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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 2013 edition of Volume 25 of the Official Code of Georgia Annotated, as supplemented by the 2019 Cumulative Supplement. The 2013 Volume 25 and its supplement may be recycled or, if so desired, retained for historical purposes.

This volume contains all laws specifically codified in Title 33 (Chapters 23-65) 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; Mercer Law Review; Georgia State Bar Journal; American Law Reports; American Jurisprudence 2d; American Jurisprudence Pleading and Practice Forms, 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 layman 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.

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Licensing of Administrators

33-23-100. Definitions; exemptions; applicability of Code Sections 33-24-59.5 and 33-24-59.14.
33-23-101. Licensing of administrators; filing fee; refusal, suspension, or revocation of license; notice and hearing; reissuance of revoked license; appeal; probationary licenses; additional qualifications for license; restrictions on licensees; penalties.
33-23-102. Bond and surety of applicant; liability insurance; remained licenses.
33-23-103. Examination of administrators by Commissioner.
33-23-104. Establishing requirements and procedures affecting administrators.
33-23-105. Rules and regulations for implementation of article.

Article 3

Insurance Navigators

33-23-200. Legislative findings; licensing of health insurance navigators.
33-23-201. Definitions.
33-23-202. Licensing and requirements therefor.
33-23-203. Violations; limitation on solicitations; navigator compensation, responsibilities, and limitations.
33-23-204. Adoption of rules and regulations.
33-23-205. Applicability.

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, Comptroller General, Insurance Department, Chapter 120-2-3.

RESEARCH REFERENCES

ALR. — Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

Substitution by common agent of two or more insurance companies of policy of one company for policy of another, 83 A.L.R. 298.

Person to whom payment of insurance premium may be made (or tendered) so as to charge insurer, 85 A.L.R. 749.

Income tax: deduction, in return on accrual basis, in respect of agents' or salesmen's commissions, 143 A.L.R. 1171.

Decision of United States Supreme Court that insurance is interstate com-

merce as affecting state statutes relating to foreign insurance companies, 164 A.L.R. 500.

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

Right to enjoin business competitor from unlicensed or otherwise illegal acts or practices, 90 A.L.R.2d 7.

Person to whom renewal premium may be paid or tendered so as to bind insurer, 42 A.L.R.3d 751.

Libel and slander: privileged nature of communications between insurer and insured, 85 A.L.R.3d 1161.

Revocation or suspension of insurance agent's license for withholding or misappropriation of premiums, 17 A.L.R.4th 1106.

Activities of insurance adjusters as unauthorized practice of law, 29 A.L.R.4th 1156.

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.

Liability of independent or public insurance adjuster to insured for conduct in adjusting claim, 50 A.L.R.4th 900.

Necessity of expert testimony to show standard of care in negligence action against insurance agent or broker, 52 A.L.R.4th 1232.

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 10 et seq.

ARTICLE 1

AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS

Editor's notes. — Ga. L. 1992, p. 2830, § 1, effective July 1, 1992, repealed the Code sections formerly codified as Articles 1 and 2 and enacted the current Article 1 in their place. The same Act also renumbered former Article 3 as Article 2. Former Articles 1 and 2 were based on Ga. L. 1960, p. 289, § 1; Ga. L. 1965, p. 368, § 1; Ga. L. 1968, p. 369, § 1; Ga. L. 1966, p. 283, § 1; Ga. L. 1966, p. 315, § 1; Ga. L. 1967, p. 630, § 1; Ga. L. 1969, p. 489, § 1; Ga. L. 1969, p. 583, §§ 1, 2; Ga. L. 1970, p. 492, § 1; Ga. L. 1972, p. 489, § 1; Ga. L. 1975, p. 1232, § 1; Ga. L. 1976, p. 535, §§ 1,2; Ga. L. 1979, p. 882, §§ 1, 2; Ga. L. 1980, p. 516, §§ 1, 2; Ga. L. 1980, p. 1163, §§ 1-5, 7, 8; Ga. L. 1981, p. 1789, §§ 1-4; Ga. L. 1982, p. 3, § 33; Ga. L. 1985, p. 1087, § 4; Ga. L. 1988, p. 1519, §§ 5-8; Ga. L. 1989, p. 665, §§ 1-5; Ga. L. 1990, p. 8, § 33; Ga. L. 1991, p. 1403; § 1; Ga. L. 1991, p. 1864, § 1; Ga. L. 1992, p. 2725, §§ 22-26; Ga. L. 1992, p. 2830, § 1.

JUDICIAL DECISIONS

License immaterial in action on adequacy of coverage. — In an action regarding the adequacy of insurance coverage, whether the agent is licensed as an "agent" or as a "broker" is immaterial, for the relationship of the parties, not the license held by the defendant, is the controlling issue. Wright Body Works, Inc. v. Columbus Interstate Ins. Agency, 233 Ga. 268, 210 S.E.2d 801 (1974).

Cited in Sutker v. Pennsylvania Ins. Co., 115 Ga. App. 648, 155 S.E.2d 694 (1967); Federated Mut. Ins. Co. v. Whitaker, 232 Ga. 811, 209 S.E.2d 161 (1974).

RESEARCH REFERENCES

ALR. — Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

Insurance by agent on his own property, 83 A.L.R. 1509.

Person to whom payment of insurance premium may be made (or tendered) so as to charge insurer, 85 A.L.R. 749.

Income tax: deduction, in return on ac-

crual basis, in respect of agents' or salesmen's commissions, 143 A.L.R. 1171.

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.

Person to whom renewal premium may be paid or tendered so as to bind insurer, 42 A.L.R.3d 751.

Liability of tortfeasor's insurance agent or broker to injured party for failure to procure or maintain liability insurance, 72 A.L.R.4th 1095.

Liability of insurance agent or broker for placing insurance with insolvent carrier, 42 A.L.R.5th 199.

33-23-1. Definitions.

(a) As used in this article, the term:

(1) "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:

(A) Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or

(B) An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.

(2) "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or negotiating insurance. Agency also means a business entity insurance producer.

(3) "Agent" means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.

(3.1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:

(A) May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;

(B) Shall comply with all claims payment requirements of the Georgia Insurance Code; and

(C) Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.

(4) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(5) "Controlled business of a person" means property or casualty insurance for a person or a person's spouse; for any relative by blood or marriage within the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person's employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person's employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person's firm; for a person's ward or employee; or for any person or in regard to any property under a person's control or supervision in any fiduciary capacity.

(6) "Counselor" means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.

(7) "Home state" means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.

(8) "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.

(9) "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.

(10) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(10.1) "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.

(11) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a

particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(12) "Person" means an individual or business entity.

(13) "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident, and who, for compensation on behalf of an insured:

(A) Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(B) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(C) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

(14) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(15) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(16) "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:

(A) An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or

(B) An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(17) "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

(b) The definitions of agent, subagent, and counselor in subsection (a) of this Code section shall not be deemed to include:

(1) An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who adjusts losses which are incidental to the practice of his or her profession;

(2) Any representative of ocean marine insurers;

(3) Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;

(4) A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;

(5) A person acting for or as a collection agency;

(6) A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;

(7) Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or

(8) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjustor or licensed agent.

(c) In addition to paragraphs (2) through (8) of subsection (b) of this Code section, the definitions of public adjuster, independent adjuster, and adjuster in subsection (a) of this Code section shall not be deemed to include an attorney admitted to practice law in this state.

History. — Code 1981, § 33-23-1, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1995, p. 1011, §§ 1, 2; Ga. L. 1999, p. 878, § 2; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 1/SB 113; Ga. L. 2012, p. 1350, §§ 3, 4, 5/HB 1067; Ga. L. 2012, p. 1040, §§ 4, 5, 6/SB 203; Ga. L. 2014, p. 181, §§ 1, 2/HB 610.

Law reviews. — For annual survey of real property law, see 68 Mercer L. Rev. 231 (2016).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Civil Code 1910, § 2443 and former Code 1933 §§ 56-501, 56-502, and 56-508 are included in the annotations for this Code section.

Constitutionality. — Part of former Civil Code 1910, § 2443, defining who is an agent, was not unconstitutional because it impaired the obligation of contracts. Globe & Rutgers Fire Ins. Co. v. Walker, 150 Ga. 163, 103 S.E. 407 (1920) (decided under former Civil Code 1910, § 2443).

Person authorized to solicit applications is "agent." — Person who had no authority to make, alter, vary, or discharge any policy contract, but was a soliciting or special agent with authority to solicit applications for insurance and to offer all such applications to the company, was an agent of the insurance company. Travelers Ins. Co. v. Harrington, 75 Ga. App. 759, 44 S.E.2d 457 (1947) (decided under former Code 1933, § 56-502).

Corporation may not be agent. — There is no decision which has construed the word "individual" as used in defining agent to include a corporation. Robinson v. Franwylie, Inc., 145 Ga. App. 507, 244 S.E.2d 73 (1978) (decided under former Code 1933, § 56-801).

Bankruptcy debtors who administered employment benefit plans were fiduciaries for purposes of nondischargeability of debts to the plans under 11 U.S.C. § 523(a)(4) as licensed insurance agents since O.C.G.A. § 33-23-35(b) created an express statutory trust, and the debtors' administration of the plans through a corporation did not abrogate the debtors' fiduciary status as individuals under O.C.G.A. § 33-23-1. Nat'l Air Traffic Controllers Assoc. v. Davenport (In re Davenport), No. 05-76748-MHM, 2007 Bankr. LEXIS 3725 (Bankr. N.D. Ga. Sept. 6, 2007).

