company system of the internationally active insurance group;

(3) The location of the executive offices or largest operational offices of the internationally active insurance group;

(4) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the Commissioner determines to be:

(A) Substantially similar to the system of regulation provided under the laws of this state; or

(B) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(5) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the Commissioner with reasonably reciprocal recognition and cooperation.

The Commissioner acting as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in paragraphs (1) through (5) of this subsection, in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of the members of the internationally active insurance

group, and in consultation with the internationally active insurance group.

(c) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the Commissioner shall acknowledge such regulatory official as the group-wide supervisor. In the event of a material change in the internationally active insurance group that results in such group's insurers domiciled in this state holding the largest share of the group's premiums, assets, or liabilities or that results in this state being the place of domicile of the top tiered insurer or insurers in the insurance holding company system of the internationally active insurance group, the Commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such internationally active insurance group pursuant to subsection (b) of this Code section.

(d) Pursuant to Code Section 33-13-6, the Commissioner is authorized to collect from any insurer registered pursuant to Code Section 33-13-4 all information necessary to determine whether the Commissioner may act as the group-wide supervisor of an internationally active insurance group or if the Commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the Commissioner, the Commissioner shall notify the insurer registered pursuant to Code Section 33-13-4 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than 30 days to provide the Commissioner with additional information pertinent to the pending determination. The Commissioner shall publish in a newspaper having general state-wide circulation and on its internet website the identity of internationally active insurance groups that the Commissioner has determined are subject to group-wide supervision by the Commissioner.

(e) If the Commissioner is the group-wide supervisor for an internationally active insurance group, the Commissioner is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

(A) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(B) Reasonable and effective mitigation measures are in place;

(2) Request from any member of such group information necessary and appropriate to assess enterprise risk, including, but not limited

to, information about the members of the internationally active insurance group regarding:

(A) Governance, risk assessment, and management;

(B) Capital adequacy; and

(C) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of Code Section 33-13-8 through supervisory colleges as set forth in Code Section 33-13-7 or otherwise;

(5) Enter into agreements with or obtain documentation from any insurer registered under Code Section 33-13-4, any member of the internationally active insurance group, and any other state, federal, and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the Commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(6) Other group-wide supervision activities consistent with the authorities and purposes enumerated in this subsection as deemed necessary by the Commissioner.

(f) If the Commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the Commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by such group-wide supervisor, provided that:

(1) The Commissioner's cooperation is in compliance with the laws of this state; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the Commissioner's activ-

ities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the Commissioner is authorized to refuse recognition and cooperation.

(g) The Commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Code Section 33-13-4, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(h) The Commissioner may promulgate rules and regulations necessary for the administration of this Code section.

(i) A registered insurer subject to this Code section shall be liable for and shall pay the reasonable expenses of the Commissioner's participation in the administration of this Code section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

History. — Code 1981, § 33-13-7.1, enacted by Ga. L. 2019, p. 1045, § 2/HB 491. **Effective date.** — This Code section became effective July 1, 2019.

33-13-8. Confidentiality of information and documents obtained during examinations or investigations; sharing certain information; not delegation of regulatory authority or rule making; responsibility for enforcement.

(a) Documents, materials, or other information in the possession or control of the department that are obtained by or disclosed to the Commissioner or any other person in the course of an examination or investigation made pursuant to Code Section 33-13-6 and all information reported or provided to the department pursuant to paragraphs (12) and (13) of subsection (b) of Code Section 33-13-3 and Code Sections 33-13-4, 33-13-5, and 33-13-7.1 shall be confidential by law and privileged, shall not be subject to public disclosure under Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which it pertains unless the Commissioner, after giving the insurer and its affiliates that would be affected thereby notice and opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in

which event the Commissioner may publish all or any part in such manner as may be deemed appropriate.

(b) Neither the Commissioner nor any person who received documents, materials, or other information while acting under the authority of the Commissioner or with whom such documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or other information subject to subsection (a) of this Code section.

(c) In order to assist in the performance of the Commissioner's duties, the Commissioner:

(1) May share documents, materials, or other information, including the confidential and privileged documents, materials, or other information subject to subsection (a) of this Code section, with other state, federal, and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities, including members of any supervisory college described in Code Section 33-13-7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material, or other information and has verified in writing the legal authority to maintain confidentiality;

(2) Notwithstanding paragraph (1) of this subsection, may only share confidential and privileged documents, materials, or other information reported pursuant to subsection (l) of Code Section 33-13-4 with commissioners of states having statutes or regulations substantially similar to subsection (a) of this Code section and who have agreed in writing not to disclose such information;

(3) May receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information from the National Association of Insurance Commissioners and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material, or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or other information; and

(4) Shall enter into written agreements with the National Association of Insurance Commissioners governing sharing and use of information provided pursuant to this article consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Associa-

tion of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state, federal, and international regulatory agencies;

(B) Specify that ownership of information shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article remains with the Commissioner and that the National Association of Insurance Commissioners' use of the information is subject to the direction of the Commissioner;

(C) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners pursuant to this article is subject to a request or subpoena to the National Association of Insurance Commissioners for disclosure or production; and

(D) Require the National Association of Insurance Commissioners and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners and its affiliates and subsidiaries pursuant to this article.

(d) The sharing of information by the Commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rule making, and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner under this Code section or as a result of sharing as authorized in subsection (c) of this Code section.

(f) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners pursuant to this article shall be confidential by law and privileged, shall not be subject to the open records laws, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

History. — Code 1933, § 56-3407, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-7; Code 1981, § 33-13-8, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108; Ga. L. 2019, p. 1045, § 3/HB 491.

The 2019 amendment, effective July 1, 2019, in subsection (a), in the first sentence, inserted "or provided to the department" in the middle and substituted "Code Section 33-13-3 and Code Sections 33-13-4, 33-13-5, and 33-13-7.1" for "Code

Section 33-13-3, Code Section 33-13-4, and Code Section 33-13-5".

Cross references. — Privileged communications generally, § 24-5-506.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-8 as present Code Section 33-13-9.

Administrative rules and regulations. — Insurance holding company regulations, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-23.

JUDICIAL DECISIONS

Cited in Georgia Farm Bureau Mut. Ins. Co. v. Fireman's Fund Ins. Co., 161 Ga. App. 276, 288 S.E.2d 263 (1982).

33-13-9. Rules and regulations and orders.

The Commissioner may, upon notice and opportunity for all interested persons to be heard, issue any rules, regulations, and orders as shall be necessary to carry out this article.

History. — Code 1933, § 56-3408, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-8; Code 1981, § 33-13-9, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-8 as present Code Section 33-13-9 and redesignated former Code Section 33-13-9 as present Code Section 33-13-10.

33-13-10. Injunctions; seizure or sequestration of voting securities.

(a) **Injunctions.** Whenever it appears to the Commissioner that any insurer or any director, officer, employee, or agent of any insurer has committed or is about to commit a violation of this article or of any rule, regulation, or order issued by the Commissioner under this article, the Commissioner may apply to the superior court of the county in which the principal office of the insurer is located or, if the insurer has no such office in this state, to the Superior Court of Fulton County for an order enjoining the insurer or the director, officer, employee, or agent of such insurer from violating or continuing to violate this article or any rule, regulation, or order and for any other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

(b) **Voting of securities; when prohibited.** No security which is the subject of any agreement or arrangement regarding acquisition or which is acquired or to be acquired in contravention of this article or of any rule, regulation, or order issued by the Commissioner under this article may be voted at any shareholders' meeting or counted for quorum purposes; and any action of shareholders requiring the affir-

mative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the Commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of this article or of any rule, regulation, or order issued by the Commissioner under this article, the insurer or the Commissioner may apply to the Superior Court of Fulton County or to the superior court of the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of Code Section 33-13-3 or any rule, regulation, or order issued by the Commissioner under Code Section 33-13-3 to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders, and for any other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

(c) **Sequestration of voting securities.** In any case in which a person has acquired or is proposing to acquire any voting securities in violation of this article or any rule, regulation, or order issued by the Commissioner under this article, the Superior Court of Fulton County or the superior court of the county in which the insurer has its principal place of business, on any notice as the court deems appropriate and upon the application of the insurer or the Commissioner, may seize or sequester any voting securities of the insurer owned directly or indirectly by the person and issue such orders with respect to the seizure or sequestration as may be appropriate to effectuate this article. Notwithstanding any other provisions of law, for the purposes of this article the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

History. — Code 1933, § 56-3409, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-9; Code 1981, § 33-13-10, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

Editor's notes. — Ga. L. 2013, p. 812, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-9 as present Code Section 33-13-10.

This Code section formerly pertained to institution of criminal proceedings. The former Code section was based on Code 1933, § 56-3410, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 2000, p. 136, § 33.

33-13-11. Violations of this article.

(a) Any insurer failing, without just cause, to file any registration statement as required in this article shall be required, after notice and hearing, to pay a penalty of $1,000.00 for each day's delay. The maximum penalty under this Code section is $50,000.00. The Commis-

sioner may reduce the penalty if the insurer demonstrates to the Commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(b) Every director or officer of an insurance holding company system who knowingly violates, participates in, or assents to or who knowingly shall permit any of the officers or agents of the insurer to engage in transactions or make investments which have not been properly reported or submitted pursuant to subsection (a) of Code Section 33-13-4, paragraph (2) of subsection (a) of Code Section 33-13-5, or subsection (b) of Code Section 33-13-5, or which violate this article, shall pay, in their individual capacity, a civil forfeiture of not more than $50,000.00 per violation, after notice and hearing before the Commissioner. In determining the amount of the civil forfeiture, the Commissioner shall take into account the appropriateness of the forfeiture with respect to the gravity of the violation, the history of previous violations, and such other matters as justice may require.

(c) Whenever it appears to the Commissioner that any insurer subject to this article or any director, officer, employee, or agent thereof has engaged in any transaction or entered into a contract which is subject to Code Section 33-13-5 and which would not have been approved had the approval been requested, the Commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the Commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of its policyholders, creditors, or the public.

(d) Whenever it appears to the Commissioner that any insurer or any director, officer, employee, or agent thereof has committed a willful violation of this article, the Commissioner may cause criminal proceedings to be instituted by the Superior Court of Fulton County against the insurer or the responsible director, officer, employee, or agent thereof. Any insurer which willfully violates this article may be fined not more than $100,000.00. Any individual who willfully violates this article may be fined in his or her individual capacity not more than $100,000.00 or be imprisoned for not more than one to three years, or both.

(e) Any officer, director, or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the Commissioner in the performance of his or her duties under this article upon conviction shall be imprisoned for not more than three years or fined $100,000.00, or both. Any fines imposed shall be paid by the officer, director, or employee in his or her individual capacity.

(f) Whenever it appears to the Commissioner that any person has committed a violation of Code Section 33-13-3 and which prevents the

full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with Code Section 33-3-18.

History. — Code 1981, § 33-13-11, enacted by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-11 as present Code Section 33-13-12.

33-13-12. Receivership.

Whenever it appears to the Commissioner that any person has committed a violation of this article which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, the Commissioner may proceed as provided in Chapter 37 of this title to take possession of the property of the domestic insurer and to conduct the business of the domestic insurer.

History. — Code 1933, § 56-3411, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-11; Code 1981, § 33-13-12, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-11 as present Code Section 33-13-12 and redesignated former Code Section 33-13-12 as present Code Section 33-13-13.

33-13-13. Revocation, suspension, or nonrenewal of license or authority to do business.

Whenever it appears to the Commissioner that any person has committed a violation of this article which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the Commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke, or refuse to renew the insurer's license or authority to do business in this state for any period as he or she finds is required for the protection of policyholders or the public. Any determination shall be accompanied by specific findings of fact and conclusions of law.

History. — Code 1933, § 56-3412, enacted by Ga. L. 1970, p. 257, § 1; Code 1981, § 33-13-12; Code 1981, § 33-13-13, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

Cross references. — Hearings before Commissioner generally, § 33-2-16 et seq.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-13 as present Code Section 33-13-14.

33-13-14. Recovery by receiver of distributions paid in event of liquidation, rehabilitation, or conservation of insurer.

(a) If an order for the liquidation, rehabilitation, or conservation of an insurer authorized to do business in this state is entered under Chapter 37 of this title, the receiver appointed under the order shall have a right to recover on behalf of the insurer (i) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement, or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one year preceding the petition for liquidation, conservation, or rehabilitation, as the case may be, subject to the limitations of subsections (b), (c), and (d) of this Code section.

(b) No distribution shall be recoverable if that insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill the obligations to claimants under its insurance contracts.

(c)(1) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments under subsection (a) of this Code section which the person received.

(2) Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he or she would have received if they had been paid immediately.

(3) If under paragraphs (1) and (2) of this subsection two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this Code section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this Code section is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered

from the parent corporation or holding company or person who otherwise controlled it.

History. — Code 1933, § 56-3411.1, enacted by Ga. L. 1975, p. 1238, § 2; Code 1981, § 33-13-13; Code 1981, § 33-13-14, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-14 as present Code Section 33-13-15.

33-13-15. Aggrieved persons; appeal of actions of Commissioner; mandamus.

(a) Any person aggrieved by any act, determination, rule, regulation, or order or any other action of the Commissioner pursuant to this article may appeal the action to the Superior Court of Fulton County. The court shall conduct its review without a jury and by trial de novo, except that, if all parties including the Commissioner so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

(b) The filing of an appeal pursuant to this Code section shall stay the application of any such rule, regulation, order, or other action of the Commissioner to the appealing party unless the court, after giving the party notice and an opportunity to be heard, determines that such a stay would be detrimental to the interests of policyholders, shareholders, creditors, or the public.

(c) Any person aggrieved by any failure of the Commissioner to act or make a determination required by this article may petition the Superior Court of Fulton County for a writ in the nature of a mandamus or a peremptory mandamus directing the Commissioner to act or make the determination immediately.

History. — Code 1933, § 56-3413, enacted by Ga. L. 1970, p. 257, § 1; Ga. L. 1982, p. 3, § 33; Code 1981, § 33-13-14; Code 1981, § 33-13-15, as redesignated by Ga. L. 2013, p. 802, § 1/HB 312; Ga. L. 2015, p. 608, § 3/SB 108.

Cross references. — Judicial review of actions of Commissioner generally, § 33-2-26 et seq.

Editor's notes. — Ga. L. 2013, p. 802, § 1/HB 312, effective July 1, 2013, redesignated former Code Section 33-13-14 as present Code Section 33-13-15.

This Code section formerly pertained to penalty for willful violation of this chapter by insurers and individuals and was based on Code 1933, § 56-3410, enacted by Ga. L. 1970, p. 257, § 1.

ARTICLE 2

OWN RISK AND SOLVENCY ASSESSMENT REPORT

33-13-30. Confidential and sensitive information within Own Risk and Solvency Assessment Summary Report; legislative intent.

(a) The General Assembly finds and declares that an Own Risk and Solvency Assessment Summary Report will contain confidential and sensitive information related to an insurer or insurance group's identification of risks material and relevant to the insurer or insurance group filing the report. This information will include proprietary and trade secret information that has the potential for harm and competitive disadvantage to the insurer or insurance group if the information is made public.

(b) It is the intent of the General Assembly that the Own Risk and Solvency Assessment Summary Report shall be a confidential document filed with the Commissioner, that the Own Risk and Solvency Assessment Summary Report will be shared only as stated in this article and to assist the Commissioner in the performance of his or her duties, and that in no event shall the Own Risk and Solvency Assessment Summary Report be subject to public disclosure.

History. — Code 1981, § 33-13-30, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

33-13-31. Purpose.

The purpose of this article is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment and provide guidance and instructions for filing an Own Risk and Solvency Assessment Summary Report with the Commissioner. The requirements of this article shall apply to all insurers domiciled in this state unless exempt pursuant to Code Section 33-13-36.

History. — Code 1981, § 33-13-31, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

33-13-32. Definitions.

As used in this article, the term:

(1) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in paragraph (5) of Code Section 33-13-1.

(2) "Insurer" shall have the same meaning as set forth in Code Section 33-1-2, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(3) "Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan and the sufficiency of capital resources to support those risks.

(4) "ORSA Guidance Manual" means the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on January 1 following the calendar year in which the changes have been adopted by the National Association of Insurance Commissioners.

(5) "ORSA Summary Report" means a confidential high-level summary of an insurer or insurance group's ORSA.

History. — Code 1981, § 33-13-32, enacted by Ga. L. 2015, p. 608, § 2/SB 108; Ga. L. 2016, p. 864, § 33/HB 737; Ga. L. 2019, p. 337, § 1-67/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "the current version of" preceding "the Own Risk" in paragraph (4).

33-13-33. Maintenance of risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing, and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

History. — Code 1981, § 33-13-33, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

33-13-34. Required conduct of ORSA.

Subject to Code Section 33-13-36, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually, but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

History. — Code 1981, § 33-13-34, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

33-13-35. Submission of ORSA Summary Report.

(a) Upon the Commissioner's request, and no more than once each year, an insurer shall submit to the Commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer or the insurance group of which it is a member. Notwithstanding any request from the Commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report or reports required by this subsection if the Commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) The report or reports shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his or her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee.

(c) An insurer may comply with subsection (a) of this Code section by providing the most recent and substantially similar report or reports provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

History. — Code 1981, § 33-13-35, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

33-13-36. Exemption.

(a) An insurer shall be exempt from the requirements of this article, if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500 million; and

(2) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1 billion.

(b) If an insurer qualifies for exemption pursuant to paragraph (1) of subsection (a) of this Code section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (2) of subsection (a) of this Code section, then the ORSA Summary Report that may be required pursuant to Code Section 33-13-35 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers, provided that any combination of reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for exemption pursuant to paragraph (1) of subsection (a) of this Code section, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (2) of subsection (a) of this Code section, then the only ORSA Summary Report that may be required pursuant Code Section 33-13-35 shall be the report applicable to that insurer.

(d) An insurer that does not qualify for exemption pursuant to subsection (a) of this Code section may apply to the Commissioner for a waiver from the requirements of this article based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the Commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the Commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one state, the Commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(e) Notwithstanding the exemptions stated in this Code section:

(1) The Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report based on unique circumstances, including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests; and

(2) The Commissioner may require that an insurer maintain a risk management framework, conduct an ORSA, and file an ORSA Summary Report if the insurer has risk-based capital for a company

action level event as set forth in Chapter 56 of this title, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as provided for pursuant to the Commissioner's rules and regulations, or otherwise exhibits qualities of a troubled insurer as determined by the Commissioner.

(f) If an insurer that qualifies for an exemption pursuant to subsection (a) of this Code section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one year following the year the threshold is exceeded to comply with the requirements of this article.

History. — Code 1981, § 33-13-36, enacted by Ga. L. 2015, p. 608, § 2/SB 108; Ga. L. 2016, p. 864, § 33/HB 737.

33-13-37. Preparation of report; review and use.

(a) The ORSA Summary Report shall be prepared consistently with the ORSA Guidance Manual, subject to the requirements of subsection (b) of this Code section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

(b) The review of the ORSA Summary Report and any additional requests for information shall be made using similar procedures used in the analysis and examination of multistate or global insurers and insurance groups.

History. — Code 1981, § 33-13-37, enacted by Ga. L. 2015, p. 608, § 2/SB 108; Ga. L. 2019, p. 337, § 1-68/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (b), substituted "ORSA Summary Report and any additional requests for information shall" for "ORSA Summary Report, and any additional requests for information, shall" and deleted "currently" following "similar procedures".

33-13-38. Confidentiality and protection.

(a) Documents, materials, or other information, including the ORSA Summary Report, in the possession of or control of the Department of Insurance that are obtained by, created by, or disclosed to the Commissioner or any other person under this article is recognized by this state as being proprietary and containing trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be subject to Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the Com-

missioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the Commissioner's official duties. The Commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer.

(b) Neither the Commissioner nor any person who received documents, materials, or other ORSA related information, through examination or otherwise, while acting under the authority of the Commissioner or with whom such documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a) of this Code section.

(c) In order to assist in the performance of the Commissioner's regulatory duties, the Commissioner:

(1) May upon request share documents, materials, or other ORSA related information, including the confidential and privileged documents, materials, or information subject to subsection (a) of this Code section, including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as described in Code Section 33-13-7, with the National Association of Insurance Commissioners and with any third-party consultants designated by the Commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(2) May receive documents, materials, or other ORSA related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as described in Code Section 33-13-7, and from the National Association of Insurance Commissioners, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the understanding that such documents, materials, or information are confidential or privileged under the laws of the jurisdiction that is the source of such documents, materials, or information; and

(3) Shall enter into a written agreement with the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to this article, consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article, including procedures and protocols for sharing by the National Association of Insurance Commissioners with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(B) Specify that ownership of information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article remains with the Commissioner and that the use of information by the National Association of Insurance Commissioners or a third-party consultant is subject to the direction of the Commissioner;

(C) Prohibit the National Association of Insurance Commissioners or third-party consultant from storing the information shared pursuant to this article in a permanent data base after the underlying analysis is completed;

(D) Require prompt notice to be given to an insurer whose confidential information in the possession of the National Association of Insurance Commissioners or a third-party consultant pursuant to this article is subject to a request or subpoena to the National Association of Insurance Commissioners or a third-party consultant for disclosure or production;

(E) Require the National Association of Insurance Commissioners or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article; and

(F) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the Commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the Commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other ORSA

related information shall occur as a result of disclosure of such ORSA related information or documents to the Commissioner under this Code section or as a result of sharing as authorized in this article.

(f) Documents, materials, or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant pursuant to this article shall be confidential by law and privileged, shall not be subject to Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

History. — Code 1981, § 33-13-38, enacted by Ga. L. 2015, p. 608, § 2/SB 108; Ga. L. 2016, p. 864, § 33/HB 737; Ga. L. 2019, p. 337, §§ 1-69, 1-93/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in the first sentence of subsection (a); substituted "as described in" for "as defined in" in paragraphs (c)(1) and (c)(2); substituted "that such documents, materials, or information are confidential or privileged under the laws of the jurisdiction that is the source of such documents, materials, or information; and" for "that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information; and" at the end of paragraph (c)(2); and substituted "Commissioner and that the use of information by the National Association of Insurance Commissioners or a third-party consultant" for "Commissioner and the National Association of Insurance Commissioner's or a third-party consultant's use of the information" near the end of subparagraph (c)(3)(B).

33-13-39. Penalty for noncompliance.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this article may be subject to any penalty set forth in subsection (g) of Code Section 33-2-24. The Commissioner may reduce the monetary penalty if the insurer demonstrates to the Commissioner that the imposition of the monetary penalty would constitute a financial hardship to the insurer.

History. — Code 1981, § 33-13-39, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

33-13-40. Severability.

Reserved. Repealed by Ga. L. 2019, p. 337, § 1-70/SB 132, effective July 1, 2019.

Editor's notes. — This Code section was based on Ga. L. 2015, p. 608, § 2/SB 108.

33-13-41. Effective date for compliance.

The requirements of this article shall become effective on July 1, 2015. The first filing of the ORSA Summary Report shall be required in 2015 pursuant to Code Section 33-13-35.

History. — Code 1981, § 33-13-41, enacted by Ga. L. 2015, p. 608, § 2/SB 108.

CHAPTER 13A

MUTUAL INSURANCE HOLDING COMPANIES

Sec.
33-13A-1. Short title.
33-13A-2. Definitions.
33-13A-3. Reorganization plans.
33-13A-4. Procedure for reorganization.
33-13A-5. Incorporation of reorganized insurer.
33-13A-6. Required compliance; treatment of assets.
33-13A-7. Application of other statutory provisions.
33-13A-8. Effect of membership interest.
33-13A-9. Offerings of voting stock; duties of Commissioner.
33-13A-10. Policyholder meetings.
33-13A-11. Treatment of stock.
33-13A-12. Legislative intent regarding impact on taxation.
33-13A-13. Regulatory authority.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 349 et seq.

33-13A-1. Short title.

This chapter shall be known and may be cited as the "Mutual Insurance Holding Company Act."

History. — Code 1981, § 33-13A-1, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-2. Definitions.

As used in this chapter, the term:

(1) "Intermediate stock holding company" means one or more stock corporations that own all of the shares of voting stock of one or more reorganized stock insurers after a reorganization under Code Section 33-13A-3 or a merger under Code Section 33-13A-4.

(2) "Majority of the voting stock of the reorganized stock insurer" means shares of the capital stock of the reorganized stock insurer that carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock of the reorganized stock insurer for the election of directors and on all other matters submitted to a vote of the shareholders of the reorganized stock insurer. The ownership of a majority of the voting stock of the reorganized stock insurer that is required pursuant to this chapter to be at all times owned by a mutual insurance holding company includes indirect ownership through one or more intermediate stock holding companies in a corporate structure approved by the Commis-

sioner. However, indirect ownership through one or more intermediate stock holding companies shall not result in the mutual insurance holding company owning less than the equivalent of a majority of the voting stock of the reorganized stock insurer. The Commissioner shall have jurisdiction over an intermediate stock holding company as if it were a mutual insurance holding company.

(3) "Member" means a person who obtains a membership interest in a mutual insurance holding company by virtue of being a policyholder of a mutual insurer that is the subject of a reorganization plan under Code Section 33-13A-3 or a merger plan under Code Section 33-13A-4.

(4) "Merger plan" means a plan approved by a mutual insurer's board of directors under Code Section 33-13A-4 which proposes to merge a domestic or foreign mutual insurer into an existing mutual insurance holding company or into an intermediate stock holding company, thereby converting the domestic or foreign mutual insurer into a stock insurer.

(5) "Mutual insurance holding company" means a domestic corporation incorporated pursuant to a reorganization plan under Code Section 33-13A-3 or a merger plan under Code Section 33-13A-4, which company is the ultimate parent of a reorganized stock insurer and which may be the parent company of one or more intermediate stock holding companies.

(6) "Policyholder" means a person who is insured under one or more insurance policies or annuity contracts by a mutual insurer at the time of a reorganization under Code Section 33-13A-3 or a merger under Code Section 33-13A-4.

(7) "Reorganization plan" means a reorganization plan adopted by a mutual insurer's board of directors in accordance with Code Section 33-13A-3 or 33-13A-4 which proposes to convert the domestic or foreign mutual insurer into a stock insurer.

(8) "Reorganized stock insurer" means the domestic or foreign stock insurer resulting from a domestic or foreign mutual insurer's reorganization under Code Section 33-13A-3 or merger under Code Section 33-13A-4.

(9) "Voting stock" means securities of any class or any ownership interest having voting power for the election of directors, trustees, or management of a corporation. Voting stock shall also mean any security convertible into or evidencing a right to acquire a voting security.

History. — Code 1981, § 33-13A-2, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-3. Reorganization plans.

(a) A domestic mutual insurer, upon approval of the Commissioner, may reorganize by forming an insurance holding company system, which shall be designated as a mutual insurance holding company, based upon a reorganization plan and continuing the corporate existence of the reorganizing insurer as a stock insurer. Such a reorganization plan must be adopted by the affirmative vote of not less than two-thirds of the mutual insurer's board of directors. The Commissioner, after a public hearing as provided in paragraph (2) of subsection (d) of Code Section 33-13-3, if satisfied that the interests of the policyholders are properly protected and that the reorganization plan is fair and equitable to the policyholders, may approve the proposed reorganization plan and may require as a condition of approval such modifications of the reorganization plan as the Commissioner finds necessary for the protection of the policyholders' interests. A reorganization pursuant to this Code section is subject to the requirements of Code Section 33-13-3. The Commissioner shall retain jurisdiction over a mutual insurance holding company organized pursuant to this Code section to ensure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company or to an intermediate stock holding company. The membership interests of the policyholders of the reorganized stock insurer shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized stock insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting stock of the reorganized stock insurer or an intermediate stock holding company.

(c) The reorganization plan shall provide that all of the initial shares of capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company or to an intermediate stock holding company. The reorganization plan shall provide that the mutual insurance holding company shall at all times own a majority of the voting stock of the reorganized stock insurer or, alternatively, that the mutual insurance holding company shall at all times own the majority of voting stock in an intermediate stock holding company, which intermediate stock holding company shall at all times own all of the voting stock of the reorganized stock insurer. The shares of voting stock required to be owned by the mutual insurance holding company or by an intermediate stock holding company shall not be pledged, hypothecated, or in any way encumbered with regard to any obligation, guaranty, or commitment undertaken by or on behalf of the mutual insurance holding

company or the intermediate stock holding company, if any. The reorganization plan shall also provide that the board of directors of the mutual insurance holding company will be elected by the members.

(d) The reorganization plan shall provide that membership interests of the policyholders of the mutual insurer shall automatically convert to membership interests in the mutual insurance holding company so long as the policy is in force as of the date the reorganization plan was adopted by the board of directors of the mutual insurer and that, concurrently upon the effective date of the reorganization, the policyholder's membership interests in the mutual insurer shall be extinguished.

History. — Code 1981, § 33-13A-3, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-4. Procedure for reorganization.

(a) A domestic mutual insurer, upon the approval of the Commissioner, may reorganize by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to Code Section 33-13A-3 and continuing the corporate existence of the reorganizing insurer as a stock insurer subsidiary of the mutual insurance holding company or an intermediate stock holding company. The Commissioner, after a public hearing as provided in paragraph (2) of subsection (d) of Code Section 33-13-3, if satisfied that the interests of the policyholders are properly protected and that the merger plan is fair and equitable to the policyholders, may approve the merger plan and may require as a condition of approval such modifications of the merger plan as the Commissioner finds necessary for the protection of the policyholders' interests. The Commissioner shall retain jurisdiction over the mutual insurance holding company organized pursuant to this Code section to ensure that policyholder interests are protected.

(b) All of the initial shares of the capital stock of the reorganized stock insurer shall be issued to the mutual insurance holding company or to an intermediate stock holding company. The membership interests of the policyholders of the reorganized stock insurer shall become membership interests in the mutual insurance holding company. Policyholders of the reorganized stock insurer shall be members of the mutual insurance holding company in accordance with the articles of incorporation and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times own a majority of the voting stock of the reorganized stock insurer or an intermediate stock holding company. A merger of policyholders' membership interests in a mutual insurer into a mutual insurance holding company shall be deemed to be the acquisition of an insurance control

company pursuant to Code Section 33-13-3 and is subject to the requirements of Code Section 33-13-3.

(c) A foreign mutual insurer which, if a domestic mutual insurer, would be organized under Chapter 14 of this title may reorganize upon the approval of the Commissioner and in compliance with the requirements of any law or rule applicable to the foreign mutual insurer by merging its policyholders' membership interests into a mutual insurance holding company formed pursuant to Code Section 33-13A-3 and continuing the corporate existence of the reorganizing foreign mutual insurer as a foreign stock insurer subsidiary of the mutual insurance holding company or one or more intermediate stock holding companies. The Commissioner, after a public hearing as provided in paragraph (2) of subsection (d) of Code Section 33-13-3, may approve the proposed merger. The reorganizing foreign mutual insurer may remain a foreign company or foreign corporation after the merger and may be admitted to do business in this state, upon approval by the Commissioner. A foreign mutual insurer that is a party to the merger may at the same time redomesticate in this state by complying with the applicable requirements of this state and its state of domicile. The provisions of subsection (b) of this Code section shall apply to a merger authorized under this subsection.

History. — Code 1981, § 33-13A-4, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-5. Incorporation of reorganized insurer.

A mutual insurance holding company resulting from the reorganization of a domestic mutual insurer and the reorganized stock insurer shall be incorporated and governed pursuant to Chapter 14 of this title and subject to Chapter 13 of this title. This requirement shall supersede any conflicting provisions of Chapter 2 of Title 14. The articles of incorporation and any amendments to such articles of the mutual insurance holding company shall be subject to approval of the Commissioner in the same manner as those of an insurer. An intermediate stock holding company shall be incorporated and governed pursuant to Chapter 2 of Title 14.

History. — Code 1981, § 33-13A-5, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-6. Required compliance; treatment of assets.

A mutual insurance holding company is deemed to be an insurer subject to this title and shall automatically be a party to any proceeding under this title involving an insurer that, as a result of a reorganization pursuant to Code Section 33-13A-3 or a merger pursuant to Code

Section 33-13A-4, is a subsidiary of the mutual insurance holding company or one or more intermediate stock holding companies. In any proceeding involving the reorganized stock insurer, the assets of the mutual insurance holding company are deemed to be assets of the estate of the reorganized stock insurer for purposes of satisfying the claims of the reorganized stock insurer's policyholders. A mutual insurance holding company shall not be dissolved or liquidated without the prior approval of the Commissioner.

History. — Code 1981, § 33-13A-6, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-7. Application of other statutory provisions.

(a) Code Section 33-14-76 is not applicable to a reorganization or merger pursuant to this chapter.

(b) The demutualization of a mutual insurance holding company is subject to the requirements of Code Section 33-14-76.

History. — Code 1981, § 33-13A-7, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-8. Effect of membership interest.

A membership interest in a mutual insurance holding company shall not constitute a security as such term is defined in Code Section 11-8-102.

History. — Code 1981, § 33-13A-8, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-9. Offerings of voting stock; duties of Commissioner.

(a) The offerings of voting stock by a reorganized stock insurer or intermediate stock holding company to any person other than the mutual insurance holding company or a wholly owned subsidiary thereof, which offering is to occur in connection with the reorganization or merger or is the first to occur after the effective date of the reorganization or merger, shall be made only in accordance with such provisions as the reorganization plan or merger plan may contain governing such an initial offering or with the prior approval of the Commissioner after submission of an application by the proposed issuer. The reorganization plan or merger plan shall describe the terms on which members, officers, and directors of the mutual insurance holding company, as well as any other persons, may participate in such offering. The Commissioner may approve any such application unless the Commissioner finds that the offering would be prejudicial to the members of the mutual holding company.

(b) The Commissioner may retain any attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff as may be reasonably necessary to assist the Commissioner in reviewing an application submitted pursuant to this Code section, the cost of which shall be borne by the proposed issuer submitting such application.

History. — Code 1981, § 33-13A-9, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-10. Policyholder meetings.

(a) Within 45 days after the date of the Commissioner's approval of a reorganization plan or merger plan pursuant to this chapter, unless extended by the Commissioner for good cause, the mutual insurer shall hold a meeting of its policyholders to vote upon such plan. The mutual insurer shall give notice at least 30 days before the time fixed for the meeting, by first-class mail to the last known address of each policyholder, that the reorganization plan or merger plan will be voted upon at a regular or special meeting of the policyholders. The notice shall include a brief description of the reorganization plan or merger plan and a statement that the Commissioner has approved such plan. The notice shall also include information regarding where the policyholder can obtain copies of the full reorganization plan or merger at no cost to the policyholder. The notice to each policyholder shall also include a written proxy permitting the policyholder to vote for or against the reorganization plan or merger plan. A reorganization plan or merger plan shall be approved only if not less than two-thirds of the policyholders voting in person or by proxy at the meeting vote in favor of such plan. Each policyholder shall be entitled to only one vote regardless of the number of policies owned by the policyholder.

(b) If a mutual insurer complies substantially and in good faith with the notice requirements of this Code section, the mutual insurer's failure to give any policyholder any required notice does not impair the validity of any action taken under this Code section.

(c) For purposes of voting, policyholder means a person who is eligible to vote under the mutual insurer's articles of incorporation or bylaws and who is also a policyholder of the mutual insurer as of the date on which the reorganization plan or merger plan is initially approved by the board of directors of the mutual insurer.

History. — Code 1981, § 33-13A-10, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-11. Treatment of stock.

The majority of the voting stock of the reorganized stock insurer, which is required by this Code section to be at all times owned by a mutual insurance holding company, shall not be conveyed, transferred, assigned, pledged, subject to a security interest or lien, encumbered, or otherwise hypothecated or alienated by the mutual insurance holding company or intermediate stock holding company. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation, or alienation of, in or on the majority of the voting stock of the reorganized stock insurer that is required by this Code section to be at all times owned by a mutual insurance holding company, is in violation of the provisions of this Code section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance, hypothecation, or alienation as to the shares necessary to constitute a majority of such voting stock. The majority of the voting stock of the reorganized stock insurer that is required by this Code section to be at all times owned by a mutual insurance holding company shall not be subject to execution and levy. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two or more reorganized stock insurers or two or more intermediate stock holding companies that were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations as provided in this Code section to which the shares of the merging or consolidating reorganized stock insurers or intermediate stock holding companies were subject as provided in this Code section prior to the merger or consolidation.

History. — Code 1981, § 33-13A-11, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-12. Legislative intent regarding impact on taxation.

It is the intent of the General Assembly that the formation of a mutual insurance holding company shall not increase the Georgia tax burden of the mutual insurance holding company system and that a reorganized stock insurer shall continue to be subject to Georgia insurance premium taxation in lieu of all other taxes except as provided in Chapter 8 of this title.

History. — Code 1981, § 33-13A-12, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

33-13A-13. Regulatory authority.

The Commissioner shall have the authority to promulgate rules and regulations to implement and enforce the provisions of this chapter.

History. — Code 1981, § 33-13A-13, enacted by Ga. L. 2015, p. 846, § 3/HB 185.

CHAPTER 14

DOMESTIC STOCK AND MUTUAL INSURERS

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Cross references. — Factors giving rise to insolvency of stock or mutual insurer, § 33-37-2.

RESEARCH REFERENCES

ALR. — Authority or custom of insurer or its agent to draw on insured for dues, 14 A.L.R. 920.

ARTICLE 1
GENERAL PROVISIONS

33-14-1. Applicability of chapter.

This chapter shall govern domestic mutual and stock insurers.

History. — Code 1933, § 56-1501, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For note on 2000 amendments of O.C.G.A. §§ 33-14-5, 33-14-6, 33-14-8, 33-14-24, 33-14-25, see 17 Ga. St. U.L. Rev. 212 (2000).

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Existing stock company must amend charter to issue participating policies. — A Georgia stock insurance company chartered after 1950, but before the adoption of this title by Ga. L. 1960, p. 289, must amend its charter in order to issue participating policies if no reference is made to such policies in the charter. 1965-66 Op. Att'y Gen. No. 66-51.

33-14-2. Definitions.

As used in this chapter, the term:

(1) "Mutual insurer" means an incorporated insurer without capital stock or shares which is owned and governed by its policyholders.

(2) "Stock insurer" means an incorporated insurer with capital divided into shares and owned by its shareholders.

History. — Code 1933, § 56-1502, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1910, § 2529 and former Code 1933, § 56-1401 are included in the annotations for this Code section.

"Mutual insurer." — Where, under the provisions of an industrial life and health insurance company's policy, each person insured becomes one of the insurers, thereby becoming interested in the profits and liable for the losses, the company is a "mutual benefit association." Stevens v. Industrial Life & Health Ins. Co., 50 Ga. App. 381, 178 S.E. 311 (1935) (decided under former Civil Code 1910, § 2529).

"Mutual insurance" is that form of insurance whereby each of the insured becomes one of the insurers, thereby becoming interested in the profits and liable for the losses. Gaston v. Keehn, 69 Ga. App. 500, 26 S.E.2d 107 (1943) (decided under former Code 1933, § 56-1401).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 58, 66.

C.J.S. — 44 C.J.S., Insurance, §§ 162 et seq., 181 et seq.

33-14-3. Applicability of general corporation statutes.

The applicable statutes of this state relating to the powers and procedures of domestic private corporations formed for profit shall apply to domestic stock insurers and to domestic mutual insurers, except where in conflict with the express provisions of this title and the reasonable implications of those provisions.

History. — Code 1933, § 56-1503, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Specific limitations upon powers of General Assembly in regard to corporations, Ga. Const. 1983, Art. III, Sec. VI, Para. V. Business corporations generally, T. 14, C. 2. Secretary of State corporations, T. 14, C. 4.

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Cited in Short v. State, 235 Ga. 394, 219 S.E.2d 728 (1975).

33-14-4. Execution and contents of application for charter.

(a) Five or more individuals of the age of 18 years or more of good moral character who have not been convicted of any crime involving moral turpitude may incorporate a stock insurer; ten or more such individuals may incorporate a mutual insurer. Not less than two-thirds of the incorporators shall be citizens of the United States and residents of this state.

(b) The application for charter shall be signed by the persons applying for the charter and shall state:

(1) The name of the corporation;

(2) That the corporation shall have perpetual duration, unless otherwise limited in the application for charter. Each domestic stock and mutual insurance corporation existing on April 1, 1969, and thereafter shall have perpetual duration unless its charter is subsequently amended under this chapter to provide for a limited period of duration;

(3) The names and addresses of the incorporators;

(4) The kinds of insurance the corporation is formed to transact according to the definitions of insurance set forth in Chapter 7 of this title;

(5) If a stock corporation, the authorized capital and the par value of each share, which par value shall be at least $1.00 per share; provided, however, that after the corporation has operated for three consecutive years the par value may be reduced below $1.00 per share but not below a par value of 50¢ per share. Shares without par

value shall not be authorized. The capitalization shall not be less than that required of the insurer under the provisions of Chapter 3 of this title;

(6) If a mutual corporation, the maximum contingent liability of its members other than as to nonassessable policies for payment of losses and expenses incurred, which liability shall be not less than one nor more than six times the premium for the member's policy at the annual premium rate for a term of one year;

(7) The number of directors, which number shall not be less than three, who shall conduct the affairs of the corporation and the names and addresses of the corporation's first directors and the officers for stated terms of office of not more than one year;

(8) The name of the city or town and county in this state in which is to be located its home office and principal place of business;

(9) If a stock corporation, the extent, if any, to which shares of its stock shall be subject to assessment;

(10) If a stock corporation, the number of shares subscribed, if any, by each incorporator;

(11) The limitations, if any, on the corporation's indebtedness; and

(12) Such other provisions not inconsistent with law deemed appropriate by the incorporators.

History. — Ga. L. 1893, p. 73, § 2; Civil Code 1895, § 2008; Civil Code 1910, § 2389; Code 1933, § 56-202; Code 1933, § 56-1504, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1973, p. 185, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 1080, § 4.

JUDICIAL DECISIONS

Particular house for home office need not be named. — Under this section, the statements of the petition must show a location in a particular county (and now city or town) and thus indicate the domicile of the corporation there; but the law makes no requirement for naming in the petition for incorporation a particular house in the county as the home of the company. Georgia Fire Ins. Co. v. City of Cedartown, 134 Ga. 87, 67 S.E. 410, 19 Ann. Cas. 954 (1910).

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"Dummy" incorporators may not be used. — A bona fide and good faith attempt or effort to incorporate an insurance company under this title cannot be accomplished by the use of "dummy" incorporators, that is, incorporators who are used merely to sign the petition for incorporation and who have no genuine interest in the formation and organization of the company. 1965-66 Op. Att'y Gen. No. 66-45.

The petition must state the names and addresses of the directors and officers for stated terms of office in order to comply with this section: it would not suffice to name the proposed officers and directors; in chartering an insurance corporation, the naming of the corpora-

tion's first directors and officers is a matter to be determined by the incorporators; there would be no objection to limiting the terms to less than one year; the petition could state that "the terms of office shall be a period of one year (or specified number of months less than 12 if desired) or until such earlier date as their successors are duly elected." 1963-65 Op. Att'y Gen. p. 675.

Par value of new preferred shares must comply with section. — An insurance company may amend its charter to authorize an increase in its capital and provide for the issuance of a new class of preferred stock which meets the requirements of paragraph (5) of subsection (b) of this section as to par value. 1958-59 Op. Att'y Gen. p. 197.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 63.

C.J.S. — 44 C.J.S., Insurance, §§ 159 et seq., 165 et seq.

33-14-5. Filing of application for charter; fee; certification and publication of application; approval or disapproval of charter.

(a) The application for charter with any and all exhibits that may be included with the application shall be filed in triplicate in the office of the Commissioner of Insurance and a fee of $100.00 shall be paid to the Commissioner to be paid by him or her into the state treasury. The Commissioner shall not receive the application until the fee shall be paid.

(b) Immediately upon receipt of the triplicate copies of the application, with any and all exhibits included with the application, the Commissioner shall certify one of the copies of the application and deliver the same to the applicants and the same shall be published by the applicants once a week for four weeks in the newspaper in which is published the legal advertisements of the county where the principal office of the company is to be located. When the application with any and all exhibits attached to it shall have been published once a week for four weeks, the applicants may apply to the judge of the probate court of the county to certify the fact of such publication, which certificate shall be filed by the applicants in the office of the Commissioner of Insurance.

(c) The Commissioner shall approve or disapprove the application within 45 days of the date the application is received by the Commissioner.

(d) The Commissioner shall examine the application to determine whether the charter, if granted, will enable the insurer to comply with the applicable insurance laws of this state; and, if the Commissioner finds that the charter, if granted, will enable the insurer to comply with the applicable provisions of law for carrying on the business for which incorporation is sought, the Commissioner shall issue under his or her

hand and official seal a certificate approving the granting of the charter for such insurer and shall transmit a copy of the certificate of approval to the Secretary of State.

(e) If the Commissioner finds that the proposed application for a charter does not comply with the law, or that the corporation, if organized, could not meet the requirements for a certificate of authority as set forth in this chapter or any other provision of this title, the Commissioner shall refuse to approve the application for charter and shall notify the incorporators in writing, as to his or her reasons for such failure to approve; and the Commissioner shall issue under his or her hand and official seal a certificate disapproving the granting of the charter for such insurer.

History. — Ga. L. 1893, p. 73, § 3; Civil Code 1895, § 2011; Civil Code 1910, § 2392; Code 1933, § 56-205; Code 1933, § 56-1505, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 1307, § 1.

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Secretary of State not required to determine if Commissioner has acted in time. — Former Code 1933, §§ 56-1505(3) and 56-1506(2) and (3) (see subsection (c) of this Code section and O.C.G.A. § 33-14-6(b) and (c)) do not place any burden or duty on the Secretary of State to ascertain that the approval of the Commissioner was given within the 45-day limit; the 45-day limit specified in subsection (c) of former Code 1933, § 56-1505 was inserted to protect the applicant from too long an investigation by the Commissioner; a law intended to benefit an applicant should not be interpreted to the applicant's detriment. 1972 Op. Att'y Gen. No. 72-76.

Company surviving merger of domestic companies must apply for charter. — Where a domestic insurance company merges with another domestic insurance company, the resulting company is a new and distinct corporation, and an application for a new charter has to be filed with the Secretary of State in order to secure a new certificate of incorporation. 1963-65 Op. Att'y Gen. p. 19.

Section must be complied with if one or both merging companies are domestic. — Former Code 1933, § 56-1534 (see O.C.G.A. § 33-14-43), insofar as it requires compliance with this section and former Code 1933, § 56-1506 (see O.C.G.A. § 33-14-6), can apply only where there is a merger of two domestic insurance companies or a merger of a domestic insurance company and a foreign insurance company, with the survivor being a Georgia company. 1963-65 Op. Att'y Gen. p. 19.

Approval is required regardless of domicile of surviving company. — This section requires exercise of the approval authority with respect to merger applications, regardless of the domicile of the surviving corporation. 1972 Op. Att'y Gen. No. 72-152.

Former Code 1933, § 22-1008 (see O.C.G.A. § 14-2-1107), considered along with former Code 1933, § 56-1505 (see O.C.G.A. § 33-14-5), impelled the conclusion that the Commissioner was required to exercise approval authority with respect to the merger of a domestic stock insurer into a foreign stock insurer even when the surviving corporation was domiciled outside this state. 1972 Op. Att'y Gen. No. 72-152.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 62.

C.J.S. — 44 C.J.S., Insurance, §§ 162, 500, 611.

33-14-6. Grant of corporate powers and privileges; issuance of certificate of incorporation; recordation of documents; appointment of attorney for acceptance of service of process.

(a) All corporate powers and privileges to insurance companies shall be issued and granted by the Secretary of State upon the terms, liabilities, and restrictions of and subject to this title and the laws and Constitution of this state. If from any cause the Secretary of State should be disqualified from issuing and granting said powers, the duties required by this title to be performed by the Secretary of State shall be performed by the Commissioner of Insurance.

(b) When the certificate of the judge of the probate court as to the fact of publication of the application for charter and the certificate of the Commissioner as to his or her approval of the application for charter shall have been received in the office of the Secretary of State, the Secretary of State shall issue to the corporation under the seal of the state a certificate of incorporation. The corporation shall not transact business as an insurer until it has applied for and received from the Commissioner a certificate of authority as provided by this title.

(c) The Secretary of State shall record the application for charter, the certificate of approval of the Commissioner, the certificate of the judge of the probate court as to publication, and the certificate of incorporation.

(d) No corporation shall directly or indirectly take risks or transact any business of insurance in this state by any agent or agents in this state until it shall have appointed an attorney in this state on whom process of law can be served and filed in the office of the Commissioner a written instrument duly signed and sealed certifying such appointment which shall continue until another attorney shall be substituted. Any process issued by any court of record in this state and served upon the attorney by the proper officer of the county in which the attorney may reside or may be found shall be deemed a sufficient service of process upon the company, but service of process upon the company may also be made in any other manner provided by law. Any violation of this subsection shall subject the party violating this subsection to a penalty of not less than $100.00 nor more than $500.00.

History. — Ga. L. 1893, p. 73, § 3; Civil Code 1895, § 2009; Civil Code 1910, § 2390; Code 1933, § 56-203; Code 1933, § 56-1506, enacted by Ga. L. 1960, p. 289,

§ 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1986, p. 855, § 13; Ga. L. 1988, p. 13, § 33; Ga. L. 2000, p. 1307, § 2.

JUDICIAL DECISIONS

Cited in Piedmont Life Ins. Co. v. Bell, 109 Ga. App. 251, 135 S.E.2d 916 (1964).

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Secretary of State not required to determine if Commissioner has acted in time. — Former Code 1933, §§ 56-1505(3) and 56-1506(2) and (3) (see O.C.G.A. § 33-14-5(c)) and subsections (b) and (c) of former Code 1933, § 56-1506 (see O.C.G.A. § 33-14-6) do not place any burden or duty on the Secretary of State to ascertain that the approval of the Commissioner was given within the 45-day limit; the 45-day limit specified in former Code 1933, § 56-1505 was inserted to protect the applicant from too long an investigation by the Commissioner; a law intended to benefit an applicant should not be interpreted to the applicant's detriment. 1972 Op. Att'y Gen. No. 72-76.

Company surviving merger of domestic companies must apply for charter. — Where a domestic insurance company merges with another domestic insurance company, the resulting company is a new and distinct corporation, and an application for a new charter has to be filed with the Secretary of State in order to secure a new certificate of incorporation. 1963-65 Op. Att'y Gen. p. 19.

Section applies when one or both merging companies are domestic. — Former Code 1933, § 56-1534 (see O.C.G.A. § 33-14-43), insofar as it required compliance with former Code 1933, §§ 56-1505 and 56-1506 (see O.C.G.A. §§ 33-14-5 and 33-14-6), can apply only when there was a merger of two domestic insurance companies or a merger of a domestic insurance company and a foreign insurance company, with the survivor being a Georgia company. 1963-65 Op. Att'y Gen. p. 19.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 62.

C.J.S. — 44 C.J.S., Insurance, §§ 162, 500, 611.

33-14-7. Name of corporation.

(a) No name shall be adopted by a domestic mutual or stock insurance corporation which is so similar to any name already in use by any such existing corporation, company, or association organized or doing business in this state as to be confusing or misleading and the Commissioner shall not approve an application from the applicant nor shall the Secretary of State issue a charter to the applicant.

(b) The name of the corporation shall include the word "company" or "corporation" or have such word or words, abbreviation, suffix, or prefix included in the name or attached to it in such a manner as will clearly indicate that it is a corporation.

(c) Except as provided in subsection (d) of Code Section 33-14-76 with regard to converted insurers, if the corporation is a mutual insurer, the term "mutual" shall also be a part of the name.

History. — Code 1933, § 56-1507, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1994, p. 300, § 1.

Law reviews. — For note on the 1994 amendment of this Code section, see 11 Ga. St. U.L. Rev. 196 (1994).

JUDICIAL DECISIONS

Cited in Piedmont Life Ins. Co. v. Bell, 109 Ga. App. 251, 135 S.E.2d 916 (1964).

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Amendment of charter changing name releases old name never used for business. — An amendment of an insurance company's charter changing the name of that insurance company would automatically release that name for immediate use by another insurance company where the original company did no insurance business under its old name; that is, it neither issued policies, paid claims, nor advertised its name or reputation in any way with the general public. 1967 Op. Att'y Gen. No. 67-457.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 164.

33-14-8. Procedures for amendment or renewal of charter.

(a) A domestic insurer may amend its charter for any lawful purpose by written authorization by the holders of a majority of the voting power of its outstanding capital stock, by members if a mutual insurer, or by affirmative vote of such a majority voting at a lawful meeting of stockholders or members of which the notice given to stockholders or members included prior notice of not less than ten days of the proposal to amend.

(b) Upon authorization of such an amendment, the insurer shall file in the office of the Commissioner of Insurance an application asking that its charter be so amended and a fee of $50.00 shall be paid to the Commissioner to be transmitted by him or her into the state treasury; and the Commissioner shall not receive said application until said fee shall be paid. The application with any and all exhibits that may be included shall be filed in triplicate, signed with the corporate name and under the corporate seal, and shall state:

(1) The name and character of the corporation, the city or town, and county in this state in which is located its principal place of business;

(2) The date of its original charter and any and all amendments to the charter, and the date or dates of renewal of the charter; and

(3)(A) That it desires an amendment to its charter and the purpose of said amendment;

(B) There shall be annexed to the application a certificate in triplicate under the corporate seal of the insurer and executed by the insurer's president or vice-president and attested to by the secretary or assistant secretary under the seal of the corporation, setting forth that amendment has been authorized in writing by the holders of a majority of the voting power of the outstanding capital stock, by members if a mutual insurer, or by affirmative vote of such a majority voting at a lawful meeting of stockholders or members of which the notice given to stockholders or members included prior notice of not less than ten days of the proposal to amend.

(c) Immediately upon receipt of the triplicate copies of the application, with any and all exhibits included with the application, the Commissioner shall certify one of the copies of the application and deliver the same to the applicants and the same shall be published by the applicants once a week for four weeks in the newspaper in which is published the legal advertisements of the county where the principal office of said company is to be located. When the application, with any and all exhibits attached to it, shall have been published once a week for four weeks, the applicants may apply to the judge of the probate court of the county to certify the fact of such publication, which certificate shall be filed by the applicants in the office of the Commissioner. The Commissioner shall approve or disapprove the application within 45 days of the date the application is received by him or her.

(d) No amendment shall be granted which will reduce authorized capital of a stock insurer below the amount required by this title for the kinds of insurance thereafter to be transacted; and no amendment shall reduce the surplus of a mutual insurer below the amount required by this title for the kinds of insurance thereafter to be transacted.

(e) If an amendment of the charter would reduce the authorized capital stock of a stock insurer below the amount then outstanding, the Commissioner shall not approve the amendment if he has reason to believe that the interest of policyholders or creditors of the insurer would be materially prejudiced by such reduction. If any reduction of capital stock is effectuated, the insurer may require return of the original certificates of stock held by each stockholder in exchange for new certificates for such number of shares as the stockholder is then entitled in the proportion that the reduced capital bears to the amount of capital stock outstanding as of immediately prior to the effective date of the reduction.

(f) When the certificate of the judge of the probate court as to the fact of publication of the application for amendment to the charter and the

certificate of the Commissioner as to his approval of the application for amendment shall have been received in the office of the Secretary of State, the Secretary of State shall issue to the corporation under the great seal of the state a certificate of amendment. The Secretary of State shall record the application for amendment to the charter, the certificate of approval of the Commissioner, the certificate of the judge of the probate court as to publication, and the certificate of amendment in a book to be kept by him for that purpose.

(g) A petition for renewal of the charter shall follow the procedure set forth in subsections (b) through (f) of this Code section, except that the fee for filing a petition for renewal of the charter shall be $100.00.

History. — Code 1933, § 56-1509, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 3, § 24; Ga. L. 2000, p. 1307, § 3.

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The word "upon" as used in subsection (b) of this section, when construed with all of the provisions of this section, must be given the meaning of "as soon as" or, at least, "within a reasonable time after." 1965-66 Op. Att'y Gen. No. 65-77.

This section was intended to apply to revivals the same as renewals of insurance company charters and that such revivals or renewals be approved by the Insurance Commissioner prior to issuance of a certificate by the Secretary of State. 1967 Op. Att'y Gen. No. 67-104.

Section applies to all nonprofit hospital service and medical service corporations. — Since this section provides for both renewal and amendment of corporate charters, the provisions of that section govern the renewal and amendment of charters of nonprofit hospital service corporations and of nonprofit medical service corporations regardless of when such corporations might have been organized. 1973 Op. Att'y Gen. No. 73-94.

Section requires approval of majority of voting power at time petition is filed. — This section requires that a petition for amendment to an insurer's corporate charter be filed within a reasonable time after approval by the stockholders and that consequently the certificate certifying that it has been approved by a majority vote of the voting power means a majority vote of the voting power at the time the petition for amendment is filed. 1965-66 Op. Att'y Gen. No. 65-77.