Employer obtaining group insurance is insurer's agent in effectuating policy. — Employer who obtains a group policy of insurance covering an employee is, for the purpose of doing every act necessary to effectuate the purpose of the policy, the agent of the insurance company issuing the policy. Cason v. Aetna Life Ins. Co., 91 Ga. App. 323, 85 S.E.2d 568 (1954).

City as agent. — Former Code 1933, § 56-2301 (see O.C.G.A. § 33-24-34), when construed with the statute existing at the time of its enactment, former Code 1933, § 56-501 (see O.C.G.A. § 33-23-1), indicated that cities were empowered to enter into agreements with insurance companies to furnish such insurance in the same manner and in the same capacity as would a nongovernmental employer, i.e., as an agent of the insurance company. Cason v. Aetna Life Ins. Co., 91 Ga. App. 323, 85 S.E.2d 568 (1954).

Employer's knowledge may estop insurer to interpose defense. — When an insurance company, through the agency of the deceased's employer, had knowledge that the deceased was ineligible for insurance under the policy increase certificate issued to the deceased and, in these circumstances, had accepted the premiums necessary to keep the certificate, the insurance company was estopped to interpose the defense that the deceased

was not entitled to protection under the certificate. Cason v. Aetna Life Ins. Co., 91 Ga. App. 323, 85 S.E.2d 568 (1954) (decided under former Code 1933, § 56-501).

Representative of master policyholder represents insurer, not insured, in attempting to cancel coverage. — When an insurance company had issued a master policy of group life insurance to an incorporated association, when a representative of the association wrote a letter notifying a partner that none of the members of the partnership were entitled to a $10,000.00 policy under the master policy, the author of the letter was not acting as the agent of the insured rather than the insurance company when the author wrote the letter, since in this state the association was the agent of the insurance company and not of the insured; the action of the association's representative did not cancel out the $10,000.00 policy. Washington Nat'l Ins. Co. v. Burch, 293 F.2d 365 (5th Cir. 1961) (decided under former Code 1933, § 56-501).

Person administering group policy need not be licensed as agent. — Effect of former paragraph (b)(2) was that a person who served the master policyholder in administering the details of group insurance was exempted from the licensing requirements of these statutes. Piedmont S. Life Ins. Co. v. Gunter, 108 Ga. App. 236, 132 S.E.2d 527 (1963) (decided under former Code 1933, § 56-801).

Section does not affect application and policy provisions as to agent's authority. — Provisions defining who are agents of an insurance company as a part of an act designed to make insurance companies and the companies' agents qualify and obtain certificates before the Insurance Commissioner and pay certain fees, but not attempting to define the authority of any agent, does not affect the provisions of the application and policy touching the authority of agents. Saul v. New York Life Ins. Co., 92 F.2d 665 (5th Cir. 1937) (decided under former Code 1910, § 2443).

Section does not make soliciting agent officer of company. — This section which, in effect, makes a soliciting agent of an insurance company its agent for all purposes does not go to the extent of making a soliciting agent an officer of the company authorized to create a new contract, which would be necessary to validate reinstatement of a lapsed policy on false evidence of insurability, contrary to the provisions of the policy. New York Life Ins. Co. v. Odom, 93 F.2d 641 (5th Cir. 1937), cert. denied, 304 U.S. 566, 58 S. Ct. 948, 82 L. Ed. 1532 (1938) (decided under former Code 1933, § 56-501).

Section does not authorize agent to issue oral binder. — Even if the acts of a party were such as to bring the party within the statutory definition of an agent under the provisions of former paragraph (a)(3) of former Code 1933, § 56-801 (see O.C.G.A. § 33-23-1), this would not automatically clothe the party with power to issue a valid oral binder as recognized under Ga. L. 1960, p. 289, § 1 (see O.C.G.A § 33-24-33(a)). Southeastern Fid. Fire Ins. Co. v. State Farm Mut. Auto. Ins. Co., 118 Ga. App. 861, 165 S.E.2d 887 (1968) (decided under former Code 1933, § 56-801).

Every person procuring property insurance for another is not made insurer's agent. — It cannot be said that every person who procures insurance to cover the property of another is the agent of the company from whom the insurance is purchased and not the person for whom the insurance is sought. Georgia Ins. Serv., Inc. v. Wise, 97 Ga. App. 461, 103 S.E.2d 445 (1958) (decided under former Code 1933, § 56-501).

Broker is agent of insurer, not insured, under section. — It seems to be necessary under former paragraph (a)(4) that an independent broker be the agent of the insured rather than the insurer. Canal Ins. Co. v. Lawson, 123 Ga. App. 376, 181 S.E.2d 91 (1971) (decided under former Code 1933, § 56-801).

Cited in Kennesaw Life & Accident Ins. Co. v. Hendricks, 108 Ga. App. 148, 132 S.E.2d 152 (1963); Kelley v. Montgomery, 108 Ga. App. 271, 132 S.E.2d 857 (1963); Chicago Title Ins. Co. v. Nash, 228 Ga. 719, 187 S.E.2d 662 (1972); Stewart v. Georgia Mut. Ins. Co., 159 Ga. App. 91, 282 S.E.2d 728 (1981); Seals v. Hygrade Distrib. & Delivery Sys., Inc., 249 Ga. App. 574, 549 S.E.2d 412 (2001).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarities of the statutory provisions, decisions under former Code 1933, §§ 56-501 and 56-801 are included in the annotations for this Code section.

Teachers collecting applications and premiums from pupils not agents. — When folders are being distributed by the county superintendent of schools to all of the superintendent's teachers, who in turn distribute the folders to the school children who return the application and the premium to the teachers, who are required to complete the applications and keep a record of the applications, this is not doing an insurance business through unlicensed agents. 1957 Op. Att'y Gen. p. 165 (decided under former Code 1933, § 56-501).

Person selected in law firm as attorney-in-fact for court bonds is "limited agent." — All types of court bonds were included in the definition given in former paragraph (a)(9) of this section, and the individual selected in a law firm as an attorney-in-fact would be a "limited agent." 1963-65 Op. Att'y Gen. p. 133 (decided under former Code 1933, § 56-801).

Authority of unlicensed administrative personnel. — Administrative personnel in the office of an insurance agent who perform clerical duties of opening envelopes containing premium checks need not be licensed as insurance agents. 1994 Op. Att'y Gen. No. U94-15.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 109 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 65, 259 et seq., 305.

ALR. — Whom does agent represent in soliciting or taking application for reinstatement of insurance policy, 23 A.L.R. 1201.

Right of insurer to challenge agent's classification of risk, 29 A.L.R. 99.

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

Statutory declaration that one who does certain prescribed acts for a surety company or an insurance company shall be deemed as acting as its agent as affected by other party's knowledge of, or opportunity to know, limitations of his actual authority, 88 A.L.R. 291.

Right of insurance company, in view of its public interest, to reject applications for insurance, 107 A.L.R. 1421; 123 A.L.R. 139.

Insured's responsibility for false answers inserted by insurer's agent in application following correct answers by insured, or incorrect answers suggested by agent, 26 A.L.R.3d 6.

Excess carrier's right to maintain action against primary liability insurer for wrongful failure to settle claim against insured, 10 A.L.R.4th 879.

33-23-1.1. Counselor's additional ancillary services considered a separate transaction.

As used in paragraph (6) of subsection (a) of Code Section 33-23-1, the definition of counselor, the term "transaction" refers to coverage or services in the same line or subline of insurance; provided, however, that additional ancillary services for commercial risks in excess of acquisition services shall be considered a separate transaction when such additional ancillary services are disclosed in writing to the insured and approved in advance by the insured. Additional ancillary services shall include, but not be limited to, the following: risk identification; loss measurement; gathering and analysis of loss information; verifica-

tion of workers' compensation experience modifiers; setting of risk retention levels; development of retention financing plans; development of insurance specifications; negotiation with insurers regarding coverages, costs, and payment options; implementation of retained and transferred risk programs; monitoring of annual program; and insurance audit services.

History. — Code 1981, § 33-23-1.1, enacted by Ga. L. 1993, p. 778, § 1; Ga. L. 2001, p. 925, § 1.

JUDICIAL DECISIONS

Substantive due process claim failed. — Bidding insurer's summary judgment motion was properly granted as to the insurer's substantive due process claim against a county as the county's decision to throw out the entire bidding process was rational in light of the taint caused by a consultant's lack of a counselor's license under O.C.G.A. §§ 33-23-1.1 and 33-23-4. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

Effect of lack of consultant's license. — Bidding insurer's summary judgment motion was properly granted as to the insurer's equal protection claim against a county as the county did not exercise arbitrary power but acted rationally and reasonably in rejecting all bids across the board after it was discovered that a consultant lacked a counselor's license under O.C.G.A. §§ 33-23-1.1 and 33-23-4; because of the taint to the process, all bids were rejected, no classification was created at all, and all similarly situated persons were treated alike. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

Damages under O.C.G.A. § 51-1-6. — Summary judgment was properly entered for a consultant and a consulting firm on a bidding insurer's claim under O.C.G.A. § 51-1-6 after all of the bids for a county contract were rejected because the consultant lacked a license under O.C.G.A. §§ 33-23-1.1 and 33-23-4 as the statutes requiring insurance counselors to be licensed and mandating that licensed individuals meet certain qualifications were designed to protect the insurance counselor's clients and not to protect or benefit providers of insurance; the generic statement that O.C.G.A. § 33-23-5(a) was "for the protection of the people of (Georgia)" did not expand the intent of the statute requiring licensure for counselors to benefit businesses that provided insurance. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

33-23-2. Licenses to be issued only to individuals.