Section implies effective date of amendment is date of approval and filing by Secretary of State. — This section is silent as to when an amendment becomes effective, or as to the right of the Secretary of State or Insurance Commissioner to approve a request that the effective date be prior to the approval of the amendment to the charter; however, the strong implication is that the effective date is the date the amendment is finally approved and filed by the Secretary of State after the amendment has been approved by the Insurance Commissioner. 1960-61 Op. Att'y Gen. p. 262.

Amendment may provide for new class of preferred stock. — An insurance company may amend its charter to authorize an increase in its capital and provide for the issuance of a new class of preferred stock which meets the requirements of former Code 1933, § 56-1504 (see O.C.G.A. § 33-14-4(b)(5)) as to par value. 1958-59 Op. Att'y Gen. p. 197.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 68.

C.J.S. — 44 C.J.S., Insurance, § 173 et seq.

33-14-9. Powers of corporations generally.

Every corporation organized under this title shall have the same corporate powers as are conferred upon private corporations except where inconsistent with this chapter.

History. — Code 1933, § 56-1508, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Specific limitations upon powers of General Assembly in regard to corporations, Ga. Const. 1983, Art. III, Sec. VI, Para. V. Business corporations generally, T. 14, C. 2. Secretary of State corporations, T. 14, C. 4.

JUDICIAL DECISIONS

Cited in Piedmont Life Ins. Co. v. Bell, 109 Ga. App. 251, 135 S.E.2d 916 (1964).

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A mutual insurance company may organize and capitalize a stock company as a subsidiary, provided the prior consent of the Commissioner is obtained and the conditions indicated in former Code 1933, § 56-1027 (see O.C.G.A. § 33-11-37) are complied with. 1962 Op. Att'y Gen. p. 294.

33-14-10. Sale of subscriptions for insurance securities and sale offer of insurance securities.

(a) As used in this Code section, "insurance securities" means the securities of an insurer who is the issuer of a security as the word "security" is defined in Chapter 5 of Title 10, the "Georgia Uniform Securities Act of 2008."

(b) No person shall sell, offer for sale, or propose to sell to the public any subscriptions for insurance securities in this state unless the insurer which shall issue the insurance securities provided in the subscription has applied for, qualified for, received, and holds authority to transact insurance in this state from the Commissioner, or has an effective registration of the subscriptions for insurance securities with the Securities and Exchange Commission, or unless the subscriptions are sold by or through a broker in accordance with the rules of the Securities and Exchange Commission.

(c) No person shall sell, offer for sale, or propose to sell to the public any insurance securities in this state unless the insurer which shall issue said insurance securities has applied for, qualified for, received, and holds authority to transact insurance in this state from the Commissioner, or has an effective registration of such securities with the Securities and Exchange Commission, or unless such securities are sold by or through a broker in accordance with the rules of the Securities and Exchange Commission.

(d) Nothing contained in this Code section shall be deemed to repeal any of Chapter 5 of Title 10 but shall be supplementary and in addition thereto.

(e) Any person violating this Code section shall be guilty of a misdemeanor.

(f) The Commissioner shall be authorized to withhold the authority of any insurer to transact insurance in this state so long as any person who has been convicted of any offense defined in this Code section remains an officer, employee, or agent of the person or entity seeking the authority to transact insurance.

History. — Code 1933, § 1506.1, enacted by Ga. L. 1966, p. 217, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2008, p. 381, § 10/SB 358.

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This section is applicable only to domestic insurers and is not applicable to foreign or alien insurers whether or not they are licensed to transact insurance in Georgia. 1982 Op. Att'y Gen. No. 82-16.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 165 et seq.

33-14-11. Charitable, scientific, or educational donations.

An insurer shall have power to make donations for the public welfare or for charitable, scientific, or educational purposes subject to such limitations, if any, as may be contained in its charter or any amendment thereto.

History. — Code 1933, § 56-1518, enacted by Ga. L. 1960, p. 289, § 1.

33-14-12. Number, qualifications, election, and terms of directors.

(a) The affairs of every domestic insurer shall be managed by not less than three directors.

(b) Directors must be elected by the members or stockholders of a domestic insurer at the annual meeting of stockholders or members. Directors may be elected for terms of not more than three years each and until their successors are elected and have qualified; and if to be elected for terms of more than one year the insurer's bylaws shall provide for a staggered term system under which the terms of a

proportionate part of the members of the board of directors will expire on the date of each annual meeting of stockholders or members.

(c) At least one-fourth of the directors of the insurer must be residents of this state. A majority of the directors must be citizens of the United States.

History. — Code 1933, § 56-1519, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Management contracts, § 33-14-14.

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Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1895, § 2007 et seq. are included in the annotations for this Code section.

Incorporators may not be given continuing management powers in certificate. — Where an application to the Secretary of State for a charter for a fraternal beneficiary order in specifying the powers desired recited powers to the incorporators to govern and control the corporation, and the Secretary of State issued a certificate of incorporation purporting to confer such powers, the certificate was not to be treated as conferring charter power on the petitioners for incorporation to control the internal affairs of the corporation after it was organized. Eminent Household of Columbian Woodmen v. Thornton, 134 Ga. 405, 67 S.E. 849 (1910), later appeal, 135 Ga. 786, 70 S.E. 666 (1911) (decided under former Civil Code 1895, § 2007 et seq.).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 70.

C.J.S. — 44 C.J.S., Insurance, §§ 170 et seq., 189 et seq.

33-14-13. Maintenance of principal place of business and records; maintenance of assets within state; removal of records or assets from state without approval.

(a) Every domestic insurer shall have and maintain its principal place of business in this state, and shall keep in its principal place of business complete records of the assets, transactions, and affairs in accordance with the methods and systems which are customary or suitable as to the kind or kinds of insurance transacted.

(b) Every domestic insurer shall have and maintain its assets in this state, except as to:

(1) Real property and personal property appurtenant thereto lawfully owned by the insurer and located outside of this state; and

(2) Any property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside of this state, as referred to in subsection (d) of this Code section.

(c) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or

consolidation approved by the Commissioner under this title, or for any reasonable purposes and periods of time as may be approved by the Commissioner in writing in advance of any removal or concealment of such records or assets or material part thereof from the Commissioner is prohibited. Any insurer or representative of an insurer who removes or attempts to remove such records or assets or any material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state or conceals or attempts to conceal the same from the Commissioner in violation of this subsection shall have its corporate charter forfeited and its certificate of authority to do business shall be revoked. Upon any removal or attempted removal of the records or assets or upon retention of the records or assets or material part of the records or assets outside this state, beyond the period specified in the Commissioner's consent under which the records were permitted to be removed, or upon concealment of or attempts to conceal records or assets in violation of this subsection, the Commissioner may institute proceedings against the insurer pursuant to Chapter 37 of this title.

(d) This Code section shall not be deemed to prohibit or prevent an insurer from:

(1) Establishing and maintaining branch offices or regional home offices in other states or foreign countries where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of the insurance in force in the jurisdiction served by such an office as long as the records and assets are made readily available at such office for examination by the Commissioner at his request; or

(2) Having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business.

History. — Code 1933, § 56-1522, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 7.

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Principal place of business is location within state where governing powers of insurer are exercised and where attendant business activities as an insurer are actually and regularly conducted. 1976 Op. Att'y Gen. No. 76-67.

Principal place of business must be at designated Georgia location. — To comply with this section, a domestic insurer must establish and maintain its principal office at a designated situs within the State of Georgia where the governing powers of the insurer are exercised and where a substantial amount of the attendant business activities are regularly conducted; it must keep in that office all records of transactions and correspondence that pertain to each policy of insurance issued. 1976 Op. Att'y Gen. No. 76-67.

A domestic insurance company cannot remove its home office to another state; the Insurance Commissioner is without power to approve such a removal. 1962 Op. Att'y Gen. p. 287.

33-14-14. Filing and terms of management and exclusive agency contracts; approval or disapproval of contracts by Commissioner.

(a) No domestic insurer shall make any contract whereby any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer unless the contract is filed with and approved by the Commissioner. The contract shall be deemed approved unless disapproved by the Commissioner within 45 days after date of filing, subject to such reasonable extension of time as the Commissioner may require by notice given within such 45 days. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor.

(b) Any contract shall provide that any manager or producer of its business shall within 90 days after expiration of each calendar year furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended under or on account of the contract during the calendar year, including the emoluments received therefrom by the respective directors, officers, and other principal management personnel of the manager or producer, with such classification of items and further detail as the insurer's board of directors may reasonably require.

(c) The Commissioner shall disapprove any contract if he finds that it:

(1) Subjects the insurer to excessive charges;

(2) Is to extend for an unreasonable length of time;

(3) Does not contain fair and adequate standards of performance; or

(4) Contains other inequitable provision or provisions which impair the proper interest of stockholders or members of the insurer.

History. — Code 1933, § 56-1532, enacted by Ga. L. 1960, p. 289, § 1.

33-14-15. Borrowing of money.

(a) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, to provide it with surplus funds, or for any purpose required by its business upon a written agreement that the

money is required to be repaid only out of the insured's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding a reasonable rate per annum which interest shall or shall not constitute a liability as provided in said agreement.

(b) Money so borrowed together with interest on the borrowed money if so stipulated in the agreement shall not be considered on the financial statements of the insurer as a legal liability or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount of borrowed money then unpaid together with any interest on the money accrued but unpaid. No borrowed surplus shall be returned to the lender except out of earned surplus in excess of that surplus required by this title to transact the kind of insurance for which the company is authorized; provided, however, that on liquidation of the company said borrowed surplus will be paid off out of any assets remaining after the payment of all other liabilities of the companies.

(c) In advance of any such loan the insurer shall file with the Commissioner a statement of the purposes of the loan and a copy of the proposed loan agreement which shall be subject to the Commissioner's approval. The loan and agreement shall be deemed approved unless within 45 days after date of such filing with the Commissioner the insurer is notified in writing of the Commissioner's disapproval and the reasons for the disapproval. The Commissioner shall so disapprove any such proposed loan or agreement if he finds that the loan is reasonably unnecessary or excessive for the purpose intended, that the terms of the loan agreement are not fair and equitable to the parties, to other similar lenders, if any, or to the insurer, that it is not fair to policyholders, or that the information so filed by the insurer is inadequate.

(d) Any loan to a mutual insurer or a substantial portion of the loan shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of the loan shall be made by a mutual insurer unless pursuant to regulations made by the Commissioner.

(e) This Code section shall not apply to loans obtained by the insurer in the ordinary course of business from banks and other financial institutions nor to loans secured by pledge of assets.

History. — Code 1933, § 56-1520, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1969, p. 490, §§ 1, 2.

33-14-16. Participating and nonparticipating policies; earned dividend not to be made contingent upon payment of renewal premium.

(a) If so provided in its charter, a domestic stock or domestic mutual insurer may issue any or all of its policies with or without participation in profits, savings, or unabsorbed portions of premiums, may classify policies issued on a participating or nonparticipating basis, and may determine the right to participate and the extent of participation of any class or classes of policies. Any classification or determination shall be reasonable and shall not unfairly discriminate as between policyholders within the same classification.

(b) No dividend, otherwise earned, shall be made contingent upon the payment of a renewal premium on any policy.

History. — Code 1933, § 56-1521, enacted by Ga. L. 1960, p. 289, § 1.

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Existing company must amend charter to issue participating shares. — A Georgia stock insurance company chartered after 1950, but before the adoption of this title by Ga. L. 1960, p. 289, must amend its charter in order to issue participating policies if no reference is made to such policies in the charter. 1965-66 Op. Att'y Gen. No. 66-51.

RESEARCH REFERENCES

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

33-14-17. Voting securities.

(a) As used in this Code section, the term "voting security" means any instrument which in law or by contract gives the holder the right to vote, consent, or authorize any corporate action of an insurer.

(b) The Commissioner may by regulation prescribe the form, content, and manner of solicitation of any proxy, consent, or authorization in respect to any voting security issued by a domestic insurer as necessary or appropriate for the public interest or for the proper protection of investors in the voting securities issued by the insurer or necessary to ensure the fair dealing in the voting securities.

(c) No person and no domestic insurer or any director, officer, or employee of an insurer shall solicit or permit the use of his name to solicit by mail or otherwise any person to give or to refrain from giving any proxy, consent, or authorization in respect to any voting security

issued by the insurer in contravention of any rule or regulation the Commissioner may prescribe pursuant to this Code section.

(d) Failure to comply with any rule or regulation of the Commissioner made pursuant to this Code section shall be unlawful and compliance may be enforced by appropriate action in law or equity. If a domestic insurer or any person who is legally entitled to vote, consent, or authorize by virtue of being the holder of record of such voting security shall fail to commence such action within 15 days after the date on which the vote was cast or counted, the Commissioner may enforce compliance with the rules and regulations made pursuant to this Code section by appropriate action in law or equity; provided, however, no action shall be brought more than 30 days after the date on which the vote, consent, or authorization was to have been effected.

(e) This Code section shall not apply to voting securities of a domestic insurer if the voting securities shall be registered pursuant to Section 12 of the Securities Exchange Act of 1934, as amended.

History. — Code 1933, § 56-1519.1, enacted by Ga. L. 1965, p. 378, § 2; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 136, § 33.

U.S. Code. — Section 12 of the Securities Exchange Act of 1934, referred to in subsection (e) of this Code section, is codified as 15 U.S.C. § 78l.

33-14-18. Filing of registration statement by holding company prior to offering of stock for sale to public; contents of statement; approval or disapproval of sale by Commissioner.

(a) Any corporation or other form of business entity which is organized for the purpose of organizing or holding the stock of a domestic insurer shall first obtain the written approval of the Commissioner prior to offering its stock for sale to the public. Prior to any offer of stock for sale to the public a registration statement shall be filed with the Commissioner which shall contain the following information:

(1) Name and address of the main office of the issuer of the securities;

(2) Title of the securities and the total amount of the securities to be offered;

(3) Price at which the securities are to be offered for sale to the public and the amount of such securities to be offered in this state;

(4) Maximum amount of commission or other form of remuneration to be paid in cash or otherwise, directly or indirectly, for or in connection with the sale or offering for sale of such securities;

(5) Date and place of organization of the issuer, form of organization of the issuer, and the general character and location of its business;

(6) A copy offering circular or prospectus to be used in connection with the offering; and

(7) Any other information which the Commissioner may deem pertinent.

(b) The Commissioner may make any investigation of any securities described in the registration statement filed with him as he may deem advisable to enable him to determine whether the sale of the securities would work or tend to work a fraud on the purchasers thereof. If the Commissioner finds from the information disclosed or in his possession that the sale of the securities would work or tend to work a fraud on purchasers thereof, he shall not approve such issue and sale of such securities in this state. The Commissioner shall not grant any domestic insurer whose stock is held by a holding company which has not obtained approval of the issuance of its stock under this Code section a certificate of authority to transact insurance in this state. Compliance with this Code section shall not dispense with the necessity of approval of such stock issue also by the Secretary of State, ex officio as securities commissioner, as now or hereafter may be required by law.

History. — Code 1933, § 56-1543, enacted by Ga. L. 1960, p. 289, § 1.

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General Assembly intended to protect Georgia purchasers of such stock as provided for in this section. 1963-65 Op. Att'y Gen. p. 66.

Exchange of stock is "sale." — Although this title gives no definition to the phrase "sale to the public," the transfer of stock of one corporation for the stock of another corporation in payment therefor is a "sale." 1965-66 Op. Att'y Gen. No. 65-72.

Exchange of holding company stock for insurance company stock must be registered. — The exchange of shares of stock of a holding company for shares of stock of an insurance company constitutes an offering by the holding company of its stock for "sale to the public" as contemplated by this section; a registration statement must be filed with the Insurance Commissioner and written approval must be obtained from him prior to offering such stock for sale to the public. 1965-66 Op. Att'y Gen. No. 65-72.

This section is applicable regardless of whether any stock is to be offered in Georgia; it is from the registration statement that the Commissioner determines whether any stock is to be offered in Georgia. 1963-65 Op. Att'y Gen. p. 66.

Filing is not limited to Georgia corporations. — This section provides for a filing with Insurance Commissioner; the language is clear as to who must file and is not limited to Georgia corporations. 1963-65 Op. Att'y Gen. p. 66.

If no sale in Georgia, Commissioner need not exercise approval authority. — If no stock is to be sold in Georgia the Commissioner need not exercise the authority vested in him to refuse approval of the sale of such stock in Georgia. 1963-65 Op. Att'y Gen. p. 66.

RESEARCH REFERENCES

ALR. — Investigative authority of administrative agencies in state regulation of securities, 58 A.L.R.5th 293.

33-14-19. Regulation of financial interests in and transactions with insurers by officers, directors, committee members, or employees.

(a) Any officer, director, member of any committee, or an employee of a domestic insurer who is charged with the duty of investing or handling the insurer's funds shall not:

(1) Deposit or invest the funds except in the insurer's corporate name, except as otherwise authorized by this title;

(2) Borrow the funds of the insurer;

(3) Be pecuniarily interested in any loan, pledge of deposit, security, investment, sale, purchase, exchange, reinsurance, or other similar transaction or property of such insurer except as a stockholder or member unless:

(A) The insurer has provided the Commissioner with written notice of the proposed transaction no later than 30 days prior to such transaction, or such lesser period as may be permitted by the Commissioner, and the Commissioner has not disapproved the proposed transaction within that period; provided, however, that the Commissioner may, upon written notice given to the insurer no less than five days prior to the expiration of the initial review period, extend the review period for an additional time not to exceed 30 days; and

(B) The proposed transaction has been approved by directors' action in accordance with the provisions of Code Section 14-2-862, or by shareholders' action in accordance with the provisions of Code Section 14-2-863, if the proposed transaction would be a director's conflicting interest transaction as defined by Code Section 14-2-860; or

(4) Take or receive to his or her own use any fee, brokerage, commission, gift, or other consideration for or on account of any such transaction made by or on behalf of the insurer.

(b) No insurer shall guarantee any financial obligation of any of its officers or directors.

(c) This Code section shall not prohibit a director, officer, member of a committee, or employee from becoming a policyholder of the insurer and enjoying the usual rights provided for its policyholders.

(d) The Commissioner may by regulation define and permit additional exceptions to the prohibition contained in subsection (a) of this Code section solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer or to a corporation or firm in which a director is interested for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of the director or the corporation or firm.

History. — Code 1933, § 56-1533, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1108, § 8; Ga. L. 1995, p. 776, § 1.

Law reviews. — For note on the 1995 amendment of this Code section, see 12 Ga. St. U.L. Rev. 264 (1995).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 70.

C.J.S. — 44 C.J.S., Insurance, §§ 170 et seq., 189 et seq.

33-14-20. Limitation on commission received by persons selling stock of insurers; participation by corporate officers in commissions.

(a) No officer, agent, or other person selling or negotiating stock in any domestic insurance company shall receive either directly or indirectly more than 10 percent of the sales price of any of said stock. No president, vice-president, secretary, treasurer, or director or any other executive officer of any insurance company shall participate in the commission received by any person selling or negotiating the sale of any stock of any insurance company either directly or indirectly.

(b) No salaried officer of any insurance company shall participate in the commissions deriving from the sale of life insurance policies or agency contracts of the companies.

History. — Ga. L. 1912, p. 119, § 19; Code 1933, § 56-522; Code 1933, § 56-1542, enacted by Ga. L. 1960, p. 289, § 1.

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Section is inapplicable to sales not for company itself. — This section has no application where one who happens to be an officer or agent of an insurance company sells stock belonging to himself or to some person, firm, or corporation to whom the company had previously sold stock; the section refers to sales in which the officers or agents are dealing either directly or indirectly for the insurance company itself. Prontaut v. Lorick & Co., 17 Ga. App. 495, 87 S.E. 716 (1916).

Agent with exclusive sales contract may be awarded commission on stock not offered the agent. — If the company breached an exclusive sales contract and allowed others to sell, this would not prevent the agent having an exclusive sales

contract from insisting on ten percent under the terms of the contract. The ten percent, as to stock which should have been offered to such a salesman to sell but was not, is not an "additional compensation" of the ten percent received on stocks actually sold by such salesman, but is the measure of damages for the breach of the contract. Piedmont Life Ins. Co. v. Bell, 109 Ga. App. 251, 135 S.E.2d 916 (1964).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 159.

C.J.S. — 44 C.J.S., Insurance, § 3115.

33-14-21. Limitation on organizational expenses.

The total expenses of organization of any insurer organized under this chapter including commissions for the sale of stock shall not exceed 12 1/2 percent of the amount for which the stock is sold in the case of a stock insurer and 12 1/2 percent of the paid-in surplus in the case of a mutual insurer.

History. — Code 1933, § 56-1542, enacted by Ga. L. 1960, p. 289, § 1.

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The word "organization" as used in this section includes the entire period from the inception of the company, the filing of application for charter, and the time required to raise the capital and surplus required by this title. 1960-61 Op. Att'y Gen. p. 271.

Limitation applies to all expenses from inception of company until certification. — The limitation on expenses of 12 1/2 percent of the amount for which the stock was sold would apply to all expenses incurred from the inception of the company until a certificate of authority was obtained. 1960-61 Op. Att'y Gen. p. 271.

33-14-22. Proceedings for correction of deficiency in assets or capital of insurer; institution of delinquency proceedings upon failure to correct deficiency.

(a) If the capital of a domestic stock insurer becomes impaired or the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required of it by this chapter for authority to transact the kinds of insurance being transacted, the Commissioner shall at once determine the amount of the deficiency and serve notice upon the insurer to make good the deficiency within 60 days after service of the notice.

(b) The deficiency may be made good in cash or in assets eligible under this title for the investment of the insurer's funds; or if a stock insurer by reduction of the insurer's capital to an amount not below the

minimum required for the kinds of insurance thereafter to be transacted; or if a mutual insurer, by amendment of its certificate of authority to cover only such kinds of insurance for which the insurer has on deposit sufficient surplus.

(c) If the deficiency is not made good and proof of the act filed with the Commissioner within such 60 day period, the insurer shall be deemed insolvent and the Commissioner shall institute delinquency proceedings against it as authorized by this title. If the deficiency exists because of increased loss reserves required by the Commissioner or because of disallowance by the Commissioner of certain assets or reduction of the value at which carried in the insurer's accounts, the Commissioner may in his or her discretion and upon application and good cause shown extend for not more than an additional 60 days the period within which the deficiency may be so made good and the proof thereof so filed.

History. — Code 1933, § 56-1531, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 1246, § 4.

Cross references. — Delinquency proceedings generally, T. 33, C. 37.

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The proper method of disposing of accumulated and undisbursed receivership funds held by the Insurance Commissioner in cases where creditors or claimants of defunct domestic stock and mutual insurance companies cannot be located or where checks issued to them for their pro rata portion have been for any reason returned unpaid is to turn such funds over to the Fiscal Division of the Department of Administrative Services (now Office of Treasury and Fiscal Services), which shall ultimately remit the funds to the Board of Regents of the University System of Georgia; in cases involving all other types of defunct insurance companies, the Insurance Commissioner should petition the superior court that supervised the particular insurance company's dissolution proceedings for leave to deposit the accumulated and undisbursed receivership funds in its registry to be subsequently dealt with by order of the court as it deems advisable. 1975 Op. Att'y Gen. No. 75-83.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83.

C.J.S. — 44 C.J.S., Insurance, § 144.

ALR. — Fire insurance: insolvency of, or appointment of receiver for, insurer as affecting subsequent losses, 79 A.L.R. 1267.

Insolvency of insurers as affecting liability of one under duty by statute or contract to carry or maintain insurance for another's protection, 106 A.L.R. 248.

Insolvency of insurer at time of issuing policy as defense against action to collect assessments or premiums, 170 A.L.R. 1008.

33-14-23. Extinguishment of charters of corporations not actively engaged in business; automatic extinguishment of charter upon merger or consolidation.

(a) The corporate charter of any other corporation formed under the laws of this state for the purpose of becoming an insurer, and which corporation, during any period of 36 consecutive months after January 1, 1961, is not actively engaged in business as a domestic insurer under a certificate of authority issued to it by the Commissioner under laws currently in force is automatically extinguished and nullified at the expiration of such 36 month period.

(b) Upon certification by the Commissioner of such facts under subsection (a) of this Code section to the Secretary of State, the Secretary of State shall enter an order extinguishing and nullifying the corporate charter.

(c) The period during which any corporation referred to in subsection (a) of this Code section is the subject of delinquency proceedings under Chapter 37 of this title shall not be counted as part of any 36 month period.

(d) Upon merger or consolidation of a domestic insurer with another insurer under this chapter, the corporate charter of the merged or consolidated domestic insurer shall thereby automatically be extinguished and nullified.

History. — Code 1933, § 56-1540, enacted by Ga. L. 1960, p. 289, § 1.

33-14-24. Procedure for voluntary dissolution generally; effective date of dissolution; conditions precedent to effectuation of dissolution.

(a) If, while a domestic stock or mutual insurer is fully solvent and it is deemed by its board of directors to be in the best interests of the insurer and its stockholders or members that the insurer be dissolved, the board of directors shall adopt a resolution to that effect and call a special meeting of its stockholders or members to consider and take action upon the proposal to dissolve the insurer corporation. The meeting shall be held upon not less than 30 days' written notice to the stockholders or members in advance of the meeting, which notice shall contain a statement of the dissolution proposal. The notice shall be given in the manner provided in the insurer's bylaws for a special meeting of stockholders or members.

(b) If, at the special meeting or any adjournment thereof, the holders of record of stock entitled to exercise two-thirds of all the voting power on such proposal or if a mutual insurer, two-thirds of the insurer's

members present or represented by proxy at the meeting shall by resolution consent that the dissolution shall take place, a copy of the resolution together with a list of the names and residences of the directors and officers certified by the president or a vice-president and the secretary or an assistant secretary or the treasurer or an assistant treasurer of the insurer shall be filed in triplicate with the application to surrender the charter required in Code Section 33-14-25 and one copy shall be filed for record in the office of the clerk of the superior court of the county in which the office or principal place of business of the insurer is located in this state.

(c) Whenever all the stockholders of record of a domestic stock insurer having power to vote on a proposal to dissolve consent in writing to the dissolution, no meeting of the stockholders shall be necessary.

(d) The effective date of the dissolution shall be the date of the issuance of the order by the Secretary of State dissolving the insurer under Code Section 33-14-25.

(e) No dissolution shall be effected, however, until after the insurer has reinsured in another authorized insurer or has otherwise terminated all its insurance then in force; nor, in the case of a domestic mutual insurer, until after the proposed plan of dissolution together with the proposed plan for distribution of assets among the insurer's members has been filed with and approved by the Commissioner after having been found by him or her to be fair and equitable to the members of the domestic mutual insurer.

History. — Code 1933, § 56-1544, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 1307, § 4.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 86 et seq.

C.J.S. — 44 C.J.S., Insurance, § 210 et seq.

33-14-25. Procedure for surrender of charter.

(a) Any insurance corporation chartered by the Secretary of State may surrender its charter upon the company filing in the office of the Commissioner of Insurance an application in triplicate, signed with its corporate name and under its corporate seal, stating:

(1) The name of the company and the location of its principal place of business in this state;

(2) The date of its charter and all amendments thereto and the date or dates of renewal or renewals of its charter;

(3) That it desires to surrender its charter and franchise to the state;

(4) A certificate attested to by two officers of the company that the procedure required by Code Section 33-14-24 has been carried out; and

(5) Any other information deemed necessary by the Commissioner of Insurance.

(b) Upon receipt thereof, the Commissioner shall take such action to investigate the proposed surrender to determine if the rights of policyholders, creditors, stockholders or members, and third party claimants under liability policies of the insurer have been paid or properly provided for in a fair and equitable manner. The Commissioner shall after making his or her determination issue under his or her hand and official seal a certificate approving or disapproving the application for surrender of the charter and shall transmit a copy of such certificate of approval to the Secretary of State. If the Commissioner does not approve the application, the Commissioner shall notify the insurer in writing of his or her reasons for not approving the application for surrender of the charter.

(c) The fee and publication requirements set out in subsections (a) through (c) of Code Section 33-14-5 shall be applicable to a surrender of charter under this Code section.

(d) Upon receipt of the certificate of the judge of the probate court as to the publication of the application and the certificate of approval of the surrender from the Commissioner, the Secretary of State shall issue under the seal of the state a certificate dissolving the insurer; and the Secretary of State shall record the application, the certificate of the judge of the probate court, the certificate of approval of the Commissioner, and the certificate dissolving the insurer.

History. — Code 1933, § 56-1545, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 1307, § 5.

33-14-26. Powers and duties of directors as trustees upon expiration of period of corporate existence; filling of vacancies and replacement of directors.

Upon the dissolution of a domestic stock or mutual insurer under Code Section 33-14-25, or upon the expiration of the period of its corporate existence in any other manner, except under Chapter 37 of this title, the directors of the corporation shall be trustees of the corporation with the full power to settle the affairs, collect the outstanding debts, sell and convey the property, real and personal, of the corporation, and divide its assets among its stockholders or members

entitled to the assets, after paying or adequately providing for the payment of its liabilities and obligations. Vacancies in the number of directors may be filled by the remaining directors, but any director may be replaced on the vote of a majority of the stockholders, or members of the corporation, if a mutual insurer.

History. — Code 1933, § 56-1546, enacted by Ga. L. 1960, p. 289, § 1.

33-14-27. Continuance of corporate existence subsequent to dissolution or expiration.

All domestic stock and mutual insurance corporations, whether they expire by their own limitation or are otherwise dissolved, shall nevertheless be continued for a term of three years from such expiration or dissolution, except in any dissolution under Chapter 37 of this title, as bodies corporate for the purpose of prosecuting and defending actions by or against them and of enabling them to settle and close their business, to dispose of and convey their property, and to divide their assets among those entitled to such assets, but not for the purpose of continuing business as insurers; provided, however, that as to any action or proceeding commenced by or against the corporation prior to such expiration or dissolution and with respect to any action or proceeding commenced by or against the corporation within three years after the date of the expiration or dissolution, the corporation shall for the purpose of the actions or proceedings only be continued as bodies corporate beyond the three-year period and until any judgments, orders, or decrees in the expiration or dissolution actions or proceedings are fully executed.

History. — Code 1933, § 56-1547, enacted by Ga. L. 1960, p. 289, § 1.

ARTICLE 2

DOMESTIC STOCK INSURERS

33-14-40. Reinsurance of risks generally; bulk insurance agreements.

(a) A domestic stock insurer may accept reinsurance for the same kinds of insurance and within the same limits as it is authorized to transact direct insurance unless such reinsurance is prohibited by its charter.

(b) A domestic stock insurer may reinsure all or substantially all of its business in force or substantially all of a major class thereof with another insurer by an agreement of bulk insurance; but the agreement

shall not become effective unless filed with and approved in writing by the Commissioner.

(c) The Commissioner shall approve agreements of bulk insurance within 60 days after their filing unless he finds that it is inequitable to the stockholders of the domestic insurer or would substantially reduce the protection or service to its policyholders. If the Commissioner does not approve the agreement, he shall so notify the insurer in writing specifying his reasons therefor.

History. — Code 1933, § 56-1538, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1818.

C.J.S. — 46A C.J.S., Insurance, § 2077 et seq.

ALR. — Effect of reinsurance of life policy as modifying the amount of liability upon death of insured, 25 A.L.R. 1535.

Who may enforce liability of reinsurer, 103 A.L.R. 1485.

Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-14-41. Dividends payable only out of realized profits or upon special approval of Commissioner.

(a) As used in this Code section, the term "unassigned surplus" means, with respect to a stock insurer, undistributed, accumulated surplus, including net income and unrealized gains, since the organization of such insurer.

(b) A domestic stock insurer may pay dividends to its stockholders only out of unassigned surplus or upon special approval of the Commissioner upon the terms and conditions set out in subsection (c) of this Code section.

(c) Notwithstanding any other provision of the law, a domestic stock insurer may, conditioned upon receipt of the Commissioner's approval, declare a dividend from other than unassigned surplus; provided, however, that such declaration shall confer no rights upon the security holders of such insurer and such insurer may not pay such dividend until the Commissioner has:

(1) Approved the payment of such dividend; or

(2) Not disapproved the payment of such dividend within 30 days after receipt of notice from such insurer of the declaration thereof.

History. — Code 1933, § 56-1523, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1965, p. 483, § 1; Ga. L. 1993, p. 625, § 3.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1993, "accumulated surplus" was substituted for "accu-

mulated, surplus" in subsection (a) and "30 days" was substituted for "thirty days" in paragraph (c)(2).

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This section does not relate to "stock dividends." 1963-65 Op. Att'y Gen. p. 205.

RESEARCH REFERENCES

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

33-14-42. Illegal dividends.

(a) Any director of a domestic stock insurer who votes for or concurs in declaration or payment of an illegal dividend to stockholders shall upon conviction thereof be guilty of a misdemeanor and shall be jointly and severally liable together with other such directors for any loss thereby sustained by the insurer.

(b) The stockholders receiving such an illegal dividend shall be liable in the amount thereof to the insurer.

(c) The Commissioner may revoke or suspend the certificate of authority of an insurer which has declared or paid an illegal dividend.

History. — Code 1933, § 56-1525, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

C.J.S. — 18 C.J.S., Corporations, § 371 et seq.
44 C.J.S., Insurance, §§ 180, 196, 199.
45 C.J.S., Insurance, § 695.

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

33-14-43. Authorization and procedure for merger or consolidation; receipt of consideration by directors, officers, agents, or employees; formation of domestic insurance company for sole purpose of merging or consolidating with existing domestic insurer.

(a) A domestic stock insurer may merge or consolidate with one or more domestic, alien, or foreign stock corporations by complying with the applicable laws of this state governing the merger or consolidation of stock corporations formed for profit and Code Sections 33-14-5 and 33-14-6.

(b) No director, officer, agent, or employee of any insurer party to such merger or consolidation shall receive any fee, commission, compensation, or other valuable consideration whatsoever for or in any manner aiding, promoting, or assisting therein except as set forth in the plan or agreement.

(c) The Commissioner may permit the formation of a domestic insurance company that is established for the sole purpose of merging or consolidating with an existing domestic insurer simultaneously with a division authorized by Article 6 of this chapter. Upon request of the dividing insurer, as defined in Code Section 33-14-120, the Commissioner may waive the requirements of subsection (a) of this Code section, Code Section 33-3-15, and Chapter 13 of this title. Each insurer formed under this subsection shall be deemed to exist before a merger and division under this Code section becomes effective, but solely for the purpose of being a party to such merger and division. The Commissioner shall not require that such insurer be licensed to transact insurance business in this state before such merger and division. All insurance policies, annuities, or reinsurance agreements allocated to such insurer shall become the obligation of the insurer that survives the merger simultaneously with the effectiveness of the merger and division. The plan of merger shall be deemed to have been approved by such insurer if the dividing insurer approved such plan. The certificate of merger shall state that it was approved by the insurer formed under this subsection.

History. — Code 1933, § 56-1534, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2019, p. 474, § 3/SB 156.

The 2019 amendment, effective July 1, 2019, added subsection (c).

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Compliance required only if at least one of companies is domestic. — This section insofar as it requires compliance with former Code 1933, §§ 56-1505 and 56-1506 (see O.C.G.A. §§ 33-14-5 and 33-14-6), can apply only where there is a merger of two domestic insurance companies or a merger of a domestic insurance company and a foreign insurance company, with the survivor being a Georgia company. 1963-65 Op. Att'y Gen. p. 19.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 62.

C.J.S. — 44 C.J.S., Insurance, § 202 et seq.

33-14-44. Authorization and procedure for conversion of stock insurer to mutual insurer.

(a) A domestic stock insurer certified to issue only those kinds of insurance which domestic mutual insurers are authorized to issue under this title may become a domestic mutual insurer pursuant to such plan and procedure as may be approved in advance by the Commissioner.

(b) The Commissioner shall not approve any such plan or procedure unless:

(1) It is equitable to stockholders and policyholders;

(2) It is subject to approval by the holders of not less than three-fourths of the insurer's outstanding capital stock having voting rights and by not less than two-thirds of the insurer's policyholders who vote on the plan in person, by proxy, or by mail pursuant to such notice and procedure as may be approved by the Commissioner;

(3) If a life insurer, the right to vote on such plan is limited as provided in the bylaws;

(4) Mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value of the insurer's capital stock as determined by competent disinterested appraisers;

(5) The plan provides for the purchase of the shares of any nonconsenting stockholder in the same manner and subject to the same applicable conditions as provided by the general corporation laws of this state as to rights of nonconsenting stockholders with respect to consolidation or merger of private corporations;

(6) The plan provides for definite conditions to be fulfilled by a designated early date upon which the mutualization will be deemed effective; and

(7) The mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance, and for the kinds of insurance included in its certificate of authority in those states.

(c) This Code section shall not apply to mutualization under order of court pursuant to rehabilitation of an insurer under Chapter 37 of this title.

History. — Code 1933, § 56-1536, enacted by Ga. L. 1960, p. 289, § 1.

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Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Ga. L. 1912, p. 119, § 16, are included in the annotations for this Code section.

Construction of certificates issued after insurer changed to mutual plan. — Where a company, operating as an industrial life insurance company issued a number of certificates, apparently claiming authority so to do under Civil Code 1910, § 2510, now repealed, and then changed to the mutual plan, with legal reserve, and issued other certificates in the same form, the certificates issued as a mutual company were not deemed to be regulated by Civil Code 1910, § 2510, but by their own terms. Lockridge v. State Mut. Life Ins. Co., 142 Ga. 30, 82 S.E. 131 (1914); Cherokee Life Ins. Co. v. Davis, 142 Ga. 32, 82 S.E. 445 (1914) (decided under former Ga. L. 1912, p. 119, § 16).

33-14-45. Classes of common or preferred shares.

A domestic stock insurer may have one or more classes of common or preferred shares, all of which shall be shares with par value in accordance with paragraph (5) of subsection (b) of Code Section 33-14-4 and any or all of which may, subject to any restrictions of this title, consist of shares with full, limited, multiple, fractional, or no voting rights and such designations, preferences, qualifications, privileges, limitations, redemption provisions (in the case of preferred shares), options, conversion rights, and other special rights as shall be stated in this article. Except as otherwise stated in this article, this title, or other applicable laws, each share shall be equal in all respects to every other share.

History. — Code 1981, § 33-14-45, enacted by Ga. L. 1994, p. 694, § 2.

Law reviews. — For note on the 1994 enactment of this Code section, see 11 Ga. St. U.L. Rev. 196 (1994).

ARTICLE 3

DOMESTIC MUTUAL INSURERS

RESEARCH REFERENCES

ALR. — Right of mutual benefit association to raise rates, 80 A.L.R. 659.

33-14-60. Bylaws.

(a) The initial board of directors of a domestic mutual insurer shall adopt original bylaws subject to the approval of the insurer's members at the next succeeding meeting. The members shall have power to adopt, modify, and revoke bylaws.

(b) The bylaws shall provide:

(1) That each member is entitled to one vote upon each matter coming to a vote at meetings of members or to more votes in accordance with a reasonable classification of members as set forth in the bylaws and based upon the amount of insurance in force, numbers of policies held, upon the amount of the premiums paid by such members, or upon other reasonable factors. A member shall have the right to vote in person or by his written proxy. No such proxy shall be made irrevocable;

(2) For election of directors by the members and for the number, qualifications, terms of office, and powers of directors;

(3) The time, notice, quorum, and conduct of annual and special meetings of members and voting procedures at the meetings. The bylaws may provide that the annual meeting shall be held at a place, date, and time to be set forth in the policy and that no other notice of the meeting shall be required;

(4) The number, designation, election, terms, and powers and duties of the respective corporate officers;

(5) For deposit, custody, disbursement, and accounting for corporate funds; and

(6) For any other reasonable provisions customary, necessary, or convenient for the management or regulation of its corporate affairs and not inconsistent with law.

(c) The insurer shall promptly file with the Commissioner a copy of its bylaws certified by the insurer's secretary or assistant secretary, and of every modification thereof or addition thereto. The Commissioner shall disapprove any bylaw provision deemed by him to be unlawful, unreasonable, inadequate, unfair, or detrimental to the proper interests or protection of the insurer's members of any class of members. The insurer shall not, after receiving written notice of such disapproval and during the existence of the corporation, effectuate any bylaw provision so disapproved.

History. — Code 1933, § 56-1515, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 68.

C.J.S. — 44 C.J.S., Insurance, § 184.

ALR. — Power of mutual benefit society to waive restrictions upon eligibility to membership, 28 A.L.R. 93.

33-14-61. Types of insurance in which newly organized insurers authorized to transact business; requirements as to transaction of particular kinds of insurance generally.

(a) When newly organized, a domestic mutual insurer may be authorized to transact any one of the kinds of insurance listed in the schedule contained in subsection (b) of this Code section and as limited in Code Section 33-3-5.

(b) When applying for an original certificate of authority, the insurer must be otherwise qualified therefor under this title, and must have received and accepted bona fide applications as to substantial insurable subjects for insurance coverage of a substantial character of the kind of insurance proposed to be transacted, must have collected in cash and full premium therefor at rates meeting the requirements of Chapter 9 of this title, if a property and casualty company must have surplus funds on hand as of the date the insurance coverages are to become effective, or, in lieu of such applications, premiums, and surplus, may deposit surplus, all in accordance with that part of the following schedule which applies to the kind of insurance the insurer proposes to transact:

(A) Kind of Insurance	(B) Min. No. of Applicants Accepted	(C) Min. No. of Subjects Covered	(D) Minimum Premiums Coll.	(E) Min. Amt. Ins. Each Subject	(F) Max. Amt. Ins. Each Subject (V)	(G) Minimum Surplus Funds (VI)	(H) Deposit of Surplus (VI)
(I) Life	500	500	Ann.	$1,000	$ 2,500	$3 million	$3 million
(II) Accident & Sickness	500	500	Quar.	10 (Weekly Indem.)	25 (Weekly Indem.)	3 million	3 million
(III) Property	100	250	Ann.	1,000	3,000	3 million	3 million
(IV) Casualty	250	500	Ann.	1,000	10,000	3 million	3 million
Casualty with Workers' Compensation	250	1,500	Quar.	1,000	Statutory	3 million	3 million

(c) The provisos listed in this subsection are respectively applicable to the schedule and provisions set out in subsection (b) of this Code section as indicated by like Roman numerals which appear in such schedule:

(I) All applicants must be bona fide residents of this state; and no group insurance or term policies for terms of less than 20 years shall be included;

(II) All applicants must be bona fide residents of this state. No group or blanket plans of insurance shall be included. In lieu of

weekly indemnity a like premium value in medical, surgical, and hospital benefits may be provided;

(III) Only insurance of the owner's interest in real property situated in this state may be included;

(IV) The policy must include insurance of legal liability for bodily injury and property damage to which the maximum and minimum insured amounts apply. All applicants must be bona fide residents of this state;

(V) The maximums provided for in column (F) are net after deducting applicable reinsurance; and

(VI) The deposit of surplus in the amount specified in columns (G) and (H) must thereafter be maintained unimpaired. The deposit is subject to Chapter 12 of this title.

History. — Code 1933, § 56-1510, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1984, p. 1080, § 3; Ga. L. 1985, p. 149, § 33; Ga. L. 1990, p. 1275, § 5; Ga. L. 1991, p. 94, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "Max. Amt." was substituted for "Max Amt." in the heading for column (F) in the chart set forth in subsection (b), and "20" was substituted for "twenty" in division (I) of subsection (c).

Editor's notes. — Ga. L. 1990, p. 1275, § 7, not codified by the General Assembly, provided that the 1990 amendment was effective for the purposes of application to new or newly admitted insurers on January 1, 1991, and effective for all purposes on July 1, 1992.

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Requirements for fire insurer to write "homeowner" policies. — Before a company presently writing fire insurance can be authorized to issue "homeowner" policies, it would be required to meet the surplus requirements of this section, that is, $200,000.00 (now $ 3 million) for each class of insurance written; and the deposit requirements of former Code 1933, § 56-309 (see O.C.G.A. § 33-3-8), that is, $100,000.00 for one class and $25,000.00 for each additional class of insurance written. 1960-61 Op. Att'y Gen. p. 274.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 31, 34.

C.J.S. — 44 C.J.S., Insurance, § 11et seq.

33-14-62. Authorization of transaction of additional kinds of insurance.

A domestic mutual insurer formed after January 1, 1961, after being authorized to transact one kind of insurance shall be authorized by the Commissioner to transact such additional kinds of insurance as are permitted under Code Section 33-3-5, while otherwise in compliance with this title and while maintaining unimpaired surplus funds in an

amount not less than the amount of paid-in capital stock required of a domestic stock insurer transacting like kinds of insurance, subject further to the additional expendable surplus requirements of this title applicable to such a stock insurer.

History. — Code 1933, § 56-1517, enacted by Ga. L. 1960, p. 289, § 1.

33-14-63. Filing of surety bond or deposit by incorporators of proposed insurer; conditions of bond or deposit; release and discharge.

(a) Prior to the solicitation of any applications for insurance pursuant to the requirements for a certificate of authority of a mutual insurer, the incorporators of the proposed insurer shall file with the Commissioner a corporate surety bond in the penalty of $15,000.00 in favor of the state and for the use and benefit of the state and of applicant members and creditors of the corporation. The bond shall be conditioned as follows:

(1) For the prompt return to applicant members of all premiums collected in advance;

(2) For payment of all indebtedness of the corporation; and

(3) For payment of costs incurred by the state in the event of any legal proceedings for liquidation or dissolution of the corporation.

All of the conditions shall become due and payable only in the event the corporation fails to complete its organization and secure a certificate of authority within two years from and after the date of the certificate of incorporation.

(b) In lieu of such bond, the incorporators may deposit with the Commissioner $15,000.00 in cash or United States government bonds negotiable and payable to the bearer, with a market value at all times of not less than $15,000.00, to be held in trust upon the same conditions as required for the bond.

(c) Any such bond filed or deposit made or remaining portion thereof held under this Code section shall be released and discharged upon settlement and termination of all liabilities against it.

History. — Code 1933, § 56-1511, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-71/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "corporation" for "corporations" at the end of paragraph (a)(3).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 10, 506.

C.J.S. — 11 C.J.S., Bonds, § 39. 44 C.J.S., Insurance, § 85.

33-14-64. Solicitation of applications for policies upon approval of bond or deposit; provisions and execution of applications; requirement of cash premiums.

(a) Upon receipt of the Commissioner's approval of the bond or deposit required by Code Section 33-14-63, the directors and officers of the proposed domestic mutual insurer may commence solicitation of such requisite applications for insurance policies as they may accept and may receive deposits of premiums thereon.

(b) All applications shall be in writing signed by the applicant.

(c) All applications shall provide that:

(1) Issuance of the policy is contingent upon the insurer qualifying for and receiving a certificate of authority; and

(2) No insurance is in effect unless and until the certificate of authority has been issued.

(d) All qualifying premiums collected shall be in cash.

History. — Code 1933, § 56-1512, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 69.

C.J.S. — 44 C.J.S., Insurance, § 185 et seq.

33-14-65. Deposit of premiums and fees collected; issuance and delivery of policies by insurers; effective date of insurance.

(a) All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance with such corporation shall be deposited in trust in a bank or trust company in this state which is authorized under the laws of this state to act as a depository of state funds and which has its deposits insured by the Federal Deposit Insurance Corporation under a written trust agreement consistent with this Code section. The corporation shall file an executed copy of the trust agreement with the Commissioner.

(b) Upon issuance to the corporation of a certificate of authority as an insurer for the kind of insurance for which the applications were solicited, all funds so held in trust shall become the funds of the insurer and the insurer shall issue and deliver its policies for which premiums have been paid and accepted. The insurance provided by the policies shall be effective as of the date of the certificate of authority.

History. — Code 1933, § 56-1513, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, §§ 142 et seq.

33-14-66. Return of deposits or premiums upon failure of proposed insurer to complete organization and secure original certificate of authority.

If the proposed domestic mutual insurer fails to complete its organization and to secure its original certificate of authority within two years from and after the date of its incorporation, the corporation shall be dissolved by the Commissioner and the Commissioner shall return or cause to be returned to the persons entitled thereto all advance deposits or payments of premiums held in trust under Code Section 33-14-65.

History. — Code 1933, § 56-1514, enacted by Ga. L. 1960, p. 289, § 1.

33-14-67. Policyholders deemed members of insurers; persons entitled to become members; liability upon insurance contracts of representatives of members; rights of members generally.

(a) Each policyholder of a domestic mutual insurer other than of a reinsurance contract is a member of the insurer with all rights and obligations of such membership, and the policy shall so specify.

(b) Any person, government, or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee, or fiduciary may be a member of a domestic, foreign, or alien mutual insurer. Any officer, stockholder, trustee, or legal representative of any corporation, board, association, or estate may be recognized as acting for or on its behalf for the purpose of membership, and shall not be personally liable upon any contract of insurance for acting in a representative capacity.

(c) Any domestic corporation may participate as a member of a mutual insurer as an incidental purpose for which the corporation is organized and as such is granted the rights and powers expressly conferred.

History. — Code 1933, § 56-1516, enacted by Ga. L. 1960, p. 289, § 1.

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Section does not change restrictions on lending local credit. — This section cannot be construed to alter or change the restrictions imposed by Ga. Const. 1976, Art. IX, Sec. IV, Para. III (see Ga. Const. 1983, Art. IX, Sec. II, Para. VIII). 1960-61 Op. Att'y Gen. p. 383.

State and its subdivisions may not assume contingent mutual insurance liability. — The state and its political subdivisions may not insure public property in a mutual company if the insured assumes any contingent liability under the contract. 1945-47 Op. Att'y Gen. p. 371.

Future liability forbidden. — If, in any way, the state, or any division thereof, taking insurance in a mutual insurance company assumes any future liability, the contract could not be binding upon the state or the division of the state taking the policy, because such a contract is forbidden by law. 1945-47 Op. Att'y Gen. p. 371.

Only bids on nonassessable contracts may be considered. — The supervisor of purchases (now Department of Administrative Services) may consider bids and quotations from mutual insurers authorized to write fire insurance and fidelity bonds in Georgia only when such contracts are written upon a nonassessable basis and where no contingent liability is assumed or agreed to be paid by the state or any of its political subdivisions. 1960-61 Op. Att'y Gen. p. 383.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 71.

C.J.S. — 44 C.J.S., Insurance, § 185.

ALR. — Power of mutual benefit society to waive restrictions upon eligibility to membership, 28 A.L.R. 93.

Liability of policyholders in mutual insurance companies to assessments, 137 A.L.R. 945.

33-14-68. Contingent liability of members.

(a) Each member of a domestic mutual insurer shall, except as provided in Code Section 33-14-71 with respect to nonassessable policies, have a contingent liability, pro rata and not one for another, for the discharge of its obligations, which contingent liability shall be in the maximum amount stated in the insurer's charter.

(b) Each policy issued by the insurer shall contain a statement of the contingent liability, if any, of its members.

(c) Termination of the policy of any member shall not relieve the member of contingent liability for his proportion, if any, of the obligations of the insurer which accrued while the policy was in force.

(d) Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

History. — Ga. L. 1893, p. 73, § 20; Civil Code 1895, § 2029; Civil Code 1910, § 2411; Code 1933, § 56-230; Code 1933, § 56-1527, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 77.

C.J.S. — 44 C.J.S., Insurance, §§ 186, 192 et seq.

ALR. — Liability of policyholders in mutual insurance companies to assessments, 137 A.L.R. 945.

33-14-69. Levy of assessment by directors; computation of assessment; allowance of offsets against assessments.

(a) If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required of it by this title for authority to transact the kinds of insurance being transacted and the deficiency is not cured from other sources, its directors shall levy an assessment only upon its members who at any time within the 12 months immediately preceding the date notice of the assessment was mailed to them held policies providing for contingent liability; and the members shall be liable to the insurer for the amount so assessed.

(b) The assessment shall be for the amount necessary to cure the deficiency and to provide a reasonable amount of working funds above the minimum amount of surplus; but the working funds so provided shall not exceed 5 percent of the insurer's liabilities as of the date as of which the amount of the deficiency was determined.

(c) In levying an assessment on policies providing for contingent liability, the assessment shall be computed on a basis of premium earned on the policy.

(d) No member shall have an offset against any assessment for which he is liable on account of any claim for unearned premium or loss payable.

History. — Code 1933, § 56-1528, enacted by Ga. L. 1960, p. 289, § 1.

33-14-70. Notice of assessment; presumption as to correctness of assessment; proceedings upon failure of member to pay assessment.

(a) Any assessment made by an insurer under Code Sections 33-14-68 and 33-14-69 is prima facie correct. The amount of the assessment to be paid by each member as determined by the insurer is likewise prima facie correct.

(b) The insurer shall notify each member of the amount of the assessment to be paid by written notice mailed to the address of the member last of record with the insurer. Failure of the member to receive the notice so mailed within the time specified therein for the payment

of the assessment or at all shall be no defense in any action to collect the assessment.

(c) If a member fails to pay the assessment within the period specified in the notice, which period shall not be less than 20 days after mailing, the insurer may institute an action to collect same.

(d) As to life insurance, any part of the assessment upon a member which remains unpaid following notice of assessment, demand for payment, and lapse of a reasonable waiting period as specified in the notice, may, if approved by the Commissioner as being in the best interests of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held by the insurer to the credit of the member.

History. — Code 1933, § 56-1529, enacted by Ga. L. 1960, p. 289, § 1.

33-14-71. Extinguishment of contingent liability; revocation of authority to issue policies without contingent liability; issuance of nonassessable policies by foreign or alien insurers.

(a) While a domestic mutual insurer maintains the deposits and surplus funds necessary for the kinds of insurance it is transacting and is otherwise in compliance with this title and is in a sound condition it may extinguish the contingent liability of its members as to all its policies in force and may omit provisions imposing contingent liability in all its policies currently issued upon receiving written approval by the Commissioner. The Commissioner shall revoke the authority of a domestic mutual insurer to issue policies without contingent liability at any time the insurer's assets are less than the sum of its liabilities and the surplus required for the authority or if the insurer, by resolution of the board of directors approved by a majority of its members present and voting in person or by proxy at a meeting called for that purpose, requests that the authority be revoked.

(b) A foreign or alien mutual insurer may issue nonassessable policies to its members in this state pursuant to its articles of incorporation and the laws of its domicile.

History. — Code 1933, § 56-1530, enacted by Ga. L. 1960, p. 289, § 1.

33-14-72. Reinsurance of risks.

(a) A domestic mutual company transacting insurance business under the laws of this state with the approval of the Commissioner may reinsure all risks undertaken by it in any company authorized to

transact a similar class of insurance business in this state and transfer to the company assuming such risks all or such of its assets, reserves, liabilities, and obligations of every character as the agreement approved by the Commissioner shall provide.

(b) This Code section shall not prevent a domestic mutual company from reinsuring any risks or fractional parts thereof not situated in this state in any company licensed by the state in which such risks are located.

History. — Code 1933, § 56-1539, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1812.

C.J.S. — 46A C.J.S., Insurance, § 2077 et seq.

ALR. — Effect of reinsurance of life policy as modifying the amount of liability upon death of insured, 25 A.L.R. 1535.

Who may enforce liability of reinsurer, 103 A.L.R. 1485.

Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-14-73. Dividends payable only out of net realized savings and earnings.

(a) The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus funds which represent net realized savings and net realized earnings from its business.

(b) A dividend otherwise proper may be payable out of the savings and earnings even though the insurer's total surplus is then less than the aggregate of its contributed surplus.

History. — Code 1933, § 56-1524, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 79 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 180 et seq., 196 et seq.

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

33-14-74. Liability of directors for declaration or payment of illegal dividend.

Any director of a domestic mutual insurer who willfully and with knowledge votes for or concurs in a declaration or payment of a dividend which reduces surplus below the minimum required surplus

shall be guilty of a misdemeanor and shall be jointly and severally liable, together with other such directors likewise voting for or concurring in willfully and with knowledge, for any loss thereby sustained by the insurer.

History. — Code 1933, § 56-1526, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Punishment for misdemeanors generally, § 17-10-3.

33-14-75. Procedure for merger or consolidation.

(a) Upon complying with the applicable procedures prescribed by the statutes of this state applying to corporations formed for profit except as provided in subsection (c) of this Code section, any domestic mutual insurer is authorized to merge or consolidate with any domestic company or with any foreign or alien company if such merger or consolidation is authorized by the laws of the state or country under which such foreign or alien company is incorporated or organized.

(b) The plan and agreement for merger or consolidation shall be submitted to and approved by at least two-thirds of the members of each mutual insurer involved voting on the merger or consolidation in person or by proxy at meetings called for the purpose pursuant to ten days' notice and such procedure as has been approved by the Commissioner. If a life insurer, right to vote may be limited to members whose policies are other than term or group policies and have been in effect for more than one year as the bylaws may provide.

(c) No merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the Commissioner and approved by him in writing. The Commissioner shall give his approval within 60 days after the filing unless he finds such plan or agreement:

(1) Is inequitable to the policyholders or any domestic insurer involved; or

(2) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state and elsewhere.

(d) If the Commissioner does not approve the plan or agreement he shall so notify the insurers in writing specifying his reasons for disapproving the merger or consolidation.

History. — Code 1933, § 56-1535, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 6, § 33.

Cross references. — Merger and share exchange of business corporations generally, § 14-2-1101 et seq. Merger or consolidation of Secretary of State corporations, § 14-4-140 et seq.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 69.

C.J.S. — 44 C.J.S., Insurance, § 202 et seq.

33-14-76. Authorization and procedure for conversion of mutual insurer to stock insurer.

(a) A mutual insurer may become a stock insurer under any plan and procedure as may be approved by the Commissioner.

(b) The Commissioner shall not approve the plan or procedure unless:

(1) It is equitable to the insurer's members;

(2) It is subject to approval by vote of not less than 60 percent of the insurer's current members who cast votes on such plan in person, by proxy, or by mail at a meeting of members called for the purpose pursuant to 20 days' notice and procedure as may be approved by the Commissioner;

(3) If a life insurer, the right to vote may be limited as the bylaws shall provide to members whose policies are other than term or group policies and have been in effect for more than one year;

(4) The equity of each policyholder in the insurer is determinable under a fair formula approved by the Commissioner, which equity shall be based upon not less than the insurer's entire statutory surplus after deducting contributed or borrowed surplus funds plus a reasonable present equity in its reserves and in all nonadmitted assets, less expenses of the conversion;

(5) The policyholders entitled to participate in the purchase of stock or distributing of assets shall include all current policyholders who own a policy for which all premiums due have been fully paid on the date the plan was adopted by the board of directors of the insurer;

(6) The plan, as elected by the insurer and voted upon by the members, gives to each policyholder of the insurer as specified in paragraph (5) of this subsection one of the following:

(A)(i) A preemptive right to acquire his or her proportionate part of all of the proposed capital stock of the insurer within a designated reasonable period and to apply upon the purchase price thereof the amount of his or her equity in the insurer as determined in paragraph (4) of this subsection.

(ii) Shares are so offered to policyholders at a price not greater than that to be thereafter offered to others.

(iii) The plan provides for payment, to each policyholder not electing to apply his or her equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in the amount of not less than 50 percent of the amount of his or her equity not so used for the purchase of stock, which cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer;

(B)(i) Payment in cash to each policyholder of 100 percent of his or her equity in the insurer, as determined in paragraph (4) of this subsection.

(ii) If a life insurer, payment may be provided as a paid-up life insurance policy with a cash value equal to 100 percent of the policyholder's equity in the insurer; provided, however, that the insurer may not impose a surrender charge on any policyholder electing to surrender his or her paid-up life insurance policy for its cash value; or

(C)(i) A preemptive right to acquire a percentage of his or her proportionate part of all of the proposed capital stock of the insurer within a designated reasonable period and to apply upon the purchase price thereof that same percentage amount of his or her equity in the insurer as determined in paragraph (4) of this subsection.

(ii) Shares are so offered to policyholders at a price not greater than that to be thereafter offered to others.

(iii) The plan provides for payment, to each policyholder not electing to apply his or her equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in the amount of not less than 50 percent of the amount of his or her equity not so used for the purchase of stock, which cash payment together with stock so purchased, if any, shall constitute full payment and discharge of the policyholder's equity as an owner of the mutual insurer; and

(7) The plan when completed would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance together with surplus funds in an amount required for the insurer under this title.

(c) The corporate existence of a mutual insurer converting to a stock insurer pursuant to this Code section shall not terminate upon such conversion, but the new stock insurer shall be deemed to be a continuation of the mutual insurer and to have been organized on the date the mutual insurer was originally organized.

(d) The insurer which has converted from a mutual to a stock company may continue to use its old name or may change its name pursuant to the laws of this state. In the event the converted insurer continues to use the word mutual in its name, then it shall include words after its name identifying the converted insurer as a stock insurer.

(e)(1) The Commissioner may approve any plan or procedure to become a stock insurer filed by a mutual insurer which at the time of the filing of such plan or procedure is insolvent or does not meet the minimum statutory surplus requirements, provided that such plan or procedure, on the date such plan or procedure is completed, would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance together with surplus funds in an amount required for the insurer under this title. The mutual insurer may provide in the plan or procedure for the waiver of the requirement to give notice to policyholders, to obtain policyholder approval of the plan or procedure, or to make any distribution of the policyholders' equity in the mutual insurer to any policyholder where the value of the mutual insurer, due to its insolvency or its failure to meet minimum statutory surplus requirements, does not warrant any such notice, approval, or distribution under the circumstances, including the expense involved in such a distribution.

(2) A plan or procedure described in paragraph (1) of this subsection must include a description of how the mutual insurer will meet the statutory surplus and capital requirements on the date the plan or procedure is completed, which may involve the issuance and sale directly to one or more purchasers of the capital stock of the converted insurer or of a corporation which will own 100 percent of the converted insurer.

History. — Ga. L. 1912, p. 119, § 16; Code 1933, § 56-1308; Code 1933, § 56-1537, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 1994, p. 300, § 2; Ga. L. 2009, p. 676, § 1/HB 550.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2009, "; and" was added at the end of division (b)(6)(C)(iii).

Law reviews. — For note on the 1994 amendment of this Code section, see 11 Ga. St. U.L. Rev. 196 (1994).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 69.

C.J.S. — 44 C.J.S., Insurance, § 183.

33-14-77. Distribution of assets to members upon liquidation of insurers generally; calculation of distributive shares of members.

(a) Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expenses of administration shall be distributed to existing persons who were its members at any time within 12 months immediately preceding the date such liquidation was authorized or ordered or the date of last termination of the insurer's certificate of authority, whichever date is the earlier; except that if the Commissioner has reason to believe that those in charge of the management of the insurer have caused or encouraged the reduction of the members of the insurer in anticipation of liquidation and for the purpose of reducing thereby the number of persons who may be entitled to share in distribution of the insurer's assets, he may enlarge the 12 month qualification period provided for in this subsection by any additional period as he may deem to be reasonable.

(b) The distributive share of each such member shall be in the proportion that the aggregate premiums earned by the insurer on the policies of the member during the combined periods of his membership bear to the aggregate of all premiums earned on the policies of all members. The insurer may and if a life insurer shall make reasonable classifications of its policies held by members and make a formula based upon the classification for determining the equitable distributive shares of each member. Such classification and formula shall be subject to the approval of the Commissioner.

History. — Code 1933, § 56-1541, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 99 et seq.
C.J.S. — 44 C.J.S., Insurance, § 212.

ARTICLE 4

INSIDER TRADING OF DOMESTIC STOCK INSURER EQUITY SECURITIES

Cross references. — Securities regulation, T. 10, C. 5.

Administrative rules and regulations. — Insider trading of domestic stock insurer equity securities, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-9.

Law reviews. — For comment, "A Negligence Approach to Section 14(E) Violations," see 69 Emory L.J. 519 (2019).

RESEARCH REFERENCES

ALR. — Convention Between the United States of America and the Swiss Confederation for the Avoidance of Double Taxation with Respect to Taxes on Income, Switz.-U.S., Oct. 2, 1996, 1996 WL 903835, S. Treaty Doc. No. 105-8, 42 A.L.R. Fed. 3d Art. 2.

Judicial Review of Debarment from Conducting Business with Department of Housing and Urban Development, 42 A.L.R. Fed. 3d Art. 3.

Application of Holding in Dirks v. S.E.C., 463 U.S. 646 (1983), that Recipient of Tip From Insider Must Abstain From Using such Information if Insider Will Benefit From Disclosing Tip, 42 A.L.R. Fed. 3d Art. 8.

33-14-90. "Equity security" defined.

As used in this article, "equity security" means any stock or similar security; any security convertible, with or without consideration, into such a security or carrying any warrant or right to subscribe to or purchase such a security; any such warrant or right; or any other security which the Commissioner shall deem to be of similar nature and consider necessary or appropriate, by any rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

History. — Code 1933, § 56-1606, enacted by Ga. L. 1965, p. 378, § 3.

33-14-91. Filing of statements of equity securities ownership.

Every person who is directly or indirectly the beneficial owner of more than 10 percent of any class of any equity security of a domestic stock insurer or who is a director or an officer of such insurer shall file in the office of the Commissioner within ten days after the person becomes the beneficial owner, director, or officer a statement in such form as the Commissioner may prescribe of the amount of all equity securities of the insurer of which the person is the beneficial owner; and within ten days after the close of each calendar month after the person becomes the beneficial owner, director, or officer, if there has been a change in such ownership during such month, the person shall file in the office of the Commissioner a statement in such form as the Commissioner may prescribe indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during that calendar month.

History. — Code 1933, § 56-1601, enacted by Ga. L. 1965, p. 378, § 3.

33-14-92. Authorization of actions to recover for insurer profits from purchases and sales, or sale and purchase, within period of less than six months.

For the purpose of preventing the unfair use of information which may have been obtained by a beneficial owner, director, or officer by reason of his relationship to an insurer, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of the insurer within any period of less than six months, unless the security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the insurer irrespective of any intention on the part of the beneficial owner, director, or officer in entering into the transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. An action to recover such profit may be instituted in any court of competent jurisdiction by the insurer or by the owner of any security of the insurer in the name and in behalf of the insurer if the insurer shall fail or refuse to bring an action within 60 days after request or shall fail diligently to prosecute the same thereafter; but no action shall be brought more than two years after the date the profit was realized. This Code section shall not be construed to cover any transaction in which the beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved or any transaction or transactions which the Commissioner by rules and regulations may exempt as not comprehended within the purpose of this Code section.

History. — Code 1933, § 56-1602, enacted by Ga. L. 1965, p. 378, § 3.

33-14-93. Unlawful sales of securities.

It shall be unlawful for any beneficial owner, director, or officer directly or indirectly to sell any equity security of such insurer if the person selling the security or his principal:

(1) Does not own the security sold;

(2) If owning the security, does not deliver it against such sale within 20 days thereafter; or

(3) Does not within five days after the sale deposit it in the mails or other usual channels of transportation;

but no person shall be deemed to have violated this Code section if he proves that notwithstanding the exercise of good faith he was unable to make the delivery or deposit within that time or that to do so would cause undue inconvenience or expense.

History. — Code 1933, § 56-1603, enacted by Ga. L. 1965, p. 378, § 3.

33-14-94. Sales by dealers in ordinary course of business and incident to establishment or maintenance of primary or secondary market exempted from article.

Code Section 33-14-92 shall not apply to any purchase and sale, or sale and purchase, and Code Section 33-14-93 shall not apply to any sale of an equity security of a domestic stock insurer not then or theretofore held by him in an investment account by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market otherwise than on an exchange as defined in the Securities Exchange Act of 1934 for such security. The Commissioner may by any rules and regulations as he deems necessary or appropriate in the public interest define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

History. — Code 1933, § 56-1604, enacted by Ga. L. 1965, p. 378, § 3.
U.S. Code. — The Securities Exchange Act of 1934, referred to in this Code section, is codified as 15 U.S.C. § 78a et seq.

33-14-95. Foreign or domestic arbitrage transactions exempted from article.

Code Sections 33-14-91 through 33-14-93 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of any rules and regulations as the Commissioner may adopt in order to carry out the purposes of this article.

History. — Code 1933, § 56-1605, enacted by Ga. L. 1965, p. 378, § 3.

33-14-96. Transactions in securities registered under Section 12 of Securities Exchange Act of 1934 exempted from article.

Code Sections 33-14-91 through 33-14-93 shall not apply to equity securities of a domestic stock insurer if the securities shall be registered pursuant to Section 12 of the Securities Exchange Act of 1934, as amended.

History. — Code 1933, § 56-1607, enacted by Ga. L. 1965, p. 378, § 3.
U.S. Code. — Section 12 of the Securities Exchange Act of 1934, referred to in this Code section, is codified as 15 U.S.C. § 78l.

33-14-97. Promulgation of rules and regulations by Commissioner; effect of rules and regulations upon liability under Code Sections 33-14-91 through 33-14-93.

(a) The Commissioner shall have the power to make any reasonable rules and regulations as may be necessary for the execution of the functions vested in him by this article and may for that purpose classify domestic stock insurers, securities, and other persons or matters within his jurisdiction.

(b) No provision of Code Sections 33-14-91 through 33-14-93 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the Commissioner notwithstanding that the rule or regulation may after the act or omission be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

History. — Code 1933, § 56-1608, enacted by Ga. L. 1965, p. 378, § 3.

ARTICLE 5

LIMITED PURPOSE SUBSIDIARY INSURANCE COMPANIES

Administrative rules and regulations. — Limited purpose subsidiaries, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-100.

33-14-100. Definitions.

As used in this article, the term:

(1) "Limited purpose subsidiary" means a subsidiary life, accident, and sickness reinsurer that is organized under this article and is wholly owned by an organizing domestic reinsurer.

(2) "Organizing domestic reinsurer" means a domestic life, accident, and sickness reinsurer that organizes a limited purpose subsidiary under this article.

(3) "Reinsurer" means an insurer that:

(A) Is principally engaged in the business of reinsurance;

(B) Does not conduct a significant amount of direct insurance as a percentage of the insurer's net premiums; and

(C) Is not engaged on an ongoing basis in the business of soliciting direct insurance.

(4) "Risk" means a risk that is associated with an insurance policy or annuity that is assumed by an organizing domestic reinsurer and for which the organizing domestic reinsurer is required to hold statutory reserves for the policy or annuity.

History. — Code 1981, § 33-14-100, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

33-14-101. Authorization to organize domestic limited purpose subsidiary.

A domestic life, accident, and sickness reinsurer may organize a domestic limited purpose subsidiary pursuant to the provisions of this article.

History. — Code 1981, § 33-14-101, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

33-14-102. Approval of operation plan and certificate of authority requirements; certain disclosure requirements; examination by Commissioner.

(a) Before assuming risk under a reinsurance agreement, a limited purpose subsidiary must:

(1) Obtain from the Commissioner approval of the limited purpose subsidiary's plan of operation; and

(2) Be granted a certificate of authority to engage in the business of reinsurance in Georgia.

(b) A limited purpose subsidiary shall produce or disclose in its plan of operation, amendments, and records, books, documents, reports, and other information that the Commissioner requires the limited purpose subsidiary to produce or disclose under:

(1) This article;

(2) Rules adopted pursuant to this article; or

(3) An order pursuant to an examination performed in accordance with the provisions of Chapter 2 of this title.

(c) The Commissioner shall examine domestic limited purpose subsidiaries pursuant to Code Section 33-2-11.

History. — Code 1981, § 33-14-102, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

33-14-103. Powers of limited purpose subsidiary.

A limited purpose subsidiary that is granted a certificate of authority by the Commissioner under this article:

(1) Is wholly owned by the organizing domestic reinsurer;

(2) Is authorized to engage in the business of reinsurance only for the lines of insurance for which the organizing domestic reinsurer is authorized;

(3) May reinsure only risks of the organizing domestic reinsurer; and

(4) May access alternative forms of financing.

History. — Code 1981, § 33-14-103, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

33-14-104. Investment of funds.

An organizing domestic reinsurer may invest funds from the surplus of the organizing domestic reinsurer in a limited purpose subsidiary that is organized by the organizing domestic reinsurer pursuant to this article.

History. — Code 1981, § 33-14-104, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

33-14-105. Officers and directors.

The officers and directors of an organizing domestic reinsurer may serve as officers and directors of a limited purpose subsidiary organized by the organizing domestic reinsurer pursuant to this article.

History. — Code 1981, § 33-14-105, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

33-14-106. Reinsurance.

A limited purpose subsidiary may, upon approval of the Commissioner, reinsure the risks assumed by the limited purpose subsidiary.

History. — Code 1981, § 33-14-106, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-14-107. Assets.

(a) Assets of a limited purpose subsidiary that are approved by the Commissioner as admitted assets must comply with requirements established by the Commissioner under rules adopted pursuant to this article.

(b) All other assets shall not be admitted assets.

History. — Code 1981, § 33-14-107, enacted by Ga. L. 2011, p. 446, § 1/HB 341; Ga. L. 2019, p. 337, § 1-72/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "not be admitted assets" for "be nonadmitted" in subsection (b).

33-14-108. Applicability of certain provisions of this title.

The following provisions of this title shall not apply to a limited purpose subsidiary organized under this article:

(1) Code Section 33-3-6;

(2) Code Section 33-3-7;

(3) Code Section 33-3-8;

(4) Code Section 33-7-14;

(5) Article 2 of Chapter 11;

(6) Code Section 33-13-4;

(7) Code Section 33-13-5;

(8) Code Section 33-14-40; and

(9) Chapter 56.

History. — Code 1981, § 33-14-108, enacted by Ga. L. 2011, p. 446, § 1/HB 341; Ga. L. 2019, p. 337, § 1-73/SB 132.

The 2019 amendment, effective July 1, 2019, in this Code section, substituted "this title shall not apply" for "the Code do not apply" in the introductory language, deleted "of this title" following "Chapter 11" in paragraph (5), and deleted "of this title" following "Chapter 56" in paragraph (9).

33-14-109. Adoption of rules.

(a) The Commissioner shall, before approving a limited purpose subsidiary under this article, adopt rules pursuant to Code Section 33-2-9 to implement this article.

(b) The rules adopted under subsection (a) of this Code section shall address, but not be limited to, the following concerning limited purpose subsidiaries:

(1) Requirements for organization of a limited purpose subsidiary;

(2) Requirements for a plan of operation;

(3) Capital, surplus, and risk-based capital requirements;

(4) Requirements for reporting and notifications;

(5) Requirements for reserves, including actuarial certification;

(6) Requirements for authorized investments;

(7) Requirements with respect to reinsurance ceded or assumed by the limited purpose subsidiary;

(8) Requirements and restrictions for material transactions;

(9) Requirements for dividends and distributions;

(10) Requirements for operations; and

(11) Conditions of, forms for, and approval of the financing of a limited purpose subsidiary.

History. — Code 1981, § 33-14-109, enacted by Ga. L. 2011, p. 446, § 1/HB 341.

ARTICLE 6

DIVISION OF DOMESTIC INSURERS

Effective date. — This article became effective July 1, 2019.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 19 et seq.

33-14-120. Definitions.

As used in this article, the term:

(1) "Capital" means the capital stock component of statutory surplus, as defined in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, version effective January 1, 2001, and subsequent revisions.

(2) "Director" means a person:

(A) By or under whose authority the powers of a corporation are exercised; and

(B) Under whose direction the business and affairs of the corporation are managed pursuant to the articles of incorporation or bylaws of the corporation.

(3) "Divide" or "division" means a transaction in which a domestic insurer divides into two or more resulting domestic insurers.

(4) "Dividing insurer" means a domestic insurer that approves a plan of division pursuant to Code Section 33-14-122.

(5) "Liability" means a debt, obligation, or any other liability arising in any manner, regardless of whether it is secured or contingent.

(6) "New insurer" means a domestic insurer that is created by a division occurring on or after July 1, 2019.

(7) "Property" means all property, whether real, personal, or mixed, tangible or intangible, or any right or interest therein, including rights under contracts and other binding agreements.

(8) "Resulting insurer" means a new insurer or a dividing insurer that survives a division.

(9) "Share" means a share of membership in a corporation.

(10) "Shareholder" means the person in whose name shares are registered in the records of a corporation or the beneficial owner of shares to the extent of the rights granted by a nominee certificate on file with a corporation.

(11) "Sign" or "signature" means any manual, facsimile, conformed, or electronic signature.

(12) "Surplus" means total statutory surplus less capital stock, adjusted for the par value of any treasury stock, calculated in accordance with the National Association of Insurance Commissioners Accounting Practices and Procedures Manual, version effective January 1, 2001, and subsequent revisions.

(13) "Transfer" means an assignment, conveyance, sale, lease, or encumbrance, including a mortgage or security interest, gift, or transfer by operation of law.

History. — Code 1981, § 33-14-120, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, "July 1, 2019" was substituted for "the effective date of this article" in paragraph (6).

33-14-121. Plans of division; requirements; amendment.

(a) Any domestic insurer may, in accordance with the requirements of this article, divide into two or more resulting insurers pursuant to a plan of division.

(b)(1) A plan of division shall include:

(A) The name of the dividing insurer seeking to divide;

(B) The name of each resulting insurer or insurers that will be created by the proposed division, including its proposed articles of incorporation and proposed bylaws;

(C) The manner of allocating between or among the resulting insurers:

(i) The property of the dividing insurer that will not be owned by all of the resulting insurers as tenants in common pursuant to Code Section 33-14-125; and

(ii) Those policies and other liabilities of the dividing insurer to which not all of the resulting insurers will be jointly and severally liable pursuant to paragraph (3) of subsection (a) of Code Section 33-14-126;

(D) The manner of distributing shares in a new insurer to the dividing insurer or its shareholders;

(E) A reasonable description of liabilities, capital, surplus, or other property the dividing insurer proposes to allocate to a new insurer, including the manner by which each reinsurance contract is to be allocated;

(F) All terms and conditions required by the laws of this state or the articles of incorporation or bylaws of the dividing insurer; and

(G) All other terms and conditions of the division.

(2) If the dividing insurer will survive the division, the plan of division shall include, in addition to the information required by paragraph (1) of this subsection:

(A) All proposed amendments to the dividing insurer's articles of incorporation and bylaws, if any;

(B) If the dividing insurer desires to cancel some but not all shares in the dividing insurer, the manner in which it will cancel such shares; and

(C) If the dividing insurer desires to convert some but not all shares in the dividing insurer into interests, securities, shares, obligations, money, other property, or rights to acquire interests,

securities, or shares, or any combination thereof, a statement disclosing the manner in which it will convert such shares.

(3) If the dividing insurer will not survive the proposed division, the plan of division shall contain, in addition to the information required by paragraph (1) of this subsection, the manner in which the dividing insurer will cancel or convert shares in the dividing insurer into interests, securities, shares, obligations, money, other property, or rights to acquire interests, securities, or shares, or any combination thereof.

(c) A dividing insurer may amend a plan of division in accordance with any procedures set forth in the plan or, if no such procedures are set forth in the plan, in any manner determined by the board of directors of the dividing insurer, except that a shareholder that was entitled to vote on or consent to approval of the plan of division is entitled to vote on or consent to any amendment of the plan that will change:

(1) The amount or kind of interests, securities, shares, obligations, money, other property, or rights to acquire interests, securities, or shares, or any combination thereof, to be received by any of the shareholders of the dividing insurer under the plan;

(2) The articles of incorporation of any resulting insurer that will be in effect when the division becomes effective, except for changes that do not require approval of the shareholders of the resulting insurer under its articles of incorporation; or

(3) Any other terms or conditions of the plan, if the change would adversely affect the shareholders in any material respect.

(d)(1) A dividing insurer may abandon a plan of division after it has approved the plan without any action by the shareholders and in accordance with any procedures set forth in the plan or, if no such procedures are set forth in the plan, in a manner determined by the board of directors of the dividing insurer.

(2) A dividing insurer may abandon a plan of division after it has delivered a certificate of division to the Secretary of State by delivering to the Secretary of State a certificate of abandonment signed by the dividing insurer. The certificate of abandonment shall be effective on the date it is filed with the Secretary of State, and the dividing insurer shall be deemed to have abandoned its plan of division on such date.

(3) A dividing insurer may not abandon its plan of division once the division becomes effective.

History. — Code 1981, § 33-14-121, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

33-14-122. Approval of plan of division.

(a) Except as provided in subsections (b) and (c) of this Code section, a dividing insurer shall not file a plan of division with the Commissioner unless such plan has been approved in accordance with:

(1) All provisions of its articles of incorporation and bylaws; or

(2) If its articles of incorporation and bylaws do not provide for approval of a division, all provisions of its articles of incorporation and bylaws that provide for approval of a merger.

(b) Shareholder approval of a plan of division shall not be required unless:

(1) The articles of incorporation and bylaws of the dividing insurer require such approval;

(2) The plan makes an amendment to the articles of incorporation and bylaws requiring such approval; or

(3) The dividing insurer will not survive the proposed division and has only one class of shares outstanding and the shares of each new insurer will not be distributed pro rata to the shareholders.

(c)(1) If any provision of the articles of incorporation and bylaws of a dividing insurer adopted before July 1, 2019, requires that a specific number or percentage of directors or shareholders approve the proposal or adoption of a plan of merger, or imposes other special procedures for the proposal or adoption of a plan of merger, such dividing insurer shall adhere to such provision in proposing or adopting a plan of division.

(2) If a provision of any debt security, note, or similar evidence of indebtedness for money borrowed, whether secured or unsecured, indenture or other contract relating to indebtedness, or a provision of any other type of contract other than an insurance policy, annuity, or reinsurance agreement, that was issued, incurred, or executed by the domestic insurer before July 1, 2019, requires the consent of the obligee to a merger of the insurer or treats such a merger as a default and does not provide that a division of the insurer does not require the consent of the obligee or treat a division as a default, as applicable, then such provision applies to a division of the insurer as if such division were a merger.

(3) If any provision described in paragraph (1) or (2) of this subsection is amended on or after July 1, 2019, such provision shall

thereafter apply to a division only in accordance with its express terms.

History. — Code 1981, § 33-14-122, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, "July 1, 2019," was substituted for "the effective date of this article" near the beginning of paragraph (c)(1) and near the middle of paragraph (c)(2) and "July 1, 2019" was substituted for "the effective date of this article" in paragraph (c)(3).

33-14-123. Approval by Commissioner after public notice and hearing; when plan of division not approved; factors for consideration; confidentiality; allocation of expenses; findings; final orders; additional procedures.

(a) A division does not become effective until it is approved by the Commissioner after reasonable notice and a public hearing. A hearing conducted under this Code section must be conducted pursuant to Chapter 2 of this title.

(b) Subject to subsection (l) of this Code section, the Commissioner shall approve a plan of division unless the Commissioner finds any of the following:

(1) The interest of the policyholders of the dividing insurer that may become policyholders of a resulting insurer will not be adequately protected by the resulting insurer or acquiring party of a resulting insurer, if any;

(2) After the division, any resulting insurer would not be able to satisfy the requirements for the issuance of a certificate of authority;

(3) The division would substantially lessen competition in insurance in this state or tend to create a monopoly in this state;

(4) The financial condition of an acquiring party of a resulting insurer, if any, is such that it might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders or the interests of a remaining shareholder that is unaffiliated with the acquiring party;

(5) The terms of the plan of division are unfair and unreasonable to the dividing insurer's policyholders or shareholders;

(6) An acquiring party of a resulting insurer, if any, has plans or proposals to liquidate the resulting insurer, sell its assets, or consolidate or merge the resulting insurer with a person, or to make any other material change in its business or corporate structure or management, that are unfair and unreasonable to the resulting insurer's policyholders, and not in the public interest;

(7) The competence, experience, and integrity of the persons who would control the operation of a resulting insurer are such that it would not be in the interest of the resulting insurer's policyholders or the general public to permit the division;

(8) The division is likely to be hazardous or prejudicial to the insurance-buying public;

(9) The proposed division violates Article 4 of Chapter 2 of Title 18, the "Uniform Voidable Transactions Act";

(10) The division is being made for purposes of hindering, delaying, or defrauding any policyholders or other creditors of the dividing insurer;

(11) One or more resulting insurers will not be solvent on the consummation of the division; or

(12) The assets allocated to one or more resulting insurers will be, on consummation of a division, unreasonably small in relation to the business and transactions in which the resulting insurer was engaged or is about to engage.

(c) If a division is undertaken in conjunction with the divestiture of one of the resulting insurers, the Commissioner shall not approve the division until the potential acquiring party has received the necessary approval under Code Section 33-13-3.

(d) In determining whether the standard set forth in paragraph (9) of subsection (b) of this Code section has been satisfied, the Commissioner shall only apply the "Uniform Voidable Transactions Act" to a dividing insurer in its capacity as a resulting insurer and shall not apply the "Uniform Voidable Transactions Act" to any dividing insurer that is not proposed to survive the division.

(e) In determining whether the standards set forth in paragraphs (9), (10), (11), and (12) of subsection (b) this Code section have been satisfied, the Commissioner may consider, among other things, all assets, liabilities, and cash flows.

(f) In determining whether the standard set forth in paragraph (9) of subsection (b) of this Code section has been satisfied, with respect to each resulting insurer, the Commissioner shall, in applying the "Uniform Voidable Transactions Act," do all of the following:

(1) Treat the resulting insurer as a debtor;

(2) Treat liabilities allocated to the resulting insurer as obligations incurred by a debtor;

(3) Treat the resulting insurer as not having received reasonably equivalent value in exchange for incurring the obligations; and

(4) Treat assets allocated to the resulting insurer as remaining property.

(g) All information, documents, materials, and copies of documents and materials submitted to, obtained by, or disclosed to the Commissioner in connection with a plan of division or in contemplation of a plan of division, including any information, documents, materials, or copies provided by or on behalf of a domestic stock insurer in advance of its adoption or submission of a plan of division, are confidential and are subject to the same protection and treatment in accordance with Code Section 33-2-14 as information and documents disclosed to or obtained by the Commissioner in the course of an examination or investigation made under Code Section 33-2-11 until the time, if any, that a notice of the hearing contemplated by subsection (a) of this Code section is issued.

(h) From and after the issuance of a notice of the hearing contemplated by subsection (a) of this Code section, all business, financial, and actuarial information for which the domestic stock insurer requests confidential treatment, other than the plan of division and any materials incorporated by reference into or otherwise made a part of the plan of division that must not be eligible for confidential treatment after the issuance of a notice of the hearing, continues to be confidential and is not available for public inspection and must be subject to the same protection and treatment in accordance with Code Section 33-2-14 as information and documents disclosed to or obtained by the Commissioner in the course of an examination or investigation made under Code Section 33-2-11. However, if the Commissioner determines that the interest of the public in making the information available for public inspection outweighs the interest of the dividing insurer in keeping the information confidential, the Commissioner may, after notice and an opportunity to be heard, make the information available to public inspection.

(i) All expenses incurred by the Commissioner in connection with proceedings under this Code section, including expenses for the services of any attorneys, actuaries, accountants, and other experts not otherwise a part of the department staff as may be reasonably necessary to assist the Commissioner in reviewing the proposed division, must be paid by the dividing insurer filing the plan of division. A dividing insurer may allocate expenses described in this subsection in a plan of division in the same manner as any other liability.

(j) If the Commissioner approves a plan of division, the Commissioner shall issue an order approving the plan of division that must be accompanied by findings of fact and conclusions of law.

(k) The conditions in this Code section for freeing one or more of the resulting insurers from the liabilities of the dividing insurer and for

allocating some or all of the liabilities of the dividing insurer are conclusively satisfied if the plan of division has been approved by the Commissioner in a final order, after all relevant appeals relating to the final order have been exhausted.

(l) The Commissioner may establish any additional procedures necessary or appropriate in connection with his or her review of a plan of division.

History. — Code 1981, § 33-14-123, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, "Code" was inserted before "section" in subsection (i).

33-14-124. Requirements for certificates of division; articles of incorporation; effective date.

(a) After a plan of division has been adopted and approved under Code Sections 33-14-122 and 33-14-123, an officer or duly authorized representative of the dividing insurer shall sign a certificate of division.

(b) The certificate of division shall set forth:

(1) The name of the dividing insurer;

(2) A statement disclosing whether the dividing insurer will survive the division;

(3) The name of each resulting insurer;

(4) The date on which the division is to be effective, which shall not be more than 90 days after the dividing insurer has filed the certificate of division with the Secretary of State;

(5) A statement that the division was approved by the dividing insurer in accordance with Code Section 33-14-122;

(6) A statement that the division was approved by the Commissioner in accordance with Code Section 33-14-123;

(7) A statement that the dividing insurer provided, not later than ten business days after the dividing insurer filed the plan of division with the Commissioner, reasonable notice to each insurer or reinsurer that is party to a reinsurance contract allocated in the plan of division;

(8) If the dividing insurer will survive the division, any amendment to its articles of incorporation approved as part of the plan of division;

(9) For each new insurer created by the division, its articles of incorporation, which need not state the name or address of an incorporator of a corporation; and

(10) A reasonable description of the capital, surplus, other property, and policies and other liabilities of the dividing insurer that are to be allocated to each resulting insurer.

(c) The articles of incorporation, if any, of each new insurer must satisfy the requirements of the laws of this state, but such articles need not be signed or include any provision that need not be included in a restatement of such articles.

(d) A certificate of division shall be effective when filed with the Secretary of State or on such other date specified in the plan of division, whichever is later; provided, however, that a certificate of division shall become effective not more than 90 days after it is filed with the Secretary of State. A division shall be effective when the relevant certificate of division becomes effective.

History. — Code 1981, § 33-14-124, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

33-14-125. Upon division becoming effective; rights upon division; requirement for new financing statement; distributions.

(a) When a division becomes effective pursuant to subsection (d) of Code Section 33-14-124:

(1) If the dividing insurer has survived the division:

(A) It continues to exist;

(B) Its articles of incorporation, if any, shall be amended as provided in the plan of division; and

(C) Its bylaws, if any, shall be amended as provided in the plan of division;

(2) If the dividing insurer has not survived the division, its separate existence ceases to exist;

(3) Each new insurer:

(A) Comes into existence;

(B) Shall hold any capital, surplus, and other property allocated to it as a successor to the dividing insurer, and not by transfer, whether directly or indirectly; and

(C) Its articles of incorporation and bylaws shall be effective;

(4) Capital, surplus, and other property of the dividing insurer:

(A) That is allocated by the plan of division either:

(i) Vests in the new insurers as provided in the plan of division; or

(ii) Remains vested in the dividing insurer;

(B) That is not allocated by the plan of division:

(i) Remains vested in the dividing insurer, if the dividing insurer survives the division; or

(ii) Is allocated to and vests equally in the resulting insurers as tenants in common, if the dividing insurer does not survive the division; or

(C) Vests as provided in this subsection without transfer, reversion, or impairment;

(5) A resulting insurer to which a cause of action is allocated as provided in paragraph (4) of this subsection may be substituted or added in any pending action or proceeding to which the dividing insurer is a party when the division becomes effective;

(6) The policies and other liabilities of the dividing insurer are allocated among the resulting insurers as provided in Code Section 33-14-126 and the resulting insurers to which policies or other liabilities are allocated are liable for those policies and other liabilities as successors to the dividing insurer, and not by transfer, whether directly or indirectly;

(7) Any division that becomes effective pursuant to subsection (d) of Code Section 33-14-124 shall not be deemed to constitute an assignment of any insurance policy, annuity, reinsurance agreement, or any other type of contract under the laws of this state; and

(8) The shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the shareholders of those shares are entitled only to the rights provided to them under the plan of division and any appraisal rights they may have pursuant to Code Section 33-14-127.

(b) Except as provided in the articles of incorporation or bylaws of the dividing insurer, the division shall not give rise to any rights that a director, shareholder, or third party would have upon a dissolution, liquidation, or winding up of the dividing insurer.

(c) The allocation to a new insurer of capital, surplus, or other property that is collateral covered by an effective financing statement shall not be effective until a new financing statement naming the new insurer as a debtor is effective under Articles 1 through 9 of Title 11.

(d) Unless otherwise provided in the plan of division, the interests in and any shares of each new insurer shall be distributed to:

(1) The dividing insurer, if it survives the division; or

(2) The shareholders of the shares of the dividing insurer that do not assert appraisal rights, pro rata, if the dividing insurer does not survive the division.

History. — Code 1981, § 33-14-125, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

33-14-126. Responsibilities of resulting insurers.

(a) Except as provided in this Code section, when a division becomes effective, a resulting insurer shall be responsible:

(1) Individually for the policies and other liabilities the resulting insurer issues, undertakes, or incurs in its own name after the division;

(2) Individually for the policies and other liabilities of the dividing insurer that are allocated to or remain the liability of the resulting insurer to the extent specified in the plan of division; and

(3) Jointly and severally with the other resulting insurers for the policies and other liabilities of the dividing insurer that are not allocated by the plan of division.

(b) If a division breaches an obligation of the dividing insurer, all of the resulting insurers shall be liable, jointly and severally, for the breach, but the validity and effectiveness of the division shall not be affected by the breach.

(c) A direct or indirect allocation of capital, surplus, property, or policies or other liabilities in a division shall not be considered a distribution for purposes of the articles of incorporation or bylaws of the dividing insurer or any of the resulting insurers.

(d) Liens, security interests, and other charges on the capital, surplus, or other property of the dividing insurer shall not be impaired by the division, notwithstanding any otherwise enforceable allocation of policies or other liabilities of the dividing insurer.

(e) If the dividing insurer is bound by a security agreement governed by Article 9 of Title 11, or Article 9 of the Uniform Commercial Code as enacted in any other jurisdiction, and the security agreement provides that the security interest attaches to after-acquired collateral, each resulting insurer shall be bound by the security agreement.

(f) Except as provided in the plan of division and specifically approved by the Commissioner, an allocation of a policy or other liability shall not affect the rights under any other law of a policyholder or

creditor owed payment on the policy, or payment of any other type of liability or performance of the obligation that creates the liability, except that those rights shall be available only against a resulting insurer responsible for the policy, liability, or obligation under this Code section.

History. — Code 1981, § 33-14-126, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

33-14-127. Rights of shareholders of dividing insurer.

A shareholder of a dividing insurer shall be entitled to appraisal rights and to obtain payment of the fair value of that shareholder's shares pursuant to Code Section 14-2-1302.

History. — Code 1981, § 33-14-127, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

33-14-128. Regulatory authority.

The Commissioner may, in accordance with the procedures set forth in Code Section 33-2-9, promulgate rules and regulations necessary to implement and enforce the provisions of this article. If the Commissioner should find that extraordinary circumstances exist and that it would be in the best interests of the citizens of this state, the Commissioner may suspend temporarily the applicability of any rule or regulation promulgated pursuant to this article.

History. — Code 1981, § 33-14-128, enacted by Ga. L. 2019, p. 474, § 1/SB 156.

CHAPTER 15

FRATERNAL BENEFIT SOCIETIES

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Cross references. — Nonprofit corporations generally, T. 14, C. 3.

Editor's notes. — Ga. L. 1993, p. 1744, § 1, effective July 1, 1993, repealed the Code sections formerly codified as this chapter and enacted the current chapter. The former chapter consisted of §§ 33-15-1 through 33-15-11.1, §§ 33-15-12 through 33-15-39 (Article 1) and §§ 33-15-50 through 33-15-56 (Article 2) and was based on Ga. L. 1960, p. 289, § 1; Ga. L. 1976, p. 983, §§ 1, 2; Ga. L. 1979, p. 786, § 2; Ga. L. 1981, Ex. Sess., p. 8; Ga. L. 1982, p. 3, § 33; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 1399, §§ 6, 7; Ga. L. 1988, p. 1537, §§ 1, 2; Ga. L. 1992, p. 2725, § 19.

Ga. L. 1993, p. 1744, § 2, not codified by the General Assembly, provided: "This Act shall become effective July 1, 1993, and shall apply on and after such date for all new or newly admitted societies. For societies admitted prior to July 1, 1993, this Act shall apply on and after January 1, 1994."

JUDICIAL DECISIONS

Illegally expelled member may recover assessments. — A member of a fraternal benefit order, association, or society may recover all assessments paid in, upon being illegally expelled therefrom. Brothers & Sisters of Charity v. Renfroe, 57 Ga. App. 646, 196 S.E. 135 (1938).

OPINIONS OF THE ATTORNEY GENERAL

Municipality may impose occupation tax on fraternal benefit societies. — This title does not prohibit the imposition of a reasonable occupation tax on fraternal benefit societies actually doing business in a municipality. 1969 Op. Att'y Gen. No. 69-187.

RESEARCH REFERENCES

ALR. — Effect of injunction restraining expulsion of member from benefit society, 1 A.L.R. 169.

Second trial of member of association for same offense, 1 A.L.R. 431.

Right of association to expel or discipline member for exercising a right, or performing duty, as a citizen, 14 A.L.R. 1446.

Right of member of society with benefits in nature of insurance to notice and hearing before suspension or expulsion, 27 A.L.R. 1512.

Expulsion or suspension of local lodge

or other unit of benefit society, 94 A.L.R. 639.

Insurance: practice of fraternal or mutual benefit society of accepting late payment of premiums or assessments as waiver of right to insist upon forfeiture for nonpayment of other premiums or assessments at time due, 108 A.L.R. 681.

Fraternal benefit societies as entitled to voluntary, or subject to involuntary, bankruptcy, 148 A.L.R. 714.

ARTICLE 1

ORGANIZATION AND GOVERNANCE; DEFINITIONS

33-15-1. Description of fraternal benefit society.

Any incorporated society, order, or supreme lodge, without capital stock, including one exempted under the provisions of paragraph (2) of subsection (a) of Code Section 33-15-123, whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter is declared to be a fraternal benefit society.

History. — Code 1981, § 33-15-1, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-2. Lodge system; lodges for children.

(a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings periodically in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children nor shall they have a voice or vote in the management of the society.

History. — Code 1981, § 33-15-2, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-3. Representative form of government; supreme governing body; officers.

A society has a representative form of government when:

(1) It has a supreme governing body constituted in one of the following ways:

(A) The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than a majority of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws; or

(B) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society;

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors, or any intermediate assembly; and

(4) Each voting member shall have one vote and no vote may be cast by proxy.

History. — Code 1981, § 33-15-3, enacted by Ga. L. 1993, p. 1744, § 1.

Cross references. — Duty of foreign or alien societies to file copies of amendments to charter, constitution, or laws with Commissioner, § 33-15-104.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Code 1933, § 56-1610 are included in the annotations for this Code section.

New bylaw not affecting substantial right held applicable to outstanding certificates. — Under former Code 1933, § 56-1610, providing that any changes or amendments to the charter,

constitution, or laws enacted subsequently to the issuance of a fraternal benefit certificate would bind the member and the member's beneficiaries and govern and control the agreements in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for membership, a bylaw, reasonable and not affecting a valid, substantial right passed after a certificate was issued to a member of an insurance society, and before the cause of action arose, was binding upon the member even though it did not specifically provide that it would apply to certificates issued before its passage. Sovereign Camp, W.O.W. v. Gunter, 59 Ga. App. 189, 200 S.E. 181 (1938) (decided under former Code 1933, § 56-1610).

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 10 et seq.

C.J.S. — 10 C.J.S., Beneficial Associations, §§ 18 et seq., 30 et seq.

ALR. — Changes in regard to benefits by subsequent amendments of bylaws or constitution of mutual benefit society, 171 A.L.R. 7.

33-15-4. Definitions.

As used in this chapter, the term:

(1) "Benefit contract" means the agreement for provision of benefits authorized by Code Section 33-15-60, as that agreement is described in subsection (a) of Code Section 33-15-63.

(2) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) "Certificate" means the document issued as written evidence of the benefit contract.

(4) "Laws" means the society's articles of incorporation, charter, constitution, and bylaws, however designated.

(5) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches, or by any other designation.

(6) "Premiums" means premiums, rates, dues, or other required contributions by whatever name known, which are payable under the certificate.

(7) "Rules" means all rules, regulations, or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(8) "Society" means fraternal benefit society, unless otherwise indicated.

History. — Code 1981, § 33-15-4, enacted by Ga. L. 1993, p. 1744, § 1.

JUDICIAL DECISIONS

Cited in Southall v. Blount, 182 Ga. 368, 185 S.E. 321 (1936).

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 1. 43 Am. Jur. 2d, Insurance, § 65.

C.J.S. — 10 C.J.S., Beneficial Associations, § 1 et seq.

33-15-5. Purposes of society; adoption of laws and rules.

(a) A society shall operate for the benefit of members and their beneficiaries by:

(1) Providing benefits as specified in Code Section 33-15-60; and

(2) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

(b) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to, or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

History. — Code 1981, § 33-15-5, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 7.

C.J.S. — 10 C.J.S., Beneficial Associations, § 7 et seq.

ALR. — Validity of by-law of mutual benefit association preventing recovery upon presumption of death from seven years' absence, 17 A.L.R. 418; 21 A.L.R. 1346; 36 A.L.R. 982; 40 A.L.R. 1274.

ARTICLE 2

PROVISIONS OF LAWS AND RULES; MEMBERSHIP CLASSES; PRINCIPAL OFFICE; INDEMNIFICATION

33-15-20. Membership classes; eligibility standards; rights and privileges.

(a) A society shall specify in its laws or rules:

(1) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age 15 and not greater than age 21;

(2) The process for admission to membership for each membership class; and

(3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(c) Membership rights in the society are personal to the member and are not assignable.

History. — Code 1981, § 33-15-20, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-21. Principal office of society; meetings; official publications; annual statement; provision for grievance or complaint procedures.

(a) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory wherein such society has at least one subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b)(1) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices, and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication

mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(2) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(c) A society may provide in its laws or rules for grievance or complaint procedures for members.

History. — Code 1981, § 33-15-21, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-22. Limited liability of officers and members; indemnification; insurance.

(a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by and liabilities imposed upon such person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed: (1) in relation to any matter in such action, suit, or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society, or (2) in relation to any matter in such action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in this subsection may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit, or proceeding or by a court of

competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors, and administrators.

(c) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this Code section.

History. — Code 1981, § 33-15-22, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 60 et seq.

C.J.S. — 10 C.J.S., Beneficial Associations, § 40.

ALR. — Disposition of benefit fund in benefit society on failure of beneficiary in absence of specific provision for such contingency, 31 A.L.R. 762.

33-15-23. Limitation on power of subordinate body.

The laws of the society may provide that no subordinate body nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

History. — Code 1981, § 33-15-23, enacted by Ga. L. 1993, p. 1744, § 1.

ARTICLE 3

FORMATION AND PETITIONS FOR CHARTER; AMENDMENTS OF LAWS; REINSURANCE; CONSOLIDATIONS AND MERGERS; CONVERSIONS

33-15-40. Formation of society; petition for charter; preliminary certificate of authority; advance premiums; certificate of authority.

(a) A domestic society organized on or after January 1, 1994, shall be formed as provided in this Code section. Ten or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge before some officer competent to take acknowledgment of deeds, a petition for a charter, in which shall be stated:

(1) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(2) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter; and

(3) The names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

(b) The petition for a charter, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the Secretary of State, who may require such further information which is deemed necessary. The bond with sureties approved by the Commissioner shall be in such amount, not less than $300,000.00 nor more than $1.5 million, as required by the Commissioner. All documents filed are to be in the English language. The Secretary of State shall transmit immediately one copy of the petition to the Commissioner and shall return one copy to the petitioner. The petition for a charter, with any and all exhibits attached thereto, shall be published in the manner

provided in subsection (b) of Code Section 33-14-5. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the Commissioner shall so certify in writing to the Secretary of State and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided, but only after the granting of the certificate of incorporation by the Secretary of State.

(c) No preliminary certificate of authority granted under the provisions of this Code section shall be valid after one year from its date or after such further period, not exceeding one year, as may be authorized by the Commissioner upon cause shown, unless the 500 applicants hereinafter required have been secured and the organization has been completed as provided in this chapter. The charter and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as provided in subsection (f) of this Code section.

(d) A fraternal benefit society shall be incorporated by the Secretary of State upon compliance with the applicable provisions of law.

(e) Upon receipt of a preliminary certificate of authority from the Commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow any benefit to any person until:

(1) Actual bona fide applications for benefits have been secured aggregating at least $500,000.00 on not less than 500 applicants and any necessary evidence of insurability has been furnished to and approved by the society;

(2) At least ten subordinate lodges have been established into which the 500 applicants have been admitted;

(3) There has been submitted to the Commissioner, under oath of the president or secretary or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and the premiums therefor; and

(4) It shall have been shown to the Commissioner, by sworn statement of the treasurer or corresponding officer of such society,

that at least 500 applicants have each paid in cash at least one regular monthly premium as provided in this subsection, which premiums in the aggregate shall amount to at least $150,000.00. Said advance premiums shall be held in trust during the period of organization and, if the society has not qualified for a certificate of authority within one year as provided in this Code section, such premiums shall be returned to said applicants.

(f) The Commissioner may make such examination and require such further information as the Commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the Commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima-facie evidence of the existence of the society at the date of such certificate. The Commissioner shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(g) Any incorporated society authorized to transact business in this state on January 1, 1994, shall not be required to reincorporate.

History. — Code 1981, § 33-15-40, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 12A Am. Jur. Pleading and Practice Forms, Fraternal Orders and Benefit Societies, § 1 et seq.

33-15-41. Amendment of laws; referendum; approval of Commissioner.

(a) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods specified in this Code section. Charter amendments shall be filed in triplicate with the Commissioner, published, and approved only under the procedure established in Code Section 33-14-8.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the Commissioner and granted by the Secretary of State as provided in Code Section 33-14-8. The Commissioner and Secretary of State shall approve the amendment if they find that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects, and purposes of the society. Unless the Commissioner shall disapprove any such amendment within 30 days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the Commissioner shall be forwarded, in writing, to the Secretary of State and also mailed to the secretary or corresponding officer of the society at its principal office. If the Commissioner disapproves such amendment, the reasons therefor shall be stated in such written notice. Amendments to charters shall not be effective until granted by the Secretary of State.

(c) Within 90 days from the approval thereof by the Commissioner, all such amendments or a synopsis thereof shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima-facie evidence that such amendments or synopsis thereof have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this state shall file with the Commissioner a duly certified copy of all amendments of, or additions to, its laws within 30 days after the enactment of same.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society, shall be prima-facie evidence of the legal adoption thereof.

History. — Code 1981, § 33-15-41, enacted by Ga. L. 1993, p. 1744, § 1; Ga. L. 2000, p. 1307, § 6.

33-15-42. Operation of not for profit institutions.

A society may create, maintain, and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by paragraph (2) of subsection (a) of Code Section 33-15-5. Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for this purpose shall be reported in every annual statement. No society shall own or operate funeral homes or undertaking establishments.

History. — Code 1981, § 33-15-42, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-43. Reinsurance.

(a) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer other than another fraternal benefit society having the power to make such reinsurance and authorized to do business in this state, in accordance with Code Section 33-7-14.

(b) Notwithstanding the limitation in subsection (a) of this Code section, a society may reinsure the risks of another society in a consolidation or merger approved by the Commissioner under Code Section 33-15-44.

History. — Code 1981, § 33-15-43, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 1812 et seq.

ALR. — Who may enforce liability of reinsurer, 103 A.L.R. 1485.

Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-15-44. Consolidations or mergers.

(a) A domestic society may consolidate or merge with any other society by complying with the provisions of this Code section. The filing of application, fee, and publication requirements of subsections (a) through (c) of Code Section 33-14-5 shall be applicable to merger under this chapter.

(b) The application shall state the names and respective locations of the proposed merged or consolidated societies with the dates of their original charters, all amendments thereto, and the name and location of the proposed consolidated or merged society. The application shall be signed with the corporate names and under the corporate seals of the societies.

(c) There shall be filed with the application:

(1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(2) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the Commissioner but not earlier than December 31 next preceding the date of the contract;

(3) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds' vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body or, if the society's laws so permit, by mail;

(4) Evidence that at least 60 days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society; and

(5) In the event any society which is a party to the contract is incorporated under the laws of any other state or territory, a certificate of approval as provided by the laws of such state or territory; if the laws of such state or territory contain no such provision, then a certificate of approval of the proposed consolidation or merger must be approved by the supervising insurance official of such state or territory.

(d) If the Commissioner finds that the contract containing the terms and conditions of the proposed consolidation or merger is in conformity with this Code section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, he shall approve the contract and issue his certificate to such effect, transmitting a copy of such certificate of approval to the Secretary of State. If the Commissioner does not approve the contract, he shall notify the society and shall transmit a copy of his certificate of disapproval to the Secretary of State. In case such contract is not approved, it shall be inoperative, and the fact of submission and its contents shall not be disclosed by the Commissioner.

(e) Upon receipt of the certificate as to the publication of the application and the certificate of approval of the Commissioner, the Secretary of State shall issue, under the great seal of the state, a certificate of merger, which certificate shall be the charter of the consolidated or merged society. The Secretary of State shall record the application, the contract of merger and the other documents required to be filed, the certificate of the judge of the probate court, the certificate of the Commissioner, and the certificate of merger in a book to be kept by him for that purpose.

(f) Upon the consolidation or merger becoming effective as provided in subsection (e) of this Code section, all the rights, franchises, and interests of the consolidated or merged societies in and to every species of property, real, personal, or mixed, and things in action belonging to the consolidated or merged societies shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be

evidenced by proper deeds, and the title to any real estate or interest therein vested under the laws of this state in any of the societies consolidated or merged shall not revert or be in any way impaired by reason of the consolidation or merger but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(g) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima-facie evidence that such notice or document has been furnished the addressees.

History. — Code 1981, § 33-15-44, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-45. Conversion to mutual life insurance company.

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the applicable requirements of Chapter 14 of this title if the plan of conversion has been approved by the Commissioner. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the Commissioner who may give such approval if the Commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

History. — Code 1981, § 33-15-45, enacted by Ga. L. 1993, p. 1744, § 1.

ARTICLE 4

BENEFIT CONTRACTS

33-15-60. Contractual benefits allowed; persons covered.

(a) A society may provide the following contractual benefits in any form:

(1) Death benefits;

(2) Endowment benefits;

(3) Annuity benefits;

(4) Temporary or permanent disability benefits;

(5) Hospital, medical, or nursing benefits;

(6) Monument or tombstone benefits to the memory of deceased members; and

(7) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(b) A society shall specify in its rules those persons who may be issued or covered by the contractual benefits in subsection (a) of this Code section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

History. — Code 1981, § 33-15-60, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 95.

C.J.S. — 10 C.J.S., Beneficial Associations, § 35 et seq.

33-15-61. Beneficiary designations; funeral benefits; payment upon death of person without lawful beneficiary.

(a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member.

(c) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as provided in subsection (b) of this Code section, shall be payable to the estate of the deceased insured the same as other property not exempt, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

History. — Code 1981, § 33-15-61, enacted by Ga. L. 1993, p. 1744, § 1.

JUDICIAL DECISIONS

Cited in Scott v. State Grand Lodge No. 1, 110 Ga. App. 762, 140 S.E.2d 86 (1964).

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 116.

ALR. — Surrender and return of benefit certificate as condition of change of beneficiaries, 1 A.L.R. 971.

Right to change beneficiary of mutual benefit certificate as affected by payment of premiums, or other consideration moving original beneficiary, 18 A.L.R. 383.

Disposition of benefit fund in benefit society on failure of beneficiary in absence of specific provision for such contingency, 31 A.L.R. 762.

Divorce of insured and beneficiary as affecting the latter's right in life insurance, 52 A.L.R. 386; 175 A.L.R. 1220.

33-15-62. Exemption of benefits from process.

No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any society shall be liable to attachment, garnishment, or other process or to be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

History. — Code 1981, § 33-15-62, enacted by Ga. L. 1993, p. 1744, § 1.

Cross references. — Attachment, T. 18, C. 3. Garnishment, T. 18, C. 4.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, § 46-213, are included in the annotations for this Code section.

Section deals with different property than exempted by Constitution. — The Legislature, in enacting this section, was dealing with a different species of property from that dealt with in Ga. Const. 1976, Art. I, Sec. I, Para. XXIII (see Ga. Const. 1983, Art. I, Sec. I, Para. XXVI). Southall v. Blount, 182 Ga. 368, 185 S.E. 321 (1936) (decided under former Code 1933, § 46-213).

Section does not violate constitutional limit on value. — This section, relating to exemption of benefits to be paid by fraternal benefit societies, is not violative of Ga. Const. 1976, Art. I, Sec. I, Para. XXIII (see Ga. Const. 1983, Art. I, Sec. I, Para. XXVI), providing for exemption from levy and sale of the property of certain specified persons, realty or personalty, or both, to the value in the aggregate of $1,600.00, such constitutional provision not being a limitation upon legislative power as to a species of property not therein dealt with and not being applicable to cases of exemption of "money or other benefit" payable by a fraternal benefit society. Southall v. Blount, 182 Ga. 368, 185 S.E. 321 (1936) (decided under former Code 1933, § 46-213).

Application in bankruptcy. — Debtor's exemption in the cash surrender value of a life insurance policy received from a fraternal benefit society was lim-

ited to the amount in O.C.G.A. §§ 33-15-62 and 44-13-100(a)(9), did not apply. O.C.G.A. § 44-13-100(a)(9) does not distinguish between policies provided by a fraternal benefit society and those that were not. Walton v. Gay (In re Gay), No. 11-60817, 2012 Bankr. LEXIS 3671 (Bankr. S.D. Ga. Aug. 9, 2012).

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 64.

ALR. — Constitutionality of statute exempting proceeds of life or benefit insurance, 1 A.L.R. 757.