Reserved. Repealed by Ga. L. 2001, p. 925, § 1, effective July 1, 2002.

Editor's notes. — This Code section was based on Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 3.

33-23-3. Agency licensing and biennial renewals; ownership restrictions.

(a) Each principal office and each branch office of an agency as defined in paragraph (2) of subsection (a) of Code Section 33-23-1 must obtain an agency license prior to commencement of operations and renew such license biennially and prior to December 31 by filing application forms prescribed by the Commissioner.

(b) An agency shall be subject to all penalties, fines, criminal sanctions, and other actions authorized for agents under this title.

(c) No person shall be an owner of an agency or, if the agency is a corporation, no person shall be an officer or director of such corporation or own 10 percent or more of the corporation if such person has had his or her license under this title refused, revoked, or suspended.

History. — Code 1981, § 33-23-3, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 3; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 623, § 2/SB 251; Ga. L. 2012, p. 37, § 1/HB 477; Ga. L. 2019, p. 386, § 4/SB 133.

The 2019 amendment, effective July 1, 2019, deleted subsection (a.1), which read: "All agency licenses that were issued with an expiration date of December 31, 2012, shall expire on that date, but shall be renewed pursuant to subsection (a) of this Code section."; and substituted "this title" for "this chapter" in subsections (b) and (c).

33-23-4. License required; restrictions on payment or receipt of commissions; positions indirectly related to sale, solicitation, or negotiation of insurance excluded from licensing requirements.

(a)(1) A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless such person is licensed for that line of authority in accordance with this article and applicable regulations.

(2) Any individual who sells, solicits, or negotiates insurance in this state shall be licensed as an agent.

(3) Any business entity that sells, solicits, or negotiates insurance in this state shall be licensed as an agency.

(4) Any individual defined as an adjuster under paragraph (1) of subsection (a) of Code Section 33-23-1 who for a fee, commission, salary, or other compensation investigates, settles, or adjusts claims arising under insurance contracts on behalf of the insurer or the insured shall be licensed as either an independent adjuster or a public adjuster.

(b) No insurer or agent doing business in this state shall pay, directly or indirectly, any commissions or any other valuable consideration to

any person for services as an agent, subagent, or adjuster within this state, unless such person is duly licensed in accordance with this article.

(c) An insurer may pay a commission or other valuable consideration to a licensed insurance agency in which all employees, stockholders, directors, or officers who sell, solicit, or negotiate insurance contracts are qualified insurance agents, limited subagents, or counselors holding valid licenses as required by the laws of this state; and an agent, limited subagent, or counselor may share any commission or other valuable consideration with such a licensed insurance agency.

(d) No person other than a duly licensed adjuster, agent, limited subagent, or counselor shall pay or accept any commission or other valuable consideration except as provided in subsections (b) and (c) of this Code section.

(e) This Code section shall not prevent the payment or receipt of renewal or deferred commissions by any agency or a person on the grounds that the licensee has ceased to be an agent, limited subagent, or counselor nor prevent the receipt or payment of any commission by an individual who has been issued a temporary license pursuant to this chapter.

(f) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from the requirement to maintain at least one certificate of authority; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply with the requirements of this article and applicable rules and regulations, including without limitation the requirements for certificate of authority.

(g) Any person who willfully violates this Code section shall be guilty of a misdemeanor and, upon conviction thereof, shall be subject to punishment as provided in Code Section 17-10-3, relating to punishment for misdemeanors.

(h)(1) Nothing in this article shall be construed to require an insurer to obtain an insurance agent's license. As used in this Code section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) A license as an insurance agent shall not be required of the following:

(A) An officer, director, or employee of an insurer or of an insurance agent or agency, provided that the officer, director, or

employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and:

(i) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance agents where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(B) A person who meets the criteria set forth in paragraph (1), (4), or (6) of subsection (b) of Code Section 33-23-1;

(C) An employer or association or its officers, directors, or employees or the trustees of an employee trust plan to the extent that the employers, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, so long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(D) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks or in the supervision of the training of insurance agents and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(E) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(F) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and

casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is otherwise licensed as an insurance agent to sell, solicit, or negotiate insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(G) A salaried, full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

History. — Code 1981, § 33-23-4, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 9; Ga. L. 1997, p. 1296, § 4; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 2/SB 113; Ga. L. 2014, p. 181, § 3/HB 610; Ga. L. 2016, p. 255, § 1/SB 290; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2019, p. 386, § 5/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "this article" for "this chapter" near the end of paragraph (a)(1) and in the proviso of subsection (f); substituted "such person" for "the person" in the middle of paragraph (a)(1); and deleted "currently" following "counselors holding" in the middle of subsection (c).

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

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, § 56-803 and former Code Section 33-23-2 are included in the annotations to this Code section.

Equal protection claim. — Bidding insurer's summary judgment motion was properly granted as to the insurer's equal protection claim against a county as the county did not exercise arbitrary power but acted rationally and reasonably in rejecting all bids across the board after it was discovered that a consultant lacked a counselor's license under O.C.G.A. §§ 33-23-1.1 and 33-23-4; because of the taint to the process, all bids were rejected, no classification was created at all, and all similarly situated persons were treated alike. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

Deduction of premiums authorized. — Consent form authorizing a common carrier to deduct insurance premiums and certain administrative fees from delivery commissions paid to a commercial trucking company for the delivery of freight was not voided by O.C.G.A. § 33-23-4(e). Seals v. Hygrade Distrib. & Delivery Sys., Inc., 249 Ga. App. 574, 549 S.E.2d 412 (2001).

Noncompliance as bar to recovery on claims. — Failure to comply with the statutory scheme governing life insurance agents will bar any recovery on the basis of a contractual claim. This strict rule has been held to be necessary to compel compliance with the licensure requirement. Management Comp. Group/Southeast, Inc. v. United Sec. Emp. Programs, Inc., 194 Ga. App. 99, 389 S.E.2d 525 (1989) (decided under former O.C.G.A. § 33-23-2).

Notwithstanding clause did not run afoul of section. — Court's interpretation of the notwithstanding clause did not run afoul of O.C.G.A. § 33-23-4 when the consultant did not charge the client for the client's services based on a percentage of the commissions received by the client, but charged a per hour fee for its services, the parties agreed to a $20,000 quarterly

fee for the services, and separately, the parties agreed to a limitation on the amount that the consultant was able to recover. Thus, the receipt of commission payments was not a condition precedent to the payment of outstanding balances. Hessmorganhouse, LLC v. Kingdom Group of Cos., LLC, No. 19-13723, 2020 U.S. App. LEXIS 19635 (11th Cir. June 24, 2020) (Unpublished).

Policy not voided by issuance by unlicensed agent. — While the law prohibits the issuance of policies by an unlicensed agent, the law does not void such insurance. Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971) (decided under former Code 1933, § 56-803).

License not required. — District court erred in holding that a plaintiff would not be harmed absent a preliminary injunction barring enforcement of certain restrictive covenants because under Georgia law, a party did not need a license to sell insurance in order to operate an insurance brokerage business and hire others to carry out insurance sales. MacGinnitie v. Hobbs Group, LLC, 420 F.3d 1234 (11th Cir. 2005).

Bid preparation costs for unlicensed consultant. — Summary judgment was properly entered for a county on a bidding insurer's claim for reimbursement of the insurer's bid preparation costs due to the county's rejection of the insurer's bid as no contract was awarded to an unqualified bidder since all the bids were rejected when it was discovered that the county's consultant lacked an insurance counselor's license under O.C.G.A. §§ 33-23-1.1 and 33-23-4. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

Effect on RICO actions. — Failure of an insurance company to file a policy with the Georgia Insurance Department and the failure of the company's agent to have a certificate of authority issued by the company before selling the policy to insureds were not predicate acts for purposes of the Racketeer Influenced and Corrupt Organizations Act, O.C.G.A. § 16-14-1 et seq. Security Life Ins. Co. v. Clark, 229 Ga. App. 593, 494 S.E.2d 388 (1997), aff'd in part and rev'd in part, 270 Ga. 165, 509 S.E.2d 602 (1998). But see Clark v. Security Life Ins. Co. of Am., 270 Ga. 165, 509 S.E.2d 602 (1998); Security Life Ins. Co. of Am. v. Clark, 273 Ga. 44, 535 S.E.2d 234 (2000); Williams General Corporation v. Stone, 280 Ga. 631, 632 S.E.2d 376 (2006).

Damages under O.C.G.A. § 51-1-6. — Summary judgment was properly entered for a consultant and a consulting firm on a bidding insurer's claim under O.C.G.A. § 51-1-6 after all of the bids for a county contract were rejected because the consultant lacked a license under O.C.G.A. §§ 33-23-1.1 and 33-23-4 as the statutes requiring insurance counselors to be licensed and mandating that licensed individuals meet certain qualifications were designed to protect the insurance counselor's clients and not to protect or benefit providers of insurance; the generic statement that O.C.G.A. § 33-23-5(a) was "for the protection of the people of (Georgia)" did not expand the intent of the statute requiring licensure for counselors to benefit businesses that provided insurance. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

Cited in Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972); Long v. Century Fin., 167 Ga. App. 196, 306 S.E.2d 87 (1983); Olukoya v. American Ass'n of Cab Cos., 219 Ga. App. 508, 465 S.E.2d 715 (1995); Am. Cent. Ins. Co. v. Lee, 273 Ga. 880, 548 S.E.2d 338 (2001).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions under former Code 1933, § 56-801 are included in the annotations to this Code section.

Adjuster for life, accident, and health insurance is not required to procure license. 1962 Op. Att'y Gen. p. 285 (decided under former Code 1933, § 56-801).