33-15-63. Certificate of benefits; effect of changes or additions; benefit contract binding upon children; assessment; evidentiary value; filing requirements; transfer of control of ownership; assignment.

(a) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions, or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate shall bind the owner and the beneficiaries and shall govern and control the benefit contract in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition, or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board and that if the payment is not made either:

(1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(2) In lieu of or in combination with paragraph (1) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this Code section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the Commissioner in the manner provided for like policies issued by life insurers in this state. Every life, accident and sickness, or disability insurance certificate and every annuity certificate issued on or after one year from January 1, 1994, shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer and may provide in all other respects for the regulation, government, and control of such certificates and all rights, obligations, and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned.

History. — Code 1981, § 33-15-63, enacted by Ga. L. 1993, p. 1744, § 1.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Code 1933, § 56-1610 are included in the annotations for this Code section.

General insurance statutes do not apply to certificate. — Certificate issued by fraternal benefit association is essentially a contract of insurance, except that it is not controlled by the general insurance statutes of the state, and the rights and liabilities of the parties are governed accordingly, even though the certificate may constitute only a part of the contract between the association and the member and is to be construed with any pertinent provisions of the charter and bylaws which with the certificate will constitute the entire contract. Sovereign Camp, W.O.W. v. Lawson, 52 Ga. App. 345, 183 S.E. 137 (1935) (decided under former Code 1933, § 56-1610).

Where a certificate of insurance is issued by a voluntary fraternal benefit association, the provisions of former Code 1933, § 56-904 (see O.C.G.A. § 33-25-2), that the application must be contained in or attached to the policy in order to be considered a part of the policy or contract between the parties, are not applicable, but this section controls. Sovereign Camp W.O.W. v. Reid, 53 Ga. App. 618, 186 S.E. 759 (1936) (decided under former Code 1933, § 56-1610).

Rules as to misrepresentation and waiver or estoppel in life and disability insurance apply. — Where a fraternal benefit association issues a life and total disability certificate, the legal rules governing the forfeiture of life and disability policies of insurance for fraud, misrepresentation, or breach of warranty by an insured, and waiver or estoppel against the insurer to forfeit or avoid policies for those reasons are applicable. Sovereign Camp, W.O.W. v. Lawson, 52 Ga. App. 345, 183 S.E. 137 (1935) (decided under former Code 1933, § 56-1610).

Association retaining premiums is estopped to claim forfeiture for known defense of misrepresentation. — A fraternal benefit association, like an insurance company, will be estopped from claiming a forfeiture or avoidance of a certificate of total disability insurance issued to a member for his alleged fraud, misrepresentation, or breach of warranty in his application or obtaining of the certificate, because of a misstatement or concealment of his true physical condition then existing, where, after the filing and with full knowledge of his claim of total disability as arising subsequent to the issuance of the certificate, and with knowledge of the facts constituting its defense that the contract was forfeited or avoided because the total disability existed at the time of the issuance of the certificate, the association nevertheless continued to receive from the holder and to retain the monthly premiums due under the certificate for more than a year after the filing of the claim and of the suit on the certificate by the member for the recovery of such total disability benefits. Sovereign Camp, W.O.W. v. Lawson, 52 Ga. App. 345, 183 S.E. 137 (1935) (decided under former Code 1933, § 56-1610).

Subsequent bylaw cannot repudiate agreement to pay certain sum. — An agreement by a fraternal benefit society to pay a certain sum constitutes a contract which cannot be repudiated by the association by a subsequently enacted bylaw reducing the amount, even though the certificate made the payment conditional upon compliance with all existing or future enacted bylaws. Eminent Household of Columbian Woodmen v. Bryant, 59 Ga. App. 283, 200 S.E. 321 (1938), later appeal, 62 Ga. App. 167, 8 S.E.2d 438 (1940) (decided under former Code 1933, § 56-1610).

Cited in Lomax v. Woodmen of the World Life Ins. Soc'y, 228 F. Supp. 2d 1360 (N.D. Ga. 2002).

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, §§ 112, 121.

C.J.S. — 10 C.J.S., Beneficial Associations, §§ 29, 35.

33-15-64. Provisions on control of exercise of rights incident to certificate; printing; notice and consent requirements.

(a) Any provision of a certificate which stipulates or relates to the control of the exercise of all rights incident to the certificate shall be set out under a separate caption and shall be printed in boldface type.

(b) Any provision of a certificate which changes the control of the exercise of all rights incident to the certificate from the original applicant to the named member upon such member's attainment of a certain age, which is less than the age of legal majority as provided in Code Section 39-1-1, shall not become effective unless written notice has been given to the original applicant and the named member and the written consent of such parties has been obtained as provided in subsection (c) of this Code section.

(c) The notice as required in subsection (b) of this Code section shall be given 180 days prior to the date the member will attain the designated age. The notice shall be delivered in person or given by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last addresses of record of the original applicant and the named member and receiving the receipt provided by the United States Postal Service or such other evidence as prescribed or accepted by the United States Postal Service.

(d) In the event the written consent of the original applicant and the named member is not obtained prior to the date such member reaches the age designated in the certificate, the original applicant shall retain control of the exercise of all rights incident to the policy until the date the named member reaches the age of legal majority as defined in Code Section 39-1-1.

History. — Code 1981, § 33-15-64, enacted by Ga. L. 1993, p. 1744, § 1; Ga. L. 2019, p. 337, § 1-74/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "subsection (b)" for "subsection (a)" in the first sentence of subsection (c).

33-15-65. Value of paid-up nonforfeiture benefits and amounts of cash surrender values, loans, or other options.

(a) For certificates issued prior to one year after January 1, 1994, the value of every paid-up nonforfeiture benefit and the amount of any cash

surrender value, loan, or other option granted shall comply with the provisions of law applicable immediately prior to January 1, 1994.

(b) For certificates issued on or after one year from January 1, 1994, for which reserves are computed on the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table, the Commissioners 1958 Standard Ordinary Mortality Table, or the Commissioners 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

History. — Code 1981, § 33-15-65, enacted by Ga. L. 1993, p. 1744, § 1.

ARTICLE 5

ASSETS AND INVESTMENTS

33-15-80. Investments of funds.

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country, or province in which it is incorporated shall be held to meet the requirements of this Code section for the investment of funds.

History. — Code 1981, § 33-15-80, enacted by Ga. L. 1993, p. 1744, § 1.

Cross references. — Authorized investments for insurers generally, § 33-11-6 et seq. Investment requirements for foreign and alien societies, § 33-15-104.

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 78.

33-15-81. Disposition of assets; funds; accounts.

(a) All assets shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account; may, for persons having beneficial interests therein, provide special voting and other rights, including, without limitation, special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account; and may issue contracts on a variable basis to which subsections (b) and (d) of Code Section 33-15-63 shall not apply.

History. — Code 1981, § 33-15-81, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

C.J.S. — 10 C.J.S., Beneficial Associations, § 22.

ALR. — Disposition of benefit fund in benefit society on failure of beneficiary in absence of specific provision for such contingency, 31 A.L.R. 762.

33-15-82. Exemption from other insurance laws.

Except as otherwise provided in this chapter, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state unless they are expressly designated therein or unless they are specifically made applicable by this chapter.

History. — Code 1981, § 33-15-82, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-83. Exemption from taxation.

Every society organized or licensed under this chapter is declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal, and school taxes other than taxes on real estate and office equipment.

History. — Code 1981, § 33-15-83, enacted by Ga. L. 1993, p. 1744, § 1.

Law reviews. — For survey of 1995 Eleventh Circuit cases on federal taxation, see 47 Mercer L. Rev. 879 (1996). For survey of 2004 Eleventh Circuit cases on federal taxation, see 56 Mercer L. Rev. 1287 (2005).

OPINIONS OF THE ATTORNEY GENERAL

Municipal occupation tax on societies not prohibited. — This title does not prohibit the imposition of a reasonable occupation tax on fraternal benefit societies actually doing business in a municipality. 1969 Op. Att'y Gen. No. 69-187.

RESEARCH REFERENCES

Am. Jur. 2d. — 18A Am. Jur. 2d, Corporations, § 679.

C.J.S. — 84 C.J.S., Taxation, § 295.

ALR. — Exemption from taxation of property of fraternal or relief association, 22 A.L.R. 907; 83 A.L.R. 773.

Tax exemption of property used by fraternal or benevolent association for clubhouse or similar purposes, 39 A.L.R.3d 640.

ARTICLE 6

VALUATION STANDARDS; LICENSES AND RENEWALS; EXAMINATIONS; VIOLATIONS; AGENTS OR REPRESENTATIVES

33-15-100. Standards of valuation.

(a) Standards of valuation for certificates issued prior to one year after January 1, 1994, shall be those provided by the laws applicable immediately prior to January 1, 1994.

(b) The minimum standards of valuation for certificates issued on or after one year from January 1, 1994, shall be based on the following tables:

(1) For certificates of life insurance—the Commissioners 1941 Standard Ordinary Mortality Table, the Commissioners 1941 Standard Industrial Table, the Commissioners 1958 Standard Ordinary Mortality Table, the Commissioners 1980 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurers; and

(2) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits, and for noncancelable accident and health benefits—such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(c) The Commissioner may, in his or her discretion, accept other standards for valuation if the Commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in subsection (b) of this Code section. The Commissioner may, in

his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extrahazardous lives by any society authorized to do business in this state.

(d) Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

History. — Code 1981, § 33-15-100, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-101. Annual statements.

(a) Reports shall be filed in accordance with the provisions of this Code section. Every society transacting business in this state shall annually, on or before March 1, unless for cause shown such time has been extended by the Commissioner, file with the Commissioner a true statement of its financial condition, transactions, and affairs for the preceding calendar year. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the Commissioner.

(b) As part of the annual statement required by this Code section, each society shall, on or before March 1, file with the Commissioner a valuation of its certificates in force on December 31 last preceding, provided the Commissioner may, in his or her discretion for cause shown, extend the time for filing such valuation for not more than two calendar months. Such valuation shall be done in accordance with the standards specified in Code Section 33-15-100. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(c) A society neglecting to file the annual statement in the form and within the time provided by this Code section shall forfeit $100.00 for each day during which such neglect continues and, upon notice by the Commissioner to that effect, its authority to do business in this state shall cease while such default continues.

History. — Code 1981, § 33-15-101, enacted by Ga. L. 1993, p. 1744, § 1.

Cross references. — American experience mortality tables, § 24-14-44. Other mortality tables, § 24-14-45

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 35.
C.J.S. — 44 C.J.S., Insurance, § 66.

33-15-102. Renewal of licenses.

The authority of all societies licensed may thereafter be renewed annually but in all cases to terminate on the succeeding June 30. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the Commissioner a fee as specified in Code Section 33-8-1. A duly certified copy or duplicate of such license shall be prima-facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

History. — Code 1981, § 33-15-102, enacted by Ga. L. 1993, p. 1744, § 1; Ga. L. 2019, p. 337, § 1-75/SB 132.
The 2019 amendment, effective July 1, 2019, deleted the former first sentence, which read: "Societies which are authorized on January 1, 1994, to transact business in this state and all societies licensed after such date but before June 30, 1994, may continue such business until June 30, 1994.", and deleted "such societies and" preceding "all societies licensed" near the beginning of the present first sentence.

33-15-103. Examinations.

(a) The Commissioner or any person he or she may appoint may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign, or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expenses of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner.

History. — Code 1981, § 33-15-103, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 45 et seq.
Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 67.

33-15-104. Licensing of foreign or alien societies.

(a) No foreign or alien society shall transact business in this state without a license issued by the Commissioner. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to transact business in this state upon a showing that its assets are invested in accordance with the provisions of this chapter and upon filing with the Commissioner:

(1) A duly certified copy of its articles of incorporation;

(2) A copy of its bylaws, certified by its secretary or corresponding officer;

(3) A power of attorney to the Commissioner as prescribed in Code Section 33-15-120;

(4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the Commissioner, duly verified by an examination made by the supervisory insurance official of its home state or other state, territory, province, or country, satisfactory to the Commissioner of this state;

(5) Certification from the proper official of its home state, territory, province, or country that the society is legally incorporated and licensed to transact business therein;

(6) Copies of its certificate forms; and

(7) Such other information as the Commissioner may deem necessary.

(b) A society domiciled in any other state, territory, province, or country shall comply fully with this chapter and agree to be treated as a domestic society unless:

(1) The state, territory, province, or country of domicile is accredited under the National Association of Insurance Commissioners Financial Regulation Standards and Accreditation Program; and

(2) The state, territory, province, or country of domicile has a statute or regulation governing fraternal benefit societies which is substantially similar to this chapter.

History. — Code 1981, § 33-15-104, enacted by Ga. L. 1993, p. 1744, § 1; Ga. L. 2019, p. 337, § 1-76/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "articles of incorporation" for "charter of incorporation" in paragraph (a)(1); substituted "supervisory insurance official" for "supervising insurance official" in paragraph (a)(4); and substituted "Program; and" for "Program.

This paragraph shall apply on and after January 1, 1994; and" at the end of paragraph (b)(1).

33-15-105. Deficiencies of domestic society; notice; surrender of charter.

(a) When the Commissioner upon investigation finds that a domestic society:

(1) Has exceeded its powers;

(2) Has failed to comply with any provision of this chapter;

(3) Is not fulfilling its contracts in good faith;

(4) Has a membership of less than 400 after an existence of one year or more; or

(5) Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business,

the Commissioner shall notify the society of such deficiency or deficiencies in the manner and under the procedures provided by Chapter 2 of this title.

(b) A domestic society may surrender its charter under the procedure in Code Section 33-14-25.

History. — Code 1981, § 33-15-105, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-106. Deficiencies of foreign or alien society; notice; enforcement procedures.

(a) When the Commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

(1) Has exceeded its powers;

(2) Has failed to comply with any of the provisions of this chapter;

(3) Is not fulfilling its contracts in good faith; or

(4) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public,

the Commissioner shall notify the society of such deficiency or deficiencies in the manner and under the procedures provided by Chapter 2 of this title.

(b) Nothing contained in this Code section shall be taken or construed as preventing any such society from continuing in good faith all

contracts made in this state during the time such society was legally authorized to transact business in this state.

History. — Code 1981, § 33-15-106, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-107. Licensing of agents or representatives; exemptions.

(a) Except as provided in subsections (b) and (c) of this Code section, agents of societies shall be licensed in accordance with the provisions of Chapter 23 of this title.

(b) No examination or license shall be required of any regular salaried officer, employee, or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any agent or representative of a society who devotes, or intends to devote, less than 50 percent of his time to solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (a) of this Code section. Any person who in the immediately preceding calendar year solicited and procured life insurance contracts on behalf of any society on the persons of more than 25 individuals and who received or will receive a commission or other compensation therefor, is presumed to be devoting or intending to devote 50 percent of his time to the solicitation or procurement of insurance contracts for the society.

History. — Code 1981, § 33-15-107, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-108. Applicability of unfair trade practices laws.

Every society authorized to do business in this state shall be subject to the provisions of Chapter 6 of this title, relating to unfair trade practices; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

History. — Code 1981, § 33-15-108, enacted by Ga. L. 1993, p. 1744, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 136.

ARTICLE 7

MISCELLANEOUS PROVISIONS

33-15-120. Appointment of Commissioner as agent for service of process.

(a) Every society authorized to do business in this state shall appoint in writing the Commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served and shall agree in such writing that any lawful process against it which is served on said attorney shall be of the same legal force and validity as if served upon the society and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by said Commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

(b) Service shall only be made upon the Commissioner or, if absent, upon the person in charge of the Commissioner's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the Commissioner, the Commissioner shall forthwith forward one of the duplicate copies by registered or certified mail or statutory overnight delivery, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading, or defense in less than 30 days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner provided in this Code section. At the time of serving any process upon the Commissioner, the plaintiff or complainant in the action shall pay to the Commissioner a fee of $15.00.

History. — Code 1981, § 33-15-120, enacted by Ga. L. 1993, p. 1744, § 1; Ga. L. 2000, p. 1589, § 3.

Cross references. — Service of process generally, § 9-11-4.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provided that the amendment to this Code section by Ga. L. 2000, p. 1589, § 3, was applicable with respect to notices delivered on or after July 1, 2000.

33-15-121. Review of decisions and findings of Commissioner.

All decisions and findings of the Commissioner made under the provisions of this chapter shall be subject to review as provided by Chapter 2 of this title.

History. — Code 1981, § 33-15-121, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-122. Violation; penalties.

(a) Any person, officer, member, or examining physician of any society doing business under this chapter who shall knowingly or willfully make any false or fraudulent statement or representation in or relating to any application for membership or for the purpose of obtaining money from or a benefit in any society shall be guilty of a misdemeanor.

(b) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate shall be guilty of false swearing and shall be subject to the penalties therefor prescribed by Code Section 16-10-71.

(c) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall, upon conviction thereof, be fined not less than $50.00 nor more than $200.00.

(d) Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this chapter for which a penalty is not otherwise prescribed shall, upon conviction thereof, be subject to a fine not to exceed $200.00.

History. — Code 1981, § 33-15-122, enacted by Ga. L. 1993, p. 1744, § 1.

33-15-123. Exempt societies, orders, or associations.

(a) Nothing contained in this chapter shall be so construed as to affect or apply to:

(1) Grand or subordinate lodges of societies, orders, or associations doing business in this state on January 1, 1994, which provide benefits exclusively through local or subordinate lodges;

(2) Orders, societies, or associations which admit to membership only persons engaged in one or more crafts or hazardous occupations

or persons in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(3) Orders, societies, or associations insuring only their own members, their families and descendants of members, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(4) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house, or corporation which provide for a death benefit of not more than $400.00 or disability benefits of not more than $350.00 to any person in any one year, or both; or

(5) Domestic societies or associations of a purely religious, charitable, or benevolent description which provide for a death benefit of not more than $400.00 or for disability benefits of not more than $350.00 to any one person in any one year, or both.

(b) Any such society or association described in paragraph (3) or (5) of subsection (a) of this Code section which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in paragraph (5) of subsection (a) of this Code section which has more than 1,000 members shall not be exempted from the provisions of this chapter but shall comply with all requirements of this chapter.

(c) No society which, by the provisions of this Code section, is exempt from the requirements of this chapter, except any society described in paragraph (2) or (3) of subsection (a) of this Code section, shall give or allow, or promise to give or allow, to any person any compensation for procuring new members.

(d) Every society which provides for benefits in case of death or disability resulting solely from accident and which does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this chapter except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability shall not apply to such society.

(e) The Commissioner may require from any society or association, by examination or otherwise, such information as will enable the Commissioner to determine whether such society or association is exempt from the provisions of this chapter.

(f) Societies exempted under the provisions of this Code section shall also be exempt from all other provisions of the general insurance laws of this state.

History. — Code 1981, § 33-15-123, enacted by Ga. L. 1993, p. 1744, § 1; Ga. L. 2013, p. 141, § 33/HB 79.

CHAPTER 16

FARMERS' MUTUAL FIRE INSURANCE COMPANIES

Sec.
33-16-1. Scope of chapter.
33-16-2. "Domestic farmers' mutual fire insurance companies" defined; risks against which companies may write insurance.
33-16-3. Procedure for incorporation of companies generally; filing and contents of application for charter; granting of charter by Secretary of State.
33-16-4. Issuance of certificate of authority; qualifications; proposed changes to plan of operation.
33-16-5. Annual license fee.
33-16-6. Board of directors generally.
33-16-7. Power of board to borrow money and pledge assets of company.
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33-16-20. Exemption from taxes, costs, and fees.
33-16-21. Applicability of other provisions of title to companies.
33-16-22. Conversion of companies into mutual insurance companies.

Cross references. — Definition of property insurance, § 33-7-6. Property insurance generally, T. 33, C. 32.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Fire Insurer's Bad Faith in Responding to Claim by Insured, 49 POF2d 1.

Am. Jur. Trials. — Handling Fire Claims Out of Court, 57 Am. Jur. Trials 155.

Actions on Fire Insurance Policies, 10 Am. Jur. Trials 301.

33-16-1. Scope of chapter.

This chapter applies only to domestic farmers' mutual fire insurance companies.

History. — Code 1933, § 56-2001, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-2. "Domestic farmers' mutual fire insurance companies" defined; risks against which companies may write insurance.

(a) "Domestic farmers' mutual fire insurance companies" are companies organized for the purpose of insuring property against loss or damage by fire, lightning, windstorm, extended coverage, and hail, and for all, or any, of such purposes.

(b) Domestic farmers' mutual fire insurance companies may write insurance against said hazards on such property risks as their charter and bylaws may provide.

History. — Code 1933, § 56-2002, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 1040, § 1/SB 203.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Civil Code 1910, § 2412 are included in the annotations for this Code section.

Cooperative companies and fraternal benefit societies differentiated. — The General Assembly has differentiated fraternal beneficiary associations from cooperative and assessment companies; the latter are classed as insurance companies, while the former are exempt from the provisions of the insurance laws. Fraternal Life & Accident Ass'n v. Evans, 140 Ga. 284, 78 S.E. 915 (1913) (decided under former Civil Code 1910, § 2412).

RESEARCH REFERENCES

ALR. — Risks and losses covered by lightning insurance, 15 A.L.R.2d 1017.

Determination of amount payable on loss to growing crop under policy insuring against loss or injury, 20 A.L.R.3d 924.

Livestock or animal insurance: risks and losses, 47 A.L.R.4th 772.

33-16-3. Procedure for incorporation of companies generally; filing and contents of application for charter; granting of charter by Secretary of State.

(a) Twenty or more persons a majority of whom are citizens of this state may become a body corporate for the purpose of transacting insurance upon the farmers' mutual fire insurance plan as defined in Code Section 33-16-2 by making an application for a charter signed by the persons applying for the charter or their counsel in triplicate specifying:

(1) The name of the proposed corporation. The name shall contain the words "Farmers' Mutual" and shall not be so similar to any name already used by any other corporation authorized to transact business in this state as to be confusing or misleading;

(2) The purpose for which the corporation is formed;

(3) The name of the county in this state in which the corporation will have its principal office and the names of any other counties in which it proposes to operate;

(4) The name and address of each incorporator;

(5) The names and addresses of those composing the board of directors of the corporation in which the management shall be vested until the first meeting of the members; and

(6) Any other provisions not inconsistent with this chapter or other applicable laws as are deemed desirable by the incorporators or as may be required by the Commissioner.

(b) The corporate charter shall be granted by the Secretary of State as provided in Chapter 14 of this title.

History. — Ga. L. 1923, p. 113, §§ 1-3; Ga. L. 1924, p. 122, § 1; Code 1933, §§ 56-1408, 56-1409, 56-1410, 56-1411; Code 1933, § 56-2003, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-4. Issuance of certificate of authority; qualifications; proposed changes to plan of operation.

(a) No person shall transact or attempt to transact business as a farmers' mutual fire insurance company unless so authorized by an effective certificate of authority issued by the Commissioner.

(b) The Commissioner shall not issue or permit to exist any certificate of authority as to any insurer not qualified for such certificate unless it is shown to the satisfaction of the Commissioner that:

(1) The farmers' mutual fire insurance company maintains the minimum surplus required by subsection (a) of Code Section 33-16-13;

(2) The farmers' mutual fire insurance company maintains a security deposit as required by subsection (c) of Code Section 33-16-13;

(3) The farmers' mutual fire insurance company has submitted an acceptable business plan to the Commissioner that includes, but is not limited to, two-year financial projections and supporting assumptions reflecting expected premiums and losses, counties where the

farmers' mutual fire insurance company intends to insure property, and the contingent liability, if any, of its members; and

(4) It must otherwise be in compliance with the requirements of this chapter.

(c) Any proposed changes to a farmers' mutual fire insurance company's plan of operation subsequent to licensure pursuant to this chapter, including but not limited to geographical expansion, shall be filed and approved in advance by the Commissioner.

History. — Code 1933, § 56-2004, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1970, p. 165, § 1; Ga. L. 1981, p. 809, § 1; Ga. L. 1989, p. 688, § 1; Ga. L. 2012, p. 1040, § 1/SB 203; Ga. L. 2019, p. 337, § 1-77/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "by an effective" for "by a currently effective" in subsection (a); and deleted "currently" preceding "qualified for such" in subsection (b).

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981).

33-16-5. Annual license fee.

Farmers' mutual fire insurance companies shall pay no annual fees or charges other than an annual license fee as provided in Code Section 33-8-1.

History. — Code 1933, § 56-2005, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1992, p. 2725, § 20; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-6. Board of directors generally.

In companies organized under this chapter, the number of directors shall be not less than three. A majority of the board of directors shall be a quorum for the transaction of business. No person shall be or act as a director of the insurer who does not have insurance in force in the insurer.

History. — Code 1933, § 56-2013, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203; Ga. L. 2019, p. 337, § 1-78/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "currently effective" following "who does not have" in the last sentence of this Code section.

33-16-7. Power of board to borrow money and pledge assets of company.

The board of directors of a farmers' mutual fire insurance company may, at any time, borrow such sum or sums of money as they may deem necessary to pay its losses, accrued or unaccrued, and may pledge the assets of the company including the contingent liability of policyholders for the losses as security for the loan.

History. — Code 1933, § 56-2014, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-8. Contents of bylaws generally; amendment of bylaws; provision for exclusion of members.

(a) The bylaws shall state the time and manner of the levy and payment of all premiums or assessments for all insurance written by the company.

(b) The bylaws shall also fix the liability of the policyholders for all losses accrued while the policies are in force, in addition to the regular premium or assessment of the policyholders, and the time and manner of payment of such liability.

(c) The bylaws may be amended and any such amendment shall be filed with the Commissioner at least 30 days prior to its adoption.

(d) The bylaws may contain provisions for the exclusion of any member of the company who refuses or neglects to pay his or her assessment or for any other reasons satisfactory to the directors to be excluded from the insurer.

History. — Ga. L. 1924, p. 122, § 2; Code 1933, § 56-1412; Code 1933, § 56-2008, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-9. Inclusion of bylaws in insurance policy; inclusion in policy of statement of contingent liability of members.

The portion of the bylaws which affects the insuring agreement shall be contained in the policy. Each policy issued by the insurer shall contain a statement of the contingent liability, if any, of its members.

History. — Orig. Code 1863, § 2787; Code 1868, § 2795; Code 1873, § 2837; Code 1882, § 2837; Civil Code 1895, § 2135; Civil Code 1910, § 2530; Code 1933, § 56-1403; Code 1933, § 56-2009, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

JUDICIAL DECISIONS

Bylaw amendment not adding condition to policy binds assured. — An amendment to the bylaws of a mutual insurance company, merely for the purpose of regulating its mode of business and adding no new condition to the policies already issued, is binding on the assured. Georgia Masonic Mut. Life Ins. Co. v. Gibson, 52 Ga. 640 (1874).

Violation of bylaw by tenant may avoid policy. — A violation of a bylaw of a mutual cooperative insurance company, which became a part of a policy of insurance issued by it by virtue of this section, avoided the policy, although done by a tenant and without the knowledge of the insured. Edwards v. Farmers Mut. Ins. Ass'n, 128 Ga. 353, 57 S.E. 707, 119 Am.

St. R. 385, 12 L.R.A. (n.s.) 484, 10 Ann. Cas. 1036 (1907).

33-16-10. Inclusion in policy of provision against waiver of bylaws.

The companies may provide in the policy that officers and agents elected by them do not have the power to waive any provision of the bylaws.

History. — Code 1933, § 56-2010, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-11. Holding of annual and special meetings of members; notice of meetings.

An annual meeting of such company shall be held at such a time as is fixed in the bylaws of the company. Special meetings may be held for such purposes and in such manner as may be specified in the insurer's bylaws, consistent with this chapter. All such meetings shall be held in the insurer's county of domicile or other location in this state that is convenient for its membership and specified in the insurer's bylaws. Notice of such meeting shall be mailed or otherwise given to each member not less than 20 days in advance of the meeting, and notice of any special meeting called by the board of directors shall be given in writing not less than ten days in advance stating the purpose of the meeting so called.

History. — Code 1933, § 56-2015, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-12. Voting by policyholders at meetings.

Each policyholder in a farmers' mutual fire insurance company shall be entitled to only one vote in all policyholders' meetings. No voting by proxy shall be permitted unless it is specially authorized in the bylaws and approved by the Commissioner.

History. — Ga. L. 1923, p. 113, § 9; Code 1933, § 56-1416; § 56-2006, enacted by Ga. L. 1960, p. 289, Code 1933, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-13. Amount of minimum surplus required.

(a) The amount of minimum surplus required for each farmers' mutual fire insurance company shall be determined on an individual basis; however, no farmers' mutual fire insurance company shall be

issued a certificate of authority unless it shall possess and thereafter maintain a minimum of $150,000.00 in surplus.

(b) Minimum surplus of up to $150,000.00 shall be maintained in any of the following:

(1) Cash;

(2) Certificates of deposit or similar certificates or evidence of deposits in banks or trust companies but only to the extent that the certificates or deposits are insured by the Federal Deposit Insurance Corporation; or

(3) Savings accounts, certificates of deposit, or similar certificates or evidence of deposit in savings and loan associations and building and loan associations but only to the extent that the same are insured by the Federal Savings and Loan Insurance Corporation.

(c) A portion of the minimum surplus, in an amount determined by the Commissioner, must be deposited with this state prior to the issuance of the certificate of authority. Chapter 12 of this title shall apply to the deposit required by this subsection.

(d) Any additional surplus in excess of $150,000.00 required by the Commissioner pursuant to subsection (a) of this Code section may be provided and maintained in any of the following:

(1) Any eligible investments of minimum capital or surplus authorized by Code Section 33-11-5; or

(2) Any other investments approved by the Commissioner that do not impair the financial solvency of the farmers' mutual fire insurance company.

History. — Code 1933, § 56-2011, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 856, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-14. Limitations on amounts of risks.

(a) The maximum amount of insurance that a farmers' mutual fire insurance company may retain on any subject or subjects of insurance reasonably exposed to loss from the same fire shall not exceed 10 percent of its surplus.

(b) In determining the amount at risk and retained by the insurer, any valid and applicable reinsurance authorized shall be deducted from the gross amount of risk directly assumed by the insurer.

History. — Code 1933, § 56-2012, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 809, § 2; Ga. L. 1986, p. 510, § 1; Ga. L. 1989, p. 688, § 2; Ga. L. 1996, p. 705, § 7; Ga. L. 2000, p. 847, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-15. Reinsurance.

A farmers' mutual fire insurance company shall not accept reinsurance of the risk of any other insurer.

History. — Ga. L. 1923, p. 113, § 17; § 56-2007, enacted by Ga. L. 1960, p. 289, Code 1933, § 56-1424; Code 1933, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-16-16. Liability of members for losses and expenses of companies.

No member of such insurer shall be liable to assessment to pay losses and expenses accruing prior to the time his policy became effective nor for losses and expenses accruing after termination or expiration of the policy.

History. — Code 1933, § 56-2019, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-17. Actions by or against companies.

Companies organized under this chapter may bring and defend actions in the name under which they are doing business.

History. — Code 1933, § 56-2020, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-18. Filing of annual statement with Commissioner.

Every farmers' mutual fire insurance company shall, on or before March 1 of each year, make and file with the Commissioner an annual statement of its business as of December 31 of the preceding year, on the form prescribed by the Commissioner.

History. — Code 1933, § 56-2016, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-19. Examination of companies by Commissioner; payment of costs of examinations.

The Commissioner shall at least once in five years, or as often as he or she deems necessary, examine farmers' mutual fire insurance companies. The costs of the examination shall be paid by the company.

History. — Code 1933, § 56-2018, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-20. Exemption from taxes, costs, and fees.

Any company organized under this chapter shall be exempt from all taxes, costs, and fees, including those listed in Chapter 8 of this title, except as expressly provided in this chapter and except taxes payable upon real and personal property owned by the company.

History. — Code 1933, § 56-2017, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

33-16-21. Applicability of other provisions of title to companies.

In addition to this chapter, farmers' mutual fire insurance companies shall be subject to the following chapters of this title to the extent so applicable: Chapters 1, 2, 5, 6, 12, and 37, and Article 1 of Chapter 11.

History. — Code 1933, § 56-2022, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

OPINIONS OF THE ATTORNEY GENERAL

Only listed chapters apply. — Since the General Assembly specifically spelled out the portions of this title which apply to farm mutual companies, the chapters not specifically named have no application to such companies. 1960-61 Op. Att'y Gen. p. 272.

33-16-22. Conversion of companies into mutual insurance companies.

Any company organized under this chapter may be converted into a mutual insurance company by complying with the applicable provisions of Chapter 14 of this title.

History. — Code 1933, § 56-2021, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2012, p. 1040, § 1/SB 203.

CHAPTER 17

RECIPROCAL INSURERS

Sec.
33-17-1. Definitions.
33-17-2. Applicability of chapter.
33-17-3. Authorization of transaction of insurance by reciprocal insurers generally.
33-17-4. Types of insurance in which reciprocal insurers authorized to transact business; reinsurance.
33-17-5. Requirements as to name; actions by and against insurers.
33-17-6. Procedure for incorporation of domestic reciprocal insurer generally; application for certificate of authority; execution and filing by attorney of declaration; contents of declaration.
33-17-7. Issuance of certificate of authority; refusal, suspension, or revocation of certificate of authority; renewal of certificate; payment of fees and taxes.
33-17-8. Filing of bond by attorney for insurer; amount of bond; cancellation of bond.
33-17-9. Maintenance by attorney of deposit in lieu of bond.
33-17-10. Actions on attorney's bond or deposit.
33-17-11. Rights and powers of attorney for insurer generally; contents and terms of power of attorney; furnishing of copy of power of attorney to subscribers.
33-17-12. Effect of discharge of duties by attorney of foreign or alien insurer; office of attorney.
33-17-13. Designation by insurer of person to acknowledge or accept service of process; manner of service of process; effect of judgment based upon process served in manner prescribed.
33-17-14. Subscribers' advisory committee.
33-17-15. Modifications of terms of subscribers' agreement or of power of attorney.
33-17-16. General requirements for transaction of insurance by domestic reciprocal insurers.
33-17-17. Advancement of sums to insurer by attorney or other parties; withdrawal or repayment of advances.
33-17-18. Persons and organizations authorized to become subscribers; exchange of insurance contracts; personal liability upon contracts.
33-17-19. Liability of subscribers for obligations of insurer generally; contingent liability assessment.
33-17-20. Enforcement against subscriber of judgment against insurer.
33-17-21. Standards for determination by Commissioner of financial condition of insurer.
33-17-22. Manner of levy of assessments against subscribers generally; computation of assessments.
33-17-23. Limitation period for assessments.
33-17-24. Maximum assessable aggregate contingent liability.
33-17-25. Insufficient assets to discharge liabilities and to maintain required surplus.
33-17-26. Authorization and procedure for issuance by Commissioner of certificate authorizing insurer to extinguish contingent liability of subscribers; revocation of certificate.
33-17-27. Distribution of unused premiums, savings, credits, or profits to subscribers.
33-17-28. Distribution of assets to subscribers upon liquidation of insurer.
33-17-29. Filing of annual statement with Commissioner.
33-17-30. Merger of reciprocal insurers; conversion of reciprocal insurers to stock or mutual insurers.
33-17-31. Exchange of contracts or indemnities by attorneys.

Cross references. — Agency, T. 10, C. 6. Factors giving rise to insolvency of reciprocal insurer, § 33-37-2.

RESEARCH REFERENCES

ALR. — Reciprocal or interinsurance, 141 A.L.R. 765; 145 A.L.R. 1121.

33-17-1. Definitions.

As used in this chapter, the term:

(1) "Attorney" means the attorney in fact of a reciprocal insurer. The attorney may be an individual, firm, or corporation.

(2) "Reciprocal insurance" means insurance resulting from an interexchange among persons, known as subscribers, of reciprocal agreements of indemnity, the interexchange being effectuated through an attorney in fact common to all such persons; provided, however, that reciprocal agreements or contracts of indemnity executed prior to March 8, 1960, creating funds for the purpose of satisfying the obligations of self-insured employers under Chapter 9 of Title 34 shall not be deemed reciprocal insurance as defined in this Code section.

(3) "Reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney in fact to provide reciprocal insurance among themselves.

History. — Code 1933, §§ 56-2101, 56-2102, 56-2106, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1964, p. 287, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 72.

C.J.S. — 46A C.J.S., Insurance, §§ 2368 et seq.

33-17-2. Applicability of chapter.

(a) All authorized reciprocal insurers shall be governed by those Code sections of this chapter not expressly made applicable to domestic reciprocal insurers.

(b) Authorized reciprocal insurers shall comply with this chapter and shall make any amendments to their subscribers' agreement, power of attorney, policies, and other documents and accounts and perform any other acts as may be required for such compliance.

History. — Code 1933, § 56-2103, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-79/SB 132.

The 2019 amendment, effective July 1, 2019, in subsection (b), substituted "Authorized reciprocal insurers shall comply" for "Existing authorized reciprocal insurers shall after January 1, 1961, comply" at the beginning and substituted "for such compliance" for "for that compliance" at the end.

33-17-3. Authorization of transaction of insurance by reciprocal insurers generally.

A reciprocal insurer may be authorized to transact insurance in this state subject to the applicable provisions of this title.

History. — Code 1933, § 56-2102, enacted by Ga. L. 1960, p. 289, § 1.

33-17-4. Types of insurance in which reciprocal insurers authorized to transact business; reinsurance.

(a) A reciprocal insurer may, upon qualifying as a reciprocal insurer as provided for by this title, transact any kind or kinds of insurance defined by this title other than life or title insurance.

(b) A reciprocal insurer may purchase reinsurance upon the risk of any subscriber and may grant reinsurance as to any kind of insurance it is authorized to transact directly.

History. — Code 1933, § 56-2104, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 73.

C.J.S. — 46A C.J.S., Insurance, § 2386 et seq.

ALR. — Who may enforce liability of reinsurer, 103 A.L.R. 1485.

33-17-5. Requirements as to name; actions by and against insurers.

A reciprocal insurer shall:

(1) Have and use a business name. The name shall include the word "reciprocal" or "interinsurer" or "interinsurance" or "exchange" or "underwriters" or "underwriting"; and

(2) Bring and defend actions in its own name.

History. — Code 1933, § 56-2105, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under former Ga. L. 1958, p. 623, and Ga. L. 1958, p. 649, § 12 are included in the annotations for this Code section.

Unincorporated reciprocal exchange may sue and be sued through agent. — Defendant underwriting alliance, an unincorporated reciprocal insurance exchange, was a legal entity, subject to sue and to be sued through an agent. Lumbermen's Underwriting Alliance v. First Nat'l Bank & Trust Co., 98 Ga. App. 289, 105 S.E.2d 585 (1958) (decided under former Ga. L. 1958, p. 623, and Ga. L. 1958, p. 649, § 12).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 72.

C.J.S. — 46A C.J.S., Insurance, § 2368 et seq.

33-17-6. Procedure for incorporation of domestic reciprocal insurer generally; application for certificate of authority; execution and filing by attorney of declaration; contents of declaration.

(a) Twenty-five or more persons domiciled in this state may organize a domestic reciprocal insurer and make application to the Commissioner for a certificate of authority to transact insurance.

(b) The proposed attorney shall fulfill the requirements of and shall execute and file with the Commissioner when applying for a certificate of authority a declaration setting forth:

(1) The name of the insurer;

(2) The location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;

(3) The kinds of insurance proposed to be transacted;

(4) The names and addresses of the original subscribers;

(5) The designation and appointment of the proposed attorney and a copy of the power of attorney;

(6) The names and addresses of the officers and directors of the attorney, if a corporation, or its members, if a firm;

(7) The powers of the subscribers' advisory committee and the names and terms of office of the members of the committee;

(8) That all moneys paid to the reciprocal shall, after deducting therefrom any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;

(9) A copy of the subscribers' agreement;

(10) A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for which the subscriber has applied for a term of not less than six months at an adequate rate that has been filed with and approved by the Commissioner;

(11) A statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by Code Section 33-17-16 is on hand; and

(12) A copy of each policy, endorsement, and application form it then proposes to issue or use.

(c) Such declaration shall be acknowledged by the attorney before an officer authorized to take acknowledgments.

History. — Code 1933, § 56-2108, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 74.

C.J.S. — 46A C.J.S., Insurance, § 2386 et seq.

33-17-7. Issuance of certificate of authority; refusal, suspension, or revocation of certificate of authority; renewal of certificate; payment of fees and taxes.

(a) The certificate of authority to transact business of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

(b) The Commissioner may refuse, suspend, or revoke the certificate of authority to transact business, in addition to other grounds for refusal, suspension, or revocation, for failure of the attorney to comply with any provision of this title.

(c) The certificate shall be renewed annually and shall be issued and renewed upon payment of the fees required of insurers under this title.

(d) Each holder of a certificate of authority to transact business of a reciprocal insurer shall pay all fees required by this title and shall pay all of the taxes required by law to be paid by companies doing a like business in this state.

History. — Code 1933, § 56-2109, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 72 et seq.

C.J.S. — 46A C.J.S., Insurance, § 2386 et seq.

33-17-8. Filing of bond by attorney for insurer; amount of bond; cancellation of bond.

(a) Concurrently with the filing of the declaration provided for in Code Section 33-17-6, the attorney of a domestic reciprocal insurer shall file with the Commissioner a bond in favor of the Commissioner for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his or her bond as set forth in subsection (b) of this Code section. The bond shall be executed by the attorney and by an authorized corporate surety and shall be subject to the Commissioner's approval.

(b) The bond shall be in the penal sum of $25,000.00, aggregate in form, conditioned that the attorney will faithfully account for all moneys and other property of the insurer coming into his or her hands and that he or she will not withdraw or appropriate to his or her own use from the funds of the insurer any moneys or property to which he or she is not entitled under the power of attorney.

(c) The bond shall provide that it is not subject to cancellation unless 30 days' advance notice in writing of cancellation is given to both the attorney and the Commissioner.

History. — Code 1933, § 56-2112, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-80/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "or her" in the first sentence of subsection (a) and twice in subsection (b), and inserted "or she" twice in subsection (b).

33-17-9. Maintenance by attorney of deposit in lieu of bond.

In lieu of the bond required under Code Section 33-17-8, the attorney may maintain on deposit with the state through the office of the Commissioner a like amount in cash or in value of securities qualified for deposit under Chapter 11 of this title, subject to the same conditions as the bond.

History. — Code 1933, § 56-2113, enacted by Ga. L. 1960, p. 289, § 1.

33-17-10. Actions on attorney's bond or deposit.

Action on the attorney's bond or to recover against a deposit made in lieu of the bond may be brought at any time by one or more subscribers suffering loss through a violation of its conditions or by the Commis-

sioner as liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of the bond.

History. — Code 1933, § 56-2114, enacted by Ga. L. 1960, p. 289, § 1.

33-17-11. Rights and powers of attorney for insurer generally; contents and terms of power of attorney; furnishing of copy of power of attorney to subscribers.

(a) The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given to it by the subscribers.

(b) The power of attorney must set forth:

(1) The powers of the attorney;

(2) That the attorney is authorized to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged;

(3) The general services to be performed by the attorney;

(4) The maximum amounts to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses to be paid by the insurer; and

(5) Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount, which amount shall be not less than one nor more than ten times the premium or premium deposit stated in the policy.

(c) The power of attorney may:

(1) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(2) Impose any restrictions upon the exercise of the power as are agreed upon by the subscribers;

(3) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(4) Contain other lawful provisions deemed advisable.

(d) The terms of any power of attorney or agreement collateral to such power shall be reasonable and equitable and shall be subject to review and approval by the Commissioner.

(e) A copy of the power of attorney shall be furnished each subscriber.

History. — Code 1933, § 56-2110, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Thaxton v. Georgia Insurer's Insolvency Pool, 158 Ga. App. 407, 280 S.E.2d 421 (1981).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 74.
C.J.S. — 46A C.J.S., Insurance, § 2387.

33-17-12. Effect of discharge of duties by attorney of foreign or alien insurer; office of attorney.

(a) The attorney of a foreign or alien reciprocal insurer, which insurer is duly authorized to transact insurance in this state, shall not, by virtue of discharge of his or her duties as such attorney with respect to the insurer's transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign firms or corporations.

(b) The office of the attorney shall be maintained at such place as is designated by the subscribers in the power of attorney.

History. — Code 1933, § 56-2106, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-81/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "or her" in subsection (a).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, annotations decided under Ga. L. 1958, p. 649, § 2 are included in the annotations for this Code section.

Venue properly laid in county where reciprocal exchange had agent at time of loss. — Provision to the effect that an insurance company can be sued, inter alia, in the county where its agent or place of business was located at the time the cause of action arose or the contract was made (see O.C.G.A. § 33-4-1(3)), is applicable to a reciprocal exchange, and venue is properly laid in county in which defendant had an agent at the time of the loss, even though when action was filed, this agent had left and service was had upon individual designated by defendant for acceptance of service. Lumbermen's Underwriting Alliance v. First Nat'l Bank & Trust Co., 98 Ga. App. 289, 105 S.E.2d 585 (1958); Lumbermen's Underwriting Alliance v. Jessup, 98 Ga. App. 305, 105 S.E.2d 596 (1958) (decided under Ga. L. 1958, p. 649, § 2).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 74.
C.J.S. — 46A C.J.S., Insurance, § 2387.

33-17-13. Designation by insurer of person to acknowledge or accept service of process; manner of service of process; effect of judgment based upon process served in manner prescribed.

(a) Every reciprocal insurer authorized to transact business in this state shall file with the Commissioner a written statement or power of attorney duly signed and sealed appointing and authorizing some person, who shall be a resident of this state, to acknowledge or accept service of process for and in behalf of such reciprocal insurer, and upon whom all process may be served against said reciprocal insurer, in all proceedings that may be instituted against the reciprocal insurer in any of the courts of this state or of the United States, and consenting that service of process upon any agent or attorney appointed under this Code section shall be as valid as if served on the reciprocal insurer.

(b) Legal process shall be served upon the reciprocal insurer by serving the insurer's attorney at his or her principal office in this state or by serving the Commissioner as the insurer's agent.

(c) Any judgment based upon legal process served in the manner prescribed in subsection (b) of this Code section shall be binding upon each of the insurer's subscribers as their respective interests may appear but in an amount not exceeding their respective contingent liabilities, if any, as though personal service of process was had upon each subscriber.

History. — Code 1933, § 56-2115, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-82/SB 132.
The 2019 amendment, effective July 1, 2019, inserted "or her" in subsection (b).

Cross references. — Service of process generally, § 9-11-4.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 77.

C.J.S. — 44 C.J.S., Insurance, § 146. 46A C.J.S., Insurance, § 2163 et seq.

33-17-14. Subscribers' advisory committee.

(a) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

(b) The committee shall:

(1) Supervise the finances of the insurer;

(2) Supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney;

(3) Procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and

(4) Have any additional powers and functions as may be conferred by the subscribers' agreement.

History. — Code 1933, § 56-2120, enacted by Ga. L. 1960, p. 289, § 1.

33-17-15. Modifications of terms of subscribers' agreement or of power of attorney.

Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No modification shall be effective until it has been filed with and approved by the Commissioner, and no modification shall be effective retroactively. Furthermore, no modification shall affect any insurance contract issued prior to the modification.

History. — Code 1933, § 56-2111, enacted by Ga. L. 1960, p. 289, § 1.

33-17-16. General requirements for transaction of insurance by domestic reciprocal insurers.

(a) A domestic reciprocal insurer formed under this chapter, if it has otherwise complied with the applicable provisions of this title, may be authorized to transact insurance if it has and thereafter maintains surplus funds as follows:

(1) To transact property insurance, surplus funds of not less than $1.5 million; and

(2) To transact casualty insurance, surplus funds of not less than $1.5 million.

(b) In addition to surplus required to be maintained under subsection (a) of this Code section, the insurer shall have, when first authorized to transact insurance, expendable surplus in such amount as is required of a like foreign reciprocal insurer under Code Section 33-3-7.

(c) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the

provisions of this title applicable to a domestic reciprocal insurer and possesses and so maintains surplus funds in an amount equal to the minimum paid-in capital stock required of a stock insurer for authority to transact a like combination of kinds of insurance.

(d) There shall be maintained at all times assets in cash, premium balances, or securities authorized by the laws of this state for the investment of assets of insurance companies doing a similar business in an amount equivalent to the pro rata unearned premiums or deposits of subscribers and reserves for losses outstanding and unpaid or any other liabilities of the reciprocal insurer.

History. — Code 1933, § 56-2107, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1990, p. 1275, § 6.

Editor's notes. — Ga. L. 1990, p. 1275, § 7, not codified by the General Assembly, provided that the 1990 amendment was effective for purposes of application to new or newly admitted insurers on January 1, 1991, and effective for all other purposes on July 1, 1992.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 72 et seq.

C.J.S. — 46A C.J.S., Insurance, §§ 2368 et seq.

33-17-17. Advancement of sums to insurer by attorney or other parties; withdrawal or repayment of advances.

The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms any funds as it may require from time to time in its operations. Sums so advanced shall not be treated as a liability of the insurer and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No withdrawal or repayment shall be made without the advance approval of the Commissioner.

History. — Code 1933, § 56-2116, enacted by Ga. L. 1960, p. 289, § 1.

33-17-18. Persons and organizations authorized to become subscribers; exchange of insurance contracts; personal liability upon contracts.

(a) Individuals, partnerships, and corporations of this state may make application to, enter into agreement for, hold policies or contracts in or with, and be a subscriber of any domestic, foreign, or alien reciprocal insurer.

(b) Any corporation organized under the laws of this state shall, in addition to the rights, powers, and franchises specified in its charter,

have full power and authority as a subscriber to exchange insurance contracts through such reciprocal insurer. The right to exchange such contracts is declared to be incidental to the purposes for which the corporations are organized and to be as fully granted as the rights and powers expressly conferred upon the corporations. Government or governmental agencies, state or political subdivisions thereof, boards, associations, estates, trustees, or fiduciaries are authorized to exchange nonassessable reciprocal interinsurance contracts with each other and with individuals, partnerships, and corporations to the same extent that individuals, partnerships, and corporations are authorized under this Code section to exchange reciprocal interinsurance contracts.

(c) Any officer, representative, trustee, receiver, or legal representative of any subscriber shall be recognized as acting for or on its behalf for the purpose of the contract but shall not be personally liable upon the contract by reason of acting in a representative capacity.

History. — Code 1933, § 56-2119, enacted by Ga. L. 1960, p. 289, § 1.

33-17-19. Liability of subscribers for obligations of insurer generally; contingent liability assessment.

(a) The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer shall be an individual, several, and proportionate liability, and not joint.

(b) Except as to a nonassessable policy, each subscriber shall have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his policy was in force. The contingent liability may be at the rate of not less than one nor more than ten times the premium or premium deposit stated in the policy, and the maximum aggregate of contingent liability shall be computed in the manner set forth in Code Section 33-17-24.

(c) Each assessable policy issued by the insurer shall contain a statement of the contingent liability.

History. — Code 1933, § 56-2121, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 75, 77.

C.J.S. — 46A C.J.S., Insurance, § 2368 et seq.

33-17-20. Enforcement against subscriber of judgment against insurer.

(a) No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for 30 days.

(b) Any judgment shall be binding upon each subscriber only in such proportion as his interests may appear and in amount not exceeding his contingent liability, if any.

History. — Code 1933, § 56-2122, enacted by Ga. L. 1960, p. 289, § 1.

33-17-21. Standards for determination by Commissioner of financial condition of insurer.

In determining the financial condition of a reciprocal insurer, the Commissioner shall apply the following rules:

(1) He shall charge as liabilities the same reserves as are required of incorporated insurers issuing nonassessable policies on a reserve basis;

(2) The surplus deposits of subscribers shall be allowed as assets, except that any premium deposits delinquent for 90 days shall first be charged against such surplus deposit;

(3) The surplus deposits of subscribers shall not be charged as a liability;

(4) All premium deposits delinquent less than 90 days shall be allowed as assets;

(5) An assessment levied upon subscribers and not collected shall not be allowed as an asset;

(6) The contingent liability of subscribers shall not be allowed as an asset; and

(7) The computation of reserves shall be based upon premium deposits other than membership fees without any deduction for expenses and the compensation of the attorney.

History. — Code 1933, § 56-2118, enacted by Ga. L. 1960, p. 289, § 1.

33-17-22. Manner of levy of assessments against subscribers generally; computation of assessments.

(a) Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer liable therefor under the terms of their policies by the attorney upon approval in advance by the subscribers' advisory committee and the Commissioner or by the Commissioner in liquidation of the insurer.

(b) Each subscriber's share of a deficiency for which an assessment is made, but not exceeding in any event his aggregate contingent liability as computed in accordance with Code Section 33-17-24, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment the ratio of the total deficiency to the total premiums earned during the period upon all policies subject to the assessment.

(c) In computing the earned premiums for the purposes of this Code section, the gross premium received by the insurer for the policy shall be used as a base deducting therefrom solely charges not recurring upon the renewal or extension of the policy.

(d) No subscriber shall have an offset against any assessment for which he is liable on account of any claim for unearned premium or losses payable.

History. — Code 1933, § 56-2123, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 72 et seq.

C.J.S. — 46A C.J.S., Insurance, § 2368 et seq.

33-17-23. Limitation period for assessments.

Every subscriber of a domestic reciprocal insurer having contingent liability shall be liable for and shall pay his share of any assessment, as computed and limited in accordance with this chapter, if:

(1) While his or her policy is in force or within one year after its termination, he or she is notified by either the attorney or the Commissioner of his or her intentions to levy the assessment; or

(2) If an order to show cause why the receiver, conservator, rehabilitator, or liquidator of the insurer should not be appointed is issued while his or her policy is in force or within one year after its termination.

History. — Code 1933, § 56-2124, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-83/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "or her" in two places in paragraph (1) and in paragraph (2), and inserted "or she" in paragraph (1).

Law reviews. — For article, "Statutes of Limitation: Counterproductive Complexities," see 37 Mercer L. Rev. 1 (1985).

33-17-24. Maximum assessable aggregate contingent liability.

No one policy or subscriber as to the policy shall be assessed or charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year in excess of the amount provided for in the power of attorney or in the subscriber's agreement computed solely upon premium earned on the policy during that year.

History. — Code 1933, § 56-2125, enacted by Ga. L. 1960, p. 289, § 1.

33-17-25. Insufficient assets to discharge liabilities and to maintain required surplus.

(a) If the assets of a domestic reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall immediately make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency, subject to the limitations set forth in the power of attorney or policy.

(b) If the attorney fails to make up the deficiency or to make the assessment within 30 days after the Commissioner orders him or her to do so or if the deficiency is not fully made up within 60 days after the date the assessment was made, the insurer shall be deemed insolvent and shall be proceeded against as authorized by this title.

(c) If liquidation of an insurer is ordered, an assessment shall be levied upon the subscribers for an amount, subject to limits as provided by this chapter, as the Commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons but including the reasonable costs of the liquidation.

History. — Code 1933, § 56-2130, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 337, § 1-84/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "or her" in subsection (b).

33-17-26. Authorization and procedure for issuance by Commissioner of certificate authorizing insurer to extinguish contingent liability of subscribers; revocation of certificate.

(a) If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum paid-in capital stock required of a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee, the Commissioner shall issue a certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for so long as all the surplus remains unimpaired.

(b) Upon impairment of the surplus, the Commissioner shall immediately revoke the certificate. The revocation shall not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has theretofore been paid but, after revocation, no policy shall be issued or renewed without providing for contingent assessment liability of the subscriber.

(c) The Commissioner shall not authorize a domestic reciprocal insurer so to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to and does extinguish the liability of all its subscribers and in all the policies for all kinds of insurance transacted by it. If required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of such of its subscribers as may acquire the policies in the state and need not extinguish the contingent liability applicable to policies theretofore in force in the state.

History. — Code 1933, § 56-2126, enacted by Ga. L. 1960, p. 289, § 1.

33-17-27. Distribution of unused premiums, savings, credits, or profits to subscribers.

A reciprocal insurer may from time to time return to its subscribers any unused premiums, savings, credits, or profits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks or policies or between subscribers, but the distribution may vary as to classes of subscribers based upon the experience of the subscribers. In no event shall there be any distribution whatsoever by a domestic reciprocal insurer while notes or advances to the minimum surplus required by Code Section 33-17-17 are outstanding, unless the Commissioner shall first approve the distribution.

History. — Code 1933, § 56-2127, enacted by Ga. L. 1960, p. 289, § 1.

33-17-28. Distribution of assets to subscribers upon liquidation of insurer.

Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharges of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus made as provided in Code Section 33-17-17, and the return of any unused premiums, savings, or credit then standing on subscribers' accounts shall be distributed to its subscribers who were such within the 12 months prior to the last termination of its certificate of authority, according to such reasonable formula as the Commissioner may approve.

History. — Code 1933, § 56-2128, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

C.J.S. — 46A C.J.S., Insurance, § 2368 et seq.

33-17-29. Filing of annual statement with Commissioner.

(a) The annual financial statement of a reciprocal insurer shall be made and filed with the Commissioner by its attorney on or before March 1 of each year.

(b) The information required by this title of other insurers doing a like insurance business in this state shall be included in the annual financial statement.

(c) The statement shall be supplemented by such information as may be required by the Commissioner relative to the affairs and transactions of the attorney, insofar as they relate to the reciprocal insurer.

History. — Code 1933, § 56-2117, enacted by Ga. L. 1960, p. 289, § 1.

33-17-30. Merger of reciprocal insurers; conversion of reciprocal insurers to stock or mutual insurers.

(a) A domestic reciprocal insurer, upon affirmative vote of not less than two-thirds of its subscribers who vote on the merger pursuant to due notice and the approval of the Commissioner of the terms for such merger, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

(b) Such a stock or mutual insurer shall be subject to the same capital or surplus requirements and shall have the same rights as a like domestic insurer transacting like kinds of insurance.

(c) The Commissioner shall not approve any plan for merger or conversion which is inequitable to subscribers or which, if for conversion to a stock insurer, does not give each subscriber preferential right to acquire stock of the proposed insurer proportionate to his interest in the reciprocal insurer as determined in accordance with Code Section 33-17-28 and a reasonable length of time within which to exercise such right.

(d) Reinsurance of all or substantially all of the insurance in force of a domestic reciprocal insurer in another insurer shall be deemed to be a merger for the purposes of this Code section.

History. — Code 1933, § 56-2129, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Merger and consolidation of Secretary of State corporations, § 14-4-140 et seq.

33-17-31. Exchange of contracts or indemnities by attorneys.

Any attorney who shall exchange any contract or indemnity of the kind and character specified in this chapter or who shall directly or indirectly solicit or negotiate any application for the contracts without first complying with all the provisions of this chapter shall be guilty of a misdemeanor, but the Commissioner may in his discretion and upon such terms and conditions as he may prescribe issue a permit for organizational purposes to continue in force and effect until canceled at the pleasure of the Commissioner.

History. — Code 1933, § 56-9914, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Punishment for misdemeanors generally, § 17-10-3.

CHAPTER 18

NONPROFIT MEDICAL SERVICE CORPORATIONS

Sec.
33-18-1 through 33-18-33 [Repealed].

Cross references. — State health planning and development, T. 31, C. 6. Public assistance for medical care, § 49-4-140 et seq.

33-18-1 through 33-18-33.

Reserved. Repealed by Ga. L. 2017, p. 164, § 1/HB 127, effective July 1, 2017.

Editor's notes. — This chapter consisted of Code Sections 33-18-1 through 33-18-33, relating to nonprofit medical service corporations, and was based on Code 1933, §§ 56-1801-1831, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1973, p. 813, §§ 2-18; Ga. L. 1983, p. 3, § 33; Ga. L. 1982, p. 1199, §§ 2, 4.

CHAPTER 19

NONPROFIT HOSPITAL SERVICE CORPORATIONS

Sec.
33-19-1 through 33-19-22 [Repealed].

Cross references. — Nonprofit corporations generally, T. 14, C. 3. State health planning and development, T. 31, C. 6. Construction and regulation of hospitals and other health care facilities, T. 31, C. 7. Public assistance for medical care, § 49-4-140 et seq.

Law reviews. — For note, "Bearing Hospital Tax Breaks: How Nonprofits Benefit From Your Surprise Medical Bills," see 35 Ga. St. U.L. Rev. 809 (2019).

33-19-1 through 33-19-22.

Reserved. Repealed by Ga. L. 2017, p. 164, § 2/HB 127, effective July 1, 2017.

Editor's notes. — This chapter consisted of Code Sections 33-19-1 through 33-19-22, relating to nonprofit hospital service corporations, and was based on Code 1933, §§ 56-1701 through 56-1720, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1972, p. 682, § 1; Ga. L. 1980, p. 68, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 1199, §§ 1, 5; Ga. L. 2008, p. 12, § 2-33/SB 433.

CHAPTER 20

HEALTH CARE PLANS

Sec.
33-20-1. Short title.
33-20-2. Purpose and construction of chapter.
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33-20-5. Procedure for formation of health care corporations; regulation and supervision of corporations by Commissioner generally.
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33-20-7. Bond of treasurer; deposit of funds collected from subscribers.
33-20-8. Requirements for certificate of authority; application.
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33-20-16. Right to become participating physician or approved health care provider.
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33-20-19. Regulation and supervision of corporations by Commissioner generally; payment of fees and taxes by corporations generally.
33-20-20. Submission to Commissioner of operating plan, schedule of rates, and amount of service; approval by Commissioner.
33-20-21. Approval of Commissioner of rates to be paid to providers of services.
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33-20-27. Imposition by Commissioner of administrative fine for certain acts of officers, employees, agents, or representatives of corporations.
33-20-28. Termination of organizers, agents, solicitors engaging in unfair or deceptive practices.
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Sec.
33-20-33. Payment of distribution of reserved funds or surplus; requirements for initial public offering; fees, taxes, and assessments; applicability of other provisions of Title 33; regulation.

Sec.
33-20-34. Conversion of nonprofit health care corporation; requirements and procedures; rules and regulations.

Cross references. — Health insurance plans for public school teachers and other public school employees, § 20-2-880 et seq. State health planning and development, T. 31, C. 6. Public assistance for medical care, § 49-4-140 et seq.

Law reviews. — For note, "Paying the Piper: Third-party Payor Liability for Medical Treatment Decisions," see 25 Ga. L. Rev. 861 (1991).

RESEARCH REFERENCES

ALR. — Health insurance: provisions excluding or limiting liability in case of chronic diseases, 4 A.L.R. 875; 15 A.L.R. 1239.

Criterion of health for purpose of warranty or condition in insurance contract, 40 A.L.R. 662; 100 A.L.R. 362.

Validity and nature of group medical and hospital service plans, 167 A.L.R. 322.

Scope of provision in group health or accident insurance policy excluding from coverage sickness or accidents arising out of, or in the course of, employment, 47 A.L.R.2d 1240.

Provision of accident or health insurance policy that insured shall be under care of physician or surgeon, 84 A.L.R.2d 375.

When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 10 A.L.R.3d 468.

Medical care insurance: right of insured under individual policy to coverage afforded by group policy from which he directly transferred on termination of his employment, 66 A.L.R.3d 1192.

Elimination of particular coverage, or termination, of health, hospitalization, or medical care insurance policy as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illness, 66 A.L.R.3d 1205.

Right of "Blue Cross" or "Blue Shield," or similar hospital or medical service organization, to be subrogated to certificate holder's claims against tortfeasor, 73 A.L.R.3d 1140.

Admissibility of opinion evidence as to employability on issue of disability in health and accident insurance and workers' compensation cases, 89 A.L.R.3d 783.

Construction and application of provision in health or hospitalization policy excluding or postponing coverage of illness originating prior to issuance of policy or within stated time, 94 A.L.R.3d 990.

Construction and application of provision in health or hospitalization policy excluding or postponing coverage of illness for which medical care or treatment was received within stated time preceding or following issuance of policy, 95 A.L.R.3d 1290.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance, 75 A.L.R.4th 763.

Validity of state statute prohibiting health providers from the practice of waiving patients' obligation to pay health insurance deductibles or copayments, or advertising such practice, 8 A.L.R.5th 855.

Coverage under medical and health insurance plans for services performed by dentists, oral surgeons, and orthodontists, 43 A.L.R.5th 657.

The propriety, under ERISA (29 USCS

§§ 1001 et seq.) and the Americans With Disabilities Act (42 USCS §§ 12101 et seq.), of capping health insurance coverage for HIV-related claims, 131 A.L.R. Fed. 191.

Am. Jur. Trials. — Actions on Health and Accident Insurance Policies, 9 Am. Jur. Trials 131.

33-20-1. Short title.

This chapter shall be known and may be cited as the "Health Care Plan Act."

History. — Code 1933, § 56-1700a, enacted by Ga. L. 1976, p. 1461, § 1.

JUDICIAL DECISIONS

"Any Willing Provider" (AWP) statute applied to a health insurer's preferred provider (PPO) network because: (1) the insurer was an O.C.G.A. T. 33, Ch. 20 health care corporation; (2) the AWP statute expressly applied to health care corporations; and (3) the AWP statute applied to the PPO network since the insurer, under the Preferred Provider Arrangements Act, O.C.G.A. § 33-30-20 et seq., could administer a preferred provider arrangement which was a health benefit plan. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 315 Ga. App. 521, 726 S.E.2d 714 (2012), cert. denied, No. S12C1322, 2012 Ga. LEXIS 1018 (Ga. 2012), cert. denied, No. S12C1413, 2012 Ga. LEXIS 1033 (Ga. 2012).

RESEARCH REFERENCES

ALR. — When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 65 A.L.R.5th 649.

33-20-2. Purpose and construction of chapter.

It is the purpose and intent of this chapter and the policy of this state to promote and finance quality health care services of demonstrated need, efficiently provided and properly utilized at a reasonable cost, in order to maintain the standing and promote the progress of comprehensive health care services in this state. This chapter shall be construed liberally to promote its humanitarian purposes.

History. — Code 1933, § 56-1700a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1991, p. 724, § 1.

33-20-3. Definitions.

As used in this chapter, the term:

(1) "Beneficiary" or "covered dependent" means a person designated in the subscription certificate or application therefor of a

subscriber as entitled to health care service with respect to whom appropriate periodic payments are made, all subject to acceptance by the health care corporation.

(2) "Health care corporation" means a corporation established in accordance with the provisions of this chapter to administer one or more health care plans.

(3) "Health care plan" means a plan or arrangement under which health care services are or may be rendered to a subscriber or a covered dependent or other beneficiary at the expense of a health care corporation in consideration of periodic payments made by the subscriber or another in his or her behalf.

(4) "Health care services" means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury, or other human physical problem and includes but is not limited to:

(A) Hospital services which include the general and usual care, services, supplies, and equipment furnished by hospitals;

(B) Medical services which include the general and usual services and care rendered and administered by doctors of medicine, doctors of dental surgery, and doctors of podiatry; and

(C) Other health care services which include appliances and supplies; nursing care by a registered nurse or a licensed practical nurse; care furnished by such other licensed practitioners as may be expressly approved by the board of directors from time to time; institutional services including the general and usual care, services, supplies, and equipment furnished by health care institutions and agencies or entities other than hospitals; physiotherapy; ambulance services; drugs and medications; therapeutic services and equipment including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances including wheelchairs, trusses, braces, crutches, and prosthetic devices including artificial limbs and eyes; and any other appliance, supply, or service related to health care.

(5) "Income at risk" means the amount of income earned on an account in which a risk of underwriting loss due to adverse claims experience exists. In the case of any risk account as to which the rate is not established directly by the health care corporation, income at risk shall be the sum total of benefits paid and administrative costs incurred for such account for which the health care corporation has been or will be reimbursed.

(6) "Participating facility" means a hospital, extended care facility, or other facility, institution, agency, or entity providing health care

services which agrees in writing with a health care corporation to provide services specified in the subscription contracts issued by the corporation at such rates of compensation as shall be determined by the board of directors of the corporation and which agrees to abide by the bylaws, rules, and regulations of the corporation applicable to participating facilities. A participating facility must be licensed or approved as such by the appropriate agency of this state, some other state, or the federal government or shall meet such requirements as shall be established by the health care corporation if no regulatory license or approval is required.

(7) "Participating physician" means a doctor of medicine licensed to practice medicine or surgery in this state under Chapter 34 of Title 43, a dental surgeon licensed to practice dental surgery in this state under Chapter 11 of Title 43, or a podiatrist licensed to practice podiatry in this state under Chapter 35 of Title 43 who agrees with a health care corporation to perform medical services under the conditions specified in the subscription contracts issued by the corporation.

(8) "Person" means a natural person, a partnership, an association, a common-law trust, or a corporation.

(9) "Provider" means any physician, hospital, or other person who is licensed or otherwise authorized in this state to furnish health care services.

(10) "Subscriber" or "member" means a person to whom a subscriber's certificate is issued by a health care corporation, which certificate sets forth the kinds and extent of the health care services which may be all or a part of the total health care services used by or provided to a subscriber for which the corporation is liable to make total or partial payment.

(11) "Subscriber surplus" means the excess of the admitted assets of a health care corporation over its liabilities as reported in the annual statement filed with the Commissioner.

(12) "Surviving corporation" means a health care corporation which is:

(A) The surviving corporation in a merger which includes one or more health care corporations;

(B) A health care corporation which has amended its articles of incorporation to become a corporation governed by Chapter 2 of Title 14, the "Georgia Business Corporation Code"; or

(C) The subsidiary of a corporation described in subparagraph (A) or (B) of this paragraph.

History. — Code 1933, § 56-1702a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, §§ 1.1, 1.2; Ga. L. 1996, p. 6, § 33; Ga. L. 2019, p. 337, § 1-85/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "periodic payments" for "periodical payments" in paragraphs (1) and (3) and inserted "or her" at the end of paragraph (3).

RESEARCH REFERENCES

ALR. — What constitutes a "hospital" within coverage or exclusionary clauses of hospitalization policy, 46 A.L.R.3d 1244.

33-20-4. Authorization of formation of health care corporations generally.

Health care corporations may be incorporated for the purpose of establishing, maintaining, and operating one or more health care plans, providing administrative or other services to employers or others that offer plans furnishing or reimbursing for health care services, including without limitation establishing, administrating, promoting, and developing programs requested, desired, or sponsored by employers or other groups, and for the other purposes authorized by this chapter.

History. — Code 1933, § 56-1705a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1991, p. 724, § 2; Ga. L. 1995, p. 745, § 1.3.

33-20-5. Procedure for formation of health care corporations; regulation and supervision of corporations by Commissioner generally.

(a) Any five or more persons, all of whom shall be residents of this state, upon filing a petition with the Secretary of State for a corporate charter as provided in Chapter 3 of Title 14, the "Georgia Nonprofit Corporation Code," or, if the resulting health care corporation is to be a surviving corporation, Chapter 2 of Title 14, the "Georgia Business Corporation Code," which petition shall also contain the information required by Chapter 14 of this title, may form a health care corporation under and in conformity with this chapter for the purpose of establishing, maintaining, and operating one or more health care plans, whereby health care services are or may be provided at the expense of the corporation. Other benefits including complete employee welfare and employee benefit programs may be added from time to time as the corporation may determine with the approval of the Commissioner.

(b) A health care corporation shall be subject to regulation and supervision by the Commissioner in the same manner as life insurers are subject to such regulation and supervision and shall be governed by the corporation laws of this state.

History. — Code 1933, § 56-1703a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.4; Ga. L. 1999, p. 81, § 33.

33-20-6. Board of directors; merger or consolidation of medical service corporations and hospital service corporations; powers of health care corporations generally.

Reserved. Repealed by Ga. L. 2017, p. 164, § 9/HB 127, effective July 1, 2017.

Editor's notes. — This Code section was based on Ga. L. 1976, p. 1461, § 1; Ga. L. 1991, p. 724, § 3.

33-20-7. Bond of treasurer; deposit of funds collected from subscribers.

The treasurer of a health care corporation shall be required to give a fidelity bond with corporate surety in such sum as may be determined by the directors of the corporation and all funds collected from the subscribers of the corporation shall be deposited to the account of the corporation in a bank which is a state depository.

History. — Code 1933, § 56-1713a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-8. Requirements for certificate of authority; application.

(a) Except for corporations subject to this chapter which are surviving corporations, a health care corporation may issue contracts only after the Commissioner has authorized it to do so.

(b) Every application for a certificate of authority shall be accompanied by copies of the following documents and information:

(1) A certified copy of its charter or certificate of incorporation;

(2) A copy of its bylaws certified by the lawful custodian of the original;

(3) Proposed contracts between the corporation and participating physicians, participating facilities, or other providers of health care services showing the terms under which health care service is to be furnished to subscribers, beneficiaries, and covered dependents;

(4) A statement of the county or counties in which it proposes to operate health care plans;

(5) A statement of its financial condition and business in such form and detail as the Commissioner may require including the amounts of contributions paid for working capital, the name or names of each

contributor, and the terms of such contributions signed and sworn to by its president and secretary or other proper officers. Contributions not paid, but agreed to be paid, may be reported as a separate item but shall not be admitted assets of the corporation; and

(6) Such other documents and information as the Commissioner may reasonably require to be filed.

History. — Code 1933, § 56-1718a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.5.

33-20-9. Certificate of authority issuance.

(a) The Commissioner shall be authorized to issue a certificate of authority in accordance with this chapter and other proper requirements of the Commissioner if the Commissioner is satisfied that:

(1) All items required to be filed are in proper form and meet his approval;

(2) The applicant is established as a bona fide health care corporation;

(3) The services rendered by the corporation are not an unnecessary duplication of similar services in the community served and are desirable for the public necessity and convenience;

(4) The applicant's proposed methods of solicitation of contracts and its proposed conditions or methods of operation appear to be fair and reasonable;

(5) The method of establishing rates charged is fair, reasonable, and adequate and the benefits to be provided are fair and reasonable, provided that rates established in accordance with the applicable provisions of this chapter and Chapter 24 of this title may differ for separate services or classes or kinds of service, including service in different facilities, and between subscribers in different groups if based upon the experience of the group or locality and between subscribers in groups and individual subscribers not in groups; and

(6) The amount provided as working capital is only provided by individuals or groups which have no financial interest in the activities of the health care corporation. Interest charged for working capital, if any, shall be reasonable, shall be subject to the general laws of this state governing permissible rates of interest, and shall be approved by the Commissioner; and payment of interest, if any, and repayment of such working capital shall be permitted only after provision has been adequately made for operating expenses, payments of benefits, and the establishment of required services.

(b) On an application for an original certificate of authority, the Commissioner may, in his discretion, consider and rely upon recommendations of the medical societies, the hospitals, or any other persons in the areas in which the health care corporation proposes to operate.

History. — Code 1933, § 56-1719a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-10. Expiration, renewal, and amendment of certificate of authority.

(a) All certificates of authority shall expire at 12:00 Midnight on June 30 following the date of issuance or renewal. A health care corporation desiring renewal shall file on March 1 preceding expiration a copy of its annual statement as of December 31 of the preceding year in a form approved for current use by the Commissioner, provided that the Commissioner may for good cause grant an extension of time for filing such annual statement not to exceed 60 days. If the health care corporation qualifies therefor its certificate shall be renewed annually; provided, however, that any certificate of authority shall continue in full force and effect until the new certificate is issued or specifically refused.

(b) The Commissioner may amend a certificate of authority at any time to accord with changes in the health care corporation's charter or powers.

History. — Code 1933, § 56-1722a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-11. Refusal, revocation, or suspension of certificate of authority generally.

The Commissioner may refuse to issue, or after a hearing refuse to renew, or revoke or suspend a health care corporation's certificate of authority in addition to other grounds provided for in this title if the corporation:

(1) Violates any provision of this title other than the provisions of Code Section 33-20-12 as to which refusal, suspension, or revocation is mandatory;

(2) Knowingly fails to comply with any lawful rule, regulation, or order of the Commissioner;

(3) Is found by the Commissioner to be in unsound condition or in such condition as to render its further transaction of business in this state hazardous to its subscribers or to the public;

(4) As a general scheme or plot, without just cause compels claimants to accept less than the amount due them or to bring action against it to secure full payment of claims;

(5) Refuses to be examined or to produce its accounts, records, and files for examination by the Commissioner when required or refuses to furnish such other additional information as the Commissioner may deem advisable to consider the application for renewal of the corporation's certificate of authority;

(6) Fails to pay any final judgment rendered against it in this state within 30 days after the judgment becomes final; or

(7) Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer or person which transacts direct insurance or other business in this state without having a certificate of authority or otherwise being authorized to do so, except as permitted under Chapter 5 of this title.

History. — Code 1933, § 56-1724a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-12. Mandatory refusal, revocation, or suspension.

The Commissioner shall refuse to issue or to renew or shall revoke or suspend a health care corporation's certificate of authority:

(1) If such action is required by any provision of this title; or

(2) If the health care corporation no longer meets the requirements for the authority originally granted on account of deficiency in assets or otherwise.

History. — Code 1933, § 56-1723a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-13. Management of corporations; general powers; requirements as to reserves, minimum subscriber's surpluses, and charges.

(a) Health care corporations shall be governed and conducted as corporations and the necessary expenses of administering the affairs of the corporations may be paid from the payments collected from subscribers.

(b) A health care corporation may in its discretion limit the benefits that it will furnish, may divide such benefits as it elects to furnish into classes or kinds, and may furnish different benefits with different kinds or classes of contracts. A health care corporation may also select the hospitals and other participating facilities with which it shall contract and may establish its own standards for approval of such facilities or classes of facilities as it shall determine appropriate, as well as levels of payment which may differ between participating and nonparticipating facilities and different classes of facilities, provided that the contracts

shall be fair and reasonable and the standards and levels of payment shall be fair and reasonable and shall not be unfairly discriminatory against any persons or facilities or classes of persons or facilities.

(c) A health care corporation shall establish and maintain at all times proper reserves subject to the approval of the Commissioner in accordance with such standards and requirements as the Commissioner may establish by rule or regulation after any notice and hearing required for unearned subscription fees, for unpaid claims, for unreported claims, and for other known liabilities.

(d) A health care corporation shall at all times maintain a minimum subscriber's surplus of not less than $1 million or such higher amount as the Commissioner may require by rule or regulation after any required notice and hearing for the protection of the subscribers.

(e) A health care corporation shall be required to charge a minimum of one-half of 1 percent of income at risk on all accounts as a contribution towards subscriber's surplus and such funds derived therefrom shall be contributed to such health care corporation's subscriber's surplus under such terms and conditions as the Commissioner may reasonably require by order or regulation after any required notice and hearing, provided that, if the Commissioner determines after notice and hearing that the level of accumulated subscriber's surplus for a health care corporation is in excess of that reasonably required for the protection of the corporation's subscribers, the Commissioner shall have the authority to suspend the operation of this subsection until such time as the corporation's accumulated subscriber's surplus has returned to a level which is adequate for the protection of policyholders but not excessive.

History. — Code 1933, § 56-1706a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1995, p. 745, § 1.6.

33-20-14. Acceptance of applications.

When organized, health care corporations shall be authorized to accept applicants individually or in groups who may become subscribers of the corporation furnishing health care services under a contract which shall entitle each subscriber, beneficiary, and covered dependent to the health care services for such period of time as is provided in the contract.

History. — Code 1933, § 56-1709a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-15. Issuance and contents of membership certificates.

(a) Every health care corporation shall issue to its subscribers a membership certificate which shall describe the health care plan under which the subscriber is enrolled and shall specify how the holder of such contract may obtain the name or names and addresses of participating providers of health care services upon whom the subscriber shall have the right to call for health care services and the nature of such services. The description in the membership certificate shall be consistent with this chapter and the purposes thereof.

(b) The form, size of type, general arrangement, and contents of the membership certificate shall be subject to the approval of the Commissioner and shall be filed with and approved by him in accordance with Chapter 24 of this title and such rules, regulations, and procedures as the Commissioner may from time to time prescribe.

History. — Code 1933, § 56-1710a, enacted by Ga. L. 1976, p. 1461, § 1.

Cross references. — Provisions of accident and sickness insurance policies generally, § 33-24-20 et seq.

33-20-16. Right to become participating physician or approved health care provider.

Every doctor of medicine, every doctor of dental surgery, every podiatrist, and every health care provider within a class approved by the health care corporation who is appropriately licensed to practice and who is reputable and in good standing shall have the right to become a participating physician or approved health care provider for medical or surgical care, or both, as the case may be, under such terms or conditions as are imposed on other participating physicians or approved health care providers within such approved class under similar circumstances in accordance with this chapter.

History. — Code 1933, § 56-1712a, enacted by Ga. L. 1976, p. 1461, § 1.

Law reviews. — For annual survey on administrative law, see 61 Mercer L. Rev. 1 (2009).

JUDICIAL DECISIONS

"Any Willing Provider" (AWP) statute did not apply to a health maintenance organization (HMO) because: (1) the statute did not apply to for-profit corporations not statutorily defined as "surviving corporations," and (2) the HMO had never been an O.C.G.A. T. 33, Ch. 20 health care corporation, nor was the HMO an insurer's subsidiary any longer, so the HMO was not a surviving corporation, and O.C.G.A. § 33-21-28(a) barred applying the AWP statute to the HMO. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 315 Ga. App. 521, 726 S.E.2d 714 (2012), cert. denied, No. S12C1322, 2012 Ga. LEXIS 1018 (Ga. 2012), cert. denied, No. S12C1413, 2012 Ga. LEXIS 1033 (Ga. 2012).

Exhaustion of remedies required. — Medical group's suit for a declaratory

judgment as to the group's rights to participate in a health maintenance organization under Georgia's Any Willing Provider Statute, O.C.G.A. § 33-20-16, was procedurally barred by the failure to exhaust administrative remedies by first submitting the group's dispute to the Georgia Insurance Commissioner pursuant to O.C.G.A. § 33-20-30. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

"Any Willing Provider" (AWP) statute applied to a health insurer's preferred provider (PPO) network because: (1) the insurer was an O.C.G.A. T. 33, Ch. 20 health care corporation; (2) the AWP statute expressly applied to health care corporations; and (3) the AWP statute applied to the PPO network since the insurer, under the Preferred Provider Arrangements Act, O.C.G.A. § 33-30-20 et seq., could administer a preferred provider arrangement which was a health benefit plan. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 315 Ga. App. 521, 726 S.E.2d 714 (2012), cert. denied, No. S12C1322, 2012 Ga. LEXIS 1018 (Ga. 2012), cert. denied, No. S12C1413, 2012 Ga. LEXIS 1033 (Ga. 2012).

33-20-17. Powers of corporations to contract for provision of health care services; receipt of payments.

(a) Any health care corporation organized or operated under this chapter and engaged in the operation of a health care plan may contract with any agency, instrumentality, or political subdivision of the United States of America or of this state for the furnishing of health care services and in aid or furtherance of said contract, may accept, receive, and administer in trust funds directly or indirectly made available by the agency, instrumentality, or political subdivision and, further, any health care corporation may subcontract with any organization which has contracted with any agency, instrumentality, or political subdivision of the United States of America or of this state for the furnishing of medical, hospital, and other health care services, by which subcontract the health care corporation undertakes to furnish the services required by the basic contract.

(b) A health care corporation may enter into contracts with a corporation or association in this state or elsewhere so that reciprocity of benefits may be provided to subscribers; transfer of subscribers from one corporation to another may be effected to conform to the subscriber's place of residence; uniform benefits may be provided for all or for separate categories of employees and the dependents of such employees of corporations and other organizations transacting business in this state or elsewhere and a composite rate, that is, a rate representing the composite experience of the areas involved, may be charged for such employees and their dependents; or hospital or other health care services may be provided for subscribers of the corporation or other corporations or associations by means of risk sharing and other joint undertakings, including reinsurance, which the directors of the corporation may from time to time approve in accordance with the laws of this state. Group master contracts and the contracts issued to subscrib-

ers by a corporation subject to this chapter may specify the circumstances under which payments will be made and the rates of such payment to hospitals or other health care providers, wherever located, with which the corporation has no contract for hospital service or other health care service furnished the subscribers and other beneficiaries under the contract.

(c) Each health care corporation may in its discretion receive and accept from governmental agencies payment covering all or part of the cost to provide health care services for needy or other persons. Each health care corporation may in its discretion receive and accept payments from private agencies, corporations, associations, groups of individuals, or others covering all or part of the cost of subscriptions to provide health care service for needy and other persons.

History. — Code 1933, § 56-1707a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1982, p. 3, § 33.

33-20-18. Sale of contracts providing for payment of specified charges made by participating physicians; right of subscribers to select physicians; liability of corporations for negligence of physicians.

(a) Health care corporations shall have the right to sell contracts providing for the payment of specified charges made by participating physicians furnishing medical or surgical care, or both, to the holders of such contracts, their beneficiaries, and covered dependents as provided for in this Code section.

(b) The contracts shall not in any manner restrict the right of the holder to obtain the services of any physician nor shall such contracts attempt to control the relationship existing between any holder or beneficiary of any such contract and his physician.

(c) The private physician-patient relationship shall be maintained, and a subscriber shall at all times have free choice of any physician or of any health care provider or facility within a class approved by the corporation in accordance with this chapter; provided, however, that nothing contained in this Code section shall be deemed to prohibit the use of either a group of participating physicians or approved health care providers and representatives of approved facilities which have been approved by the medical societies in the county or counties in which corporations operate to review charges made by physicians or other providers of health care services participating in the plan so as to ensure that the charges do not exceed the usual, customary, and reasonable charges made by other physicians or other providers of health care services for similar services and that such services are

necessary and do not involve unnecessary utilization of services or facilities.

(d) No provision of this chapter shall be construed as authorizing the corporate practice of medicine; and health care corporations shall not practice medicine. No physician rendering service or called on to render service to a member, beneficiary, or covered dependent and no other provider of health care services shall be construed to be an agent or employee of such corporation; and such corporation shall not be liable for the negligence, misfeasance, malfeasance, or nonfeasance of any provider of health care services or of any physician rendering medical or surgical services to any member, beneficiary, or covered dependent.

History. — Code 1933, § 56-1711a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 2000, p. 136, § 33.

RESEARCH REFERENCES

ALR. — Health service plan as violation of medical practice acts, 119 A.L.R. 1290.

33-20-19. Regulation and supervision of corporations by Commissioner generally; payment of fees and taxes by corporations generally.

Health care corporations shall be subject to regulation and supervision by the Commissioner and shall be required to pay any fees and taxes, including premium taxes, as are now or may hereafter be required of life insurers under this title in accordance with Chapters 2, 3, 8, and 12 of this title and the other applicable provisions of this title.

History. — Code 1933, § 56-1715a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-20. Submission to Commissioner of operating plan, schedule of rates, and amount of service; approval by Commissioner.

Except for corporations subject to this chapter which are surviving corporations, health care corporations shall before accepting applications from subscribers in a nonprofit health care plan submit to the Commissioner a plan of operating and overhead expenses, operation cost, and salaries paid or to be paid during any current year together with a schedule of its rates to be charged and the amount of health care service contracted to be rendered, which plan, rates, and amount of service shall be first approved by the Commissioner as fair and reasonable before the corporation shall engage in business.

History. — Code 1933, § 56-1716a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.7.

33-20-21. Approval of Commissioner of rates to be paid to providers of services.

Except for corporations subject to this chapter which are surviving corporations, the Commissioner shall first approve the rates of payment to be made by health care corporations to providers of health care services on behalf of said corporation, its subscribers, beneficiaries, and covered dependents as being fair and reasonable before said corporation shall engage in business.

History. — Code 1933, § 56-1717a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.8.

33-20-22. Investment of funds of corporations.

Health care corporations shall invest in or lend their funds on security of and shall hold as invested assets only such assets as are authorized by Articles 1 and 3 of Chapter 11 of this title for the investments of assets of domestic insurance companies and such investments shall be subject to the same requirements, conditions, restrictions, and limitations as are applicable to the investments by such insurers.

History. — Code 1933, § 56-1714a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1999, p. 592, § 16.

33-20-23. Maintenance of books and records showing funds collected and disbursed; examination of books and records by Commissioner.

Every health care corporation shall keep complete books and records in accordance with the requirements of the Commissioner showing all funds collected and disbursed. All books and records shall be subject to examination by the Commissioner in accordance with Chapter 2 of this title applicable to life insurers and the expenses of the examination borne by said corporation.

History. — Code 1933, § 56-1720a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-24. Filing of reports with Commissioner.

Every health care corporation shall on or before March 1 in each year after it shall have commenced to do business pursuant to a certificate of authority make and file with the Commissioner a report of its affairs and operations during the year ending December 31 of the preceding year. The annual report shall be made in such form and contain such information as the Commissioner may by regulation from time to time prescribe and require in protecting the public interest and the interest of the subscribers of any health care corporation. The Commissioner may by regulation require such additional periodic reports as he may from time to time prescribe as necessary or appropriate to protect the policyholders and the public and to ensure the solvency of any health care corporation. The Commissioner may require that the reports be verified under oath by such appropriate officers or agents as he may designate by regulation and may require the reports to be published. Compliance with this Code section shall be a condition to the renewal of a certificate of authority under Code Section 33-20-10.

History. — Code 1933, § 56-1721a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-25. Liability for expenses of Commissioner's supervisory and other activities.

Any and all supervision, conservation, rehabilitation, liquidation, or examination of the affairs of any corporation by the Commissioner shall be at the expense of the corporation.

History. — Code 1933, § 56-1729a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.9.

33-20-26. Powers of Commissioner as to protection of subscribers and public health and welfare.

The Commissioner shall have the authority to take appropriate actions authorized by this title for the protection of a health care corporation's subscribers and the public health and welfare, including but not limited to those authorized in Code Section 33-2-24, and shall have authority to institute civil actions and other appropriate proceedings authorized by and in accordance with Chapter 37 of this title to conserve the assets of, rehabilitate, or liquidate a health care corporation organized under or subject to this chapter in the same manner and under the same conditions and causes applicable to domestic life insurers under Chapter 37 of this title.

History. — Code 1933, § 56-1727a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-27. Imposition by Commissioner of administrative fine for certain acts of officers, employees, agents, or representatives of corporations.

(a) The Commissioner may after a hearing impose upon a health care corporation an administrative fine if he finds that the corporation through the acts of its officers, employees, agents, or representatives has with such frequency as to indicate its general business practice in this state:

(1) Refused without just cause to pay proper claims arising under coverage provided by its contracts whether the claim is in favor of a subscriber or in favor of any other person entitled to the proceeds of a contract; or

(2) Compelled without just cause subscribers, claimants, or other persons entitled to the proceeds of its contracts in this state to accept less than the amount due them or to bring action against the corporation to secure full payment or settlement of their claims.

(b) The administrative fine imposed for violations set forth in paragraph (1) or (2) of subsection (a) of this Code section shall not exceed $1,000.00 for each act of misconduct constituting a violation; provided, however, that a fine of not more than $5,000.00 for each act of willful misconduct constituting a violation may be imposed.

History. — Code 1933, § 56-1725a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-28. Termination of organizers, agents, solicitors engaging in unfair or deceptive practices.

Whenever the Commissioner finds after investigation that an organizer, agent, or solicitor of a health care corporation has unfairly or improperly solicited subscription certificates by misrepresenting the terms of the certificates or has engaged in any other unfair or deceptive practice, or for any reason is incompetent to serve as an organizer, agent, or solicitor, or that his or her services are not, in fact, needed, he or she shall order such corporation to dispense with the services and the organizer, agent, or solicitor of the corporation. The corporation shall be subject to the fines, penalties, and provisions of Chapter 6 of this title and Code Section 33-2-24 that are applicable to life insurers and their agents and that are not inconsistent with this chapter.

History. — Code 1933, § 56-1726a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 2019, p. 337, § 1-86/SB 132.

The 2019 amendment, effective July 1, 2019, in the first sentence, substituted "organizer, agent, or solicitor" for "organizer, solicitor, or agent" in two places and inserted "or her" and "or she"; and substituted "The corporation" for "The corporations" at the beginning of the second sentence.

33-20-29. Unlawful actions by unauthorized persons.

It shall be unlawful for any person except a health care corporation established in accordance with this chapter and operating in accordance with authority from the Commissioner to establish, maintain, or operate a health care plan or to solicit subscribers to or enter into contracts with respect to a health care plan, provided that nothing in this chapter shall be construed as preventing a person from furnishing medical services for the prevention of disease among his employees or from furnishing such medical services as are required under the workers' compensation law or other laws of this state, as preventing any duly licensed insurance company from writing medical indemnity insurance or otherwise operating in accordance with this title, as preventing any duly authorized corporation from operating in accordance with Chapter 18 or 19 of this title, or as preventing any other duly authorized person or entity from operating in accordance with any other provisions of this title.

History. — Code 1933, § 56-1708a, enacted by Ga. L. 1976, p. 1461, § 1.

33-20-30. Resolution of disputes.

Any dispute arising within the purview of this chapter with reference to the regulation and supervision of any health care corporation shall within 30 days after such dispute arises be submitted by the aggrieved person to the Commissioner for his decision with reference thereto, provided nothing in this Code section shall authorize or require the Commissioner to determine the contractual rights between the parties interested in any such corporations. After proper notice and hearing, any decisions and order of the Commissioner made pursuant to this chapter shall be binding on the persons involved unless set aside on review as provided by this Code section.

History. — Code 1933, § 56-1728a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1982, p. 3, § 33.

JUDICIAL DECISIONS

Exhaustion of remedies required. — Medical group's suit for a declaratory judgment as to the group's rights to participate in a health maintenance organi-

zation under Georgia's Any Willing Provider Statute, O.C.G.A. § 33-20-16, was procedurally barred by the failure to exhaust administrative remedies by first submitting the group's dispute to the Georgia Insurance Commissioner pursuant to O.C.G.A. § 33-20-30. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

33-20-31. Applicability and construction of chapter.

Except for corporations subject to this chapter which are surviving corporations, this chapter shall not apply to nor govern any corporation which is organized for profit or which contemplates any pecuniary gain to its shareholders or members. A corporation subject to this chapter may organize subsidiary or affiliated corporations to engage in allied business ventures in accordance with Chapters 13 and 14 of this title.

History. — Code 1933, § 56-1701a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.10.

33-20-32. Application of other provisions of Code to health care corporations.

Except where the context otherwise requires, the applicable provisions of Title 14 shall govern a health care corporation. A health care corporation shall not be considered to be a corporation described in paragraph (2) of subsection (a) of Code Section 14-3-1302. All of the provisions of this title which are not in conflict with this chapter shall be applicable to any health care corporation subject to such modifications as the Commissioner may prescribe by order, directive, interpretation, guideline, or rule or regulation after any notice and hearing as may be required by this title.

History. — Code 1933, § 56-1730a, enacted by Ga. L. 1976, p. 1461, § 1; Ga. L. 1995, p. 745, § 1.11.

33-20-33. Payment of distribution of reserved funds or surplus; requirements for initial public offering; fees, taxes, and assessments; applicability of other provisions of Title 33; regulation.

(a) No reserved funds as defined in subsection (b) of this Code section or surplus of such nonprofit health care corporation as increased pursuant to the charge required in subsection (e) of Code Section 33-20-13 shall be distributed or paid to any person as a part of any plan of conversion of a nonprofit health care corporation to a for profit health care corporation.

(b) For the purposes of this Code section, "reserved funds" means those funds as described and defined in subsection (c) of Code Section 33-20-13 and any unassigned funds.

(c) A health care corporation which issues shares in connection with an initial public offering shall first offer such shares to its subscribers on similar terms as such shares are offered to the public consistent with applicable federal law and regulations.

(d) No options, warrants, or fees shall be paid to any officer, director, or trustee of a nonprofit health care corporation in connection with a conversion from a nonprofit to a for profit health care corporation or in regard to the initial public offering of a health care corporation.

(e) A health care corporation shall be required to pay any and all fees, taxes, including premium taxes, and assessments, specifically excluding assessments with respect to the Georgia Life and Health Insurance Guaranty Association, as are required of other companies which provide life and accident and sickness insurance under Georgia law.

(f) A health care corporation, including a surviving corporation, subject to this chapter shall be subject to all the provisions of this title not otherwise provided for in this chapter which are applicable to other insurers which provide life or accident and sickness insurance.

(g) Any distribution of surplus funds by a surviving corporation shall be subject to regulation by the Commissioner pursuant to the provisions of this title governing distributions by insurers which provide life or accident and sickness insurance and shall in no event cause the surplus funds of the surviving corporation to be less than that of the predecessor corporation as of the date of the conversion, unless the Commissioner finds that such distribution is in the public interest.

History. — Code 1981, § 33-20-33, enacted by Ga. L. 1995, p. 745, § 1.12.

33-20-34. Conversion of nonprofit health care corporation; requirements and procedures; rules and regulations.

(a)(1) Any health care corporation which is governed generally by Chapter 3 of Title 14, the "Georgia Nonprofit Corporation Code," and authorized under this chapter may merge with, or amend its articles of incorporation to become, a corporation governed by Chapter 2 of Title 14, the "Georgia Business Corporation Code," provided a detailed, written plan is submitted to the Commissioner for such conversion, written notice of such submission is given to the Attorney General, and, after a public hearing thereon, such plan is approved by

the Commissioner after being found to be in the best interest of the company, its policyholders, and the general public.

(2) In any such public hearing, the Attorney General may appear before the Commissioner and make such presentation as he or she shall deem to be in the public's interest. The Attorney General shall provide representation to the Commissioner in any other legal action relating thereto. Nothing in this Code section shall be construed as a limitation upon the Attorney General in providing legal representation to the Commissioner during the pendency of any decision concerning conversion.

(b) The Commissioner may promulgate rules and regulations which are necessary to implement the provisions of this Code section.

History. — Code 1981, § 33-20-34, enacted by Ga. L. 1995, p. 745, § 1.12; Ga. L. 2019, p. 337, § 1-87/SB 132.

The 2019 amendment, effective July 1, 2019, inserted "health care" and "generally" near the beginning of paragraph (a)(1).

JUDICIAL DECISIONS

Administrative review of conversion plan. — When the plaintiffs sought an interpretation of a plan of conversion which had been reviewed and approved by the Commissioner of Insurance, the parties were required to follow the administrative review process before seeking judicial review. Cerulean Cos. v. Tiller, 271 Ga. 65, 516 S.E.2d 522 (1999).

The trial court erred in deciding the merits of a proceeding seeking an interpretation of a plan of conversion because the Commissioner of Insurance had reviewed the plan, approved it, and participated in the conversion process after approval, and the parties were required to follow the administrative review process before seeking judicial review. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

Review of order on plan of conversion. — The orders encompassed by O.C.G.A. § 33-2-26 include hearings to determine the propriety of plans of conversion set forth in O.C.G.A. § 33-20-34. Blue Cross & Blue Shield of Ga., Inc. v. Deal, 244 Ga. App. 700, 536 S.E.2d 590 (2000).

CHAPTER 20A

MANAGED HEALTH CARE PLANS

Article 1

Patient Protection

Sec.

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Article 2

Patient's Right to Independent Review

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Article 3

Managed Health Care Plans

33-20A-60. Definitions.
33-20A-61. Physician contracts.
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Article 4

Joint Committee to Study Prescription Costs in State Funded Health Care Plans

33-20A-70. Creation; members; meetings; duties; cooperation by the Department of Community Health; members' expenses; repealer [Repealed].

Law reviews. — For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999).

For symposium on managed health care, see 31 Ga. L. Rev. 367 (1997).

RESEARCH REFERENCES

ALR. — Coverage under medical and health insurance plans for services performed by dentists, oral surgeons, and orthodontists, 43 A.L.R.5th 657.

The propriety, under ERISA (29 USCS §§ 1001 et seq.) and the Americans with Disabilities Act (42 USCS §§ 12101 et seq.), of capping health insurance coverage for HIV-related claims, 131 A.L.R. Fed. 191.

ARTICLE 1

PATIENT PROTECTION

Editor's notes. — Ga. L. 1999, p. 350, § 4, not codified by the General Assembly, provides that this Act "shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after July 1, 1999."

Ga. L. 1999, p. 350, § 2, effective July 1, 1999, designated the existing provisions of this chapter as Article 1.

33-20A-1. Short title.

This article shall be known and may be cited as the "Patient Protection Act of 1996."

History. — Code 1981, § 33-20A-1, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 350, § 2.

Law reviews. — For article, "Price Transparency and Incomplete Contracts in Health Care," see 67 Emory L.J. 1 (2017).

For review of 1996 health care plans legislation, see 13 Ga. St. U.L. Rev. 190 (1996). For notes on 1999 amendments of Code sections in this article, see 16 Ga. St. U.L. Rev. 151, 163 (1999).

33-20A-2. Legislative findings.

(a) The General Assembly finds and declares that it is a vital government concern that the citizens of the State of Georgia have access to quality health care services and that informed consumers will be better able to identify and select plans that offer quality health care services if they are provided specific information before they enroll in health care plans. As the health care market becomes increasingly dominated by health care plans that use managed care techniques that include decisions as to the appropriateness of care, the General Assembly finds and declares that it is a vital government function to protect patients from managed care practices which have the effect of denying or limiting appropriate care. The General Assembly further finds that it is the public policy of the State of Georgia that physicians and health

care providers be encouraged to advocate for medically appropriate health care for their patients.

(b) To achieve these ends, the General Assembly declares it necessary for the Commissioner of Insurance to certify qualified managed care plans to conduct business in the State of Georgia and for the Commissioner of Insurance to establish standards for such certification.

History. — Code 1981, § 33-20A-2, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 350, § 2.

33-20A-3. Definitions.

As used in this article, the term:

(1) "Emergency services" or "emergency care" means those health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(2) "Enrollee" means an individual who has elected to contract for or participate in a managed care plan for that individual or for that individual and that individual's eligible dependents.

(3) "Facility" means a hospital, ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution for examination, diagnosis, treatment, surgery, or maternity care but does not include physicians' or dentists' private offices and treatment rooms in which such physicians or dentists primarily see, consult with, and treat patients.

(4) "Health benefit plan" has the same meaning as provided in Code Section 33-24-59.5.

(5) "Health care provider" or "provider" means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech language pathologist, audiologist, dietitian, or physician assistant.

(6) "Home health care provider" means any provider or agency that provides health care services in a patient's home including the supply of durable medical equipment for use in a patient's home.

(7) "Limited utilization incentive plan" means any compensation arrangement between the plan and a health care provider or provider group that has the effect of reducing or limiting services to patients.

(8) "Managed care contractor" means a person who:

(A) Establishes, operates, or maintains a network of participating providers;

(B) Conducts or arranges for utilization review activities; and

(C) Contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(9) "Managed care entity" includes an insurance company, hospital or medical service plan, hospital, health care provider network, physician hospital organization, health care provider, health maintenance organization, health care corporation, employer or employee organization, or managed care contractor that offers a managed care plan.

(10) "Managed care plan" means a major medical, hospitalization, or dental plan that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(A) Arrangements with selected providers to furnish health care services;

(B) Explicit standards for the selection of participating providers; and

(C) Cost savings for persons enrolled in the plan to use the participating providers and procedures provided for by the plan; provided, however, that the term "managed care plan" does not apply to Chapter 9 of Title 34, relating to workers' compensation.

(11) "Nonurgent procedure" means any nonemergency or elective care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient's health or well-being.

(12) "Out of network" or "point of service" refers to health care items or services provided to an enrollee by providers who do not belong to the provider network in the managed care plan.

(13) "Patient" means a person who seeks or receives health care services under a managed care plan.

(14) "Precertification" or "preauthorization" means any written or oral determination made at any time by an insurer or any agent thereof that an enrollee's receipt of health care services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. "Agent" as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

(15) "Qualified managed care plan" means a managed care plan that the Commissioner certifies as meeting the requirements of this article.

(16) "Verification of benefits" means any written or oral determination by an insurer or agent thereof of whether given health care services are a covered benefit under the enrollee's health benefit plan without a determination of precertification or preauthorization as to such services. "Agent" as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

History. — Code 1981, § 33-20A-3, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 327, § 1; Ga. L. 1999, p. 350, § 2; Ga. L. 2002, p. 441, § 4; Ga. L. 2009, p. 859, § 3/HB 509; Ga. L. 2012, p. 775, § 33/HB 942; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 337, § 1-88/SB 132.

The 2019 amendment, effective July 1, 2019, deleted former paragraph (1), which read: "'Commissioner' means the Commissioner of Insurance." and redesignated former paragraphs (2) through (17) as present paragraphs (1) through (16), respectively.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "refers" was substituted for "refer" in paragraph (8) (now paragraph (12)).

Pursuant to Code Section 28-9-5, in 2002, "Nonurgent" was substituted for "Non-urgent" in paragraph (12) (now paragraph (11)).

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

Law reviews. — For note on the 2002 amendment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

OPINIONS OF THE ATTORNEY GENERAL

The definitions of "emergency services" and "emergency care" in paragraph (2) (now paragraph (1)) of O.C.G.A. § 33-20A-3 must be included in plan provisions and disclosed to plan participants. 1997 Op. Att'y Gen. No. U97-4.

33-20A-4. Certification requirements; review and recertification; sanctions for failure to meet requirements; alternative methods for certification.

(a) In addition to other requirements of law, prior to offering a managed care plan to any resident in Georgia, a managed care entity must first obtain a certificate from the Commissioner of Insurance indicating that such managed care plan meets the requirements of this article. The Commissioner may impose such costs, by rule or regulation, on managed care entities as deemed necessary to carry out the provisions of this article.

(b) The Commissioner shall establish procedures for the periodic review and recertification of qualified managed care plans.

(c) The Commissioner shall terminate the certification of a qualified managed care plan, revoke or suspend the license of a managed care entity, or in lieu thereof impose a monetary penalty in accordance with Chapter 2 of this title, if the Commissioner determines that such plan no longer meets the applicable requirements for certification or violates any provision of this article. Before effecting any such sanction, the Commissioner shall provide the plan with notice and opportunity for a hearing on the proposed sanctions. Nothing in this Code section shall be construed as precluding other remedies at law.

(d) The Commissioner shall establish a process for certification through alternative methods providing that:

(1) An eligible organization, as defined in Section 1876(b) of the federal Social Security Act, shall be deemed to meet the requirements of subsections (a) and (b) of this Code section for certification as a qualified managed care plan; or

(2) If the Commissioner finds that a national accreditation body has established requirements for accreditation of a managed care entity which offers a managed care plan that are at least equivalent to the requirements established under this article and that the eligible organization and its plans comply with the requirements of such national accreditation body, then such organization and its plans shall be deemed to meet the requirements of subsections (a) and (b) of this Code section.

History. — Code 1981, § 33-20A-4, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 350, § 2.

33-20A-5. Standards for certification.

The Commissioner shall establish standards for the certification of qualified managed care plans that conduct business in this state. Such standards must include the following provisions:

(1) **Disclosure to enrollees and prospective enrollees.**

(A) A managed care entity shall disclose to enrollees and prospective enrollees who inquire as individuals into a plan or plans offered by the managed care entity the information required by this paragraph. In the case of an employer negotiating for a health care plan or plans on behalf of his or her employees, sufficient copies of disclosure information shall be made available to employees upon request. Disclosure of information under this paragraph shall be readable, understandable, and on a standardized form containing information regarding all of the following for each plan it offers:

(i) The health care services or other benefits under the plan offered as well as limitations on services, kinds of services, benefits, or kinds of benefits to be provided, which disclosure may also be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(ii) Rules regarding copayments, prior authorization, or review requirements including, but not limited to, preauthorization review, concurrent review, postservice review, or postpayment review that could result in the patient's being denied coverage or provision of a particular service;

(iii) Potential liability for cost sharing for out-of-network services, including, but not limited to, providers, drugs, and devices or surgical procedures that are not on a list or a formulary;

(iv) The financial obligations of the enrollee, including premiums, deductibles, copayments, and maximum limits on out-of-pocket expenses for items and services (both in and out of network);

(v) The number, mix, and distribution of participating providers. An enrollee or a prospective enrollee shall be entitled to a list of individual participating providers upon request, and the list of individual participating providers shall also be updated at least every 30 days and may be published on an Internet service site made available by the managed care entity at no cost to such enrollees;

(vi) Enrollee rights and responsibilities, including an explanation of the grievance process provided under this article;

(vii) An explanation of what constitutes an emergency situation and what constitutes emergency services;

(viii) The existence of any limited utilization incentive plans;

(ix) The existence of restrictive formularies or prior approval requirements for prescription drugs. An enrollee or a prospective enrollee shall be entitled, upon request, to a description of specific drug and therapeutic class restrictions;

(x) The existence of limitations on choices of health care providers;

(xi) A statement as to where and in what manner additional information is available;

(xii) A statement that a summary of the number, nature, and outcome results of grievances filed in the previous three years shall be available for inspection. Copies of such summary shall be made available at reasonable costs; and

(xiii) A summary of any agreements or contracts between the managed care plan and any health care provider or hospital as they pertain to the provisions of Code Sections 33-20A-6 and 33-20A-7. Such summary shall not be required to include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by the managed care plan and any health care provider or hospital; provided, however, that such summary may include a disclosure of the category or type of compensation, whether capitation, fee for service, per diem, discounted charge, global reimbursement payment, or otherwise, paid by the managed care plan to each class of health care provider or hospital under contract with the managed care plan.

(B) Such information shall be disclosed to each enrollee under this article at the time of enrollment and at least annually thereafter.

(C) Any managed care plan licensed under Chapter 21 of this title is deemed to have met the certification requirements of this paragraph.

(D) A managed care entity which negotiates with a primary care physician to become a health care provider under a managed care plan shall furnish that physician, beginning on and after January 1, 2001, with a schedule showing fees payable for common office based services provided by such physicians under the plan;

(2) **Access to services.** A managed care entity must demonstrate that its plan:

(A) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined service area with reasonable promptness and in a manner that promotes continuity in the provision of health care services, including continuity in the provision of health care services after termination of a physician's contract as provided in Code Section 33-20A-61;

(B) When medically necessary provides health care services 24 hours a day and seven days a week;

(C) Provides payment or reimbursement for emergency services and out-of-area services; and

(D) Complies with the provisions of Code Section 33-20A-9.1 relating to nomination and reimbursement of out of network health care providers and hospitals; and

(3) **Quality assurance program.** A managed care plan shall comply with the following requirements:

(A) A managed care plan must have arrangements, established in accordance with regulations of the Commissioner, for an ongoing quality assurance program for health care service it provides to such individuals; and

(B) The quality assurance program shall:

(i) Provide for a utilization review program which, in addition to the requirements of Chapter 46 of this title:

(I) Stresses health outcomes;

(II) Provides for the establishment of written protocols for utilization review, based on standards of the relevant health care profession;

(III) Provides review by physicians and appropriate health care providers of the process followed in the provision of such health care services;

(IV) Monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

(V) Evaluates the continuity and coordination of care that enrollees receive; and

(VI) Has mechanisms to detect both underutilization and overutilization of services; and

(ii) Establish a grievance procedure which provides the enrollee with a prompt and meaningful hearing on the issue of

denial, in whole or in part, of a health care treatment or service or claim therefor. Such hearing shall be conducted by a panel of not less than three persons, at least one member of which shall be a physician other than the medical director of the plan and at least one member of which shall be a health care provider competent by reason of training and licensure in the treatment or procedure which has been denied. The enrollee shall be provided prompt notice in writing of the outcome of the grievance procedure. In the event the outcome of the grievance is favorable to the enrollee, appropriate relief shall be granted without delay. In the event the outcome is adverse to the enrollee, the notice shall include specific findings related to the care, the policies and procedures relied upon in making the determination, the physician's and provider's recommendations, including any recommendations for alternative procedures or services, and a description of the procedures, if any, for reconsideration of the adverse decision.

History. — Code 1981, § 33-20A-5, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 342, § 1; Ga. L. 1999, p. 350, § 2; Ga. L. 2000, p. 802, § 1; Ga. L. 2002, p. 441, §§ 5, 8; Ga. L. 2005, p. 481, § 2/HB 291; Ga. L. 2019, p. 337, § 1-89/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "current" following "based on" in subdivision (3)(B)(i)(II).

Editor's notes. — Ga. L. 1999, p. 342, § 7, not codified by the General Assembly, provides that: "This Act shall become effective on July 1, 1999, for purposes of preparing for implementation of the consumer choice option and shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after January 1, 2000."

Ga. L. 2000, p. 802, § 3, not codified by the General Assembly, provides that: "This Act shall become effective on July 1, 2000, and shall be applicable to any contract, policy, or other agreement of a managed care plan or preferred provider arrangement if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, renewed, or executed on or after July 1, 2000."

Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

Law reviews. — For note on the 2002 amendment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

33-20A-6. Financial incentive programs prohibited; capitated payment arrangement allowed.

(a) A managed care plan may not use a financial incentive or disincentive program that directly or indirectly compensates a health care provider or hospital for ordering or providing less than medically necessary and appropriate care to his or her patients or for denying, reducing, limiting, or delaying such care. Nothing in this Code section shall be deemed to prohibit a managed care entity from using a capitated payment arrangement consistent with the intent of this Code section.

(b) A managed care plan shall make full and timely payment or reimbursement to any health care provider or hospital in the same manner and subject to the same penalties as required of insurers for group accident and sickness insurance policies under paragraph (5) of subsection (b) of Code Section 33-30-6.

History. — Code 1981, § 33-20A-6, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 342, § 2; Ga. L. 1999, p. 350, § 2; Ga. L. 2000, p. 136, § 33.

Editor's notes. — Ga. L. 1999, p. 342, § 7, not codified by the General Assembly, provides that: "This Act shall become effective on July 1, 1999, for purposes of preparing for implementation of the consumer choice option and shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after January 1, 2000."

33-20A-7. Penalizing provider for discussing necessary or appropriate care with patient prohibited; penalty for providing records and assistance prohibited; penalty for violations.