Licensed insurance agent can pay commissions into a corporation of which the agent is an employee. 1962 Op. Att'y Gen. p. 286 (decided under former Code 1933, § 56-801).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 161 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 67 et seq., 146, 147.

33-23-5. Qualifications and requirements for license.

(a) For the protection of the people of this state, the Commissioner shall not issue, continue, or permit to exist any license, except in compliance with this chapter and except as provided in Code Sections 33-23-3, 33-23-4, 33-23-12, 33-23-13, 33-23-14, 33-23-16, 33-23-17, 33-23-29, 33-23-29.1, and 33-23-37. The Commissioner shall not issue a license to any individual applicant for a license who does not meet or conform to qualifications or requirements set forth in paragraphs (1) through (7) of this subsection:

(1) The individual applicant shall be a resident of this state who shall reside and be present within this state for at least six months of every year or an individual whose principal place of business is within this state; provided, however, that in cities, towns, or trade areas, either unincorporated or composed of two or more incorporated cities or towns, located partly within and partly outside this state, requirements as to residence and principal place of business shall be deemed met if the residence or place of business is located in any part of the city, town, or trade area and if the other state in which the city, town, or trade area is located in part has established like requirements as to residence and place of business. The individual applying for an agent, adjuster, or counselor license shall be at least 18 years of age;

(2) If applying for an agent's license for property and casualty insurance, the applicant shall not use or intend to use such license for the purpose of obtaining a rebate or commission upon controlled business; and the applicant shall not in any calendar year effect controlled business that will aggregate as much as 25 percent of the volume of insurance effected by such applicant during such year, as measured by the comparative amounts of premiums;

(3) The individual applicant shall be of good character;

(4) The individual applicant shall pass any written examination required for the license by this article, provided that:

(A) An individual who applies for an insurance agent's license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any

prelicensing education or examination. This exemption shall only be available if the individual is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer data base records maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries indicate that the agent is or was licensed in good standing for the line of authority requested; and

(B) An individual licensed as an insurance agent in another state who moves to this state shall make application within 90 days of establishing legal residence to become a resident licensee pursuant to Code Section 33-23-8. No prelicensing education or examination shall be required of that individual to obtain a license for any line of authority previously held in the prior state except where the Commissioner determines otherwise by rule or regulation;

(5) If applying for a license as counselor, the applicant shall show that he or she either has had five years' experience as an agent, subagent, or adjuster or in some other phase of the insurance business or has sufficient teaching or educational qualifications or experience which, in the opinion of the Commissioner, has qualified the applicant to act as such counselor; and the applicant shall pass such examination as shall be required by the Commissioner unless such applicant is exempted by the Commissioner, based on the applicant's experience and qualifications and pursuant to a regulation adopted by the Commissioner;

(6) If applying for an agent's license, limited subagent's license, or adjuster's license, no applicant shall be qualified therefor or be so licensed unless he or she has successfully completed classroom courses in insurance satisfactory to the Commissioner at a school which has been approved by the Commissioner; and

(7) The Commissioner shall by rule or regulation establish criteria and procedures for the scope of prelicensing requirements and exemptions, if any, to the prelicensing or examination requirements.

(b) An individual who was licensed as an agent, counselor, limited subagent, surplus line broker, or adjuster at the time such individual was employed by the Commissioner and who while so employed was employed in responsible insurance duties as a full-time bona fide employee shall be permitted to reinstate his or her license upon termination of employment if written request is made within 90 days after the date of termination of employment with the Commissioner.

(c) Active licensees who apply for additional licenses and individuals who apply for the reinstatement of a license prior to six months from

the license expiration date shall not be required to submit fingerprints pursuant to Code Section 33-23-5.1.

(d) Notwithstanding paragraph (1) of subsection (a) of this Code section, no resident of Canada may be licensed as an independent adjuster pursuant to this Code section or designate Georgia as his or her home state unless such person has successfully passed the adjuster examination and has complied with other applicable portions of this Code section.

History. — Code 1981, § 33-23-5, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 10; Ga. L. 1997, p. 1296, § 5; Ga. L. 2001, p. 4, § 33; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2006, p. 652, § 7/HB 1257; Ga. L. 2008, p. 1076, § 3/SB 113; Ga. L. 2009, p. 616, § 1/SB 144; Ga. L. 2012, p. 1040, § 7/SB 203; Ga. L. 2012, p. 1350, § 6/HB 1067.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 109 et seq. 51 Am. Jur. 2d, Licenses and Permits, § 30.

C.J.S. — 53 C.J.S., Licenses, § 58 et seq.

JUDICIAL DECISIONS

Damages under O.C.G.A. § 51-1-6. — Summary judgment was properly entered for a consultant and a consulting firm on a bidding insurer's claim under O.C.G.A. § 51-1-6 after all of the bids for a county contract were rejected because the consultant lacked a license under O.C.G.A. §§ 33-23-1.1 and 33-23-4 as the statutes requiring insurance counselors to be licensed and mandating that licensed individuals meet certain qualifications were designed to protect the insurance counselor's clients and not to protect or benefit providers of insurance; the generic statement that O.C.G.A. § 33-23-5(a) was "for the protection of the people of (Georgia)" did not expand the intent of the statute requiring licensure for counselors to benefit businesses that provided insurance. Benefit Support, Inc. v. Hall County, 281 Ga. App. 825, 637 S.E.2d 763 (2006), cert. denied, No. S07C0306, 2007 Ga. LEXIS 214 (Ga. 2007).

33-23-5.1. Conviction data.

(a) As used in this Code section, the term "conviction data" means a record of a finding or verdict of guilty or plea of guilty or nolo contendere with regard to any crime regardless of whether an appeal of the conviction has been sought.

(b) With respect to the requirements of paragraph (3) of subsection (a) of Code Section 33-23-5, the Commissioner shall be authorized to obtain conviction data with respect to an applicant as authorized in this Code section. The Commissioner shall submit to the Georgia Crime Information Center two complete sets of fingerprints of the applicant for appointment or employment, the required records search fees, and such other information as may be required. Upon receipt of such

material, the Georgia Crime Information Center shall promptly forward one set of fingerprints to the Federal Bureau of Investigation for a search of bureau records and the preparation of an appropriate report concerning such records search and shall retain the other set and promptly conduct a search of its own records and all records to which the center has access. The Georgia Crime Information Center shall notify the Commissioner in writing of any derogatory finding, including, but not limited to, any conviction data regarding the fingerprint records check or if there is no such finding. All conviction data received by the Commissioner shall not be a public record, shall be privileged, and shall not be disclosed to any other person or agency except as provided in this Code section and except to any person or agency that otherwise has a legal right to inspect the employment file. All such records shall be maintained by the Commissioner pursuant to the laws regarding such records and the rules and regulations of the Federal Bureau of Investigation and the Georgia Crime Information Center, as applicable.

History. — Code 1981, § 33-23-5.1, enacted by Ga. L. 2008, p. 1076, § 4/SB 113; Ga. L. 2009, p. 616, § 2/SB 144.

33-23-6. Bond requirements for applicants for adjuster's license.

In addition to other applicable provisions of this chapter, an applicant for a public adjuster's license must have previously filed a bond as required by rule or regulation of the Commissioner.

History. — Code 1981, § 33-23-6, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-7. Bond requirement for applicants for counselor's license.

In addition to other applicable provisions of this chapter, an applicant for a counselor's license must have previously filed a bond as required by rule or regulation by the Commissioner.

History. — Code 1981, § 33-23-7, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-8. Form and contents of license application; fees.

(a) An individual applicant for any license required by this chapter shall file with the Commissioner an application upon forms prescribed by the Commissioner.

(b) If the application is for an agent's or limited subagent's license, the application shall state the kinds of insurance proposed to be transacted. If applying as a limited subagent, the applicant shall be appointed as a limited subagent by a sponsoring agent prior to the issuance of such license.

(c) As to any application for a limited subagent's license or certificate of authority, the Commissioner shall require as part of the application a certificate of the sponsoring agent proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the sponsoring agent is satisfied that the applicant is trustworthy and qualified to act as its limited subagent and to hold himself or herself out in good faith to the general public as a limited subagent and the fact that the sponsoring agent desires that the applicant be licensed as a limited subagent to represent it in this state.

(d) Each applicant for an agency license shall file with the Commissioner the information required under Code Section 33-23-3.

(e) All such applications shall be accompanied by the appropriate fees in the respective amounts as provided by law.

History. — Code 1981, § 33-23-8, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 6; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 5/SB 113.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 33 et seq., 109 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 67 et seq., 124.

33-23-9. Study materials for applicants.

The rules and regulations of the Commissioner shall designate textbooks, manuals, and other materials to be studied by the applicant in preparation for examinations in each classification designated by the Commissioner. The textbooks, manuals, or other materials may consist of matter available to applicants by purchase from the publisher or may consist of matter prepared at the direction of the Commissioner and distributed to applicants upon request therefor and payment of reasonable costs. When textbooks, manuals, or other materials shall have been designated by or prepared at the direction of the Commissioner, all

examination questions shall be prepared from the contents of those textbooks, manuals, or other materials.

History. — Code 1981, § 33-23-9, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-10. Examination of applicants.

(a) Each individual applicant for a license as agent, limited subagent, counselor, adjuster, or surplus line broker shall submit to a personal examination in writing as to his or her competence to act in such capacity. The examination shall be prepared and given by the Commissioner or a designee of the Commissioner and shall be given and graded in a fair and impartial manner and without unfair discrimination as between individuals examined. Any required examination may be supplemented by an oral examination at the discretion of the Commissioner. The Commissioner shall provide by rule or regulation for a reasonable waiting period before giving a reexamination to an applicant who failed to pass a previous similar examination.

(b) The Commissioner shall by rule or regulation establish criteria and procedures for:

(1) The scope of any examination; and

(2) Exemptions, if any, to examinations, provided that the Commissioner shall not, under any circumstances, exempt himself or herself from any written examination requirements set forth in this Code section.

(c) An applicant for a license to act as an agent, limited subagent, surplus line broker, counselor, or adjuster who held a valid license to act as such which lapsed while the applicant was a member of any branch of the armed forces of the United States shall be granted a new license if application is made within a period of five years from the date of the expiration of the old license and proof satisfactory to the Commissioner is furnished that:

(1) The individual was a member of the armed forces of the United States at the time the previous license lapsed; and

(2) The individual's service in the armed forces of the United States was not terminated more than one year prior to the date of application for a new license.

History. — Code 1981, § 33-23-10, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 6/SB 113; Ga. L. 2011, p. 449, § 9/HB 413.

33-23-11. Issuance and contents of license; display certificate of licensure.

(a) The Commissioner shall issue licenses applied for to persons qualified for the licenses in accordance with this article.

(b) The license shall state the name and address of the licensee, the date of issue, the general conditions relative to expiration or termination, the kind or kinds of insurance covered if not an insurance agency license, and the other conditions of licensing.

(c) Upon the request of a licensee under this chapter, the Commissioner shall provide a certificate of licensure which shall be suitable for display at the business premises of the licensee. The Commissioner shall provide by rule or regulation the application procedures for the certificate and the form and content of the certificate.

(d) The Commissioner shall have the authority to enter into agreements with persons for the purposes of providing licensing testing, administrative, record keeping, printing, mounting, and other services related to the administration of the Commissioner's duties under this article and to set appropriate charges by rule or regulation to cover the costs of such services which shall be in addition to the fees otherwise provided for in this title and may be paid directly to the providers of such services. The Commissioner may require applicants for licenses to pay such charges for licensing testing and for the cost of the printing and mounting of a certificate of licensure which is suitable for display directly to the provider of such services. The Commissioner may require insurers to pay such charges for licensing testing, administrative, record keeping, and other services provided for in this subsection directly to the provider of such services in an amount corresponding to the number of their authorized agents.

History. — Code 1981, § 33-23-11, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1993, p. 702, § 1; Ga. L. 1995, p. 1348, § 2; Ga. L. 1997, p. 1296, § 7; Ga. L. 2001, p. 925, § 1; Ga. L. 2019, p. 386, § 6/SB 133; Ga. L. 2020, p. 138, § 3/SB 377.

The 2019 amendment, effective July 1, 2019, substituted "this article" for "this chapter" in subsections (a) and (d); and, in the last sentence of subsection (d), inserted "licensing testing," in the middle and substituted "in an amount corresponding" for "in proportion" near the end.

The 2020 amendment, effective June 30, 2020, in subsection (d), substituted "record keeping" for "record-keeping" twice and substituted "may be paid" for "shall be paid" near the end of the first sentence.

33-23-12. Limited licenses.

(a) Except as provided in subsection (b) of this Code section for credit insurance licenses, subsection (b.1) of this Code section, subsection (c) of this Code section for rental companies, subsection (d) of this Code section for portable electronics, and subsection (f) of this Code section

for travel insurance, the Commissioner may provide by rule or regulation for licenses which are limited in scope to specific lines or sublines of insurance.

(b)(1) Licenses shall be issued to individuals for the purpose of writing credit insurance as provided in this subsection.

(2) Resident applicants must be sponsored by an insurer authorized to write credit insurance in this state, and the applicant must certify that he or she has read and understands the provisions of this title and regulations promulgated pursuant to this title which are pertinent to credit insurance in this state.

(3) Nonresident applicants must follow the appointment process set forth in subsection (g) of Code Section 33-23-16.

(4) No prelicensing education or prelicensing examination shall be required for issuance of such license, and the insurer shall certify that the licensee has completed a minimum of five hours of self-study in credit insurance subjects.

(5) The lines or sublines of insurance included in the scope of authority of credit insurance licenses issued under this Code section shall include, but not be limited to, the following:

(A) Credit life and credit accident and sickness insurance;

(B) Credit casualty insurance;

(C) Credit property insurance;

(D) Credit unemployment insurance;

(E) Accidental death and dismemberment insurance;

(F) Nonfiling or nonrecording insurance;

(G) Vendors' single interest insurance; 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.

(b.1)(1) In lieu of requiring individual employees to obtain a limited credit insurance license pursuant to the provisions of subsection (b) of this Code section, any business entity that sells, solicits, or negotiates the lines or sublines of credit insurance pursuant to paragraph (5) of subsection (b) of this Code section may make application to the Commissioner for a limited credit insurance agency license so long as:

(A) The entity examines the character and fitness of each of its employees that sell, solicit, or negotiate credit insurance on its

behalf to the satisfaction of the Commissioner, including but not limited to performing criminal background checks;

(B) The entity provides at least five hours of training in minimum basic insurance concepts and credit insurance subjects to its employees who sell, solicit, or negotiate credit insurance on its behalf prior to allowing these employees to sell, solicit, or negotiate such insurance. The Commissioner shall approve materials for this training course in a manner provided for by rules and regulations. The entity shall maintain records of compliance with this subparagraph and shall submit such records upon the Commissioner's request;

(C) The entity provides at least two hours of annual continuing education courses taught by such entity or an insurer to its employees who sell, solicit, or negotiate credit insurance on its behalf. The Commissioner shall approve materials for this training course by rules and regulations. Such entity shall maintain records of compliance with this subparagraph and shall submit such records upon the request of the Commissioner;

(D) The entity submits to the Commissioner along with its application for licensure a list of employees who sell, solicit, or negotiate credit insurance on behalf of the entity in a manner prescribed by the Commissioner. Such entity shall update such employee list in a manner prescribed by the Commissioner; and

(E) The entity submits to the Commissioner with its application for licensure a list of all physical locations where its employees sell, solicit, or negotiate credit insurance on its behalf. The entity shall update such list in a manner prescribed by the Commissioner.

(2) The entity shall make application to the Commissioner for a limited credit insurance agency license in such form or forms and providing such information as the Commissioner may prescribe and shall pay an initial license fee pursuant to Code Section 33-8-1 or as provided for by rules and regulations.

(3) The lines or sublines of insurance included in the scope of authority of limited credit insurance agency licenses issued under this subsection shall include such licenses as provided for in paragraph (5) of subsection (b) of this Code section.

(4) Any limited credit insurance agency license issued under this subsection shall also authorize any employee of such limited licensee to act individually on behalf and under the supervision of such limited licensee with respect to selling, soliciting, and negotiating the kinds of coverage specified in this subsection only and any such employee shall be authorized to receive related compensation, notwithstanding any other provision of law.

(5) In the event that any provision of this title is violated by a limited licensee or any employee selling, soliciting, or negotiating credit insurance on behalf of such limited licensee, the Commissioner may:

(A) Revoke, suspend, or place on probation the entity's limited credit insurance agency license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22, and the procedures for notice and the conduct of hearings pursuant to Chapter 2 of this title; or

(B) Impose such other penalties, including but not limited to suspending the transaction of insurance at specific locations where violations of this subsection have occurred as the Commissioner determines to be necessary or convenient to carry out the purposes of this subsection in accordance with the procedures for notice and the conduct of hearings set forth in Chapter 2 of this title.

(6) An appeal from any order or decision of the Commissioner made pursuant to this subsection shall be conducted pursuant to Chapter 2 of this title.

(7) Limited credit insurance agency licenses issued pursuant to this Code section shall renew biennially on December 31 of the applicable renewal year. The entity shall make application for renewal to the Commissioner for such licenses in such form or forms and containing such information required by the Commissioner and shall pay a renewal license fee pursuant to Code Section 33-8-1 and rules and regulations.

(c)(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection.

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed 90 days.

(D) "Rental period" means the term of the rental agreement.

(E) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and

sport utility vehicles, and of the cargo type, including cargo vans, pick-up trucks, and trucks with a gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(2) The Commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with the rental of vehicles.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the Commissioner may:

(A) After notice and a hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22; or

(B) After notice and a hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to paragraph (2) of this subsection may only offer or sell insurance through licensed insurers in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in an individual, master, corporate, or group rental agreement, in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance, which, at the exclusive option of the rental company, may include uninsured and underinsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or vehicle related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance shall be offered by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed 90 consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that such policies offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and

(C) Evidence of coverage on the face of the rental agreement is disclosed to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall provide a training program in which employees being trained by an instructor licensed under this article receive basic insurance instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles. Additionally, each rental company shall provide for such employees two hours of continuing education courses annually to be taught by an instructor licensed under this article. A rental company shall certify that, prior to offering such coverages, each employee has received such instruction.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(d)(1) As used in this subsection, the term:

(A) "Customer" means a person who purchases portable electronics or services.

(B) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(C) "Location" means any physical location in this state or any website, call center site, or similar location directed to residents of this state.

(D) "Portable electronics" means handsets, pagers, personal digital assistants, portable computers, automatic answering devices, cellular telephones, batteries, and other similar devices and their accessories and includes services related to the use of such devices, including, but not limited to, individual customer access to a wireless network.

(E) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. Such term shall not include a service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property in cases of operational or structural failure due to a defect in materials, workmanship, accidental damage from handling power surges, or normal wear and tear.

(F) "Portable electronics transaction" means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer.