(a) No health care provider may be penalized for considering, studying, or discussing medically necessary or appropriate care with or on behalf of his or her patient.

(b) No health care provider may be penalized by a managed care plan for providing testimony, evidence, records, or any other assistance to an enrollee who is disputing a denial, in whole or in part, of a health care treatment or service or claim therefor.

(c) A finding of a violation of this Code section or Code Section 33-20A-6 by a managed care plan shall constitute an unfair trade practice punishable under Article 1 of Chapter 6 of this title.

History. — Code 1981, § 33-20A-7, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 342, § 2; Ga. L. 1999, p. 350, § 2.

Editor's notes. — Ga. L. 1999, p. 342, § 7, not codified by the General Assembly, provides that: "This Act shall become effective on July 1, 1999, for purposes of preparing for implementation of the consumer choice option and shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after January 1, 2000."

33-20A-7.1. Application; managed care plan's liability following precertification; availability of personnel for precertification procedure.

(a)(1) The provisions of this chapter shall apply to any managed care plan offered pursuant to Article 1 of Chapter 18 of Title 45 and to any managed care plan offered by any managed care entity.

(2) When an enrollee, provider, facility, or home health care provider calls during regular business hours to request verification of benefits from a managed care plan, the caller shall have the clear and immediate option to speak to an employee or agent of such managed care plan who shall advise the caller that:

(A) Such verification is only a determination of whether given health care services are a covered benefit under the health benefit plan and is not a guarantee of payment for those services; and

(B) If the health care services so verified are a covered benefit, whether precertification is required and the phone number to request precertification.

(3) If a managed care plan provides verification of benefits after regular business hours or by electronic or recorded means, the enrollee, provider, facility, or home health care provider making the request shall be provided by either electronic or recorded means or, at the option of the insurer, by a live person the information required in subparagraphs (A) and (B) of paragraph (2) of this subsection.

(b) When an enrollee, provider, facility, or home health care provider obtains precertification for any covered health care service, the managed care plan is liable for such precertified services at the reimbursement level provided under the health benefit plan for such services where rendered within the time limits set in the precertification unless the enrollee is no longer covered under the plan at the time the services are received by the enrollee, benefits under the contract or plan have been exhausted, or there exists substantiation of fraud by the enrollee, provider, facility, or home health care provider.

(c) Any managed care plan which requires precertification shall have sufficient personnel available 24 hours a day, seven days a week, to

provide such precertifications for all procedures, other than nonurgent procedures; to advise of acceptance or rejection of such request for precertification; and to provide reasons for any such rejection. Such acceptance or rejection of a precertification request may be provided through a recorded or computer generated communication, provided that the individual requesting precertification has the clear and immediate option to speak to an employee or representative of the managed care plan capable of providing information about the precertification request.

History. — Code 1981, § 33-20A-7.1, enacted by Ga. L. 2002, p. 441, § 6.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, the introductory paragraph of subsection (a) was redesignated as paragraph (a)(1), and paragraphs (a)(1) and (a)(2) were redesignated as (a)(2) and (a)(3), respectively, in paragraph (a)(2), "paragraph (2)" was substituted for "paragraph (1)" and in subsection (c), "nonurgent" was substituted for "non-urgent".

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

Law reviews. — For note on the 2002 enactment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

33-20A-8. Confidentiality and accuracy of patient records.

Each managed care plan shall establish procedures to safeguard the privacy of individually identifiable patient information and to maintain accurate and timely records for patients.

History. — Code 1981, § 33-20A-8, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 350, § 2.

33-20A-9. Emergency services requirements; restrictive formulary requirements.

Every managed care plan shall include provisions that:

(1)(A) In the event that a patient seeks emergency services and if necessary in the opinion of the emergency health care provider

responsible for the patient's emergency care and treatment and warranted by his or her evaluation, such emergency provider may initiate necessary intervention to stabilize the condition of the patient without seeking or receiving prospective authorization by the managed care entity or managed care plan. No managed care entity or private health benefit plan may subsequently deny payment for an evaluation, diagnostic testing, or treatment provided as part of such intervention for an emergency condition. For purposes of this Code section, the term "emergency health care provider" includes without limitation an emergency services provider and a licensed ambulance service providing 911 emergency medical transportation.

(B) No managed care entity or private health benefit plan which has given prospective authorization after the stabilization of a person's condition for an evaluation, diagnostic testing, or treatment may subsequently deny payment for the provision of such evaluation, diagnostic testing, or treatment. An acknowledgment of an enrollee's eligibility for benefits by the managed care entity or private health benefit plan shall not, by itself, be construed as a prospective authorization for the purposes of this Code section.

(C) If in the opinion of the emergency health care provider, a patient's condition has stabilized and the emergency health care provider certifies that the patient can be transported to another facility without suffering detrimental consequences or aggravating the patient's condition, the patient may be relocated to another facility which will provide continued care and treatment as necessary; and

(2) When a managed care plan uses a restrictive formulary for prescription drugs, such use shall include a written procedure whereby patients can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

(A) The formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or

(B) The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.

History. — Code 1981, § 33-20A-9, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1997, p. 908, § 2; Ga. L. 1999, p. 350, § 2; Ga. L. 2006, p. 652, § 3/HB 1257.

Cross references. — Evaluation of persons with emergency conditions, § 31-11-82.

33-20A-9.1. Legislative intent; consumer choice option; provisions; increased expenses; covered benefits; forms.

(a) It is the intent of the General Assembly to allow citizens to have the right to choose their own health care providers and hospitals with as few mandates from government and business as possible. It is also the intent to allow these choices with minimal additional cost to any business or consumer in this state.

(b) As used in this Code section, the term "consumer choice option" means a plan for health care delivery which grants enrollees a right to receive covered services outside of any plan provider panel and under the terms and conditions of the plan.

(c) Except for managed care plans offering a consumer choice option under subparagraph (d)(2)(C) of this Code section, every managed care plan offered by a managed care entity shall offer a separate consumer choice option to enrollees at least annually with the following provisions:

(1) Every enrollee of a managed care plan shall have the right to nominate one or more out of network health care providers or hospitals for use by that enrollee and that enrollee's eligible dependents, if:

(A) Such health care provider or hospital is located within and licensed by the state;

(B) Such health care provider or hospital agrees to accept reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to similarly situated participating providers and hospitals. The reimbursement rates for the plan may be proportionally reduced from those paid to participating providers if the cost-sharing provisions in paragraph (3) of subsection (d) of this Code section are utilized in the consumer choice option;

(C) Such health care provider or hospital agrees to adhere to the managed care plan's quality assurance requirements and to provide the plan with necessary medical information related to such care; and

(D) Such health care provider or hospital meets all other reasonable criteria as required by the managed care plan of in network providers and hospitals; and

(2) Each nominated health care provider or hospital which meets the requirements of subparagraphs (A), (B), (C), and (D) of paragraph (1) of this subsection shall be reimbursed by the plan, subject to the agreement in subparagraph (B) of paragraph (1) of this subsection, as

though it belonged to the managed care plan's provider network. Such reimbursement shall be full and final payment for the health care services provided to the enrollee and no health care provider or hospital shall bill the enrollee for any portion of a payment exclusive of the requirements of subparagraph (B) of paragraph (1) of this subsection.

(d)(1) An enrollee who selects the consumer choice option shall be responsible for any increases in premiums and cost sharing associated with the option; provided, however, that any differential in cost sharing as provided in paragraph (3) of this subsection shall only apply when the enrollee goes out of network.

(2) Any increases in premiums for the consumer choice option shall be limited as follows:

(A) For health benefit plans offered by health maintenance organizations under Chapter 21 of this title, the managed care entity may offer both of the following options, but must offer either:

(i) The actuarial basis of the option taking into account administrative and other costs associated with the exercise of this option or a 17.5 percent increase in premium over the plan without the option, whichever is less; or

(ii) The actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 15 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less;

(B) For all other managed care plans under this chapter, the managed care entity may offer both of the following options, but must offer either:

(i) The actuarial basis of the option taking into account administrative and other costs associated with the exercise of this option or a 10 percent increase in premium over the plan without the option, whichever is less; or

(ii) The actuarial basis of the option with cost sharing as provided under paragraph (3) of this subsection taking into account administrative and other costs associated with the exercise of this option or a 7.5 percent increase in premium over the plan without the option and with cost sharing as provided under paragraph (3) of this subsection, whichever is less;

(C) Notwithstanding subparagraph (B) of this paragraph, for all other managed care plans under this chapter, a health benefit plan

may offer at no additional premiums or cost sharing a preferred provider organization network plan under Article 2 of Chapter 30 of this title, which plan contains standards for participating providers and hospitals which:

(i) Meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) of subsection (c) of this Code section; and

(ii) Includes only health care providers and hospitals which agree to accept the reimbursement from both the plan and the enrollee at the rates and on the terms and conditions applicable to similarly situated participating providers and hospitals and under any cost-sharing conditions required of other similarly situated preferred providers, which reimbursement shall be accepted as full and final payment for the covered health care services provided to the enrollee and no preferred provider shall bill the enrollee for any portion of a payment exclusive of the requirements of this subparagraph.

Managed care plans offering the preferred provider organization network plan under this subparagraph shall not place capacity limits on the number or classes of providers authorized to be preferred providers except where the services regularly performed by a particular class of providers are not covered services within the scope of the health benefit plan or plans offered by the managed care plan pursuant to Article 2 of Chapter 30 of this title. This subparagraph shall not supersede any other requirement of this title regarding the coverage of a certain class or classes of providers.

(3) Except as provided in subparagraph (C) of paragraph (2) of this subsection for a consumer choice option without cost sharing, any increases in cost sharing for the consumer choice option, as compared to in network cost sharing, shall be limited as follows:

(A) If deductibles are used in network, any deductibles in the consumer choice option shall not exceed a 20 percent difference between in and out of network; provided, however, that deductibles cannot be accumulated separately between in network and out of network;

(B) If copayments are used in network, any copayments in the consumer choice option shall not exceed a 20 percent difference between in and out of network;

(C) In all cases, any coinsurance in the consumer choice option shall not exceed 10 percentage points difference between in and out of network; and

(D) In all cases, the maximum differential for out-of-pocket expenditures of the consumer choice option shall not exceed 20

percent as compared to in network; provided, however, that out-of-pocket expenditures cannot be accumulated separately between in network and out of network. Further, all cost sharing that is counted toward the out-of-pocket limit for the consumer choice option shall be the same as that counted toward the in network plan.

(4) After 12 months of full implementation, the pricing of the consumer choice option may be reevaluated to consider actual costs incurred and the experience of the standard plan without the option as compared to the consumer choice option. Based on an independent actuarial evaluation of such actual costs incurred and experience, managed care entities may apply for a waiver of the cost provisions of paragraphs (2) and (3) of this subsection to the Insurance Commissioner's office.

(e) The consumer choice option shall have substantially the same covered benefits as the managed care plan without the option.

(f) For an enrollee who chooses the consumer choice option, the managed care entity shall provide such enrollee with a form to be completed by the enrollee nominated health care provider or hospital. This form shall indicate such health care provider's or hospital's agreement to accept reimbursement as provided in subparagraph (c)(1)(B) of this Code section and such health care provider's or hospital's agreement to adhere to the quality assurance requirements and other reasonable criteria of the plan as provided in subparagraphs (c)(1)(C) and (c)(1)(D) of this Code section. The form required by this subsection shall be one page, shall be signed and dated by the nominated health care provider or hospital, and shall be mailed to the managed care entity at the address indicated on the form. In a timely manner and upon receipt of such form from a nominated health care provider or hospital, the plan shall indicate acceptance of the health care provider or hospital and provide any necessary information to the health care provider or hospital including but not limited to a complete copy of the reimbursement terms, quality assurance requirements, and any other reasonable criteria required by the managed care plan of in network health care providers and hospitals. The plan may refuse to approve for reimbursement an enrollee nominated health care provider or hospital only upon a showing by clear and convincing evidence that the health care provider or hospital does not meet the requirements of paragraph (1) of subsection (c) of this Code section.

History. — Code 1981, § 33-20A-9.1, enacted by Ga. L. 1999, p. 342, § 3; Ga. L. 2008, p. 1088, § 1/HB 1328; Ga. L. 2015, p. 1088, § 23/SB 148.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, in subsection (c), "; and" was substituted for a period, the formerly undesignated paragraph was designated as paragraph (2), and "paragraph (1) of this subsection" was substituted for "this paragraph" in three places in paragraph (2); in subsection (d),

a semicolon was substituted for a comma in subdivision (d)(2)(A)(i), "toward" was substituted for "towards" in the last sentence of subparagraph (d)(3)(D), and, in the last sentence of paragraph (d)(4), "paragraphs" was substituted for "paragraph" and capitalization changes were made; and "The plan" was substituted for "A plan" in the last sentence in subsection (f).

Editor's notes. — Ga. L. 1999, p. 342, § 7, not codified by the General Assembly, provides that: "This Act shall become effective on July 1, 1999, for purposes of preparing for implementation of the consumer choice option and shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after January 1, 2000."

Law reviews. — For note on 1999 enactment of this Code section, see 16 Ga. St. U.L. Rev. 163 (1999).

33-20A-10. Chapter inapplicable to workers' compensation provisions.

Nothing in this article shall apply to Chapter 9 of Title 34, relating to workers' compensation.

History. — Code 1981, § 33-20A-10, enacted by Ga. L. 1996, p. 485, § 1; Ga. L. 1999, p. 350, § 2.

ARTICLE 2

PATIENT'S RIGHT TO INDEPENDENT REVIEW

Editor's notes. — Ga. L. 1999, p. 350, § 4, not codified by the General Assembly, provides that this Act "shall be applicable to any contract, policy, or other agreement of a managed care plan or health maintenance organization if such contract, policy, or agreement provides for health care services or reimbursement therefor and is issued, issued for delivery, delivered, or renewed on or after July 1, 1999."

Administrative rules and regulations. — Patient's Right to Independent Review, Official Compilation of the Rules and Regulations of the State of Georgia, Department of Community Health, Health Planning, Chapter 111-2-3.

33-20A-30. Short title.

This article shall be known and may be cited as the "Patient's Right to Independent Review Act."

History. — Code 1981, § 33-20A-30, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

Law reviews. — For note on 1999 amendments to Code sections in this article, see 16 Ga. St. U.L. Rev. 151 (1999).

33-20A-31. Definitions.

As used in this article, the term:

(1) "Department" means the Department of Community Health established under Chapter 2 of Title 31.

(2) "Eligible enrollee" means a person who:

(A) Is an enrollee or an eligible dependent of an enrollee of a managed care plan or was an enrollee or an eligible dependent of an enrollee of such plan at the time of the request for treatment;

(B) Seeks a treatment which reasonably appears to be a covered service or benefit under the enrollee's evidence of coverage; provided, however, that this subparagraph shall not apply if the notice from a managed care plan of the outcome of the grievance procedure was that a treatment is experimental; and

(C) Is not a Medicaid care management member.

(3) "Grievance procedure" means the grievance procedure established pursuant to Code Section 33-20A-5.

(4) "Independent review organization" means any organization certified as such by the department under Code Section 33-20A-39.

(5) "Medicaid care management member" means a recipient of medical assistance, as that term is defined in paragraph (7) of Code Section 49-4-141, and shall also include a child receiving health care benefits pursuant to Article 13 of Chapter 5 of Title 49.

(6) "Medical and scientific evidence" means:

(A) Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

(C) Medical journals recognized by the United States secretary of health and human services, under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information; or

(E) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized

federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, the Centers for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(7) "Medical necessity," "medically necessary care," or "medically necessary and appropriate" means care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

(A) Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition;

(B) Compatible with the standards of acceptable medical practice in the United States;

(C) Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

(D) Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and

(E) Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage.

(8) "Treatment" means a medical service, diagnosis, procedure, therapy, drug, or device.

(9) Any term defined in Code Section 33-20A-3 shall have the meaning provided for that term in Code Section 33-20A-3 except that "enrollee" shall include the enrollee's eligible dependents.

History. — Code 1981, § 33-20A-31, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2002, p. 415, § 33; Ga. L. 2005, p. 1438, § 2/SB 140; Ga. L. 2006, p. 72, § 33/SB 465; Ga. L. 2009, p. 453, § 1-7/HB 228.

33-20A-32. Right to appeal.

An eligible enrollee shall be entitled to appeal to an independent review organization when:

(1) The eligible enrollee has received notice of an adverse outcome pursuant to a grievance procedure or the managed care entity has not complied with the requirements of Code Section 33-20A-5 with regard to such procedure; or

(2) A managed care entity determines that a proposed treatment is excluded as experimental under the managed care plan, and all of the following criteria are met:

(A) The eligible enrollee has a terminal condition that, according to the treating physician, has a substantial probability of causing death within two years from the date of the request for independent review or the eligible enrollee's ability to regain or maintain maximum function, as determined by the treating physician, would be impaired by withholding the experimental treatment;

(B) After exhaustion of standard treatment as provided by the evidence of coverage or a finding that such treatment would be of substantially lesser or of no benefit, the eligible enrollee's treating physician certifies that the eligible enrollee has a condition for which standard treatment would not be medically indicated for the eligible enrollee or for which there is no standard treatment available under the evidence of coverage of the eligible enrollee more beneficial than the treatment proposed;

(C) The eligible enrollee's treating physician has recommended and certified in writing treatment which is likely to be more beneficial to the eligible enrollee than any available standard treatment;

(D) The eligible enrollee has requested a treatment as to which the eligible enrollee's treating physician, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the eligible enrollee's condition, has certified in writing that scientifically valid studies using accepted protocols, such as control group or double-blind testing, published in peer reviewed literature, demonstrate that the proposed treatment is likely to be more beneficial for the eligible enrollee than available standard treatment; and

(E) A specific treatment recommended would otherwise be included within the eligible enrollee's certificate of coverage, except for the determination by the managed care entity that such treatment is experimental for a particular condition.

History. — Code 1981, § 33-20A-32, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-33. Minimum expense of treatment prior to review.

Except where required pursuant to Code Section 51-1-49, a proposed treatment must require the expenditure of a minimum of $500.00 to qualify for independent review.

History. — Code 1981, § 33-20A-33, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-34. Representatives for enrollee; cost of review; cooperation.

(a) The parent or guardian of a minor who is an eligible enrollee may act on behalf of the minor in requesting independent review. The legal guardian or representative of an incapacitated eligible enrollee shall be authorized to act on behalf of the eligible enrollee in requesting independent review. Except as provided in Code Section 51-1-49, independent review may not be requested by persons other than the eligible enrollee or a person acting on behalf of the eligible enrollee as provided in this Code section.

(b) A managed care entity shall be required to pay the full cost of applying for and obtaining the independent review.

(c) The eligible enrollee and the managed care entity shall cooperate with the independent review organization to provide the information and documentation, including executing necessary releases for medical records, which are necessary for the independent review organization to make a determination of the claim.

History. — Code 1981, § 33-20A-34, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-35. Request for independent review.

(a) In the event that the outcome of the grievance procedure under Code Section 33-20A-5 is adverse to the eligible enrollee, the managed care entity shall include with the written notice of the outcome of the grievance procedure a statement specifying that any request for independent review must be made to the department on forms developed by the department, and such forms shall be included with the notification. Such statement shall be in simple, clear language in boldface type which is larger and bolder than any other typeface which is in the notice and in at least 14 point typeface.

(b) An eligible enrollee must submit the written request for independent review to the department. Instructions on how to request independent review shall be given to all eligible enrollees with the written notice required under this Code section together with instructions in simple, clear language as to what information, documentation, and procedure are required for independent review.

(c) Upon receipt of a completed form requesting independent review as required by subsection (a) of this Code section, the department shall

notify the eligible enrollee of receipt and assign the request to an independent review organization on a rotating basis according to the date the request is received.

(d) Upon assigning a request for independent review to an independent review organization, the department shall provide written notification of the name and address of the assigned organization to both the requesting eligible enrollee and the managed care entity.

(e) No managed care entity may be certified by the Commissioner under Article 1 of this chapter unless the entity agrees to pay the costs of independent review to the independent review organization assigned by the department to conduct each review involving such entity's eligible enrollees.

History. — Code 1981, § 33-20A-35, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-36. Additional information required for independent review.

(a) Within three business days of receipt of notice from the department of assignment of the application for determination to an independent review organization, the managed care entity shall submit to that organization the following:

(1) Any information submitted to the managed care entity by the eligible enrollee in support of the eligible enrollee's grievance procedure filing;

(2) A copy of the contract provisions or evidence of coverage of the managed care plan; and

(3) Any other relevant documents or information used by the managed care entity in determining the outcome of the eligible enrollee's grievance.

Upon request, the managed care entity shall provide a copy of all documents required by this subsection, except for any proprietary or privileged information, to the eligible enrollee. The eligible enrollee may provide the independent review organization with any additional information the eligible enrollee deems relevant.

(b) The independent review organization shall request any additional information required for the review from the managed care entity and the eligible enrollee within five business days of receipt of the documentation required under this Code section. Any additional information requested by the independent review organization shall be submitted within five business days of receipt of the request, or an

explanation of why the additional information is not being submitted shall be provided.

(c) Additional information obtained from the eligible enrollee shall be transmitted to the managed care entity, which may determine that such additional information justifies a reconsideration of the outcome of the grievance procedure. A decision by the managed care entity to cover fully the treatment in question upon reconsideration using such additional information shall terminate independent review.

(d) The expert reviewer of the independent review organization shall make a determination within 15 business days after expiration of all time limits set forth in this Code section, but such time limits may be extended or shortened by mutual agreement between the eligible enrollee and the managed care entity. The determination shall be in writing and state the basis of the reviewer's decision. A copy of the decision shall be delivered to the managed care entity, the eligible enrollee, and the department by at least first-class mail.

(e) The independent review organization's decision shall be based upon a review of the information and documentation submitted to it.

(f) Information required or authorized to be provided pursuant to this Code section may be provided by facsimile transmission or other electronic transmission.

History. — Code 1981, § 33-20A-36, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-37. Effect of favorable determinations.

(a) A decision of the independent review organization in favor of the eligible enrollee shall be final and binding on the managed care entity and the appropriate relief shall be provided without delay. A managed care entity bound by such decision of an independent review organization shall not be liable pursuant to Code Section 51-1-48 for abiding by such decision. Nothing in this Code section shall relieve the managed care entity from liability for damages proximately caused by its determination of the proposed treatment prior to such decision.

(b) A determination by the independent review organization in favor of a managed care entity shall create a rebuttable presumption in any subsequent action that the managed care entity's prior determination was appropriate.

(c) In the event that, in the judgment of the treating health care provider, the health condition of the enrollee is such that following the provisions of Code Section 33-20A-36 would jeopardize the life or health of the eligible enrollee or the eligible enrollee's ability to regain

maximum function, as determined by the treating health care provider, an expedited review shall be available. The expedited review process shall encompass all elements enumerated in Code Sections 33-20A-36 and 33-20A-40; provided, however, that a decision by the expert reviewer shall be rendered within 72 hours after the expert reviewer's receipt of all available requested documents.

History. — Code 1981, § 33-20A-37, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140; Ga. L. 2011, p. 99, § 46/HB 24.

Editor's notes. — Ga. L. 2011, p. 99, § 101/HB 24, not codified by the General Assembly, provides that the amendment to this Code section by that Act shall apply to any motion made or hearing or trial commenced on or after January 1, 2013.

Law reviews. — For article, "Evidence," see 27 Ga. St. U.L. Rev. 1 (2011). For article on the 2011 amendment of this Code section, see 28 Ga. St. U.L. Rev. 1 (2011).

33-20A-38. Organizational and employee liability.

Neither an independent review organization nor its employees, agents, or contractors shall be liable for damages arising from determinations made pursuant to this article, unless an act or omission thereof is made in bad faith or through gross negligence, constitutes fraud or willful misconduct, or demonstrates malice, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to the consequences.

History. — Code 1981, § 33-20A-38, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "an" was inserted near the beginning of this Code section.

33-20A-39. Certification of independent review organizations; conflict of interest; quality assurance mechanism; copies of nonproprietary information.

(a) The department shall certify independent review organizations that meet the requirements of this Code section and any regulations promulgated by the department consistent with this article. The department shall deem certified any independent review organization meeting standards developed for this purpose by an independent national accrediting organization. To qualify for certification, an independent review organization must show the following:

(1) Expert reviewers assigned by the independent review organization must be physicians or other appropriate providers who meet the following minimum requirements:

(A) Are expert in the treatment of the medical condition at issue and are knowledgeable about the recommended treatment through actual clinical experience;

(B) Hold a nonrestricted license issued by a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of review; and

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, government, or regulatory body;

(2) The independent review organization shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, a managed care entity, or a professional association of health care providers; and

(3) The independent review organization shall submit to the department the following information upon initial application for certification, and thereafter within 30 days of any change to any of the following information:

(A) The names of all owners of more than 5 percent of any stock or options, if a publicly held organization;

(B) The names of all holders of bonds or notes in excess of $100,000.00, if any;

(C) The names of all corporations and organizations that the independent review organization controls or is affiliated with, and the nature and extent of any ownership or control, including the affiliated organization's type of business; and

(D) The names of all directors, officers, and executives of the independent review organization, as well as a statement regarding any relationships the directors, officers, and executives may have with any health care service plan, disability insurer, managed care entity or organization, provider group, or board or committee.

(b) Neither the independent review organization nor any expert reviewer of the independent review organization may have any material professional, familial, or financial conflict of interest with any of the following:

(1) A managed care plan or entity being reviewed;

(2) Any officer, director, or management employee of a managed care plan which is being reviewed;

(3) The physician, the physician's medical group, health care provider, or the independent practice association proposing a treatment under review;

(4) The institution at which a proposed treatment would be provided;

(5) The eligible enrollee or the eligible enrollee's representative; or

(6) The development or manufacture of the treatment proposed for the eligible enrollee whose treatment is under review.

(c) As used in subsection (b) of this Code section, the term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center or other similar medical research center provides health care services to eligible enrollees of a managed care plan, except as subject to the requirement of paragraph (4) of subsection (b) of this Code section; affiliations which are limited to staff privileges at a health care facility; or an expert reviewer's participation as a contracting plan provider where the expert is affiliated with an academic medical center or other similar medical research center that is acting as an independent review organization under this article. An agreement to provide independent review for an eligible enrollee or managed care entity is not a conflict of interest under subsection (b) of this Code section.

(d) The independent review organization shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts, and the confidentiality of medical records and review materials.

(e) The department shall provide upon the request of any interested person a copy of all nonproprietary information filed with it pursuant to this article. The department shall provide at least quarterly a current list of certified independent review organizations to all managed care entities and to any interested persons.

History. — Code 1981, § 33-20A-39, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-40. Determining medical necessity or whether a treatment is experimental.

(a) For the purposes of this article, in making a determination as to whether a treatment is medically necessary and appropriate, the expert reviewer shall use the definition provided in paragraph (7) of Code Section 33-20A-31.

(b) For the purposes of this article, in making a determination as to whether a treatment is experimental, the expert reviewer shall determine:

(1) Whether such treatment has been approved by the federal Food and Drug Administration; or

(2) Whether medical and scientific evidence demonstrates that the expected benefits of the proposed treatment would be greater than

the benefits of any available standard treatment and that the adverse risks of the proposed treatment will not be substantially increased over those of standard treatments.

For either determination, the expert reviewer shall apply prudent professional practices and shall assure that at least two documents of medical and scientific evidence support the decision.

History. — Code 1981, § 33-20A-40, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-41. Rules and regulations.

The department shall provide necessary rules and regulations for the implementation and operation of this article.

History. — Code 1981, § 33-20A-41, enacted by Ga. L. 1999, p. 350, § 3; Ga. L. 2005, p. 1438, § 2/SB 140.

33-20A-42. Grievance procedures and hearings for Medicaid care management members.

Medicaid care management members shall, after first exhausting the grievance procedure of the managed care plan providing health care benefits pursuant to Article 7 of Chapter 4 of Title 49 or Article 13 of Chapter 5 of Title 49, be afforded the fair hearing rights provided pursuant to Code Section 49-4-153 or the state plan provided for in Article 13 of Chapter 5 of Title 49.

History. — Code 1981, § 33-20A-42, enacted by Ga. L. 2005, p. 1438, § 2/SB 140.

ARTICLE 3

MANAGED HEALTH CARE PLANS

Editor's notes. — Ga. L. 2002, p. 441, § 1, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Consumers' Health Insurance Protection Act.'"

Ga. L. 2002, p. 441, § 11, not codified by the General Assembly, provides that: "This Act shall apply only to health benefit plan contracts issued, delivered, issued for delivery, or renewed in this state on or after October 1, 2002; provided, however, that Section 8 of this Act shall apply to all claims relating to health care services provided on or after July 1, 2002. Any carrier, plan, network, panel, or agent thereof conducting a post-payment audit or imposing a retroactive denial on any claim initially submitted prior to July 1, 2002, shall, no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such a retroactive denial of any such claim or part thereof, including the specific reason for the audit or denial and

shall complete the audit or retroactive denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004." The reference to Section 8 of the Act apparently should be to Section 9 of the Act, which enacted Article 3 of this chapter.

33-20A-60. Definitions.

As used in this article, the term:

(1) "Agent" shall not include an agent or agency as defined in Code Section 33-23-1.

(2) "Carrier" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity and any self-insured health benefit plan not subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq., which entity provides for the financing or delivery of health care services through a health benefit plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(3) "Claimant" means any provider, facility, or individual making a claim under a health benefit plan on behalf of an enrollee.

(4) "Enrollee" has the same meaning as provided in Code Section 33-20A-3.

(5) "Health benefit plan" has the same meaning as provided in Code Section 33-24-59.5.

(6) "Physician contract" means any contract between a physician and a carrier or a carrier's network, physician panel, intermediary, or representative providing the terms under which the physician agrees to provide health care services to an enrollee pursuant to a health benefit plan.

(7) "Postpayment audit" means an investigation by a health benefit plan, carrier, insurer, or panel, or agent thereof, of whether a claim was properly paid to a claimant.

(8) "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a claimant with respect to a claim, or any portion thereof, by requiring repayment of such payments, by reducing other payments owed to the claimant, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the claimant.

History. — Code 1981, § 33-20A-60, enacted by Ga. L. 2002, p. 441, § 9; Ga. L. 2003, p. 140, § 33; Ga. L. 2019, p. 337, § 1-90/SB 132.

The 2019 amendment, effective July 1, 2019, deleted "as used in this article" preceding "shall not include" in paragraph (1); deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in paragraph (2); deleted former paragraph (4), which read: "'Commissioner' means the Commissioner of Insurance."; redesignated former paragraphs (5) through (9) as present paragraphs (4) through (8), respectively; and, in paragraph (8), deleted "currently" following "other payments".

Editor's notes. — For short title and applicability, see the Editor's notes at the beginning of this article.

Law reviews. — For note on the 2002 enactment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

33-20A-61. Physician contracts.

(a) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that an insurance carrier, plan, network, panel, or any agent thereof should terminate a physician's contract and thereby affect any enrollee's opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician's contract. Any enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee's physician's contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six weeks' postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician's contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician's contract is terminated because of the suspension or revocation of the physician's license or if the carrier, plan, network, panel, or any agent thereof determines that the physician poses a threat to the health, safety, or welfare of enrollees.

(b) Every physician contract entered into, amended, extended, or renewed after July 1, 2002, by a carrier shall contain a specific provision which shall provide that, in the event that a physician should terminate his or her contract with an insurance carrier, plan, network, panel, or any agent thereof and thereby affect any enrollee's opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to receive health care services from that

physician for a period of up to 60 days from the date of the termination of the physician's contract. Any enrollee who is pregnant and receiving health care services in connection with that pregnancy at the time of the termination of that enrollee's physician's contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six weeks' postdelivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician's contract. The enrollee shall not have the right to the continuation provisions provided in this Code section if the physician terminates his or her contract because of the suspension or revocation of the physician's license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of enrollees.

History. — Code 1981, § 33-20A-61, enacted by Ga. L. 2002, p. 441, § 9.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, "six weeks'" was substituted for "six-weeks" in subsections (a) and (b).

Editor's notes. — For short title and applicability, see the Editor's notes at the beginning of this article.

33-20A-62. Payment.

(a) No carrier, plan, network, panel, or any agent thereof may conduct a postpayment audit or impose a retroactive denial of payment on any claim by any claimant relating to the provision of health care services that was submitted within 90 days of the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within 18 months of the last date of service or discharge covered by such claim.

(b) No carrier, plan, network, panel, or any agent thereof may conduct a postpayment audit or impose a retroactive denial of payment

on any claim by any claimant relating to the provision of health care services that was submitted more than 90 days after the last date of service or discharge covered by such claim unless:

(1) The carrier, plan, network, panel, or agent thereof has provided to the claimant in writing notice of the intent to conduct such an audit or impose such a retroactive denial of payment of such claim or any part thereof and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

(2) Not more than 12 months have elapsed since such claim was initially submitted by the claimant prior to the delivery to the claimant of such written notice; and

(3) Any such audit or retroactive denial of payment must be completed and notice provided to the claimant of any payment or refund due within the sooner of 18 months after the claimant's initial submission of such a claim or 24 months after the date of service.

(c) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility's request for additional payment or to adjust any previously paid provider or facility's claim or any part thereof following a final payment unless:

(1) The provider or facility makes a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility's claim was submitted within 90 days of the last date of service or discharge covered by such claim, the written request for additional payment or adjustment must be submitted within the earlier of 12 months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(d) No carrier, plan, network, panel, or any agent thereof shall be required to respond to a provider or facility's request for additional payment or to adjust any previously paid provider or facility's claim or any part thereof following a final payment unless:

(1) The provider or facility makes a request in writing to the carrier, plan, network, panel, or any agent thereof specifically identifying the previously paid claim or any part thereof and provides the specific reason for additional payment; and

(2) If the provider or facility's claim was submitted more than 90 days after the last date of service or discharge covered by such claim,

the written request for additional payment or adjustment must be submitted within the earlier of six months of the date both the provider or facility and the insurer, network, panel, plan, or carrier or any agent thereof agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by the provider or facility or 24 months have elapsed from the date of service or discharge.

(e) An enrollee who is not billed for services by any provider, facility, or agent thereof within 45 days of the date that the provider, facility, or agent thereof knew that further payment was due as the result of a postpayment audit, retroactive denial, or rejected request to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a request for additional payment.

(f) Notwithstanding any other provision in this article to the contrary, when precertification has been obtained for a service, the insurer, carrier, plan, network, panel, or agent thereof shall be prohibited from contesting, requesting payment, or reopening such claim or any portion thereof at any time following precertification except to the extent the insurer is not liable for the payment under Code Section 33-20A-7.1.

(g) Nothing in this article shall be construed as prohibiting reimbursement subject to Code Section 33-24-56.1.

History. — Code 1981, § 33-20A-62, enacted by Ga. L. 2002, p. 441, § 9; Ga. L. 2003, p. 140, § 33.

Editor's notes. — For short title and applicability, see the Editor's notes at the beginning of this article.

ARTICLE 4

JOINT COMMITTEE TO STUDY PRESCRIPTION COSTS IN STATE FUNDED HEALTH CARE PLANS

Editor's notes. — Code Section 33-20A-70 provided for the repeal of this article on December 31, 2005.

33-20A-70. Creation; members; meetings; duties; cooperation by the Department of Community Health; members' expenses; repealer.

Repealed by Ga. L. 2005, p. 1438, § 1/SB 140, effective December 31, 2005.

Editor's notes. — This article was based on Code 1981, § 33-20A-70, enacted by Ga. L. 2005, p. 1438, § 1/SB 140.

CHAPTER 20B

ESSENTIAL RURAL HEALTH CARE PROVIDER ACCESS

Sec.
33-20B-1. Short title.
33-20B-2. Definitions.
33-20B-3. Qualifications for participating providers; reasonable consideration.
33-20B-3.1. Health maintenance organizations' expansion into rural areas.
33-20B-4. Termination as a participating provider.
33-20B-5. Hearing and appeal rights of denied providers.
33-20B-6. Administration.

Editor's notes. — Ga. L. 1998, p. 900, § 1, not codified by the General Assembly, provides that: "It is the intent of the General Assembly to encourage the continued existence and availability of certain health care providers in rural areas of the state so as to promote and preserve the provision of primary care to the residents of such rural areas. The General Assembly finds that a severe shortage of health care providers currently exists in many rural areas, and those providers which do exist continue to do so under financial hardship. The General Assembly further finds that rural health care providers are being arbitrarily excluded from participating in certain health benefit plans and that, should such practice continue, these providers will be harmed and forced either to discontinue their services or relocate to urban areas thereby further exacerbating the shortage which already exists. The General Assembly therefore concludes that certain steps must be taken to promote the continued existence and expansion of rural health care providers in order to preserve the availability of primary health care services to Georgia's rural citizens."

33-20B-1. Short title.

This chapter shall be known and may be cited as the "Essential Rural Health Care Provider Access Act."

History. — Code 1981, § 33-20B-1, enacted by Ga. L. 1998, p. 900, § 2.

Law reviews. — For review of 1998 legislation relating to insurance, see 15 Ga. St. U.L. Rev. 143 (1998).

33-20B-2. Definitions.

As used in this chapter, the term:

(1) "Essential rural health care provider" means any hospital, federally qualified health center, or rural health clinic, as such terms are defined in this Code section, which is located in a rural area and which complies with the provisions of Code Section 33-20B-3.

(2) "Federally qualified health center" means, for the purposes of this Code section, a facility which meets the definition of a federally qualified health center as described in Section 1395x(aa)(4) of Title 42 of the United States Code Annotated and which is located in a rural area.

(3) "Health benefit plan" or "plan" means the health insurance policy or subscriber agreement between a covered person or policyholder and a health care insurer which defines the covered services and benefit levels available.

(4) "Health care insurer" means an insurer, a fraternal benefit society, a health care plan, a health care corporation, a health maintenance organization, or any other entity authorized to sell accident and sickness insurance policies, subscriber certificates, or other contracts of health insurance by whatever name called under this title.

(5) "Health care services" means services rendered or products sold by an essential rural health care provider within the scope of such provider's license or legal authorization.

(6) "Hospital" means any building or facility licensed by the Department of Community Health as a hospital under this chapter which:

(A) Operates no more than 100 beds;

(B) Provides 24 hour emergency care as well as a range of health care services sufficient to support the practice of a primary care physician; and

(C) For at least one of the immediately preceding two fiscal years, derived at least 40 percent of its patient revenues from medicare, Medicaid, or any combination of medicare and Medicaid.

(7) "Physician" for purposes of this Code section only means any person who is licensed to practice medicine by the Georgia Composite Medical Board pursuant to Chapter 34 of Title 43 who practices as a family physician, general internist, pediatrician, general practitioner, general surgeon, or obstetrician/gynecologist and who has medical staff privileges at a hospital as defined in paragraph (6) of this Code section.

(8) "Rural area" means any county having a population of less than 35,000 according to the United States decennial census of 1990 or any future such census.

(9) "Rural health clinic" means a facility which is located in a rural area and which meets the definition of a rural health clinic as

described in Section 1395x(aa)(2) of Title 42 of the United States Code Annotated.

History. — Code 1981, § 33-20B-2, enacted by Ga. L. 1998, p. 900, § 2; Ga. L. 1999, p. 81, § 33; Ga. L. 2009, p. 859, § 2/HB 509; Ga. L. 2017, p. 164, § 10/HB 127; Ga. L. 2019, p. 337, § 1-91/SB 132; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, inserted "of community health" in paragraph (6).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised capitalization in paragraph (6).

Editor's notes. — Ga. L. 2019, p. 337, § 1-91/SB 132, which amended this Code section, purported to amend Code Section 22-20B-2 but actually amended Code Section 33-20B-2.

U.S. Code. — Section 1395x of Title 42 of the United States Code, referred to in paragraphs (2) and (9), refers to health insurance for the aged and disabled under the Social Security Act.

33-20B-3. Qualifications for participating providers; reasonable consideration.

(a) Any essential rural health care provider shall have the opportunity to become a participating provider of health care services in a health benefit plan if such provider meets all of the following conditions:

(1) Participates in the medicare and Medicaid programs;

(2) Adopts and complies with a policy for the provision of health care services to indigent and charity patients;

(3) Is licensed, where required under law, and qualified to render the services provided by the plan;

(4) Agrees to payment terms which are either:

(A) The same payment terms applicable to other similar participating providers in the plan; or

(B) Such payment terms as may be mutually agreed upon by such provider and a health care insurer; and

(5) Meets the reasonable and nondiscriminatory qualifications and standards established by the plan. Plan standards must comply with all applicable laws and regulations, but such qualifications and standards may not discriminate against essential rural health care providers on the basis of geographic proximity to other participating providers or corporate status.

(b) All essential rural health care providers within a defined service area who meet the conditions established in subsection (a) of this Code section shall be given the opportunity to apply to become a participating provider in a plan. Provisions within a health benefit plan applicable to

providers in such plan shall be applied by the health care insurer in a uniform and consistent manner to similarly situated providers. In the event an essential rural health care provider requests the opportunity to become a participating provider in any health benefit plan, the health care insurer shall conduct reasonable and good faith negotiations with such essential rural health care provider to determine whether it meets the applicable qualifications and standards established by the plan in accordance with all applicable laws, rules, and regulations as promulgated by the Commissioner of Insurance.

(c) Health benefit plans shall include sufficient and reasonable numbers of physicians located in rural areas.

History. — Code 1981, § 33-20B-3, enacted by Ga. L. 1998, p. 900, § 2; Ga. L. 2000, p. 439, § 1.

Law reviews. — For note on 2000 amendment of this Code section, see 17 Ga. St. U.L. Rev. 215 (2000).

33-20B-3.1. Health maintenance organizations' expansion into rural areas.

When reviewing a health maintenance organization's request to originate or expand an area of service into a rural area, the commissioner of community health shall consider whether the health maintenance organization has demonstrated its willingness to grant reasonable consideration to essential rural health care providers in the negotiating and contracting process.

History. — Code 1981, § 33-20B-3.1, enacted by Ga. L. 2000, p. 439, § 1; Ga. L. 2009, p. 453, § 1-6/HB 228.

Law reviews. — For note on 2000 enactment of this Code section, see 17 Ga. St. U.L. Rev. 215 (2000).

33-20B-4. Termination as a participating provider.

To deny, reject, or terminate an essential rural health care provider from serving as a participating provider in a health benefit plan, the health care insurer shall:

(1) Inform the essential rural health care provider in writing of the basis for such rejection or termination, including a reference to any specific qualification or standard established by the plan in accordance with all applicable laws and regulations which the provider failed to meet; and

(2) Where possible, afford the essential rural health care provider a reasonable opportunity to cure the deficiency which is the basis for such rejection or termination.

History. — Code 1981, § 33-20B-4, enacted by Ga. L. 1998, p. 900, § 2.

33-20B-5. Hearing and appeal rights of denied providers.

Any essential rural health care provider which is denied, rejected, or terminated from serving as a participating provider in a health benefit plan shall have the right of hearing and appeal before the Commissioner, or his or her designee, if that provider believes there has been a violation of this chapter and of judicial appeal as provided in Chapter 2 of this title. To the extent proprietary materials, trade secrets, rate data, or other materials not generally known to the public are presented at a hearing or an appeal, such information shall be admissible but shall be sealed by the Commissioner and held as confidential and shall not be subject to Article 4 of Chapter 18 of Title 50.

History. — Code 1981, § 33-20B-5, enacted by Ga. L. 1998, p. 900, § 2; Ga. L. 1999, p. 81, § 33.

33-20B-6. Administration.

The administration of this chapter shall be through the Commissioner of Insurance.

History. — Code 1981, § 33-20B-6, enacted by Ga. L. 1998, p. 900, § 2.

CHAPTER 20C

ACCURATE PROVIDER DIRECTORIES

Sec.
33-20C-1. Definitions.
33-20C-2. Online provider directories; printed directories by request; required content; accessibility.
33-20C-3. Required and accurate information in directories; reporting; reimbursement for reliance.
33-20C-4. Information and searchable format for directories; exclusion for dental plans.
33-20C-5. Printed directories; accuracy; application to standalone dental plans.
33-20C-6. Exclusion for services provided through Department of Community Health.
33-20C-7. Disclosure of health benefit plan surprise bill rating in advertisement; other disclosures; regulation; optional annual reporting.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2016, the chapter enacted by Ga. L. 2016, p. 319, § 1/SB 158 was redesignated as Chapter 20D of Title 33.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 540 et seq.
44 Am. Jur. 2d, Insurance, § 1046 et seq.

33-20C-1. Definitions.

As used in this chapter, the term:

(1) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

(2) "Facility" means an institution providing physical, mental, or behavioral health care services or a healthcare setting, including, but not limited to, hospitals; licensed inpatient centers; ambulatory surgical centers; skilled nursing facilities; residential treatment centers; diagnostic, treatment, or rehabilitation centers; imaging centers; and rehabilitation and other therapeutic health settings.

(3) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a standalone dental plan.

(4) "Health benefit plan surprise bill rating" means the number of checkmarks and X-marks between zero and four that a health benefit plan's in-network hospital has earned based upon the number of

qualified hospital based specialty group types with which such health benefit plan is contracted for the provision of healthcare services. Each checkmark indicates the presence of a in-network particular type of qualified hospital based specialty group. An X-mark indicates the absence of an in-network particular type of qualified hospital based specialty group. If a hospital does not provide one of the qualified hospital based specialties, the absence of that specialty shall be designated by a green N/A mark. Any color advertisement which includes a health benefit plan surprise bill rating shall use green checkmarks, red X-marks, and green N/A marks.

(5) "Healthcare professional" means a physician or other healthcare practitioner licensed, accredited, or certified to perform specified physical, mental, or behavioral healthcare services consistent with his or her scope of practice under state law.

(6) "Healthcare provider" or "provider" means a healthcare professional, pharmacy, or facility.

(7) "Healthcare services" means services for the diagnosis, prevention, treatment, cure, or relief of a physical, mental, or behavioral health condition, illness, injury, or disease, including mental health and substance abuse disorders.

(8) "Insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including an accident and sickness insurance company, a health maintenance organization, a healthcare plan, or any other entity providing a health insurance plan, a health benefit plan, or healthcare services.

(9) "Network" means the group or groups of participating healthcare providers providing services under a network plan.

(10) "Network plan" means a health benefit plan of an insurer that either requires a covered person to use healthcare providers managed by, owned by, under contract with, or employed by the insurer or that creates incentives, including financial incentives, for a covered person to use such healthcare providers.

(11) "Qualified hospital based specialty group" means a medical group of anesthesiologists, pathologists, radiologists, or emergency medicine physicians.

(12) "Standalone dental plan" means a plan of an insurer that provides coverage substantially all of which is for treatment of the mouth, including any organ or structure within the mouth, which is

provided under a separate policy, certificate, or contract of insurance or is otherwise not an integral part of a group benefit plan.

(13) "Tiers" or "tiered network" means a network that identifies and groups some or all types of providers and facilities into specific groups to which different provider reimbursement, covered person cost sharing, or provider access requirements, or any combination thereof, apply for the same services.

History. — Code 1981, § 33-20C-1, enacted by Ga. L. 2016, p. 149, § 1/SB 302; Ga. L. 2017, p. 164, § 11/HB 127; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2020, p. 228, § 2/HB 789.

The 2020 amendment, effective November 1, 2020, substituted "healthcare" for "health care" throughout the Code section; added paragraph (4); redesignated former paragraphs (4) through (9) as present paragraphs (5) through (10), respectively; added paragraph (11); and redesignated former paragraphs (10) and (11) as present paragraphs (12) and (13), respectively.

Editor's notes. — Ga. L. 2020, p. 228, § 1/HB 789, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Surprise Bill Transparency Act.'"

Ga. L. 2020, p. 228 contains two sections numbered as "2". The language in the first Section 2 of the Act amended this Code section.

33-20C-2. Online provider directories; printed directories by request; required content; accessibility.

(a)(1) An insurer shall post on its website a current and accurate electronic provider directory for each of its network plans with the information described in Code Section 33-20C-4. Such online provider directory shall be easily accessible in a standardized, downloadable, searchable, and machine readable format.

(2) In making the provider directory available online, the insurer shall ensure that the general public is able to view all of the current providers for a network plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(3) The insurer shall update each network plan on the online provider directory no less than every 30 days.

(b) An insurer shall provide a print copy of a current provider directory, or a print copy of the requested directory information, with the information described in Code Section 33-20C-5 upon request by a covered person or a prospective covered person.

(c) For each network plan, an insurer shall include in plain language, in both the online and print directory, the following general information:

(1) A description of the criteria the insurer has used to build its provider network;

(2) If applicable, a description of the criteria the insurer has used to tier providers;

(3) If applicable, how the insurer designates the different provider tiers or levels, such as by name, symbols, or grouping, in the network and for each specific provider in the network, which tier each is placed in order for a covered person or a prospective covered person to be able to identify the provider tier; and

(4) If applicable, a notice that authorization or referral may be required to access some providers.

(d) The insurer shall make clear for both its online and print directories the provider directory that applies to each network plan by identifying the specific name of the network plan as marketed and issued in this state.

(e) The insurer shall make available through its online and print directories the source of the information required pursuant to Code Sections 33-20C-4 and 33-20C-5 pertaining to each health care provider and any limitations, if applicable.

(f) Provider directories, whether in electronic or print format, shall be accessible to individuals with disabilities and individuals with limited English proficiency as defined in 45 C.F.R. Section 92.201 and 45 C.F.R. Section 155.205(c).

History. — Code 1981, § 33-20C-2, enacted by Ga. L. 2016, p. 149, § 1/SB 302.

33-20C-3. Required and accurate information in directories; reporting; reimbursement for reliance.

(a) The insurer shall include in both its online and print directories a clearly identifiable telephone number and either a dedicated e-mail address or a link to a dedicated webpage that covered persons or the general public may use to report to the insurer inaccurate information listed in the provider directory. Whenever an insurer receives such a report, it shall promptly investigate such report and no later than 30 days following receipt of such report either verify the accuracy of the information or update the information, as applicable.

(b)(1) An insurer shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the insurer's provider directory and shall, no later than January 1, 2017, review and update the entire provider directory for each network plan offered. Thereafter, the insurer shall, at least annually, audit at least a reasonable sample size of its provider directories for accuracy, retain documentation of such an audit to be made available to the Commissioner upon request, and based on the results of such an

audit, verify the accuracy of the information or update the information, if applicable.

(2) The insurer shall notify any provider in its network that has not submitted claims to the insurer or otherwise communicated intent to continue participation in the insurer's network within a 12 month period. Such notice shall be accomplished in accordance with provisions of the contract entered into between the insurer and the provider regarding notice, if applicable. If the insurer does not receive a response from the provider within 30 days of such notification confirming that the information regarding the provider is current and accurate or, as an alternative, updating any information, the insurer shall remove the provider from the network; provided, however, that prior to removal, the insurer may use any other available information or means to determine if the provider is still participating in the insurer's network, including any means delineated in the contract entered into between the insurer and the provider.

(c) The insurer shall report to the Commissioner, in accordance with timeframes and requirements established by the Commissioner:

(1) The number of reports received pursuant to subsection (a) of this Code section, the timeliness of the insurer's response, and the corrective actions taken; and

(2) All auditing reports conducted by the insurer pursuant to subsection (b) of this Code section.

(d) In circumstances where the Commissioner finds that a covered person reasonably relied upon materially inaccurate information contained in an insurer's provider directory, the Commissioner may require the insurer to provide coverage for all covered health care services provided to the covered person and to reimburse the covered person for any amount that he or she would have paid, had the services been delivered by an in-network provider under the insurer's network plan; provided, however, that the Commissioner shall take into consideration that insurers are relying on health care providers to report changes to their information prior to requiring any reimbursement to a covered person. Prior to requiring reimbursement in these circumstances, the Commissioner shall conclude that the services received by the insurer were covered services under the covered person's network plan. In such circumstances, the fact that the services were rendered or delivered by a noncontracting or out-of-network provider shall not be used as a basis to deny reimbursement to the covered person.

History. — Code 1981, § 33-20C-3, enacted by Ga. L. 2016, p. 149, § 1/SB 302; Ga. L. 2018, p. 1112, § 33/SB 365.

The 2018 amendment, effective May 8, 2018, part of an Act to revise, modernize, and correct the Code, revised punctuation in the first sentence of subsection (a).

33-20C-4. Information and searchable format for directories; exclusion for dental plans.

(a) The insurer shall make available through an online provider directory, for each network plan, the following information, in a searchable format:

(1) For healthcare professionals:

(A) Name;

(B) Gender;

(C) Contact information;

(D) Participating office location or locations;

(E) Specialty, if applicable;

(F) Board certifications, if applicable;

(G) Medical group affiliations, if applicable;

(H) Participating facility affiliations, if applicable;

(I) Languages spoken other than English by the healthcare professional or clinical staff, if applicable;

(J) Tier; and

(K) Whether they are accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) Hospital type, such as acute, rehabilitation, children's, or cancer;

(C) Participating hospital location;

(D) Hospital accreditation status;

(E) Telephone number; and

(F) Health benefit plan surprise bill rating; and

(3) For facilities other than hospitals:

(A) Facility name;

(B) Facility type;

(C) Types of services performed;

(D) Participating facility location or locations; and

(E) Telephone number.

(b) Paragraphs (2) and (3) of subsection (a) of this Code section shall not apply to standalone dental plans.

History. — Code 1981, § 33-20C-4, enacted by Ga. L. 2016, p. 149, § 1/SB 302; Ga. L. 2020, p. 228, § 2/HB 789.

The 2020 amendment, effective November 1, 2020, substituted "healthcare" for "health care" in paragraph (a)(1) and subparagraph (a)(1)(I), deleted "and" at the end of subparagraph (a)(2)(D), and added subparagraph (a)(2)(F).

Editor's notes. — Ga. L. 2020, p. 228, § 1/HB 789, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Surprise Bill Transparency Act.'"

Ga. L. 2020, p. 228 contains two sections numbered as "2". The language in the second Section 2 of the Act amended this Code section.

33-20C-5. Printed directories; accuracy; application to standalone dental plans.

(a) The insurer shall make available in print, upon request, the following provider directory information for the applicable network plan:

(1) For healthcare professionals:

(A) Name;

(B) Contact information;

(C) Participating office location or locations;

(D) Specialty, if applicable;

(E) Languages spoken other than English, if applicable; and

(F) Whether accepting new patients;

(2) For hospitals:

(A) Hospital name;

(B) Hospital type, such as acute, rehabilitation, children's, or cancer;

(C) Participating hospital location and telephone number; and

(D) Health benefit plan surprise bill rating; and

(3) For facilities other than hospitals:

(A) Facility name;

(B) Facility type;

(C) Types of services performed; and

(D) Participating facility location or locations and telephone number.

(b) The insurer shall include a disclosure in the print directory that the information in subsection (a) of this Code section and included in the directory is accurate as of the date of printing and that covered persons or prospective covered persons should consult the insurer's electronic provider directory on its website or call a specified customer service telephone number to obtain current provider directory information.

(c) Paragraphs (2) and (3) of subsection (a) of this Code section shall not apply to standalone dental plans.

History. — Code 1981, § 33-20C-5, enacted by Ga. L. 2016, p. 149, § 1/SB 302; Ga. L. 2017, p. 713, § 1/HB 262; Ga. L. 2020, p. 228, § 3/HB 789.

The 2020 amendment, effective November 1, 2020, substituted "healthcare" for "health care" in paragraph (a)(1), deleted "and" at the end of subparagraph (a)(2)(B), and added subparagraph (a)(2)(D).

Editor's notes. — Ga. L. 2020, p. 228, § 1/HB 789, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Surprise Bill Transparency Act.'"

33-20C-6. Exclusion for services provided through Department of Community Health.

This chapter shall not apply to the provision of health care services pursuant to a contract entered into by an insurer and the Department of Community Health for recipients of Medicaid or PeachCare for Kids and the state health benefit plan under Article 1 of Chapter 18 of Title 45.

History. — Code 1981, § 33-20C-6, enacted by Ga. L. 2016, p. 149, § 1/SB 302.

33-20C-7. Disclosure of health benefit plan surprise bill rating in advertisement; other disclosures; regulation; optional annual reporting.

(a) Each insurer that advertises or designates any hospital as in-network shall be required to disclose the relevant health benefit plan surprise bill rating within such advertisement, notwithstanding the type or form of such advertisement.

(b) If a health benefit plan surprise bill rating is less than four checkmarks, each insurer advertising a hospital as in-network shall describe which qualified hospital based specialty group types are not contracted with such health benefit plan.

(c) The Commissioner may promulgate rules and regulations which require insurers to provide explanatory footnotes to each health benefit plan surprise bill rating in such special circumstances as the Commissioner may determine to be appropriate.

(d) If an insurer processes a claim on a covered person from an out-of-network qualified hospital based specialty group provider at out-of-network rates, such insurer shall update the relevant health benefit plan surprise bill rating within 30 days to reflect any necessary reduction in such rating.