(G) "Supervising entity" means a business entity that is a licensed insurer, or insurance producer that is authorized by a

licensed insurer, to supervise the administration of a portable electronics insurance program.

(H) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(2) The Commissioner may issue to a retail vendor of portable electronics that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell portable electronics insurance policies.

(3) A limited license issued under this subsection shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to customers at each location where the vendor engages in portable electronics transactions.

(4) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the Commissioner and with ten days' notice to the supervising entity, the registry shall be open to inspection and examination by the Commissioner during regular business hours of the supervising entity.

(5) The sale of such insurance policies shall be limited to sales in connection with the sale of or provision of service for portable electronics by the retail vendor.

(6) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer which:

(A) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(B) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with a similar make and model or with reconditioned or nonoriginal manufacturer parts or equipment;

(C) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(D) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(7) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Coverage under portable electronics insurance shall be primary to any other insurance.

(8) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(9) Notwithstanding any other provision of law, employees or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited license which are incidental to their overall compensation.

(10) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

(11) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application

for such limited license or licenses in a form and manner prescribed by the Commissioner. The application shall provide:

(A) The name, residence address, and other information required by the Commissioner of an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this subsection;

(B) If the vendor derives more than 50 percent of its revenue from the sale of portable electronics insurance, the information required by subparagraph (A) of this paragraph for all officers, directors, and shareholders of record having beneficial ownership of 10 percent or more of any class of securities registered under the federal securities law; and

(C) The location of the applicant's home office.

(12) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Code section, provided that the supervising entity supervises the administration of a training program in which employees and authorized representatives of a vendor shall be trained and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective purchasers. The training required by this subsection may be provided in electronic form. However, if provided in electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance that is conducted and overseen by an instructor licensed under this article.

(13) No prelicensing examination shall be required for issuance of such license.

(14) If a vendor or its employee or authorized representative violates any provision of this subsection, the Commissioner may impose any of the following penalties:

(A) After notice and hearing, fines not to exceed $500.00 per violation or $5,000.00 in the aggregate for such conduct;

(B) After notice and hearing, other penalties that the Commissioner deems necessary and reasonable to carry out the purpose of this article, including:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this subsection at specific business locations where violations have occurred; and

(ii) Suspending or revoking the ability of individual employees or authorized representatives to act under the license;

(15) Notwithstanding any other provision of law:

(A) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 60 days' notice;

(B) If the insurer changes the terms and conditions, then such insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of such changes;

(C) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim;

(D) Notwithstanding subparagraph (A) of this paragraph, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) For nonpayment of premium;

(ii) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(iii) If the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer; and

(E) When a portable electronics insurance policy is terminated by a policyholder, the vendor shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(16) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this subsection or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other

provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this paragraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's email address specified for such purpose and to its affected enrolled customers' last known email address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an email address to the insurer or vendor of portable electronics, as the case may be, shall be deemed as consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(17) Notice or correspondence required by this subsection or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

(e)(1) As used in this subsection, the term:

(A) "Limited licensee" means an owner authorized to act as an agent of an insurance provider for purposes of selling certain insurance coverages for personal property maintained in self-service storage facilities pursuant to this subsection.

(B) "Occupant" means a person, his or her sublessee, successor, or assign entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others.

(C) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility, his or her agent, or any other person authorized by him or her to manage the self-service storage facility or to receive rent from an occupant under a rental agreement.

(D) "Personal property" means movable property not affixed to land and includes, but is not limited to, goods, wares, merchandise, motor vehicles, watercraft, and household items and furnishings.

(E) "Rental agreement" means any agreement or lease, written or oral, that establishes or modifies the terms, conditions, rules, or

any other provisions concerning the use and occupancy of a self-service storage facility.

(F) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to such for the purpose of storing and removing personal property. No occupant shall use a self-service storage facility for residential purposes. A self-service storage facility is not a warehouse within the meaning of Article 1 of Chapter 4 of Title 10, the "Georgia State Warehouse Act." A self-service storage facility is not a safe-deposit box or vault maintained by banks, trust companies, or other financial entities.

(2) The Commissioner may issue to an owner that is in compliance with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with a self-service storage facility.

(3) A limited licensee shall be authorized to offer or sell insurance on behalf of a licensed insurer only in connection with a rental agreement and only for either an individual policy issued to an individual occupant or as a group policy for occupants for personal property insurance. A limited licensee shall only be authorized to provide to occupants insurance coverage for:

(A) The loss of or damage to personal property stored at a self-service storage facility where the loss or damage occurs at such self-service storage facility during the occupant's rental agreement; or

(B) Such other loss directly related to an occupant's rental agreement.

(4) No insurance shall be issued pursuant to this subsection unless the limited licensee provides to a prospective occupant written material that:

(A) Provides a summary of the terms of insurance coverage, including the identity of the insurer;

(B) Conspicuously discloses that the policy of insurance may provide a duplication of coverage already provided by an existing policy of insurance;

(C) Describes the process for filing a claim in the event the occupant elects to purchase coverage and experiences a covered loss;

(D) Provides information regarding the price, deductible, benefits, exclusions, conditions, and any other limitations of such policy;

(E) States that the limited licensee is not authorized to evaluate the adequacy of the occupant's existing insurance coverages, unless such limited licensee is otherwise licensed; and

(F) States that the occupant may cancel the insurance at any time, and any unearned premium will be refunded in accordance with applicable law.

(5) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee licensed pursuant to this subsection shall not be required to treat moneys collected from occupants under rental agreements as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental agreement. The sale of insurance not in conjunction with a rental agreement shall not be permitted.

(6) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(7) Each owner licensed pursuant to this subsection shall provide a training program in which employees and authorized representatives of such owner shall be trained by an instructor licensed pursuant to this article and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective occupants.

(8) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(9) In the event that any provision of this title is violated by a limited licensee, or an employee of a limited licensee, the limited licensee shall be subject to all penalties, fines, criminal sanctions, and other actions authorized by this title.

(10) No prelicensing examination shall be required for issuance of a limited license pursuant to this subsection.

(f)(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages related to travel pursuant to the provisions of this subsection.

(B) "Limited lines travel insurance producer" means a:

(i) Licensed managing general underwriter;

(ii) Licensed managing general agent or third-party administrator; or

(iii) Licensed insurance producer, including a limited licensee, designated by an insurer as the travel insurance supervising entity as set forth in division (2)(C)(iii) of this subsection.

(C) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application, collecting premiums, and performing other nonlicensable activities permitted by this state.

(D) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including, but not limited to:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damage to accommodations or rental vehicles; or

(iv) Sickness, accident, disability, or death occurring during travel.

Travel insurance shall not include major medical plans which provide comprehensive medical protection for travelers with trips lasting six months or longer, including, but not limited to, those working overseas as an expatriate or military personnel being deployed.

(E) "Travel retailer" means a business entity that makes, arranges, or offers travel services and that may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(2)(A) Notwithstanding any other provision of law, the Commissioner may issue to an individual or business entity that has complied with the requirements of this subsection a limited lines travel insurance producer license which authorizes the limited lines travel insurance producer to sell, solicit, or negotiate travel insurance through a licensed insurer.

(B) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license in a form and manner prescribed by the Commissioner.

(C) Notwithstanding any other provision of law, a travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(i) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(I) A description of the material terms or the actual material terms of the insurance coverage;

(II) A description of the process for filing a claim;

(III) A description of the review or cancellation process for the travel insurance policy; and

(IV) The identity and contact information of the insurer and limited lines travel insurance producer;

(ii) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the Commissioner of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the Department of Insurance upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer registered complies with 18 U.S.C. Section 1033;

(iii) The limited lines travel insurance producer shall designate one of its employees who is a licensed individual producer as the person responsible for the limited lines travel insurance producer's compliance with the travel insurance laws and rules and regulations of this state;

(iv) The employee designated as provided in division (iii) of this subparagraph, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

(v) The limited lines travel insurance producer shall pay all applicable insurance producer licensing fees as set forth in applicable state law;

(vi) The limited lines travel insurance producer shall require each employee or authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the Commissioner. The training material shall, at a minimum, contain instructions on the types of insur-

ance offered, ethical sales practices, and required disclosures to prospective customers; and

(vii) No prelicensing examination or continuing education shall be required for issuance of a limited license pursuant to this subsection.

(D) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(i) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(ii) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(E) A travel retailer employee or authorized representative that is not licensed as an insurance producer shall not:

(i) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Hold itself out as a licensed insurer, licensed producer, or insurance expert.

(3) Notwithstanding any other provision of law, a travel retailer whose insurance related activities, and those of its employees or authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this subsection shall be authorized to do so and receive related compensation upon registration by the limited lines travel insurance producer as provided in subparagraph (C) of paragraph (2) of this subsection.

(4) Travel insurance may be provided under an individual policy or under a group or master policy.

(5) As the insurer designee, the limited lines travel insurance producer shall be responsible for the acts of the travel retailer and

authorized representative and shall use reasonable means to ensure compliance by the travel retailer with this subsection.

(6) The limited lines travel insurance producer and any travel retailer or authorized representative offering and disseminating travel insurance under the limited lines travel insurance producer's license shall be subject to the unfair trade practices provisions under Article 1 of Chapter 6 of this title and to the other provisions of this article relating to insurance producers.

History. — Code 1981, § 33-23-12, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1995, p. 437, § 3; Ga. L. 1999, p. 878, § 4; Ga. L. 2001, p. 4, § 33; Ga. L. 2001, p. 925, § 1; Ga. L. 2002, p. 1047, § 1; Ga. L. 2008, p. 1076, § 7/SB 113; Ga. L. 2012, p. 757, § 1/HB 463; Ga. L. 2012, p. 1040, §§ 2, 3/SB 203; Ga. L. 2012, p. 1350, §§ 1, 2/HB 1067; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2013, p. 742, §§ 1, 2/SB 234; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2018, p. 1081, § 1/HB 938; Ga. L. 2019, p. 337, § 1-93/SB 132; Ga. L. 2019, p. 386, § 7/SB 133; Ga. L. 2019, p. 1056, § 33/SB 52; Ga. L. 2020, p. 493, § 33/SB 429.

The 2018 amendment, effective July 1, 2018, inserted "subsection (b.1) of this Code section," near the middle of subsection (a) and added subsection (b.1).

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in the third sentence of division (f)(2)(C)(ii). The second 2019 amendment, effective July 1, 2019, substituted "Commissioner" for "commissioner" near the beginning of paragraph (d)(2), in two places in paragraph (d)(4), in the middle of introductory paragraph (d)(14), and in subparagraph (d)(14)(B); added "and" at the end of division (c)(6)(B)(iv); substituted "an instructor licensed under this article" for "a licensed instructor" in the first and second sentences of paragraph (c)(8); substituted "this state" for "the State of Georgia" in two places in subparagraph (d)(1)(C); deleted "causes of loss" following "more of the following" in the middle of the first sentence of subparagraph (d)(1)(E); inserted "a" following "authorized by" in the middle of subparagraph (d)(1)(G); substituted "ten days'" for "ten days" in the middle of the second sentence of paragraph (d)(4); substituted "by an instructor licensed under this article" for "by a licensed instructor" at the end of paragraph (d)(12); in subparagraph (d)(15)(B), substituted "then such insurer" for "then the insurer" near the middle, and substituted "such changes" for "material changes" near the end; substituted "subparagraph (A) of this paragraph" for "paragraph (15) of subsection (a) of this Code section" near the beginning of subparagraphs (d)(15)(C) and (d)(15)(D); and substituted "When" for "Where" at the beginning of subparagraph (d)(15)(E); substituted "paragraph" for "subparagraph" at the end of the second sentence of paragraph (d)(16); deleted "the provisions of" following "facilities pursuant to" near the end of subparagraph (e)(1)(A); and substituted "an instructor licensed pursuant to this article" for "a licensed instructor" in paragraph (e)(7). The third 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, revised punctuation near the end of the first sentence of subparagraph (b.1)(1)(B).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "email" for "e-mail" in three places in paragraph (d)(16); and substituted "laws and rules and regulations" for "laws, rules and regulations" near the end of division (f)(2)(C)(iii).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, subparagraphs (c)(1)(D), (c)(1)(E), and (c)(1)(F) were redesignated as subparagraphs (c)(1)(E), (c)(1)(F), and (c)(1)(D), respectively, and "two hours of continuing" was substituted for "2 hours continuing" in the second sentence of paragraph (c)(8).

33-23-13. Temporary licenses.

(a) In the event of the death of an agent or limited subagent, including a temporary agent or limited subagent, or the inability to act as an agent or limited subagent by reason of service in the armed services of the United States, illness or other disability, or termination of appointment by the insurer, if there is no other individual connected with the agency who is licensed as an agent or limited subagent in regard to insurance of the classification transacted by the agent or limited subagent deceased or unable to act, the Commissioner may issue a temporary license as agent or limited subagent in regard to insurance of such classification to an employee of the agency, to a member of the family of said former agent or limited subagent, or to some associate or to a guardian, receiver, executor, or administrator for the purpose of continuing or winding up the business affairs of the agent, limited subagent, or agency. A temporary license shall be issued only to an applicant who has filed a sworn application upon forms prescribed by the Commissioner. The applicant shall not be required to meet the requirements as to examination, residence, and education required for licensing of agents or limited subagents other than temporary agents. If the Commissioner deems the applicant to be qualified for a temporary license, the Commissioner shall issue the license.

(b) A temporary license may be issued to an individual at the request of an insurer for the purposes of training such individual to act as an agent; provided, however, such individual must perform his or her duties under the supervision of an individual licensed under this article. The Commissioner may prescribe by rules or regulations such further restrictions on such temporary licenses as may be necessary for the protection of the public.

(c) A license issued pursuant to this Code section shall be effective for six months, renewable from time to time for renewal periods of three months in the discretion of the Commissioner; but in no event shall such renewal or any other temporary license of renewal with reference to the same matter extend to a time more than 15 months after the date of the first issuance of a temporary license in such matter.

(d) A temporary license issued pursuant to subsection (a) of this Code section shall authorize the negotiation of renewal policies, the receipt and collection of premiums, and such other acts as are necessary to the continuance of the particular insurance business of the agent or limited subagent. The license shall not authorize the holder thereof to sell, solicit, or negotiate new insurance accounts.

(e) As to any application for a temporary agent's license pursuant to subsection (b) of this Code section, the Commissioner shall require as

part of the application a certificate of the insurer proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the insurer is satisfied that such applicant is trustworthy and qualified to act as its temporary agent and to hold himself or herself out in good faith to the general public as a temporary agent and the fact that the insurer desires that the applicant be licensed as a temporary agent to represent it in this state.

History. — Code 1981, § 33-23-13, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 8/SB 113.

33-23-14. Probationary licenses.

(a) The Commissioner shall have the authority to issue a probationary license to any applicant under this chapter.

(b) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

(c) The Commissioner, at his or her discretion, shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period.

History. — Code 1981, § 33-23-14, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-15. Additional licenses.

The Commissioner may issue two or more licenses to one individual provided the individual meets all qualifications and conditions for each such license.

History. — Code 1981, § 33-23-15, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-16. Licensing of nonresidents.

(a) Unless denied licensure pursuant to Code Section 33-23-21, a nonresident person shall receive a nonresident agent's license if:

(1) The person is currently licensed as a resident and in good standing in such person's home state;

(2) The person has submitted the proper request for licensure and has paid the fees required by Code Section 33-8-1;

(3) The person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to such person's home state or, in lieu of the same, a completed uniform application or a form prescribed by the Commissioner by rule or regulation for licensure of nonresident agents; and

(4) The person's home state awards nonresident agent licenses to residents of this state on the same basis.

(b) The Commissioner may verify the agent's licensing status through the producer data base maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(c) A nonresident agent who moves from one state to another state or a resident agent who moves from this state to another state shall file a change of address and provide certification from the new resident home state within 30 days of the change in legal residence. No fee or application is required.

(d) Notwithstanding any other provision of this title, a person licensed as a surplus lines broker in such person's home state shall receive a nonresident surplus lines broker license pursuant to subsection (a) of this Code section. Except as to subsection (a) of this Code section, nothing in this Code section otherwise amends or supersedes any portion of this title.

(e) Notwithstanding any other provision of this title, a person licensed as a limited lines credit insurance or other type of limited lines agent in such person's home state shall receive a nonresident limited lines agent license pursuant to subsection (a) of this Code section granting the same scope of authority as granted under the license issued by the agent's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to applicable Georgia regulations.

(f) The Commissioner may by rule or regulation implement a renewal process and set expiration dates.

(g)(1) A nonresident individual agent shall not act as an agent of an insurer unless the agent becomes an appointed agent of that insurer as follows:

(A) To appoint an individual as its agent, the appointing insurer shall file, pursuant to Code Section 33-23-26, a notice of appointment within 15 days from the date of licensure or before the first insurance application is submitted. An insurer may also elect to appoint an agent to all or some insurers within the insurer's

holding company system or group by the filing of a single appointment request;

(B) Upon receipt of the notice of appointment, the Commissioner shall verify within a reasonable time, not to exceed 30 days, that the insurance agent is eligible for appointment. If the insurance agent is determined to be ineligible for appointment, the Commissioner shall notify the insurer within five days of such determination; and

(C) An insurer shall pay an appointment fee, in the amount and method of payment set forth in Code Section 33-8-1, for each insurance agent appointed by the insurer.

(2) An insurer shall remit, in a manner prescribed by the Commissioner, a renewal appointment fee in the amount as provided for initial appointments set forth in Code Section 33-8-1.

(3) An agent who is not acting as an agent of an insurer is not required to become appointed.

(h) Applicants whose home state does not require a license to transact business may be licensed in this state, provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from his or her resident state demonstrating the lack of licensing requirement and the state's reciprocity with residents from this state. If the resident state does not license independent adjusters, the independent adjuster shall designate as his or her home state any state in which the independent adjuster is licensed and in good standing.

History. — Code 1981, § 33-23-16, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2012, p. 1040, § 8/SB 203; Ga. L. 2012, p. 1350, § 7/HB 1067.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, "supersedes" was substituted for "supercedes" in the last sentence in subsection (d).

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 109 et seq.

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

33-23-17. Registration of nonresident representatives to represent life insurers in military installations in foreign countries.

An individual who is not a resident of this state may be registered to represent an authorized life insurer domiciled in this state, provided

such individual only represents the insurer exclusively at a United States military installation located in a foreign country. The Commissioner may, upon request of the insurer on application forms prescribed by the department and upon payment of an annual registration fee of $25.00, issue a certificate of registration to the individual. An official of the insurer shall certify to the Commissioner that the applicant has the necessary training to hold himself or herself out as a foreign life or accident and sickness insurance representative; and the official of the insurer shall further certify on behalf of his or her insurer that it is willing to be bound by the acts of such applicant within the scope of his or her employment and that such applicant has not had his or her privileges to solicit on or enter any United States military installation revoked, suspended, or restricted in any manner. Such certificate shall expire as of December 31 succeeding the date of its issuance unless it is terminated at an earlier time in accordance with this chapter and Chapter 2 of this title.