(e) The Commissioner may submit an annual report to the House Committee on Insurance and the Senate Insurance and Labor Committee beginning January 1, 2022. Such report may include such aggregate data as the Commissioner determines beneficial to share with such committees.

History. — Code 1981, § 33-20C-7, enacted by Ga. L. 2020, p. 228, § 4/HB 789.

Effective date. — This Code section became effective November 1, 2020.

Editor's notes. — Ga. L. 2020, p. 228, § 1/HB 789, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Surprise Bill Transparency Act.'"

CHAPTER 20D

RENTAL PROVIDER NETWORK

Sec.
33-20D-1. Definitions.
33-20D-2. Registration with Commissioner; requirements; fee; approved list.
33-20D-3. Prohibited activities; confidentiality agreements.
33-20D-4. Rights and responsibilities imposed on third parties.
33-20D-5. Exclusions.
33-20D-6. Penalties.

33-20D-1. Definitions.

As used in this chapter, the term:

(1) "Affiliate" means an entity owned or controlled, either directly or through a parent or subsidiary entity, by a contracting entity that accesses the rates, terms, or conditions of health care services.

(2) "Contracting entity" means any person or entity that enters into direct contracts with health care providers for the delivery of health care services in the ordinary course of business, including a health care organization or hospital organization when leasing or renting the health care organization's or hospital organization's network to a third party.

(3) "Covered person" means an individual who is covered under a health insurance plan.

(4) "Health care services" means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from illness, injury, or other human physical problem.

(5) "Health insurer" means an accident and sickness insurer, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity regulated by the Commissioner.

(6) "Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of and payment for health care services to covered persons.

(7) "Rental preferred provider network" means a preferred provider network that contracts with a health insurer or other payor or with another preferred provider network to grant access to the terms and conditions of its contract with providers of health care services. Such contracts are often referred to as "renting" or "leasing" the

network. The term "rental preferred provider network" does not refer to a proprietary network of a licensed insurer or to arrangements providing for access to the proprietary network of a licensed insurer by affiliates of the licensed insurer or by entities receiving administrative services from the licensed insurer or its affiliates.

(8) "Third party" means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract.

History. — Code 1981, § 33-20D-1, enacted by Ga. L. 2016, p. 319, § 1/SB 158.

33-20D-2. Registration with Commissioner; requirements; fee; approved list.

(a) Any person who commences business as a rental preferred provider network shall register with the Commissioner within 30 days of commencing business in this state unless such person is licensed by the Commissioner as a health insurer. Each rental preferred provider network not licensed by the Commissioner on July 1, 2016, shall be required to register with the Commissioner no later than September 30, 2016, and shall be placed on an approved list maintained by the Commissioner.

(b) Registration shall consist of the submission of the following information:

(1) The official name of the rental preferred provider network, including any d/b/a designations used in this state;

(2) The mailing address and main telephone number for the rental preferred provider network's main headquarters; and

(3) The name and telephone number of the rental preferred provider network representative who shall serve as the primary contact with the department.

(c) The information required by this Code section shall be submitted in written or electronic format, as prescribed by the Commissioner by rule or regulation.

(d) The Commissioner may, pursuant to rule or regulation, collect a reasonable fee for the purpose of administering the registration process.

(e) The Commissioner shall maintain an approved list of rental preferred provider networks.

History. — Code 1981, § 33-20D-2, enacted by Ga. L. 2016, p. 319, § 1/SB 158.

33-20D-3. Prohibited activities; confidentiality agreements.

(a) A rental preferred provider network shall not:

(1) Knowingly access or utilize a network provider's contractual discount pursuant to a provider network contract without a contractual relationship with the network provider, rental preferred provider network, or third party; or

(2) Lease, rent, or otherwise grant to a third party access to a provider network contract unless:

(A) The third party is a payor or third-party administrator or another entity that administers or processes claims on behalf of the payor;

(B) The provider network contract states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity;

(C) The provider network contract, and all agreements between a contracting entity and any third party, prohibits such third party from increasing the contractual discounts or otherwise reducing the compensation to a network provider to an amount below that which the network provider was entitled from the contracting entity for health care services at the time the third party was granted access to the provider network contract unless such third party becomes a contracting entity; and

(D) The third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

(b) A contracting entity that grants access to a network provider's health care services and contractual discounts to any third party pursuant to a provider network contract shall maintain an Internet website, mobile communication device application, or other readily available mechanism, such as a toll-free telephone number, through which a network provider may obtain a listing, updated at least every 30 days, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such network provider's health care services and contractual discounts pursuant to a provider network contract.

(c) All information made available to a network provider in accordance with the requirements of this chapter shall be confidential and shall not be disclosed to any person or entity not employed by the network provider or involved in the network provider's practice or the

administration thereof without the prior written consent of the contracting entity; provided, however, that this shall not preclude a network provider from disclosing such information to an outside consultant or attorney for the purpose of assisting the network provider with any disputes with a contracting entity.

(d) Nothing contained in this chapter shall be construed to prohibit a contracting entity from requiring a network provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the network provider's direct practice management or billing activities.

History. — Code 1981, § 33-20D-3, enacted by Ga. L. 2016, p. 319, § 1/SB 158.

33-20D-4. Rights and responsibilities imposed on third parties.

(a) A third party, having itself been granted access to a network provider's health care services and contractual discounts pursuant to a provider network contract, that subsequently grants access to another third party shall be obligated to comply with the rights and responsibilities imposed on contracting entities pursuant to this chapter.

(b) A third party that enters into a contract with another third party to access a network provider's health care services and contractual discounts pursuant to a provider network contract shall be obligated to comply with the rights and responsibilities imposed on third parties under this Code section.

History. — Code 1981, § 33-20D-4, enacted by Ga. L. 2016, p. 319, § 1/SB 158.

33-20D-5. Exclusions.

This chapter shall not apply to:

(1) Provider network contracts for services provided to Medicaid, medicare, the state health benefit plan under Article 1 of Chapter 18 of Title 45, or State Children's Health Insurance Program (SCHIP) beneficiaries;

(2) Employers, church plans, or government plans receiving administrative services from a rental preferred provider network or its affiliates, or pharmacy benefits managers;

(3) Circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity;

(4) The provision of any medical services for injuries covered under Chapter 9 of Title 34, relating to workers' compensation; or

(5) Self-funded, employer sponsored health insurance plans regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. Section 1001, et seq.

History. — Code 1981, § 33-20D-5, enacted by Ga. L. 2016, p. 319, § 1/SB 158.

33-20D-6. Penalties.

Any person or entity that is not duly licensed or that should be licensed by the department or that is not duly registered or that should be registered with the department pursuant to Code Section 33-20D-2 and acts as a rental preferred provider network, as defined in paragraph (7) of Code Section 33-20D-1, shall be subject to penalties set forth in subsection (g) of Code Section 33-2-24. The Commissioner shall have the authority, in addition to any other remedies and damages allowed by law, to seek to restrain or enjoin any person or entity, whether or not such person or entity is licensed or registered pursuant to this title, that is determined to be in violation of Code Section 33-20D-2 or 33-20D-3, and such person or entity shall be liable for attorney fees and litigation expenses incurred in the action to restrain or enjoin such violation.

History. — Code 1981, § 33-20D-6, enacted by Ga. L. 2016, p. 319, § 1/SB 158.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2016, in the first sentence, "33-20D-2" was substituted for "33-20C-2" and "33-20D-1" was substituted for "33-20C-1" and, in the second sentence, "33-20D-2" was substituted for "33-20C-2" and "33-20D-3" was substituted for "33-20C-3".

CHAPTER 20E

SURPRISE BILLING CONSUMER PROTECTION ACT

Sec.
33-20E-1. Short title.
33-20E-2. Application to insurers; definitions.
33-20E-3. Exemption.
33-20E-4. Payment for emergency medical services.
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33-20E-6. Denying or restricting benefits based on balance billing; notice to insured.
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33-20E-19. Quarterly reporting by resolution organizations.
33-20E-20. Annual reporting by Commissioner.
33-20E-21. Exclusion from other statutory provisions.
33-20E-22. Reporting to credit reporting agencies.
33-20E-23. Financial responsibilities for ground ambulance transportation.

Effective date. — This chapter becomes effective January 1, 2021.

Cross references. — Emergency medical services, T. 31, C. 11.

33-20E-1. Short title.

This chapter shall be known and may be cited as the "Surprise Billing Consumer Protection Act."

History. — Code 1981, § 33-20E-1, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-2. Application to insurers; definitions.

(a) This chapter shall apply to all insurers providing a healthcare plan that pays for the provision of healthcare services to covered persons.

(b) As used in this chapter, the term:

(1) "Balance bill" means the amount that a nonparticipating provider charges for services provided to a covered person. Such amount

equals the difference between the amount paid or offered by the insurer and the amount of the nonparticipating provider's bill charge, but shall not include any amount for coinsurance, copayments, or deductibles due by the covered person.

(2) "Contracted amount" means the median in-network amount paid during the 2017 calendar year by an insurer for the emergency or nonemergency services provided by in-network providers engaged in the same or similar specialties and provided in the same or nearest geographical area. Such amount shall be annually adjusted by the department for inflation which may be based on the Consumer Price Index, and shall not include Medicare or Medicaid rates.

(3) "Covered person" means an individual who is insured under a healthcare plan.

(4) "Emergency medical provider" means any physician licensed by the Georgia Composite Medical Board who provides emergency medical services and any other healthcare provider licensed or otherwise authorized in this state to render emergency medical services.

(5) "Emergency medical services" means medical services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(6) "Facility" means a hospital, an ambulatory surgical treatment center, birthing center, diagnostic and treatment center, hospice, or similar institution.

(7) "Geographic area" means a specific portion of this state which shall consist of one or more zip codes as defined by the Commissioner pursuant to department rule and regulation.

(8) "Healthcare plan" means any hospital or medical insurance policy or certificate, healthcare plan contract or certificate, qualified higher deductible health plan, health maintenance organization or other managed care subscriber contract, or state healthcare plan. This term shall not include limited benefit insurance policies or plans listed under paragraph (3) of Code Section 33-1-2, air ambulance insurance, or policies issued in accordance with Chapter 21A or 31 of

this title or Chapter 9 of Title 34, relating to workers' compensation, Part A, B, C, or D of Title XVIII of the Social Security Act (Medicare), or any plan or program not described in this paragraph over which the Commissioner does not have regulatory authority. Notwithstanding paragraph (3) of Code Section 33-1-2 and any other provision of this title, for purposes of this chapter this term shall include stand-alone dental insurance and stand-alone vision insurance.

(9) "Healthcare provider" or "provider" means any physician, other individual, or facility other than a hospital licensed or otherwise authorized in this state to furnish healthcare services, including, but not limited to, any dentist, podiatrist, optometrist, psychologist, clinical social worker, advanced practice registered nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech-language pathologist, audiologist, dietitian, or physician assistant.

(10) "Healthcare services" means emergency or nonemergency medical services.

(11) "Insurer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including those of an accident and sickness insurance company, a health maintenance organization, a healthcare plan, a managed care plan, or any other entity providing a health insurance plan, a health benefit plan, or healthcare services.

(12) "Nonemergency medical services" means the examination or treatment of persons for the prevention of illness or the correction or treatment of any physical or mental condition resulting from an illness, injury, or other human physical problem which does not qualify as an emergency medical service and includes, but is not limited to:

(A) Hospital services which include the general and usual care, services, supplies, and equipment furnished by hospitals;

(B) Medical services which include the general and usual care and services rendered and administered by doctors of medicine, dentistry, optometry, and other providers; and

(C) Other medical services which, by way of illustration only and without limiting the scope of this chapter, include the provision of appliances and supplies; nursing care by a registered nurse; institutional services, including the general and usual care, ser-

vices, supplies, and equipment furnished by healthcare institutions and agencies or entities other than hospitals; physiotherapy; drugs and medications; therapeutic services and equipment, including oxygen and the rental of oxygen equipment; hospital beds; iron lungs; orthopedic services and appliances, including wheelchairs, trusses, braces, crutches, and prosthetic devices, including artificial limbs and eyes; and any other appliance, supply, or service related to healthcare which does not qualify as an emergency medical service.

(13) "Out-of-network" refers to healthcare services provided to a covered person by providers or facilities who do not belong to the provider network in the healthcare plan.

(14) "Nonparticipating provider" means a healthcare provider who has not entered into a contract with a healthcare plan for the delivery of medical services.

(15) "Participating provider" means a healthcare provider that has entered into a contract with an insurer for the delivery of healthcare services to covered persons under a healthcare plan.

(16) "Resolution organization" means a qualified, independent, third-party claim dispute resolution entity selected by and contracted with the department.

(17) "State healthcare plan" means:

(A) The state employees' health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45;

(B) The health insurance plan for public school teachers established pursuant to Subpart 2 of Part 6 of Article 17 of Chapter 2 of Title 20;

(C) The health insurance plan for public school employees established pursuant to Subpart 3 of Part 6 of Article 17 of Chapter 2 of Title 20; and

(D) The Regents Health Plan established pursuant to authority granted to the board pursuant to Code Sections 20-3-31, 20-3-51, and 31-2-4.

(18) "Surprise bill" means a bill resulting from an occurrence in which charges arise from a covered person receiving healthcare services from an out-of-network provider at an in-network facility.

History. — Code 1981, § 33-20E-2, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-3. Exemption.

(a) Nothing in this chapter shall be applicable to healthcare plans which are subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.

(b) This chapter shall be applicable only to healthcare plans and state healthcare plans as defined in this chapter.

History. — Code 1981, § 33-20E-3, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-4. Payment for emergency medical services.

(a) An insurer that provides any benefits to covered persons with respect to emergency medical services shall pay for such emergency medical services regardless of whether the healthcare provider or facility furnishing emergency medical services is a participating provider or facility with respect to emergency medical services, in accordance with this chapter:

(1) Without need for any prior authorization determination and without any retrospective payment denial for medically necessary services; and

(2) Regardless of whether the healthcare provider or facility furnishing emergency medical services is a participating provider or facility with respect to emergency medical services.

(b) In the event a covered person receives the provision of emergency medical services from a nonparticipating emergency medical provider, the nonparticipating provider shall collect or bill no more than such person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy directly and such insurer shall directly pay such provider the greater of:

(1) The verifiable contracted amount paid by all eligible insurers subject to the provisions of this chapter for the provision of the same or similar services as determined by the department;

(2) The most recent verifiable amount agreed to by the insurer and the nonparticipating emergency medical provider for the provision of the same services during such time as such provider was in-network with such insurer; or

(3) Such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount that the insurer pays the nonparticipating provider under this subsection shall not be required to include any amount of coinsur-

ance, copayment, or deductible owed by the covered person or already paid by such person.

(c) A healthcare plan shall not deny benefits for emergency medical services previously rendered based upon a covered person's failure to provide subsequent notification in accordance with plan provisions, where the covered person's medical condition prevented timely notification.

(d) For purposes of the covered person's financial responsibilities, the healthcare plan shall treat the emergency medical services received by the covered person from a nonparticipating provider or nonparticipating facility pursuant to this Code section as if such services were provided by a participating provider or participating facility, and shall include applying the covered person's cost-sharing for such services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from a participating provider or a participating facility under the healthcare plan.

(e) In the event a covered person receives emergency medical services from a nonparticipating facility, the nonparticipating facility shall bill the covered person no more than such covered person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such person's policy directly.

(f) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14. Such payments shall accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.

History. — Code 1981, § 33-20E-4, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-5. Payment for nonemergency medical services.

(a) In accordance with Code Section 33-20E-7 and this chapter, an insurer that provides any benefits to covered persons with respect to nonemergency medical services shall pay for such services in the event that such services resulted in a surprise bill regardless of whether the healthcare provider furnishing nonemergency medical services is a participating provider with respect to nonemergency medical services.

(b) In the event a covered person receives a surprise bill for the provision of nonemergency medical services from a nonparticipating medical provider, the nonparticipating provider shall collect or bill the covered person no more than such person's deductible, coinsurance, copayment, or other cost-sharing amount as determined by such

person's policy directly and such insurer shall directly pay such provider the greater of:

(1) The verifiable contracted amount paid by all eligible insurers subject to the provisions of this chapter for the provision of the same or similar services as determined by the department;

(2) The most recent verifiable amount agreed to by the insurer and the nonparticipating provider for the provision of the same services during such time as such provider was in-network with such insurer; or

(3) Such higher amount as the insurer may deem appropriate given the complexity and circumstances of the services provided.

Any amount that the insurer pays the nonparticipating provider under this subsection shall not be required to include any amount of coinsurance, copayment, or deductible owed by the covered person or already paid by such person.

(c) For purposes of the covered person's financial responsibilities, the healthcare plan shall treat the nonemergency medical services received by the covered person from a nonparticipating provider pursuant to this Code section as if such services were provided by a participating provider, and shall include applying the covered person's cost-sharing for such services toward the covered person's deductible and maximum out-of-pocket limit applicable to services obtained from a participating provider under the healthcare plan.

(d) All insurer payments made to providers pursuant to this Code section shall be in accord with Code Section 33-24-59.14. Such payments shall accompany notification to the provider from the insurer disclosing whether the healthcare plan is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.

History. — Code 1981, § 33-20E-5, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-6. Denying or restricting benefits based on balance billing; notice to insured.

No healthcare plan shall deny or restrict the provision of covered benefits from a participating provider to a covered person solely because the covered person obtained treatment from a nonparticipating provider leading to a balance bill. Notice of such protection shall be provided in writing to the covered person by the insurer.

History. — Code 1981, § 33-20E-6, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-7. Surprise bill exclusion; requirements.

(a) Nothing in this chapter shall reduce a covered person's financial responsibilities in the event that such covered person chose to receive nonemergency medical services from an out-of-network provider. Such services shall not be considered a surprise bill for purposes of this chapter.

(b) The covered person's choice described in subsection (a) of this Code section must:

(1) Be documented through such covered person's written and oral consent in advance of the provision of such services; and

(2) Occur only after such person has been provided with an estimate of the potential charges.

(c) If during the provision of nonemergency medical services, a covered person requests that the attending provider refer such covered person to another provider for the immediate provision of additional nonemergency medical services, such referred provider shall be exempt from the requirements in subsection (b) of this Code section if the following requirements are satisfied:

(1) The referring provider advises the covered person that the referred provider may be a nonparticipating provider and may charge higher fees than a participating provider;

(2) The covered person orally and in writing acknowledges that he or she is aware that the referred provider may be a nonparticipating provider and may charge higher fees than a participating provider;

(3) The written acknowledgment referenced in paragraph (2) of this subsection shall be on a document separate from other documents provided by the referring provider and shall include language to be determined by the Commissioner through rule and regulation; and

(4) The referring provider records the satisfaction of the requirements in paragraphs (1), (2), and (3) of this subsection in the covered person's medical file.

History. — Code 1981, § 33-20E-7, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-8. Payer health claims data base; annual updating of website.

(a) Subject to appropriation, the department shall provide for the maintenance of an all-payer health claims data base and maintain records of insurer payments which shall track such payments by a wide

variety of healthcare services and by geographic areas of this state. Such appropriation must specifically reference the Surprise Billing Consumer Protection Act. The department shall update information in the all-payer health claims data base on no less than an annual basis and shall maintain such information on the department's website.

(b) In the event that the appropriation described in subsection (a) of this Code section is not made, the department shall update information from such other verifiable data as the Commissioner shall determine appropriate on no less than an annual basis and shall maintain such information on the department's website.

History. — Code 1981, § 33-20E-8, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2020, "the Surprise Billing Consumer Protection Act" was substituted for "this Act" at the end of the second sentence of subsection (a).

33-20E-9. Arbitration of payment issues.

(a) If an out-of-network provider concludes that payment received from an insurer pursuant to Code Section 33-20E-4 or 33-20E-5 or if an out-of-network facility concludes that payment received from an insurer pursuant to Code Section 33-20E-4 is not sufficient given the complexity and circumstances of the services provided, the provider or facility may initiate a request for arbitration with the Commissioner. Such provider or facility shall submit such request within 30 days of receipt of payment for the claim and concurrently provide the insurer with a copy of such request.

(b) A request for arbitration may involve a single patient and a single type of healthcare service, a single patient and multiple types of healthcare services, multiple patients and a single type of healthcare service, or multiple substantially similar healthcare services in the same specialty on multiple patients.

History. — Code 1981, § 33-20E-9, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

Code Commission notes. — Pursuant to Code Sectiton 28-9-5, in 2020, "Code Section 33-20E-4" was substituted for "Code Section 3-20E-4" in the middle of the first sentence of subsection (a).

33-20E-10. Dismissal or arbitration requests.

The Commissioner shall dismiss certain requests for arbitration if the disputed claim is:

(1) Related to a healthcare plan that is not regulated by the state;

(2) The basis for an action pending in state or federal court at the time of the request for arbitration;

(3) Subject to a binding claims resolution process entered into prior to July 1, 2021;

(4) Made against a healthcare plan subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.; or

(5) In accord with other circumstances as may be determined by department rule.

History. — Code 1981, § 33-20E-10, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-11. Submission to Commissioner by insurer of data pending arbitration.

Within 30 days of the insurer's receipt of the provider's or facility's request for arbitration, the insurer shall submit to the Commissioner all data necessary for the Commissioner to determine whether such insurer's payment to such provider or facility was in compliance with Code Section 33-20E-4 or 33-20E-5. The Commissioner shall not be required to make such a determination prior to referring the dispute to a resolution organization for arbitration.

History. — Code 1981, § 33-20E-11, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-12. Regulation; contracting with resolution organizations.

The Commissioner shall promulgate rules implementing an arbitration process requiring the Commissioner to select one or more resolution organizations to arbitrate certain claim disputes between insurers and out-of-network providers or facilities. Prior to proceeding with such arbitration, the Commissioner shall allow the parties 30 days from the date the Commissioner received the request for arbitration to negotiate a settlement. The parties shall timely notify the Commissioner of the result of such negotiation. If the parties have not notified the Commissioner of such result within 30 days of the date that the Commissioner received the request for arbitration, the Commissioner shall refer the dispute to a resolution organization within five days. The department shall contract with one or more resolution organizations by July 1, 2021, to review and consider claim disputes between insurers and out-of-network providers or facilities as such disputes are referred by the Commissioner.

History. — Code 1981, § 33-20E-12, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-13. Selection of arbitrator.

Upon the Commissioner's referral of a dispute to a resolution organization, the parties shall have five days to select an arbitrator by mutual agreement. If the parties have not notified the resolution organization of their mutual selection before the fifth day, the resolution organization shall select an arbitrator from among its members. Any selected arbitrator shall be independent of the parties and shall not have a personal, professional, or financial conflict with any party to the arbitration. The arbitrator shall have experience or knowledge in healthcare billing and reimbursement rates. He or she shall not communicate ex parte with either party.

History. — Code 1981, § 33-20E-13, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-14. Submission of final offers; supporting documentation.

The parties shall have ten days after the selection of the arbitrator to submit in writing to the resolution organization each party's final offer and each party's argument in support of such offer. The parties' initial arguments shall be limited to written form and shall consist of no more than 20 pages per party. The parties may submit documents in support of their arguments. The arbitrator may require the parties to submit such additional written argument and documentation as the arbitrator determines necessary, but the arbitrator may require such additional filing no more than once. Such additional written argument shall be limited to no more than ten pages per party. The arbitrator may set filing times and extend such filing times as appropriate. Failure of either party to timely submit the supportive documentation described herein may result in a default against the party failing to make such timely submission.

History. — Code 1981, § 33-20E-14, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-15. Proposed payment amounts.

Each party shall submit one proposed payment amount to the arbitrator. The arbitrator shall pick one of the two amounts submitted and shall reveal that amount in the arbitrator's final decision. The

arbitrator may not modify such selected amount. In making such a decision, the arbitrator shall consider the complexity and circumstances of each case, including, but not limited to, the level of training, education, and experience of the relevant physicians or other individuals at the facility who are licensed or otherwise authorized in this state to furnish healthcare services and other factors as determined by the Commissioner through rule. The arbitrator's final decision shall be in writing and shall describe the basis for such decision, including citations to any documents relied upon. Notwithstanding Code Section 33-20E-14, such decision shall be made within 30 days of the Commissioner's referral. Any default or final decision issued by the arbitrator shall be binding upon the parties and is not appealable through the court system.

History. — Code 1981, § 33-20E-15, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-16. Payment of expenses and fees.

The party whose final offer amount is not selected by the arbitrator shall pay the amount of the verdict, the arbitrator's expenses and fees, and any other fees assessed by the resolution organization, directly to such resolution organization. In the event of default, the defaulting party shall also pay such moneys due directly to such organization. In the event that both parties default, the parties shall each be responsible for paying such organization one-half of all moneys due. Moneys due under this Code section shall be paid in full to the resolution organization within 15 days of arbitrator's final decision. Within three days of such organization's receipt of moneys due to the party whose final offer was selected, such moneys shall be distributed to such party.

History. — Code 1981, § 33-20E-16, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-17. Referral of parties for violations.

Following the resolution of arbitration, the Commissioner may refer the decision of the arbitrator to the appropriate state agency or the governing entity with governing authority over such provider or facility if the Commissioner concludes that a provider or facility has either displayed a pattern of acting in violation of this chapter or has failed to comply with a lawful order of the Commissioner or the arbitrator. Such referral shall include a description of such violations and the Commissioner's recommendation for enforcement action. Such state agency or governing entity shall initiate an investigation regarding such referral

within 30 days of receiving such referral and shall conclude the investigation within 90 days of receiving such referral.

History. — Code 1981, § 33-20E-17, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-18. Limitation on litigation when arbitration sought.

Once a request for arbitration has been filed with the Commissioner by a provider or facility under this chapter, neither such provider nor such facility nor the insurer in such dispute shall file a lawsuit in court regarding the same out-of-network claim.

History. — Code 1981, § 33-20E-18, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-19. Quarterly reporting by resolution organizations.

Each resolution organization contracted with by the department shall report to the department on a quarterly basis the results of all disputes referred to such organization as follows: the number of arbitrations filed, settled, arbitrated, defaulted, or dismissed during the previous calendar year and whether the arbitrators' decisions were in favor of the insurer or the provider or facility.

History. — Code 1981, § 33-20E-19, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-20. Annual reporting by Commissioner.

On or before July 1, 2022, and each July 1 thereafter, the Commissioner shall provide a written report to the House Committee on Insurance and the Senate Insurance and Labor Committee, or their successor committees, and shall post the report on the department's website summarizing the number of arbitrations filed, settled, arbitrated, defaulted, and dismissed during the previous calendar year; and a description of whether the arbitration decisions were in favor of the insurer or the provider or facility.

History. — Code 1981, § 33-20E-20, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-21. Exclusion from other statutory provisions.

The arbitration conducted under this chapter shall be subject to neither Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," nor Chapter 11 of Title 9, the "Georgia Civil Practice Act."

History. — Code 1981, § 33-20E-21, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-22. Reporting to credit reporting agencies.

No nonparticipating provider shall report to any credit reporting agency any covered person who receives a surprise bill for the receipt of healthcare services from such provider and does not pay such provider any copay, coinsurance, deductible, or other cost-sharing amount beyond what such covered person would pay if such nonparticipating provider had been a participating provider.

History. — Code 1981, § 33-20E-22, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

33-20E-23. Financial responsibilities for ground ambulance transportation.

Nothing in this chapter shall reduce a covered person's financial responsibilities with regard to ground ambulance transportation.

History. — Code 1981, § 33-20E-23, enacted by Ga. L. 2020, p. 210, § 1/HB 888.

CHAPTER 21

HEALTH MAINTENANCE ORGANIZATIONS

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33-21-27. Enforcement of chapter; penalties for violations of chapter.
33-21-28. Applicability of provisions of title and of other laws to health maintenance organizations and representatives.
33-21-29. Point-of-service option for persons offered health care coverage through health maintenance organization.

Cross references. — State health planning and development, T. 31, C. 6. Public assistance for medical care, § 49-4-140 et seq.

Administrative rules and regulations. — Health maintenance organizations, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-33.

Independent Accreditation of Health Maintenance Organizations, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-92.

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

For note, "Paying the Piper: Third-party Payor Liability for Medical Treatment Decisions," see 25 Ga. L. Rev. 861 (1991).

OPINIONS OF THE ATTORNEY GENERAL

State Personnel Board may offer membership in qualified HMO plan. — Since health maintenance organizations (HMO) may operate and contract with an insurer in Georgia, the State Personnel Board may include in its self-insurance plan the option of membership in a qualified HMO to provide the benefits under the plan of health insurance determined in accordance with the law (see O.C.G.A. §§ 20-2-880 through 20-2-898 and 45-18-1 through 45-18-17) by contracting through its insurer administrator. Since the State Personnel Board may contract with its insurer administrator to offer this HMO membership option, logically it is the organization best able to provide this option. 1980 Op. Att'y Gen. No. 80-8.

RESEARCH REFERENCES

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ALR. — Health insurance: provisions excluding or limiting liability in case of chronic diseases, 4 A.L.R. 875; 15 A.L.R. 1239.

Criterion of health for purposes of warranty or condition in insurance contract, 40 A.L.R. 662; 100 A.L.R. 362.

Validity and nature of group medical and hospital service plans, 167 A.L.R. 322.

Scope of provision in group health or accident insurance policy excluding from coverage sickness or accidents arising out of, or in the course of, employment, 47 A.L.R.2d 1240.

Provision of accident or health insurance policy that insured shall be under care of physician or surgeon, 84 A.L.R.2d 375.

When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 10 A.L.R.3d 468.

Medical care insurance: right of insured under individual policy to coverage afforded by group policy from which he directly transferred on termination of his employment, 66 A.L.R.3d 1192.

Elimination of particular coverage, or termination, of health hospitalization, or medical care insurance policy as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illness, 66 A.L.R.3d 1205.

Admissibility of opinion evidence as to employability on issue of disability in health and accident insurance and workers' compensation cases, 89 A.L.R.3d 783.

Construction and application of provision in health or hospitalization policy excluding or postponing coverage of illness originating prior to issuance of policy or within stated time, 94 A.L.R.3d 990.

Construction and application of provision in health or hospitalization policy excluding or postponing coverage of illness for which medical care or treatment was received within stated time preceding or following issuance of policy, 95 A.L.R.3d 1290.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance, 75 A.L.R.4th 763.

Coverage under medical and health insurance plans for services performed by dentists, oral surgeons, and orthodontists, 43 A.L.R.5th 657.

Liability of health maintenance organizations (HMOs) for negligence of member physicians, 51 A.L.R.5th 271.

33-21-1. Definitions.

As used in this chapter, the term:

(1) "Basic health care services" means health care services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum but not restricted to preventive care, emergency care, inpatient hospital and physician care, and outpatient medical services.

(2) "Enrollee" means an individual who has elected to contract for or participate in a health benefits plan for that individual or for that individual and that individual's eligible dependents.

(3) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled.

(4) "Health benefits plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, at least part of which consists of arranging for or the provision of health care services, as distinguished from an arrangement which provides only for indemnification against the cost of such services on a prepaid basis through insurance or otherwise.

(5) "Health care services" means any services included in the furnishing to any individual of medical or dental care or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(6) "Health maintenance organization" means any person who undertakes to provide or arrange for one or more health benefits plans.

(7) "Insurer" means every insurer authorized under this title to issue contracts of accident and sickness insurance. Health care corporations and health maintenance organizations are included within such term.

(7.1) "Patient" means a person who seeks or receives health care services fron a health maintenance organization.

(8) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, or corporations.

(9) "Provider" means any physician, hospital, or other person who is licensed or otherwise authorized in this state to furnish health care services.

History. — Code 1933, § 56-3601, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 1995, p. 745, § 2.4; Ga. L. 1996, p. 485, §§ 1.2, 1.3; Ga. L. 2017, p. 164, § 12/HB 127.

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Dental services alone do not constitute basic health care services. — Plan offering only dental services may not be licensed as a health maintenance organization pursuant to O.C.G.A. T. 33, C. 21 since it does not provide basic health care services as defined in O.C.G.A. § 33-21-1. 1982 Op. Att'y Gen. No. 82-71.

RESEARCH REFERENCES

ALR. — When is medical expense "incurred" under policy providing for payment of medical expenses incurred within fixed period of time from date of injury, 65 A.L.R.5th 649.

33-21-2. Procedure for establishment of health maintenance organizations generally; notice of modification; exemption of item from filing requirements.

(a) Any domestic stock, mutual, or nonprofit corporation whose charter powers include the business of a health maintenance organization may apply to the Commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person shall establish or operate a health maintenance organization in this state; sell, offer to sell, or solicit offers to purchase; or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this chapter.

(b) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the Commissioner, and shall set forth or be accompanied by the following:

(1) A copy of the corporation's charter and all amendments to the charter;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, and the principal officers of the corporation;

(4) A copy of any contract made or to be made between any providers or persons listed in paragraph (3) of this subsection and the applicant;

(5) A statement describing in detail the health maintenance organization, its health benefits plan or plans, facilities, and personnel;

(6) A copy of the form of evidence of coverage to be issued to the enrollees;

(7) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall be deemed to satisfy this requirement unless the Commissioner directs that additional or more recent financial information is required for the proper administration of this chapter;

(9) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(10) A power of attorney duly executed by such applicant, if not domiciled in this state, appointing the Commissioner, his successors in office, and duly authorized deputies as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(11) A statement describing the geographic area or areas to be served;

(12) A description of the complaint procedures to be utilized as required under Code Section 33-21-9;

(13) A description of the procedures and programs to be implemented to meet the quality of health care requirements in subsection (b) of Code Section 33-21-3;

(14) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under subsection (b) of Code Section 33-21-6; and

(15) Such other information as the Commissioner may require.

(c)(1) A health maintenance organization shall, unless otherwise provided for in this chapter, file a notice describing any modification of the operation set out in the information required by subsection (b) of this Code section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 60 days of filing, such modification shall be deemed approved.

(2) The Commissioner may promulgate rules and regulations exempting from the filing requirements of paragraph (1) of subsection (b) of this Code section those items he deems unnecessary.

History. — Code 1933, § 56-3602, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, §§ 2, 3; Ga. L. 1987, p. 3, § 33; Ga. L. 2000, p. 1246, § 5.

33-21-3. Grounds and procedure for issuance or denial of certificate of authority; endorsement of change of address upon certificate of authority.

(a) Upon receipt of an application for issuance of a certificate of authority, the Commissioner of Insurance shall forthwith transmit copies of such application and accompanying documents to the commissioner of community health; provided, however, that if the applicant meets the standards of subsection (b.1) of this Code section the Commissioner shall not be required to transmit the application and accompanying documents to the commissioner of community health.

(b) The commissioner of community health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

(1) Has demonstrated the willingness and potential ability to assure that such health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service;

(2) Has arrangements, established in accordance with existing laws and regulations promulgated by the commissioner of community health, for an ongoing quality of health care assurance program concerning health care processes and outcomes;

(3) Has a procedure, established in accordance with regulations of the commissioner of community health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the commissioner of community health;

(4) Has arrangements, established in accordance with existing laws and regulations promulgated by the commissioner of community health, for coverage of out-of-area emergency services rendered to its enrollees; and

(5) Has arrangements to comply with the provisions of Code Section 33-20A-9.1, relating to nomination and reimbursement of providers which are not on that health maintenance organization's provider panel.

(b.1) An applicant that is compliant with or accredited by a nationally recognized accreditation agency or organization shall be deemed to be in compliance with subsection (b) of this Code section; and, upon submission of proof of compliance or accreditation to the Commissioner of Insurance, certification pursuant to subsection (c) of this Code section shall not be required. The Commissioner of Insurance shall be authorized to promulgate rules and regulations to determine which national accreditation agencies shall be used for purposes of this Code section.

(c) Within 90 days of receipt of the application for issuance of a certificate of authority, the commissioner of community health shall certify to the Commissioner of Insurance whether the proposed health maintenance organization meets the requirements of subsection (b) of this Code section. If the commissioner of community health certifies that the health maintenance organization does not meet the requirements, he or she shall specify in what respects it is deficient.

(d) The Commissioner of Insurance shall issue or deny a certificate of authority to any person filing an application pursuant to Code Section 33-21-2 within 90 days of receipt of the certification from the commissioner of community health or upon the applicant's presentation of proof to the Commissioner of Insurance of its compliance with or accreditation by a national accreditation agency or organization. Issuance of a certificate of authority shall be granted upon payment of the application fees prescribed in Code Sections 33-8-1 and 33-8-3 if the Commissioner of Insurance is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent and trustworthy, possess good reputations, and have had appropriate administrative experience, training, or education in health care delivery systems or allied professions;

(2) The commissioner of community health certifies, in accordance with subsection (a) of this Code section, that the health maintenance organization's proposed plan of operation meets the requirements of subsection (b) of this Code section or the Commissioner of Insurance has received proof of the health maintenance organization's compliance with or accreditation by a nationally recognized accreditation agency or organization;

(3) The health benefits plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments;

(4) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commissioner of Insurance may consider:

(A) The financial soundness of the health benefits plan's arrangements for health care services and the schedule or charges used in connection with providing health care services;

(B) The adequacy of working capital;

(C) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan;

(D) Any agreement with providers for the provision of health care services; and

(E) Any deposit of cash or securities submitted in accordance with Code Section 33-21-10 as a guarantee that the obligations will be duly performed;

(5) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Code Section 33-21-6;

(6) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Code Section 33-21-2 or by independent investigation, is contrary to the public interest; and

(7) Any deficiencies, if applicable, certified by the commissioner of community health have been corrected.

(e) Before any health maintenance organization changes its address, the certificate of authority shall be returned to the Commissioner of Insurance who shall endorse the certificate of authority indicating the change.

History. — Code 1933, § 56-3603, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 4; Ga. L. 1999, p. 342, § 4; Ga. L. 2004, p. 493, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2009, p. 453, § 1-6/HB 228.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1986, "Commissioner of Insurance" was substituted for "Insurance Commissioner" in subsections (a), (c), and (e).

Law reviews. — For note on 1999 amendment to this Code section, see 16 Ga. St. U.L. Rev. 163 (1999).

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Plan offering only dental services may not be licensed as a health maintenance organization pursuant to O.C.G.A. T. 33, C. 21 since it does not provide basic health care services as defined in O.C.G.A. § 33-21-1. 1982 Op. Att'y Gen. No. 82-71, distinguished in 1986 Op. Att'y Gen. 86-49.

33-21-4. Annual license fee.

Every health maintenance organization subject to this chapter shall pay to the Commissioner of Insurance the annual license fee provided in Code Section 33-8-3.

History. — Code 1933, § 56-3621, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 5.

33-21-5. Suspension or revocation of certificate of authority.

(a) The Commissioner of Insurance may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if he finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health benefits plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under Code Section 33-21-2, unless amendments to the submissions have been filed with and approved by the Commissioner of Insurance;

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Code Section 33-21-13;

(3) The health benefits plan does not provide or arrange for basic health care services;

(4) The health maintenance organization does not meet the requirements of Code Section 33-21-3 or is unable to fulfill its obligations to furnish health care services as required under its health benefits plan;

(5) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(6) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under Code Section 33-21-6;

(7) The health maintenance organization has failed to implement the complaint system required by Code Section 33-21-9 in a manner to resolve valid complaints reasonably;

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(10) The health maintenance organization has violated any provision of this chapter or of the rules and regulations of the Commissioner of Insurance or of the rules and regulations of the commissioner of community health; provided, however, that health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to the rules and regulations of the commissioner of community health.

(b) The Commissioner of Insurance may, without advance notice or a hearing thereon, suspend immediately the certificate of authority of any health maintenance organization as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings have been commenced in any state.

(c) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of the suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

(d) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The Commissioner of Insurance may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History. — Code 1933, § 56-3617, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 2004, p. 493, § 2; Ga. L. 2009, p. 453, § 1-6/HB 228.

33-21-6. Composition of governing body; duty to establish mechanism for participation by enrollees in matters of policy and operation.

(a) The governing body of any health maintenance organization shall include providers and other individuals, provided that at least one-third of the members of the governing body shall be public members.

(b) The governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referendums on major policy decisions, or through the use of other mechanisms.

History. — Code 1933, § 56-3605, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 2000, p. 136, § 33.

33-21-7. Fiduciary responsibilities of directors, officers, or partners.

Any director, officer, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization shall be responsible for the funds in a fiduciary relationship to the health maintenance organization.

History. — Code 1933, § 56-3606, enacted by Ga. L. 1979, p. 1148, § 1.

33-21-8. Powers of organizations generally; filing of notice of exercise of powers.

(a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, their ancillary equipment, and such property as may reasonably be required for the organization's principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

(2) The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees;

(3) The furnishing of health care services through providers which are under contract with or employed by the organization;

(4) The contracting with any person for the performance on its behalf of certain functions such as marketing and enrollment;

(5) The contracting with another insurer licensed in this state for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the organization;

(6) The offering, in addition to basic health care services, of:

(A) Additional health care services;

(B) Indemnity benefits covering out-of-area or emergency services; and

(C) Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers; and

(7) The extension of malpractice insurance to a medical group with which it has a mutually exclusive contract to provide medical services to the enrollees of the health maintenance organization; provided, however, that coverage only protects against liability arising from medical care provided to enrollees of the health maintenance organization who receive medical care at a facility under contract with or owned or operated by the health maintenance organization.

(b)(1) A health maintenance organization shall file notice, with adequate supporting information, with the Commissioner prior to the exercise of any power granted in paragraph (1) or (2) of subsection (a) of this Code section. The Commissioner shall disapprove the exercise of power if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the Commissioner does not disapprove within 90 days of the filing, it shall be deemed approved.

(2) The Commissioner may promulgate rules and regulations exempting from the filing requirement of paragraph (1) of this subsection those activities having a de minimis effect.

History. — Code 1933, § 56-3604, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 6; Ga. L. 2013, p. 802, § 2/HB 312.

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Offering dental services. — A licensed health maintenance organization may offer additional services such as a dental plan, and may offer such service as a "stand-alone" plan. 1986 Op. Att'y Gen. No. 86-49, distinguishing 1982 Op. Att'y Gen. No. 82-71.

RESEARCH REFERENCES

ALR. — Validity and construction of prescription drug insurance plans, 42 A.L.R.3d 897.

33-21-9. Establishment and maintenance of complaint system; maintenance of records of complaints; summary reports; examination of system.

(a) Every health maintenance organization shall establish and maintain a complaint system which has been approved by the Commissioner of Insurance to provide reasonable procedures for the resolution of written complaints initiated by enrollees or providers concerning health care services.

(b) The health maintenance organization shall maintain records of written complaints concerning health care services for five years from the time the complaints are filed and shall submit to the Commissioner of Insurance a summary report at such times and in such format as the Commissioner of Insurance may require.

(c) The Commissioner of Insurance may examine the complaint system at any time.

History. — Code 1933, § 56-3610, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 7; Ga. L. 2004, p. 493, § 3.

33-21-10. Responsibility of organizations for financial risks of providing services generally; reinsurance of risks; deposit of cash or securities with Commissioner.

(a) Every health maintenance organization shall be responsible for the assumption of full financial risk of providing basic health services to its members, except that the health maintenance organization may reinsure its risks with solvent reinsurers who qualify to transact reinsurance in this state under Code Section 33-7-14 and may enter into reinsurance treaties or agreements with such reinsurers in order to obtain reinsurance for:

(1) The cost of providing basic health services which exceeds in the aggregate $5,000.00 per member per year;

(2) The cost of providing basic health services to members when they are outside the health maintenance organization's service area; and

(3) Not more than 90 percent of the amount of which the health maintenance organization's costs for any fiscal year exceed 115

percent of its income for that fiscal year, provided that all reinsurance treaties and agreements entered into by health maintenance organizations shall under this Code section also be required to meet the same standards as would be required by this title for reinsurance treaties or agreements made by a property and casualty insurer as a ceding insurer.

(b) Each health maintenance organization shall deposit with the Commissioner cash or securities acceptable to the Commissioner in the amount of $100,000.00, provided that the Commissioner shall also have the authority to require such additional amounts of deposits as he may deem necessary to protect the enrollees of the health maintenance organization. The deposits shall be administered by the Commissioner pursuant to Chapter 12 of this title. The Commissioner shall also have the authority to waive, modify, or authorize accumulation and incremental adjustments of such deposits as he deems necessary to protect the enrollees of the health maintenance organization.

History. — Code 1933, § 56-3612, enacted by Ga. L. 1979, p. 1148, § 1.

33-21-11. Investment of funds of organizations.

With the exception of investments made in accordance with paragraphs (1) and (2) of subsection (a) and subsection (b) of Code Section 33-21-8, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the Commissioner may permit. The investments shall be subject to the same terms, conditions, and limitations which apply to life insurance companies.

History. — Code 1933, § 56-3611, enacted by Ga. L. 1979, p. 1148, § 1.

33-21-12. Participation in organizations by members of associations.

No employer, union, trade organization, or any other association shall force its members, either by payroll deduction or other means, to join a health maintenance organization.

History. — Code 1933, § 56-3628, enacted by Ga. L. 1979, p. 1148, § 1.

33-21-13. Evidence of coverage; filing and approval of basic rates and method of computation of coverage.

(a) Every enrollee residing in this state is entitled to evidence of coverage under a health benefits plan. The health maintenance organization shall issue the evidence of coverage.

(b) No evidence of coverage or amendment to the evidence of coverage shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with and approved by the Commissioner.

(c) An evidence of coverage shall contain:

(1) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in paragraphs (1) through (3) of subsection (a) of Code Section 33-21-26; and

(2) No provisions or statements which are in violation of Code Section 33-24-23 or paragraph (9) of subsection (a) of Code Section 33-29-2; and

(3) A disclosure to enrollees and prospective enrollees who inquire as individuals into the plan or plans offered by the health maintenance organization the information required by this paragraph. In the case of an employer negotiating for a health care plan or plans on behalf of his or her employees, sufficient copies of disclosure information shall be made available to employees upon request. Disclosure under this paragraph shall be readable, understandable, and on a standardized form containing information regarding all of the following for each plan it offers:

(A) The health care services or other benefits under the plan offered as well as limitations on services, kinds of services, benefits, or kinds of benefits to be provided;

(B) Rules regarding copayments, prior authorization, or review requirements including, but not limited to, preauthorization review, concurrent review, postservice review, or postpayment review that could result in the enrollee's being denied coverage or provision of a particular service;

(C) Potential liability for cost sharing for out of network services, including but not limited to providers, drugs, and devices or surgical procedures that are not on a list or a formulary;

(D) The financial obligations of the enrollee, including premiums, deductibles, copayments, and maximum limits on out-of-pocket expenses for items and services (both in and out of network);

(E) The number, mix, and distribution of participating providers. An enrollee or a prospective enrollee shall be entitled to a list of individual participating providers upon request;

(F) Enrollee rights and responsibilities, including an explanation of the grievance process provided under Chapter 20A of this title;

(G) An explanation of what constitutes an emergency situation and what constitutes emergency services, as defined in Chapter 20A of this title;

(H) The existence of any limited utilization incentive plans as defined in Chapter 20A of this title;

(I) The existence of restrictive formularies or prior approval requirements for prescription drugs. An enrollee or a prospective enrollee shall be entitled, upon request, to a description of specific drug and therapeutic class restrictions;

(J) The existence of limitations on choices of health care providers; and

(K) A summary of any agreements or contracts between the health maintenance organization and any provider in the same manner and subject to the same conditions as required for summaries of managed care plan contracts and agreements under division (1)(A)(xiii) of Code Section 33-20A-5.

(4) Any subsequent change may be evidenced in a separate document issued to the enrollee.

(d) A copy of the form of the evidence of coverage to be used in this state and any amendment thereto shall be subject to the filing and approval requirements of subsection (b) of this Code section unless it is subject to the jurisdiction of the Commissioner under the laws governing health insurance in which event the filing and approval provisions of such laws shall apply. To the extent, however, that the provisions do not apply to the requirements in subsection (c) of this Code section, the requirements in subsection (c) of this Code section shall be applicable.

(e)(1) Basic rates along with the method of computation of charges for enrollee coverage must be filed with and approved by the Commissioner prior to use.

(2) The basic rates and the method of computation of specific rate charges shall be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. Basic rates and charges shall not be excessive, inadequate, or unfairly discriminatory. A certification by a qualified actu-

ary to the appropriateness of the basic rates, based on reasonable assumptions as to expected medical expenses, administrative expenses, and margins for contingencies, shall accompany the filing along with adequate supporting information.

(f) The Commissioner shall, within a reasonable period, approve any form if the requirements of subsections (a) through (e) of this Code section are met. It shall be unlawful to issue the form until approved. If the Commissioner disapproves the filing, he shall notify the filer. The Commissioner shall specify the reasons for his disapproval in the notice. At the expiration of 90 days the form or basic rate or method of computation of charges so filed shall be deemed approved unless prior to such expiration the filing has been approved or disapproved by the Commissioner.

(g) The Commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Code section.

History. — Code 1933, § 56-3607, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 8; Ga. L. 1988, p. 1760, § 1; Ga. L. 1996, p. 485, § 2; Ga. L. 1999, p. 342, § 5.

Cross references. — Provisions of accident and sickness insurance policies generally, § 33-24-20 et seq.

Law reviews. — For note on 1999 amendment to this Code section, see 16 Ga. St. U.L. Rev. 163 (1999).

33-21-14. Annual information to enrollees.

Every health maintenance organization shall annually provide to its enrollees:

(1) A description of services and information as to where and how to secure them; and

(2) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

History. — Code 1933, § 56-3609, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 9.

33-21-15. Filing of annual reports; contents.

(a) Every health maintenance organization shall annually, on or before March 1, file with the Commissioner of Insurance, on forms to be designated by him and certified by at least two principal officers of said health maintenance organization, an annual statement as of December 31 of the preceding year and a copy of said report shall also be delivered to the commissioner of community health.

(b) Such report shall be on forms prescribed by the Commissioner of Insurance and shall include:

(1) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant;

(2) Any material changes in the information submitted pursuant to subsection (b) of Code Section 33-21-2;

(3) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(4) A summary of information compiled pursuant to paragraph (3) of subsection (b) of Code Section 33-21-3 in such form as required by the commissioner of community health; and

(5) Any other information relating to the financial condition or performance of the health maintenance organization as is necessary to enable the Commissioner of Insurance and the commissioner of community health to carry out their duties under this chapter.

History. — Code 1933, § 56-3608, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2009, p. 453, § 1-6/HB 228.

33-21-16. Fees and taxes.

The same fees and taxes provided for in Chapter 8 of this title applicable to life insurers shall apply to and shall be imposed upon each health maintenance organization provided for in this chapter; and the organizations shall also be entitled to the same tax deductions, reductions, abatements, and credits that life insurers are entitled to receive.

History. — Code 1933, § 56-3627, enacted by Ga. L. 1979, p. 1148, § 1.

33-21-17. Examinations of organizations and providers; reports of examinations; payment of expenses of examinations.

(a) Whenever the Commissioner of Insurance shall deem it expedient, but not less than once every three years, he or his designee shall visit and examine the transactions, accounts, financial records, and documents of any health maintenance organization and of the providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health benefits plan; and in connection with such examination the Commissioner of Insurance shall also have the authority to conduct an examination into the market conduct of the health maintenance organization.

(b) Whenever the commissioner of community health shall deem it expedient, but not less than once every five years, he or she or his or her designee shall visit and examine all matters relating to the quality of health care services of any health maintenance organization and providers with whom the organization has contracts, agreements, or other arrangements pursuant to its health benefits plan as often as he or she deems it necessary for the protection of the interests of the people of this state; provided, however, that health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to examination by the commissioner of community health.

(c) Every health maintenance organization, its officers, employees, representatives, and providers shall produce and make freely accessible to the Commissioner of Insurance or the commissioner of community health the accounts, records, documents, and files in its possession or control relating to the subject of the examination. The officers, employees, representatives, and providers shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(d) The Commissioner or his or her designee shall make a full written report of each examination made by him or her containing only facts ascertained from the accounts, records, and documents examined and from the sworn testimony of witnesses.

(e) The report shall be certified by the Commissioner of Insurance or by the examiner in charge of the examination and, when so certified and after filing as provided in subsection (f) of this Code section, shall be admissible in evidence in any proceeding brought by the Commissioner against the health maintenance organization examined or any officer or agent of the health maintenance organization and shall be prima-facie evidence of the facts stated in such report.

(f) The Commissioner of Insurance shall furnish a copy of the proposed report to the health maintenance organization examined not less than 20 days prior to filing the report. If the health maintenance organization so requests in writing within such 20 day period or any longer period as the Commissioner may grant, the Commissioner shall grant a hearing with respect to the report and shall not file the report until after the hearing and such modifications have been made in the report as the Commissioner may deem proper.

(g) The Commissioner of Insurance may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the health maintenance organization examined from unwarranted injury.

(h) After the report has been filed, the Commissioner of Insurance may publish the report or the results of such report in one or more

newspapers published in this state if he should deem it to be in the public interest.

(i) The health maintenance organization so examined shall pay, at the direction of the Commissioner of Insurance, all the actual travel and living expenses connected with the examination. When the examination is made by an examiner who is not a regular employee of the Department of Insurance, the health maintenance organization examined shall pay the proper charges for the services of the examiner and his assistants in an amount approved by the Commissioner. A consolidated account for the examination shall be filed by the examiner with the Commissioner. No health maintenance organization or other entity shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted in whole or in part by regular salaried employees of the department, payment for the services and proper expenses shall be made by the health maintenance organization examined to the Commissioner; and such payment shall be deposited with the Office of the State Treasurer.

History. — Code 1933, § 56-3616, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 1993, p. 1402, § 18; Ga. L. 2004, p. 493, § 4; Ga. L. 2009, p. 453, § 1-6/HB 228; Ga. L. 2010, p. 863, § 2/SB 296; Ga. L. 2019, p. 337, § 1-93/SB 132; Ga. L. 2019, p. 386, § 1/SB 133.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in the second sentence of subsection (i). The second 2019 amendment, effective July 1, 2019, in subsection (d), substituted "The Commissioner or his or her designee" for "The Commissioner of Insurance or his designee" at the beginning, inserted "or her" in the middle, and substituted "witnesses" for "witness" at the end.

33-21-18. Adoption of rules and regulations generally.

(a) The Commissioner of Insurance shall adopt rules and regulations necessary for the implementation of this chapter with respect to all matters of organization, control of the matters relating to business, agents, examinations, and all other Code sections not exempted by this Code section.

(b) The commissioner of community health shall adopt rules and regulations for health maintenance organizations subject to his or her jurisdiction which are not inconsistent with this chapter and which are necessary to establish and control the standards of health care which a health maintenance organization shall maintain. Health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to the jurisdiction of the commissioner of community health.

History. — Code 1933, § 56-3619, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2004, p. 493, § 5; Ga. L. 2009, p. 453, § 1-6/HB 228.

Administrative rules and regulations. — Review of health benefit plan increases, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of the Comptroller General, Commissioner of Insurance, Chapter 120-2-98.

33-21-18.1. Emergency services requirements; restrictive formulary requirements.

Every health benefits plan of every health maintenance organization shall include provisions that:

(1) In the event a patient seeks emergency services and if necessary in the opinion of the health care provider responsible for the patient's emergency care and treatment and warranted by his or her evaluation, such emergency provider may initiate necessary intervention necessary to stabilize the condition of the patient without seeking or receiving prospective authorization by the health maintenance organization or health benefits plan. If in the opinion of the emergency health care provider a patient's condition has stabilized and the emergency health care provider certifies that the patient can be transported to another facility without suffering detrimental consequences or aggravating the patient's condition, the patient may be relocated to another facility which will provide continued care and treatment as necessary; and

(2) When a health maintenance organization uses a restrictive formulary for prescription drugs, such use shall include a written procedure whereby patients can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

(A) The formulary's equivalent has been ineffective in the treatment of the patient's disease or condition; or

(B) The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.

History. — Code 1981, § 33-21-18.1, enacted by Ga. L. 1996, p. 485, § 3.

33-21-19. Promulgation of rules and regulations for licensing of agents.

The Commissioner of Insurance may, after notice and hearing, promulgate any reasonable rules and regulations which are necessary to provide for the licensing of agents. "Agent" means a person directly or indirectly associated with a health benefits plan who engages in solicitation or enrollment.

History. — Code 1933, § 56-3614, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33.

33-21-20. Conduct of hearings generally; participation in hearings by commissioner of community health; judicial review.

(a) Except as otherwise provided in this chapter, all hearings and proceedings held under this chapter shall be conducted in accordance with Chapter 2 of this title and the Commissioner of Insurance shall have all the powers granted to him in Chapter 2 of this title.

(b) The commissioner of community health, or his or her designated representative, shall be in attendance at the hearings and shall participate in the proceedings. The recommendation and findings of the commissioner of community health with respect to matters regarding health maintenance organizations under his or her jurisdiction relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority shall be conclusive and binding upon the Commissioner of Insurance. Health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to the jurisdiction of the commissioner of community health. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the Commissioner of Insurance shall take action as is deemed advisable on written findings which shall be mailed to the health maintenance organization with a copy of the findings mailed to the commissioner of community health. The action of the Commissioner of Insurance and the recommendation and findings of the commissioner of community health shall be subject to review by the superior court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the Commissioner of Insurance in whole or in part.

(c) Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," shall apply to proceedings under this Code section to the extent that they are not in conflict with subsections (a) and (b) of this Code section.

History. — Code 1933, § 56-3620, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2004, p. 493, § 6; Ga. L. 2009, p. 453, § 1-6/HB 228.

33-21-20.1. Regulation of HMOs by commissioner of community health.

All health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to regula-

tion by the commissioner of community health. Upon the Commissioner's determination that a health maintenance organization no longer meets the requirements of subsection (b.1) of Code Section 33-21-3, the Commissioner shall immediately notify the commissioner of community health and such health maintenance organization shall be subject to regulation by the commissioner of community health until such time as it again meets the requirements of subsection (b.1) of Code Section 33-21-3 as determined by the Commissioner.

History. — Code 1981, § 33-21-20.1, enacted by Ga. L. 2004, p. 493, § 7; Ga. L. 2009, p. 453, § 1-40/HB 228; Ga. L. 2019, p. 386, § 2/SB 133.

The 2019 amendment, effective July 1, 2019, rewrote the first sentence, which formerly read: "On May 13, 2004, all health maintenance organizations meeting the requirements of subsection (b.1) of Code Section 33-21-3 shall not be subject to regulation by the commissioner of human resources (now known as the commissioner of community health for these purposes).", and, in the second sentence, substituted "Commissioner's" for "Commissioner of Insurance's" at the beginning, deleted a semicolon following "community health" in the middle, and deleted "of Insurance" following "Commissioner" at the end.

33-21-21. Authority of commissioner of community health to contract for making of recommendations required by chapter; acceptance of recommendations.

The commissioner of community health, in carrying out his obligations under subsection (b) of Code Section 33-21-3, paragraph (4) of subsection (a) of Code Section 33-21-5, and subsection (b) of Code Section 33-21-17, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. Such recommendations may be accepted in full or in part by the commissioner of community health.

History. — Code 1933, § 56-3626, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 2009, p. 453, § 1-6/HB 228.

33-21-22. Applications, filings, and reports to be treated as public documents.

All applications, filings, and reports required under this chapter shall be treated as public documents.

History. — Code 1933, § 56-3624, enacted by Ga. L. 1979, p. 1148, § 1.

33-21-23. Confidentiality of medical information; claim of privileges by organizations.

(a) Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this chapter;

(2) Upon the express consent of the enrollee or applicant;

(3) Pursuant to statute or court order for the production of evidence;

(4) The discovery of evidence; or

(5) In the event of claim or litigation between the person and the health maintenance organization wherein such data or information is pertinent.

(b) A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

History. — Code 1933, § 56-3625, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 2019, p. 386, § 3/SB 133.

The 2019 amendment, effective July 1, 2019, substituted the present provisions of subsection (a) for the former provisions, which read: "Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from the person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery of evidence; or in the event of claim or litigation between the person and the health maintenance organization wherein such data or information is pertinent."

33-21-24. Rehabilitation, liquidation, or conservation of organizations.

Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The Commissioner may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set forth in Chapter 37 of this title, relating to the rehabilitation, liquidation, or conservation of insurers or when in his

opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state.

History. — Code 1933, § 56-3618, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 10.

33-21-25. Organization and operation of health maintenance organizations by insurers or health care corporations.

Notwithstanding any other law which may be inconsistent with this Code section, an insurer or a health care corporation licensed in this state may directly or through a subsidiary or affiliate organize and operate a health maintenance organization.

History. — Code 1933, § 56-3615, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 11; Ga. L. 1995, p. 745, § 2.5; Ga. L. 2017, p. 164, § 13/HB 127.

33-21-26. Untrue or misleading statements; deceptive evidence of coverage; cancellation or nonrenewal of enrollees.

(a) No health maintenance organization or representative of a health maintenance organization may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this Code section:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health benefits plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health care coverage as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health benefits plan, if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person not possessing special knowledge regard-

ing health benefits plans and evidences of coverage for the health benefits plan to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health benefits plan issuing the evidence of coverage does not regularly make available for enrollees covered under evidence of coverage.

(b) The provisions of Chapter 6 of this title applicable to insurers shall apply to health maintenance organizations in this chapter and, for the purpose of determining whether a violation of Chapter 6 of this title has occurred, an "enrollee" as defined in this chapter shall be deemed to be an insured or a policyholder as used in Chapter 6 of this title, whichever is applicable.

(c) An enrollee may not be canceled or nonrenewed except for the failure to pay the charge for such coverage or for such other reasons as may be promulgated by the Commissioner.

History. — Code 1933, § 56-3613, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1986, p. 676, § 12.

33-21-27. Enforcement of chapter; penalties for violations of chapter.

(a)(1) In lieu of suspension or revocation of a certificate of authority for any of the causes enumerated in Code Section 33-21-5, the Commissioner of Insurance may place a health maintenance organization on probation or may fine the health maintenance organization in accordance with Chapter 2 of this title when, in his judgment, he finds that the public interest would not be harmed by the continued operation of the health maintenance organization. The amount of any penalty shall be paid by the health maintenance organization to the Commissioner for use by the state. At any hearing conducted in accordance with this title, the Commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered the oath, shall be subject to the penalty of perjury.

(2) Any action of the Commissioner of Insurance taken pursuant to this Code section shall be subject to such review as may be provided in Chapter 2 of this title.

(b)(1) If the Commissioner of Insurance or the commissioner of community health shall, for any reason, have cause to believe that any violation of this chapter has occurred or is threatened, the Commissioner of Insurance or the commissioner of community health may give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation to arrange a conference with the alleged violators

or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(2) Proceedings under this subsection shall not be governed by any formal procedural requirements and may be conducted in such manner as the Commissioner of Insurance or the commissioner of community health may deem appropriate under the circumstances.

(c)(1) The Commissioner of Insurance may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of this chapter.

(2) Within five days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. The hearings shall be conducted pursuant to Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," and judicial review shall be available as provided in Chapter 13 of Title 50.

(d) In the case of any violation of this chapter, if the Commissioner of Insurance elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order issued pursuant to this Code section, the Commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the superior court having jurisdiction of the parties.

(e) In addition to any other liability or punishment prescribed, any person who violates this chapter shall be guilty of a misdemeanor.

History. — Code 1933, § 56-3622, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1992, p. 6, § 33; Ga. L. 2009, p. 453, § 1-6/HB 228.

33-21-28. Applicability of provisions of title and of other laws to health maintenance organizations and representatives.

(a) Except as otherwise provided by law, all provisions of this title which are not in conflict with this chapter shall apply to health maintenance organizations and all other persons subject to this chapter, and specifically, the requirements and restrictions of Code Sections 33-20A-6, 33-20A-7, 33-20A-8, and 33-20A-9.1 shall apply to health maintenance organizations and all other persons subject to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives shall not be

construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provision of Chapter 34 of Title 43, relating to the practice of medicine.

History. — Code 1933, § 56-3623, enacted by Ga. L. 1979, p. 1148, § 1; Ga. L. 1999, p. 342, § 6.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "33-20A-7.1" was deleted following "33-20A-7" in subsection (a).

Law reviews. — For note on 1999 amendment to this Code section, see 16 Ga. St. U.L. Rev. 163 (1999).

JUDICIAL DECISIONS

Applicability of O.C.G.A. § 33-20-16. — "Any Willing Provider" (AWP) statute did not apply to a health maintenance organization (HMO) because: (1) the statute did not apply to for-profit corporations not statutorily defined as "surviving corporations," and (2) the HMO had never been an O.C.G.A. T. 33, C. 20 health care corporation, nor was the HMO an insurer's subsidiary any longer, so the HMO was not a surviving corporation, and O.C.G.A. § 33-21-28(a) barred applying the AWP statute to the HMO. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 315 Ga. App. 521, 726 S.E.2d 714 (2012), cert. denied, No. S12C1322, 2012 Ga. LEXIS 1018 (Ga. 2012), cert. denied, No. S12C1413, 2012 Ga. LEXIS 1033 (Ga. 2012).

Exhuastion of remedies. — Medical group's suit for a declaratory judgment as to the group's rights to participate in a health maintenance organization under Georgia's Any Willing Provider Statute, O.C.G.A. § 33-20-16, was procedurally barred by the failure to exhaust administrative remedies by first submitting the group's dispute to the Georgia Insurance Commissioner pursuant to O.C.G.A. § 33-20-30. Northeast Ga. Cancer Care, LLC v. Blue Cross & Blue Shield of Ga., Inc., 297 Ga. App. 28, 676 S.E.2d 428 (2009), cert. denied, No. S09C1241, 2009 Ga. LEXIS 805 (Ga. 2009).

33-21-29. Point-of-service option for persons offered health care coverage through health maintenance organization.

(a) It is the intent of the General Assembly to allow citizens to have the right to choose their own health care providers with as few mandates from government and business as possible. It is also the intent to allow these choices with no additional cost to any business in this state. With these intentions, and the recognition of necessary governmental involvement through various laws, the General Assembly enacts this Code section.

(b) As used in this Code section, the term:

(1) "Employer" means an employer, association, or other private group arrangement.

(2) "Enrollee" means any person entitled to receive health care services or reimbursement for such services pursuant to a contract

with a health maintenance organization, whether the contract is with the person entitled to receive those services or reimbursement or the contract is with an employer of which such person is an employee or member.

(3) "Point-of-service option" means a delivery system that permits an enrollee of a health maintenance organization to receive services outside the provider panel of the health maintenance organization under the terms and conditions of the enrollee's contract with the health maintenance organization.

(4) "Provider" means a provider or a group of providers designated to provide health care services to the health maintenance organization's enrollees, as provider is defined in Code Section 33-21-1.

(5) "Provider panel" means those providers with which a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

(c) If the only type of insurance that an employer offers to eligible employees or individuals is health benefit plan coverage through a health maintenance organization, then the health maintenance organization with which such employer contracts to provide such coverage shall offer or make arrangements for the offering of a point-of-service option to such employer for the employer's eligible employees or individuals, and each such eligible employee or individual shall have the right to accept or reject such option.

(d) An employer may require an employee or individual who accepts the point-of-service option to be responsible for the payment of a premium over the amount of the premium for the coverage offered by the health maintenance organization or by an arrangement with another entity in conjunction with the health maintenance organization either directly to the health maintenance organization or other entity or by payroll deduction.

(e) A health maintenance organization may impose different cost-sharing provisions for the point-of-service option based on whether the service is provided through the provider panel of the health maintenance organization or outside the provider panel of the health maintenance organization.

(f) This Code section shall not apply to the Department of Community Health with regard to any and all health benefits that the department may provide pursuant to Article 7 of Chapter 4 of Title 49, the "Georgia Medical Assistance Act of 1977," nor shall this Code section apply to Chapter 9 of Title 34, relating to workers' compensation.

(g) An employer may charge an employee or individual who accepts the point-of-service option a reasonable administrative fee for costs

associated with the employer's reasonable administration of the point-of-service option.

History. — Code 1981, § 33-21-29, enacted by Ga. L. 1996, p. 705, § 8; Ga. L. 1999, p. 296, § 24.

Law reviews. — For review of 1996 department and commissioner of insurance legislation, see 13 Ga. St. U.L. Rev. 183 (1996).

CHAPTER 21A

MEDICAID CARE MANAGEMENT ORGANIZATIONS

Sec.
33-21A-1. Short title.
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33-21A-11. Hospital statistical and reimbursement reports from care management organizations; penalty.
33-21A-12. Federal law, rule and regulations control.

33-21A-1. Short title.

This chapter shall be known and may be cited as the "Medicaid Care Management Organizations Act."

History. — Code 1981, § 33-21A-1, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-2. Definitions.

As used in this chapter, the term:

(1) "Care management organization" means an entity that is organized for the purpose of providing or arranging health care, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title, and which has entered into a contract with the Department of Community Health to provide or arrange health care services on a prepaid, capitated basis to members.

(2) "Coordination of care" means early identification of members who have or may have special needs; assessment of a member's risk factors; development of a plan of care; referrals and assistance to ensure timely access to providers; actively linking the member to providers, medical services, and residential, social, and other support services where needed; monitoring; continuity of care; and follow-up and documentation, all as further described pursuant to the terms of the contracts between the Department of Community Health and the care management organizations.

(3) "Critical access hospital" means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid

Services to be designated as a critical access hospital and that is recognized by the Department of Community Health as a critical access hospital for purposes of Medicaid.

(4) "Emergency health care services" means health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(5) "Health care provider" or "provider" means any person, partnership, professional association, corporation, facility, or institution certified, licensed, or registered by the State of Georgia that has contracted with a care management organization to provide health care services to members.

(6) "Health care services" has the same meaning as in paragraph (5) of Code Section 33-21-1.

(7) "Health maintenance organization" means an entity which has been issued a certificate of authority by the Commissioner of Insurance pursuant to Chapter 21 of this title to establish and operate a health maintenance organization.

(8) "Hospital Statistical and Reimbursement Report" or "HS&R report" means a report created by a care management organization, using the same format that is used by the Department of Community Health in completing HS&R reports, that includes data related to an individual hospital, including aggregate statistics and reimbursement data for all Medicaid recipients who are covered by the care management organization and who received health care services at such hospital during a specific fiscal year, including data regarding services that were provided out of network. HS&R reports are utilized by the Department of Community Health for purposes of the Indigent Care Trust Fund's disproportionate share hospital survey and are also utilized by hospitals to claim payments under medicare's disproportionate share hospital program.

(9) "Medicaid" means the joint federal and state program of medical assistance established by Title XIX of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 7 of Chapter 4 of Title 49.

(10) "Member" means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(11) "PeachCare for Kids" means the State of Georgia's State Children's Health Insurance Program established pursuant to Title XXI of the federal Social Security Act, which is administered in this state by the Department of Community Health pursuant to Article 13 of Chapter 5 of Title 49.

(12) "Post-stabilization services" means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

(13) "Responsible health organization" means the entity that a health care provider reasonably identifies to be responsible for providing or arranging health care services for a patient who is a Medicaid or PeachCare for Kids recipient after the provider has properly conducted an eligibility verification in accordance with the procedures of the Department of Community Health.

History. — Code 1981, § 33-21A-2, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-3. Certificate of authority required; setting of rates; authority of commissioners.

(a) A care management organization shall be required to obtain a certificate of authority as a health maintenance organization pursuant to Chapter 21 of this title prior to providing or arranging health care for members pursuant to a contract with the Department of Community Health. On and after the date of issuance of its certificate of authority as a health maintenance organization, a care management organization shall comply with all provisions relating to health maintenance organizations and all provisions relating to managed health care plans, with the exception of Code Section 33-20A-9.1.

(b) The Commissioner of Insurance shall not have the authority to approve, disapprove, or set rates paid by the Department of Community Health to a care management organization or paid by a care management organization to a health care provider.

(c) The Commissioner of Insurance shall not have the authority to approve, disapprove, or modify any plan offered by a care management organization or any contract between a care management organization and the Department of Community Health.

(d) Nothing in this chapter shall be interpreted as altering the authority of the commissioner of community health.

History. — Code 1981, § 33-21A-3, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-4. Reimbursement for emergency health care services.

(a) In particular, but without limitation, a care management organization shall not:

(1) Deny or inappropriately reduce payment to a provider of emergency health care services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or

(2) Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.

(b) In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

(1) The age of the patient;

(2) The time and day of the week the patient presented for services;

(3) The severity and nature of the presenting symptoms;

(4) The patient's initial and final diagnosis; and

(5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

A care management organization shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services. The Department of Community Health may develop and publish in print or electronically a list of additional standards to be used by care management organizations to maximize the identification and accurate payment of claims for emergency health care services.

(c) If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization's member, the care management organization shall reimburse the noncontracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by the Department of Community Health for Medicaid claims that it reimburses directly.

History. — Code 1981, § 33-21A-4, enacted by Ga. L. 2008, p. 704, § 1/HB 1234; Ga. L. 2010, p. 838, § 10/SB 388.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, a misspelling of "symptoms" was corrected in paragraph (b)(3).

33-21A-5. Requirements relating to critical access hospitals.

(a) A critical access hospital must provide notice to a care management organization and the Department of Community Health of any alleged breaches in its contract by such care management organization.

(b) If a critical access hospital satisfies the requirement of subsection (a) of this Code section, and if the Department of Community Health concludes, after notice and hearing, that a care management organization has substantively and repeatedly breached a term of its contract with a critical access hospital, the department is authorized to require the care management organization to pay damages to the critical access hospital in an amount not to exceed three times the amount owed. Notwithstanding the foregoing, nothing in this Code section shall be interpreted to limit the authority of the Department of Community Health to establish additional penalties or fines against a care management organization for failure to comply with the contract between a care management organization and the Department of Community Health.

History. — Code 1981, § 33-21A-5, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-6. Coverage for newborn infants until discharged from inpatient care.

(a) Each care management organization shall pay for health care services provided to a newborn infant who is born to a mother who is a member currently enrolled with that care management organization until such time as the newborn is finally discharged from all inpatient care to a home environment subject to approval by the federal Centers for Medicare and Medicaid Services. For a newborn infant whose mother is enrolled in a Medicaid program under which she receives Medicaid benefits directly from the Department of Community Health, the Department of Community Health shall pay for health care services provided to the newborn until such time as the newborn is finally discharged from all inpatient care to a home environment.

(b) In the event a newborn is disenrolled from a care management organization and re-enrolled into the Medicaid fee-for-service program conducted directly by the Department of Community Health, the care management organization shall ensure the coordination of care for that child until the child has been appropriately discharged from the hospital and placed in an appropriate care setting.

History. — Code 1981, § 33-21A-6, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-7. Bundling of provider complaints and appeals.

(a) In reviewing provider complaints or appeals related to denial of claims, a care management organization shall allow providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

(b) Each care management organization shall allow a provider that has exhausted the care management organization's internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative review process described in subsection (e) of Code Section 49-4-153 or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the care management organization and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.

(c) For all claims that are initially denied or underpaid by a care management organization but eventually determined or agreed to have been owed by the care management organization to a provider of health care services, the care management organization shall pay, in addition to the amount determined to be owed, interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the care management organization to the provider. A care management organization shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162

for electronic claims, a CMS Form 1500 for nonelectronic claims, or any claim prescribed by the Department of Community Health.

(d) Each care management organization shall maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically. To the extent a provider has the capability, each care management organization shall submit payments to providers electronically and submit remittance advices to providers electronically within one business day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

(e) Each care management organization shall post on its website a searchable list of all providers with which the care management organization has contracted. At a minimum, this list shall be searchable by provider name, specialty, and location. At a minimum, the list shall be updated once each month.

(f) The Department of Community Health shall require each care management organization to utilize the same timeframes and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims as the timeframes and deadlines that the Department of Community Health uses on claims it pays directly.

(g) No care management organization shall, as a condition of contracting with a provider, require that provider to participate or accept other plans or products offered by the care management organization unrelated to providing care to members. Any care management organization which violates this prohibition shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A care management organization shall not reduce the funding available for members as a result of payment of such penalties.

(h) No health care provider shall, as a condition of contracting with a care management organization, require that a care management organization contract with or not contract with another health care provider. Any health care provider which violates this subsection shall be subject to a penalty of $1,000.00 per violation. Such penalty shall be collected by the Department of Community Health. A health care provider shall not terminate an agreement with a care management organization as a result of payment of such penalties.

History. — Code 1981, § 33-21A-7, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-8. Participation by dentists.

(a) Except as provided in subsection (b) of this Code section, no care management organization or agent of such care management organization shall deny any dentist from participating in the Medicaid and PeachCare for Kids dental program administered by such care management organization if:

(1) Such dentist has obtained a license to practice in this state and is an enrolled provider who has met all of the requirements of the Department of Community Health for participation in the Medicaid and PeachCare for Kids program; and

(2)(A) The licensed dentist will provide dental services to members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, each care management organization shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the care management organization's Medicaid and PeachCare for Kids dental programs;

(B) The geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by the Department of Community Health, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services; or

(C) Such care management organization fails to establish to the satisfaction of the Department of Community Health that a sufficient number of general dentists and specialists have contracted with the care management organization to provide covered dental services to members in the geographic region.

(b) A care management organization may decline to contract with a dentist who meets the requirements of subsection (a) of this Code section if such dentist has had his or her license to practice dentistry sanctioned in any manner or fails to meet the credentialing criteria established by the care management organization. Any dentist denied on this basis shall be entitled to a hearing before an administrative law judge as set forth in subsection (e) of Code Section 49-4-153.

(c) The Department of Community Health shall also provide a means for dentists to request an annual hearing to determine whether a condition described in subparagraph (B) or (C) of paragraph (2) of subsection (a) of this Code section exists. The department may compel the attendance of care management organizations or agents of care management organizations to attend such hearings. The department

may request additional information as a result of the hearing, and it shall consider matters raised in the hearing when deciding whether a condition described in subparagraph (A) or (B) of paragraph (2) of subsection (a) of this Code section exists.

History. — Code 1981, § 33-21A-8, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-9. Submission and payment of claims.

(a) If a provider submits a claim to a responsible health organization for services rendered within 72 hours after the provider verifies the eligibility of the patient with that responsible health organization, the responsible health organization shall reimburse the provider in an amount equal to the amount to which the provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the provider's claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the provider.

(b) If a provider verifies the eligibility of a patient as set forth in subsection (a) of this Code section, and if a provider determines that a person other than the responsible health organization to which it has submitted a claim is responsible for Medicaid or PeachCare for Kids coverage of the patient at the time the service was rendered, the provider may submit the claim to the person that is responsible for Medicaid or PeachCare for Kids coverage and that person shall reimburse all medically necessary services, without application of any penalty for failure to file claims in a timely manner, for failure to obtain prior authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the Department of Community Health for the same type of claim that it pays directly if the provider is not under contract with that person.

History. — Code 1981, § 33-21A-9, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-10. New and renewal agreements with care management organizations and health care providers.

(a) On and after May 13, 2008, the Department of Community Health shall include provisions in all new or renewal agreements with

a care management organization, which require the care management organization to comply with all provisions of this chapter.

(b) On and after May 13, 2008, a care management organization shall not include any provisions in new or renewal agreements with providers entered into pursuant to the contract between the Department of Community Health and the care management organization, which are inconsistent with the provisions of this chapter.

History. — Code 1981, § 33-21A-10, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, paragraphs (1) and (2) were redesignated as subsections (a) and (b), respectively, and "May 13, 2008" was substituted for "the effective date of this chapter" in subsections (a) and (b).

33-21A-11. Hospital statistical and reimbursement reports from care management organizations; penalty.

Upon request by a hospital provider related to a specific fiscal year, a care management organization shall, within 30 days of the request, provide that hospital with an HS&R report for the requested fiscal year. Any care management organization which violates this Code section by not providing the requested report within 30 days shall be subject to a penalty of $1,000.00 per day, starting on the thirty-first day after the request and continuing until the report is provided. It is the intent of the General Assembly that such penalty be collected by the Department of Community Health and deposited into the Indigent Care Trust Fund created pursuant to Code Section 31-8-152. A care management organization shall not reduce the funding available for health care services for members as a result of payment of such penalties.

History. — Code 1981, § 33-21A-11, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

33-21A-12. Federal law, rule and regulations control.

To the extent any provision in this chapter is inconsistent with applicable federal law, rule, or regulation, the applicable federal law, rule, or regulation shall govern.

History. — Code 1981, § 33-21A-12, enacted by Ga. L. 2008, p. 704, § 1/HB 1234.

CHAPTER 22

INSURANCE PREMIUM FINANCE COMPANIES

Sec.
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33-22-13. Procedure for cancellation of insurance contract upon default.
33-22-14. Disposition of unearned premiums upon cancellation of insurance policy.
33-22-14.1. Transmissions of electronic records subject to provisions of Uniform Electronic Transactions Act.
33-22-15. Promulgation of rules and regulations by Commissioner.
33-22-16. Applicability of chapter.

Administrative rules and regulations. — Insurance premium finance companies, Official Compilation of the Rules and Regulations of the State of Georgia, Rules of Comptroller General, Commissioner of Insurance, Chapter 120-2-21.

JUDICIAL DECISIONS

Reason for giving regulatory powers to Commissioner over premium finance companies. — Although a premium finance company performs much the same role as other finance companies, this role has been recognized by the state as forming an integral part of the insurer-insured relationship. The finance company is legally empowered to act as an agent for the insured, and to terminate a policy, much like an insurance company, if premium installments are not paid. If the state were free to regulate the terms of insurance contracts between the company and the insured, but not free to regulate the finance companies, the entire state regulatory structure could be frustrated. Georgia has recognized this and has therefore extended the Insurance Commissioner's control to such companies. Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975), rev'd and remanded on other grounds, 606 F.2d 460 (5th Cir. 1979).

Assignment of premium finance agreements. — Because a written security agreement between a creditor and premium finance company assigned to the

creditor all of the company's interest in premium financing agreements, the creditor had standing to bring suit on its right to the return of unearned premiums. Paulsen Street Investors v. EBCO Gen. Agencies, 224 Ga. App. 507, 481 S.E.2d 246 (1997).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 157 et seq.

33-22-1. Short title.

This chapter shall be known and may be cited as the "Insurance Premium Finance Company Act."

History. — Ga. L. 1969, p. 561, § 1.

33-22-2. Definitions.

As used in this chapter, the term:

(1) "Insurance premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to a premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent or insurance broker in payment of premiums on an insurance contract together with a service charge as authorized and limited by this chapter.

(2) "Insurance premium finance company" means a person engaged in the business of entering into insurance premium finance agreements.

(3) "Licensee" means an insurance premium finance company holding a license issued by the Commissioner under this chapter.

History. — Ga. L. 1969, p. 561, § 3.

JUDICIAL DECISIONS

Cited in United Budget Co. v. Georgia Insurers Insolvency Pool, 253 Ga. 435, 321 S.E.2d 333 (1984).

33-22-3. Requirement of license for transaction of business; fees; change of address; examination of applicants.

(a) No person shall engage in the business of financing insurance premiums in this state without first having obtained a license as a premium finance company from the Commissioner.

(b) The annual license fee shall be as provided in Code Section 33-8-1. Licenses may be renewed from year to year as of March 1 of each year upon payment of the fee as provided in Code Section 33-8-1. The fee for said license shall be paid to the Commissioner for use by the state.

(c) Before any licensee changes his or her address, he or she shall inform the Commissioner of the change in writing.

(d) Subject to the penalties of perjury, the person to whom the license or the renewal of the license may be issued shall file sworn answers to such interrogatories as the Commissioner may require. The Commissioner shall have authority at any time to require the applicant fully to disclose the identity of all stockholders, partners, officers, and employees, and he may in his discretion refuse to issue or renew a license in the name of any firm, partnership, or corporation if he is not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(e) Any person who shall engage in the business of financing insurance premiums in this state without obtaining a license as provided in this Code section shall, upon conviction, be subject to a fine of not more than $1,000.00.

History. — Ga. L. 1969, p. 561, § 4; Ga. L. 1975, p. 1234, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1992, p. 2725, § 21; Ga. L. 2002, p. 1192, § 2.

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 42, 43.

C.J.S. — 44 C.J.S., Insurance, §§ 77et seq.

ALR. — Failure to procure occupational or business license or permit as affecting validity or enforceability of contract, 30 A.L.R. 834; 42 A.L.R. 1226; 118 A.L.R. 646.

Single or isolated transactions as falling within provisions of commercial or occupational licensing requirements, 93 A.L.R.2d 90.

33-22-4. Investigation of applicants for licenses; issuance or denial of license generally; hearing; grounds for issuance or denial.

(a) Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and shall issue a license if he finds the applicant is qualified in

accordance with this chapter. If the Commissioner does not so find, he shall within 30 days after he has received such application so notify the applicant and, at the request of the applicant, give the applicant a full hearing.

(b) The Commissioner shall issue or renew a license as may be applied for when he is satisfied that the person to be licensed:

(1) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license for which application is made;

(2) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the application for the license is made;

(3) If a corporation, is a corporation incorporated under the laws of this state or a foreign corporation authorized to transact business in this state; and

(4) Will contribute to and promote the convenience and advantage of the citizens of this state by providing a necessary additional market for the financing of insurance premiums.

History. — Ga. L. 1969, p. 561, § 5; Ga. L. 1976, p. 1074, § 1.

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 30, 42.

C.J.S. — 44 C.J.S., Insurance, § 77 et seq.

ALR. — Recovery back of money paid to unlicensed person required by law to have occupational or business license or permit to make contract, 74 A.L.R.3d 637.

33-22-5. Minimum capital requirements; deposit of securities or filing of bond.

No license shall be issued to any applicant for a license or renewal license under this chapter unless the applicant:

(1) Shall possess and thereafter maintain a minimum balance of at least $5,000.00 in his capital account as shown in his annual report to the Commissioner; provided, however, the Commissioner shall in his discretion require such higher amounts of capital as he deems necessary for the protection of the public; and

(2) Shall deposit with the Commissioner securities acceptable to the Commissioner in the amount of $25,000.00; or

(3) Shall file with the Commissioner a bond, to be approved by the Commissioner and made payable to the Commissioner or his successor in office, executed by the applicant as principal and by a corporate surety authorized to do business in this state in the penal sum of $25,000.00, conditioned that the licensee will conduct his business in accordance with this chapter and the laws of this state and that the licensee will properly account for all moneys collected in connection with this chapter and the laws of this state. The bond shall remain in full force and effect until the surety is released from liability by the Commissioner or until the bond is canceled by the surety and the bond shall not be canceled or terminated unless prior to the cancellation or termination 30 days' written notice is filed with the Commissioner.

History. — Ga. L. 1975, p. 1234, § 2.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 861, 907, 908.

C.J.S. — 44 C.J.S., Insurance, §§ 82 et seq., 142, 178, 194 et seq.

33-22-6. Grounds and procedure for revocation, suspension, or nonrenewal of license or imposition of probation or fine.

(a) The Commissioner may revoke or suspend the license of any premium finance company when and if after investigation the Commissioner finds that:

(1) Any license issued to the company was obtained by fraud;

(2) There was any misrepresentation in the application for the license;

(3) The holder of the license has otherwise shown himself untrustworthy or incompetent to act as a premium finance company;

(4) The holder of such license has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any moneys belonging to an insurer or insured entrusted to the holder in its fiduciary capacity;

(5) The holder is found to be in an unsound condition or in such condition as to render the future transaction of business in this state hazardous to the public; or

(6) The company has violated any of the provisions of this chapter.

(b) Before the Commissioner shall revoke, suspend, or refuse to renew the license of any premium finance company, he shall give to the

person an opportunity to be fully heard and to introduce evidence in his behalf.

(c) In lieu of revoking or suspending the license for any of the causes enumerated in subsection (a) of this Code section, the Commissioner shall have the authority after a hearing to place the premium finance company on probation for a period of time not to exceed one year and may subject such company to a penalty of not more than $1,000.00 for each offense when, in his judgment, he finds that the public interest would not be harmed by the continued operation of the company.

(d) The Commissioner shall also have the authority after a hearing to subject any person or entity who is acting as a premium finance company in this state without a license, as provided for by this chapter, to a penalty of not more than $1,000.00 for each violation of this chapter. The amount of any such penalty shall be paid by the company, person, or entity to the Commissioner for the use of the state.

(e) At any hearing provided by this Code section, the Commissioner or his designee shall have authority to administer oaths to witnesses. After having been administered the oath, anyone testifying falsely commits the offense of perjury.

(f) Any hearings provided for in this Code section shall be conducted in accordance with Chapter 2 of this title. Any action of the Commissioner in refusing to issue or renew a license or in assessing a monetary fine shall be subject to review as provided in Chapter 2 of this title.

History. — Ga. L. 1969, p. 561, § 6; Ga. L. 1975, p. 1234, § 3; Ga. L. 1980, p. 505, § 1; Ga. L. 1982, p. 3, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2000, "Code section" was substituted for "subsection" in the first sentence of subsection (f).

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 42, 43.

C.J.S. — 44 C.J.S., Insurance, § 154 et seq.

45 C.J.S., Insurance, §§ 811, 817, 835.

ALR. — Hearsay in proceeding for suspension or revocation of license to conduct business or profession, 142 A.L.R. 1388.

Practices forbidden by state deceptive trade practice and consumer protection acts, 89 A.L.R.3d 449.

33-22-7. Maintenance of records of transactions by licensees; examination of records by Commissioner.

(a) Every licensee shall maintain records of its premium finance transactions and the said records shall be open to examination and investigation by the Commissioner.

(b) Every licensee shall preserve its records of its premium finance transactions, including cards used in a card system, for at least three years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic or electronic form shall constitute compliance with this requirement.

(c) The Commissioner may at any time require any licensee to bring such records as he may direct to the Commissioner's office for examination or, if he deems it necessary, the Commissioner or his duly authorized representative may conduct an examination of the records on the premises of the licensee. The expense of any on-the-premise examination shall be borne by the licensee, as provided in the case of examinations of insurers conducted pursuant to Code Section 33-2-15.

History. — Ga. L. 1969, p. 561, § 7; Ga. L. 1975, p. 1234, § 4; Ga. L. 1980, p. 505, § 2; Ga. L. 2002, p. 1192, § 3.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 45 et seq., 66 et seq.

33-22-8. Form, contents, execution, and delivery of premium finance agreement; financing of additional premiums.

(a) A premium finance agreement shall:

(1) Be dated and signed by or on behalf of the insured, and the printed portion of the agreement shall be in approximately eight-point type and shall be readable by an individual with average eyesight;

(2) Contain the name and place of business of the insurance agent or insurance broker negotiating the related insurance contract, the name and residence or place of business of the insured as specified by him or her, the name and place of business of the premium finance company to which payments are to be made, a description of the insurance contracts involved, and the amount of the premium for the contracts; and

(3) Set forth the following items, where applicable:

(A) The total amount of the premiums;

(B) The amount of the down payment;

(C) The principal balance (the difference between subparagraphs (A) and (B) of this paragraph);

(D) The amount of the service charge, including the additional charge as provided in Code Section 33-22-9;

(E) The balance payable by the insured (the sum of subparagraphs (C) and (D) of this paragraph); and

(F) The number of payments required, the amount of each payment expressed in dollars, and the due date or period of payment.

(b) The items set out in paragraph (3) of subsection (a) of this Code section need not be stated in the sequence or order in which they appear in such paragraph, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(c) The licensee or the insurance agent or insurance broker shall deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement a complete copy of the agreement.

(d) Whenever an insurance policy has been financed pursuant to this chapter, an additional premium to such policy or a renewal or extension of such policy may be financed with the same premium finance company without the execution of a new premium finance agreement. The premium finance company or the insurance agent or insurance broker shall deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement an addendum to the existing premium finance agreement, and such addendum shall contain the information required under subsection (a) of this Code section.

History. — Ga. L. 1969, p. 561, § 9; Ga. L. 1970, p. 567, § 1; Ga. L. 1981, p. 760, § 1; Ga. L. 1995, p. 1047, § 1; Ga. L. 2002, p. 1192, § 4.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, "paragraph" was substituted for "clause" in subsection (b).

Editor's notes. — Ga. L. 1981, p. 760, § 4, provided that that Act, § 1 of which amended this section, was to apply to all insurance premium finance agreements entered into on or after the date the Act was signed by the Governor or became law without his approval. The Act was approved April 7, 1981.

JUDICIAL DECISIONS

This section is similar but not identical to the Truth in Lending Act (15 U.S.C. §§ 1601-1667e). Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975), rev'd and remanded on other grounds, 606 F.2d 460 (5th Cir. 1979).

33-22-9. Service charges.

(a) As used in this Code section, the term:

(1) "Commercial insurance premium finance agreement" means any insurance premium finance agreement other than a consumer premium finance agreement.

(2) "Consumer insurance premium finance agreement" means an insurance premium finance agreement, as defined in Code Section 33-22-2, wherein the insurance contracts which are the subject of the premium finance agreement are for personal, family, or household purposes rather than business or professional purposes.

(b) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by this chapter.

(c) The service charge shall be computed on the balance of the premiums due, after subtracting the down payment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which the premiums are being advanced, to and including the date when the final payment of the premium finance agreement is payable; provided, however, that service charges as specified in the premium finance agreement may continue to be charged until such agreement is paid in full.

(d) The service charge per consumer insurance premium finance agreement shall be a maximum of $12.00 per $100.00 per annum plus an additional charge which shall not exceed $20.00 per premium finance agreement, which additional charge need not be refunded upon prepayment. Any insured may prepay his or her premium finance agreement in full at any time before the due date of the final payment and in such event the unearned service charge shall be refunded in accordance with the Rule of 78 and shall represent at least as great a proportion of the service charge, if any, as the sum of the periodic balances after the month in which prepayment is made bears to the sum of all periodic balances under the schedule of payments in the agreement.

(e) The service charge for a commercial insurance premium finance agreement shall be properly agreed upon by the parties to the contract. The claim or defense of usury by such insureds who enter into such a commercial insurance premium finance agreement or their successors or anyone in their behalf shall not be valid if such agreement is a valid contract in all other respects.

History. — Ga. L. 1969, p. 561, § 10; Ga. L. 1970, p. 567, § 2; Ga. L. 1979, p. 1076, § 1; Ga. L. 1981, p. 760, § 2; Ga. L. 2002, p. 1192, § 5; Ga. L. 2003, p. 140, § 33.

Editor's notes. — Ga. L. 1981, p. 760, § 4, provided that that Act, § 2 of which amended this section, was to apply to all insurance premium finance agreements entered into on or after the date the Act was signed by the Governor or became law without his approval. The Act was approved April 7, 1981.

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

33-22-10. Delinquency charges; returned check fees.

(a) A premium finance agreement may provide for the payment by the insured of a delinquency charge ranging in amount from $1.50 to a maximum of 5 percent of the delinquent payment on any payment which is in default for a period of five days or more. If the default results in the cancellation of any insurance contract listed in the agreement, the agreement may provide for the payment by the insured of a cancellation charge of $15.00 in the case of a commercial insurance premium finance agreement or $5.00 in the case of a consumer insurance premium finance agreement.

(b) A premium finance agreement may provide for a returned check fee of $20.00 for each installment payment check returned by the financial institution as the result of insufficient funds.

History. — Ga. L. 1969, p. 561, § 11; Ga. L. 1981, p. 760, § 3; Ga. L. 1995, p. 1047, § 2.

Editor's notes. — Ga. L. 1981, p. 760, § 4, provided that that Act, § 3 of which amended this section, was to apply to all insurance premium finance agreements entered into on or after the date the Act was signed by the Governor or became law without his approval. The Act was approved April 7, 1981.

33-22-11. Necessity of filing of premium finance agreement.

No filing of the premium finance agreement shall be necessary to perfect the validity of the agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, successors, or assigns.

History. — Ga. L. 1969, p. 561, § 14.

33-22-12. Notification of insurer by finance company of existence of premium finance agreement.

Any premium finance company which enters into a premium finance agreement under this chapter shall notify the insurer whose premiums are being financed of the existence of the agreement. A draft of the premium finance company made payable directly to the order of the insurer of the premium due such insurer for a policy or policies financed by such premium finance company shall constitute sufficient notice under this Code section. The insurer shall not be required to comply with Code Sections 33-22-13 and 33-22-14 until notification of the existence of the insurance premium finance agreement has been furnished to the insurer in accordance with this Code section.

History. — Ga. L. 1975, p. 1234, § 5; Ga. L. 1976, p. 1564, § 2; Ga. L. 1984, p. 1345, § 1.

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Effect of former notification period provision. — The mere failure to provide notification within the 30-day notification period will not bar the premium finance company from recovery of unearned premiums where there has been notification to the insurer prior to the time the insurer processes the return of the unearned premiums. International Indem. Co. v. Bakco Acceptance, Inc., 172 Ga. App. 28, 322 S.E.2d 78 (1984) (decided prior to 1984 amendment).

Insured obligated to pay balance of financed amount upon cancellation of insurance policy. — Trial court properly granted an insurance premium finance corporation summary judgment on the corporation's claim against the insured for unpaid premiums because O.C.G.A. § 33-22-14(a) was not the corporation's exclusive remedy based on the finance agreement obligating the insured to pay the balance remaining once the policy was canceled. Burke v. Prime Rate Premium Fin. Corp., 325 Ga. App. 760, 754 S.E.2d 802 (2014).

33-22-12.1. Notice to insured by premium finance company; copy of premium finance agreement; notice of existence of power of attorney.

Whenever a premium finance company executes a premium finance agreement relative to a personal or family-type policy of insurance, it shall deliver to the insured or send by electronic means or mail to the insured at his or her address shown in the agreement a copy of the agreement and a written notice which clearly discloses to the insured the existence of the power of attorney contained in such agreement. The written notice shall substantially comply with the following form:

"NOTICE

Your insurance policy premiums have been financed and are payable on a monthly payment basis. If you do not pay each payment on or before the date due or within 15 days of the date due, we have the right to CANCEL your insurance policy or policies which are financed under the premium finance agreement. To avoid cancellation of your policy or policies, MAKE YOUR PAYMENTS ON TIME."

History. — Code 1981, § 33-22-12.1, enacted by Ga. L. 1995, p. 1047, § 3; Ga. L. 2002, p. 1192, § 6.

33-22-13. Procedure for cancellation of insurance contract upon default.

(a) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be canceled by the premium finance company unless the cancellation is effectuated in accordance with this Code section.

(b) Not less than ten days' written notice shall be delivered to the insured or sent by electronic means or mailed to the insured at his or her address shown in the agreement of the intent of the premium finance company to cancel the insurance contract unless the default is cured within such ten-day period. A copy of said notice shall also be sent to the insurance agent or insurance broker indicated on the premium finance agreement.

(c)(1) After expiration of such ten-day period, the premium finance company may thereafter in the name of the insured cancel such insurance contract or contracts by mailing or delivering to the insurer a notice of cancellation; and the insurance contract shall be canceled as if the notice of cancellation had been submitted by the insured, but without requiring the return of the insurance contract or contracts. The premium finance company, when mailing or delivering notice to the insurance company to cancel the policy, shall mail notice to the insured notifying him or her of the action taken. Such notice to the insured shall contain the date and time the policy is to be canceled, which date shall be after the date of mailing of such notice, and shall inform the insured that any payment received after the mailing or delivery of notice to the insurance company to cancel the policy will not reinstate the policy. The notice may contain information to the effect that the premium finance company will make a request to the insurance company to reinstate the policy. Language sufficiently clear and specific so that a person of average intelligence can

understand the action being taken by the premium finance company shall be used. The notice to the insured required by this subsection shall be delivered as provided in subsection (d) of Code Section 33-24-14 or mailed to the last address of record of the insured and shall be dispatched by at least first-class mail and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(2) The receipt of the notice of cancellation provided in paragraph (1) of this subsection by the insurer shall create a conclusive presumption that the premium finance company has fully complied with all the requirements of this Code section, that the insurer is entitled to rely on such presumption, and that the cancellation of the insurance contract or contracts is concurred in and authorized by the insured. No liability of any nature whatsoever shall be imposed upon the insurer as a result of the failure by the insured to receive the notice of the action taken required by paragraph (1) of this subsection or as a result of the failure of the insurance premium finance company to comply with any of the requirements of this Code section.

(d) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under this Code section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days required to complete the cancellation.

History. — Ga. L. 1969, p. 561, § 12; Ga. L. 1984, p. 1345, § 2; Ga. L. 1985, p. 149, § 33; Ga. L. 1986, p. 496, § 1; Ga. L. 1995, p. 1047, § 4; Ga. L. 2002, p. 1192, § 7; Ga. L. 2014, p. 829, § 2/HB 645.

JUDICIAL DECISIONS

Language of this section must be strictly construed. Freeman v. Government Employees Ins. Co., 151 Ga. App. 161, 259 S.E.2d 165 (1979); Brooks Brown Ins. Agency, Inc. v. Harden, 236 Ga. App. 781, 513 S.E.2d 755 (1999).

When a premium finance company seeks to cancel an insurance contract pursuant to authorization of a power of attorney contained in an agreement with its insured, it must do so in strict compliance with O.C.G.A. § 33-22-13. Clark v. Superior Ins. Co., 209 Ga. App. 290, 433 S.E.2d 394 (1993).

Terms of section must be exactly followed. Garber v. American Mut. Fire Ins. Co., 131 Ga. App. 366, 206 S.E.2d 86 (1974).

Notice requirements. — The notice required by O.C.G.A. § 33-22-13 applies to all subsections of the statute; it is necessary first to notify the insured of the intent to cancel and then of the election to cancel the policy. Georgia Mut. Ins. Co. v.

Gardner, 205 Ga. App. 458, 422 S.E.2d 324 (1992).

Premium finance company's notice to an insured, pursuant to O.C.G.A. § 33-22-13(b), that the policy would be cancelled for nonpayment of premiums was effective because the check the insured sent to pay the premium had been returned for insufficient funds. Kolencik v. Stratford Ins. Co., No. 1:05-cv-0007-GET, 2005 U.S. Dist. LEXIS 34956 (N.D. Ga. Nov. 28, 2005).

Any ambiguities of notice must be resolved in favor of insured. Freeman v. Government Employees Ins. Co., 151 Ga. App. 161, 259 S.E.2d 165 (1979).

Address of insured required on postal receipt. — A receipt bearing the name and policy number—but not the address—of an insured to whom notice of cancellation is sent does not constitute a form of proof of mailing within the meaning of subsection (c) of O.C.G.A. § 33-22-13 regardless of whether it is acceptable to the United States Postal Service. Moore v. Scottsdale Ins. Co., 264 Ga. 808, 450 S.E.2d 198 (1994).

The company has the burden of proving strict compliance with this section. Freeman v. Government Employees Ins. Co., 151 Ga. App. 161, 259 S.E.2d 165 (1979); Brooks Brown Ins. Agency, Inc. v. Harden, 236 Ga. App. 781, 513 S.E.2d 755 (1999).

Proof of accuracy of receipt not required. — There is nothing in subsection (c) of O.C.G.A. § 33-22-13 requiring proof of the accuracy of the receipt, and the defendant complied with that provision by providing the receipt which it obtained in connection with the mailing; in other words, no hearsay was involved in the matter to be proven by the defendant, that the bulk mailing document was the receipt received from the post office in connection with the mailing to the plaintiff, and the required evidence was provided by the statements in the affidavit of the defendant's president which also authenticated the bulk mailing document so as to permit its consideration by the superior court. Oriental Farmers Food Corp. v. Agency Servs., Inc., 237 Ga. App. 75, 514 S.E.2d 80 (1999).

Separate notice to mortgagee. — O.C.G.A. § 33-22-13 allows a premium finance company to terminate coverage under an insurance policy notwithstanding the existence of a mortgagee. Subsection (d) merely requires that the insurer provide separate notice of cancellation to the mortgagee and set the effective date of cancellation of the mortgagee's coverage. Massachusetts Bay Ins. Co. v. Photographic Assistance Corp., 732 F. Supp. 1572 (N.D. Ga. 1990).

Limited power of attorney given by insured to an insurance premium finance company authorizing the company to cancel policies and perform certain other duties relating thereto did not create a fiduciary relationship between the insured and the company. Gill Plumbing Co. v. Imperial Premium Fin., Inc., 213 Ga. App. 754, 445 S.E.2d 840 (1994).

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975); Leader Nat'l Ins. Co. v. Gaydon, 185 Ga. App. 322, 363 S.E.2d 859 (1987).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 95, 907.

C.J.S. — 45 C.J.S., Insurance, § 776 et seq., 790 et seq.

ALR. — Remedies and measure of damages for wrongful cancellation of life, health, and accident insurance, 34 A.L.R.3d 245.

Remedies and measure of damages for wrongful cancellation of liability and property insurance, 34 A.L.R.3d 385.

33-22-14. Disposition of unearned premiums upon cancellation of insurance policy.

(a) Whenever an insurance policy is canceled and the premiums have been paid by an insurance premium finance company on behalf of the

insured, if the insurer has been notified of the existence of the insurance premium finance agreement as required in Code Section 33-22-12, the insurer shall return whatever unearned premiums are due to the insurance premium finance company for the account of the insured. Whenever an insurer, after receiving notification of the existence of the insurance premium finance agreement, returns any unearned premium to anyone other than the insurance premium finance company named in the agreement, the insurer shall be directly responsible to such insurance premium finance company for any and all unearned premiums due as a result of the cancellation. The insurer shall furnish to the agent, agency, or broker placing the insurance a report setting forth an itemization of the unearned premiums under the policy.

(b)(1) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess within ten working days of receipt of the return premium or tender of return premium to the insured via the agent, agency, or broker placing the insurance and shall furnish such agent, agency, or broker, upon a written request, a report setting forth an itemization of the unearned finance charge and other charges under the premium finance agreement; provided, however, there shall be no refund required when the excess due the insured is less than $5.00.

(2) Any insurance premium finance company failing to tender refunds or to furnish any report requested by the agent, agency, or broker as required in paragraph (1) of this subsection shall pay to the insured via the agent, agency, or broker a penalty equal to 25 percent of the amount of the refund and interest equal to 18 percent per annum until such time as the refund is made; provided, however, the maximum amount of such penalty and interest shall not exceed 50 percent of the amount of the refund due.

(3) Upon receipt of the refund from the insurance premium finance company, the agent, agency, or broker shall return any unearned premiums to the insured either in person or by depositing such refund in the mail within ten working days of receipt of the refund.

(4) Any agent, agency, or broker failing to tender any unearned premium as prescribed in paragraph (3) of this subsection shall be subject to the penalties prescribed in paragraph (3) of subsection (c) of Code Section 33-24-44.

(c) Failure to refund any surplus or return any unearned premium or to furnish any reports requested by the agent, agency, or broker under subsection (b) of this Code section shall not invalidate a notice of cancellation given in accordance with this chapter.

History. — Ga. L. 1969, p. 561, § 13; Ga. L. 1971, p. 324, § 1; Ga. L. 1976, p. 1564, § 1; Ga. L. 1984, p. 1345, § 3; Ga. L. 1985, p. 149, § 33; Ga. L. 2002, p. 1192, § 8.

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

JUDICIAL DECISIONS

Construction of finance agreement. — O.C.G.A. § 33-22-14(a) does not create an exclusive remedy for a premium finance company for a claim against an insured pursuant to the finance agreement; rather the statute creates a chose in action or statutory lien right in the unearned premiums in favor of the premium finance company, and the premium financing agreement with the insured constitutes an account receivable entitling the finance company to recapture the company's principal one way or the other, as well as any fees and penalties. Burke v. Prime Rate Premium Fin. Corp., 325 Ga. App. 760, 754 S.E.2d 802 (2014).

No recovery when premiums not actually paid over to insurer. — When premiums paid by a premium finance company to an insurance agency were never actually paid over to the insurer, O.C.G.A. § 33-22-14, considered in light of the common law, does not entitle premium finance company to recover from insurer. International Indem. Co. v. Bakco Acceptance, Inc., 172 Ga. App. 28, 322 S.E.2d 78 (1984).

When insurance agency not "insurer". — When insurance agency is not licensed as an insurance company but operates under a local agent's license and when all policies prepared by the agency are issued in the name of a licensed insurance company, agency is not the "insurer" under O.C.G.A. § 33-22-14 despite evidence that agency performed many functions on behalf of insurance companies. International Indem. Co. v. Bakco Acceptance, Inc., 172 Ga. App. 28, 322 S.E.2d 78 (1984).

Unlicensed premium finance company. — The failure of a premium finance company to obtain a license in its own name foreclosed any claim the company had under O.C.G.A. § 33-22-14 for the return of unearned premiums. Paulsen St. Investors v. EBCO Gen. Agencies, 237 Ga. App. 116, 514 S.E.2d 904 (1999).

After premium finance company accepted late premium tendered by insured, the court found that no coverage existed on the date of the accident and reversed the judgment of the superior court affirming the award of the state board of workers' compensation and the administrative law judge, since the premium finance company had notified insured of policy cancellation and forwarded unearned premiums to insured in compliance with the requirements of O.C.G.A. § 33-22-14. Georgia Ins. Co. v. White, 190 Ga. App. 208, 378 S.E.2d 523 (1989).

Return of unearned premiums to agent or broker insufficient compliance. — That the insurance company may return such premiums either directly or by way of the agent does not support the contention that the return of unearned premiums to the agent, agency, or broker placing the insurance constituted return to the premium finance company and fulfilled the insurance company's statutory obligations. Perry & Co. v. Knight Ins. Underwriters, Inc., 149 Ga. App. 128, 253 S.E.2d 808 (1979).

Twenty-year limitation of actions applies. — When action was brought on the independent statutory remedy afforded by subsection (a) of Ga. L. 1976, p. 1564, § 1 (see O.C.G.A. § 33-22-14), and the claim for relief was predicated on the statutory obligation contained therein, and the statutory remedy is not a codification of a remedy existing at common law, but is one arising solely from the statute, former Code 1933, § 3-704 (see O.C.G.A. § 9-3-22), providing a 20-year limitation period, applies rather than the statute of limitations of four years contained in former Code 1933, § 3-706 (see O.C.G.A. § 9-3-25). Perry & Co. v. Knight Ins. Underwriters, Inc., 149 Ga. App. 128, 253 S.E.2d 808 (1979).

Insured obligated to pay balance of financed amount upon cancellation of insurance policy. — Trial court prop-

erly granted an insurance premium finance corporation summary judgment on the company's claim against the insured for unpaid premiums because O.C.G.A. § 33-22-14(a) was not the corporation's exclusive remedy based on the finance agreement obligating the insured to pay the balance remaining once the policy was canceled. Burke v. Prime Rate Premium Fin. Corp., 325 Ga. App. 760, 754 S.E.2d 802 (2014).

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975); Balboa Ins. Co. v. Hunter, 165 Ga. App. 273, 299 S.E.2d 91 (1983); Perry & Co. v. New S. Ins. Brokers of Ga., Inc., 182 Ga. App. 84, 354 S.E.2d 852 (1987).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 909.

C.J.S. — 45 C.J.S., Insurance, §§ 664 et seq., 720 et seq.

33-22-14.1. Transmissions of electronic records subject to provisions of Uniform Electronic Transactions Act.

Any use or transmission of electronic records or electronic signatures for purposes of this chapter shall be subject to the provisions of Chapter 12 of Title 10, the "Uniform Electronic Transactions Act."

History. — Code 1981, § 33-22-14.1, enacted by Ga. L. 2002, p. 1192, § 9; Ga. L. 2009, p. 698, § 2/HB 126.

33-22-15. Promulgation of rules and regulations by Commissioner.

The Commissioner may make and enforce such reasonable rules and regulations as may be necessary in making effective this chapter, but the rules and regulations shall not be contrary to nor inconsistent with this chapter.

History. — Ga. L. 1969, p. 561, § 8.

JUDICIAL DECISIONS

Cited in Cochran v. Paco, Inc., 409 F. Supp. 219 (N.D. Ga. 1975).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 21.

C.J.S. — 44 C.J.S., Insurance, § 45 et seq.

33-22-16. Applicability of chapter.

This chapter shall not apply with respect to:

(1) Any insurance company authorized to do business in this state;

(2) Any bank, trust company, savings and loan association, credit union, or other lending institution authorized to transact business in this state that does not possess or acquire any right, title, or interest with respect to the insurance policy for which the premiums are financed other than in the proceeds of the insurance policy in the event of loss;

(3) The inclusion of a charge for insurance in connection with an installment sale in accordance with Article 1 of Chapter 1 of Title 10;

(4) The financing of insurance premiums in this state in accordance with Article 1 of Chapter 4 of Title 7 relating to rates of interest;

(5) Insurance premiums in connection with the kinds of business defined in Code Sections 33-7-4 (life insurance) and 33-7-2 (accident and sickness insurance) and for those persons licensed under Chapter 3 of Title 7 to write the insurance authorized in Chapter 3 of Title 7;

(6) Any insurance agent or agency as defined in Code Section 33-23-1 who only finances premiums on policies written by or through such agent or agency, unless such agent or agency wishes to charge, contract for, receive, or collect the service charges, delinquency charges, and other fees or charges permitted under this chapter; in which event such agent or agency shall be required to comply with all of the provisions of this chapter except for the provisions of paragraph (4) of subsection (b) of Code Section 33-22-4, relating to the necessity of showing convenience or advantage to the community in order to obtain a license; or

(7) A holder in due course of the receivables generated by a premium finance company but who is not otherwise acting as a premium finance company under the provisions of this chapter.

History. — Ga. L. 1969, p. 561, § 2; Ga. L. 1982, p. 1054, § 1; Ga. L. 1985, p. 1087, § 3; Ga. L. 2000, p. 136, § 33; Ga. L. 2002, p. 1192, § 10.

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