History. — Code 1981, § 33-23-17, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 563, § 4/HB 407.

33-23-18. Issuance of license on biennial basis; filing for renewal; continuing education requirements.

(a) All resident agent, limited subagent, adjuster, and counselor licenses, with the exception of temporary or probationary licenses, shall be issued on a biennial basis and shall expire on the last day of the licensee's birth month.

(b) Resident agent, limited subagent, adjuster, and counselor licenses may be renewed upon receipt by the Commissioner of evidence of such continuing education as the Commissioner may establish by rule or regulation and payment of such fees as are provided by law.

(c) Renewal of the license on forms prescribed by rule or regulation must be made prior to the last day of the licensee's birth month and biennially thereafter.

(d) Continuing education requirements imposed by the Commissioner pursuant to this Code section shall not exceed 15 classroom hours for each licensed individual who has held a license for less than 20 years during the year. For those individuals who have held a license for 20 years or more, the requirement shall be no more than ten classroom hours during the year. However, the Commissioner may provide by rule or regulation for continuing education requirements on a biennial basis.

(e) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the

functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from continuing education requirements; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply with the requirements of this chapter, including without limitation the requirements for continuing education. The Commissioner may provide, by rule or regulation, for any other exemption to or reduction in continuing education required under this Code section.

(f) Every individual required to participate in a continuing education program pursuant to this Code section, or such individual's insurer, shall furnish the Commissioner such information as the Commissioner deems necessary to verify compliance with the continuing education requirements.

(g) The Commissioner by rule or regulation may establish the following:

(1) Staggered deadlines for the filing of forms for renewal of licenses and the corresponding required fees; and

(2) Penalties and procedures for licensees who fail to comply with subsection (c) of this Code section.

History. — Code 1981, § 33-23-18, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 11; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 9/SB 113; Ga. L. 2011, p. 623, § 3/SB 251; Ga. L. 2012, p. 37, § 2/HB 477; Ga. L. 2019, p. 386, § 8/SB 133.

The 2019 amendment, effective July 1, 2019, deleted ", except as provided in subsection (c.1) of this Code section" at the end of subsections (a) and (c); and deleted subsection (c.1), which read: "All licenses that expire on December 31, 2012, shall be transitioned to a biennial term and shall expire on the last day of the licensee's birth month, provided that, during the transition, the Commissioner may, as provided by rule or regulation, renew such licenses for a term greater or shorter than the biennial term and may prorate the license renewal fees."

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "ten" was substituted for "10" in subsection (d).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, §§ 67 et seq., 129, 130.

33-23-19. Placing of license on inactive status; subsequent revocation.

(a) An agent's license shall be placed on inactive status when the agent no longer has on file with the Commissioner a certificate of

authority to represent at least one insurer licensed to do business in this state.

(b) When a license is placed on inactive status under this Code section, the agent shall be prohibited from selling, soliciting, or negotiating insurance.

(c) During the time a license is in inactive status under the provisions of this Code section, the licensee still shall be required to provide evidence of compliance with the continuing education requirements of Code Section 33-23-18.

History. — Code 1981, § 33-23-19, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 10/SB 113.

33-23-20. Effect of license suspension or placement of license on inactive status.

(a) The suspension of the license of an agent or limited subagent or the placing of such license on inactive status shall not deprive such individual or the executors or administrators of such individual's estate of any right that may have been acquired by a contract made before such suspension or placement on inactive status to receive all or a portion of commissions upon contracts of insurance written before such suspension or placement on inactive status with reference to the periods of time during which such contracts are in effect, including renewal option periods provided in the contracts.

(b) In case of a sale of an agency upon a work-out basis, the seller without maintaining his or her license or the executors and administrators of the seller's estate may participate in the proceeds of premiums on insurance written by the purchaser of the agency when and as authorized to do so by the contract of sale of the agency; and this participation may be without limitation of time after the seller ceased to hold a license. An agent whose license has been suspended or placed in inactive status may, when the countersignature of a resident licensed agent is required pursuant to Code Section 33-3-26 and if authorized by the insurer, countersign certificates and endorsements necessary to continue coverage to the expiration date, including renewal option periods.

(c) Nothing in this article shall be construed to permit an agent or limited subagent whose license has been suspended or placed in inactive status to sell, solicit, or negotiate insurance other than as expressly permitted in subsections (a) and (b) of this Code section.

History. — Code 1981, § 33-23-20, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 5; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 11/SB 113; Ga. L. 2019, p. 386, § 9/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (b), in the first sentence, substituted "seller" for "vendor" in two places and substituted "seller's" for "vendor's".

33-23-21. Grounds for refusal, suspension, or revocation of license.

A license, other than a probationary license, may be refused or a license duly issued may be suspended or revoked by the Commissioner if the Commissioner finds that the applicant for or holder of the license:

(1) Has violated any provision of this title, of any other law or regulation of this state relating to insurance, or the law or regulation of any jurisdiction, including those of a military installation, relating to the transaction of insurance;

(2) Has misrepresented or concealed any material fact in any application for a license or on any form filed with the Commissioner;

(3) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(4) Has misappropriated, converted to his or her own use, or illegally withheld money belonging to an insurer, insured, agent, agency, applicant, or a beneficiary;

(5) Has committed fraudulent or dishonest practices;

(6) Has materially misrepresented the terms and conditions of an insurance policy or contract;

(7) Has failed to pass an examination pursuant to this article, or cheated on any examination required for a license;

(8) Has failed to comply with or has violated any proper order, rule, or regulation, issued by the Commissioner, including any order issued by the Commissioner or the Commissioner's designated representative during the course of any administrative hearing proceeding;

(9) Is not in good faith carrying on business as an agent or subagent, but, on the contrary, is holding such license for the purpose of securing rebates or commissions or controlled business;

(10) Is not in good faith carrying on business as a licensee under this chapter;

(11) Has shown lack of trustworthiness or lack of competence to act as an licensee under this chapter;

(12) Has knowingly participated in the writing or issuance of substantial overinsurance of any property insurance risk;

(13) Has failed or refused, upon written demand, to pay over to any insurer, agent, agency, applicant, beneficiary, or insured any moneys which belong to such insurer, agent, agency, applicant, beneficiary, or insured;

(14) Has failed to provide documentation or records, or refused to appear:

(A) In compliance with Code Section 33-2-12 or 33-2-13;

(B) In response to a written demand by the Commissioner sent by registered or certified mail or statutory overnight delivery to the last known address of the licensee as shown in the records of the Commissioner; or

(C) In support of an application for license or renewal of license upon request by the department or as otherwise required by the application or renewal;

(15) Has been convicted of any felony or of any crime involving moral turpitude in the courts of this state or any other state, territory, or country or in the courts of the United States; as used in this paragraph and paragraph (16) of this subsection, the term "felony" shall include any offense which, if committed in this state, would be deemed a felony, without regard to its designation elsewhere; and, as used in this paragraph, the term "conviction" shall include a finding or verdict of guilty or a plea of guilty, regardless of whether an appeal of the conviction has been sought;

(16) Has been arrested, charged, and sentenced for the commission of any felony, or any crime involving moral turpitude, where:

(A) First offender treatment without adjudication of guilt pursuant to the charge was granted; or

(B) An adjudication of guilt or sentence was otherwise withheld or not entered on the charge.

The order entered pursuant to the provisions of Article 3 of Chapter 8 of Title 42, relating to probation of first offenders, or other first offender treatment shall be conclusive evidence of arrest and sentencing for such crime;

(17) Has failed to report to the Commissioner any criminal prosecution of the applicant or licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from any hearing that has taken place, and any other relevant legal documents. Such report must be filed with the application or within 30 days of the date of arrest;

(18) Has had a license to practice a business or profession licensed under the laws of this state or any other state, territory, country, or

the United States revoked, suspended, or annulled by any lawful licensing authority; had other disciplinary action taken against him or her by any such lawful licensing authority; was denied or refused a license by any such lawful licensing authority pursuant to disciplinary proceedings; or was refused the renewal of a license by any such lawful licensing authority pursuant to disciplinary proceedings;

(19) Has failed to notify the Commissioner within 60 days of any event referred to in paragraph (15), (16), or (18) of this Code section;

(20) Is not in compliance with an order for child support as defined by Code Section 19-6-28.1 or 19-11-9.3; for violations of this paragraph only, any hearing and appeal procedures conducted pursuant to such Code sections shall be the only such procedures required to suspend, deny, or revoke any license under this title;

(21) In relation to the licensee's ability to transact the business of insurance, has had a license, permit, authorization, registration, or privilege refused, revoked, suspended, limited, or restricted by any federal, state, county, municipality, territory, military, or other legal authority authorized to issue licenses, permits, authorizations, registrations, or privileges to conduct business within its respective jurisdiction; otherwise has failed to comply with the legal requirements related to the license, permit, authorization, registration, or privilege; or has had other disciplinary action taken against him or her by any such lawful authority; or

(22) Has failed to report to the department within 60 days of the action taken, any refusal, revocation, suspension, limitation, or restriction of any license, permit, authorization, registration, or privilege of any lawful authority referenced in paragraph (18) or (21) of this Code section.

History. — Code 1981, § 33-23-21, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 1996, p. 453, § 9; Ga. L. 1997, p. 1296, § 8; Ga. L. 1998, p. 1094, § 8; Ga. L. 2000, p. 1589, § 3; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 563, § 5/HB 407; Ga. L. 2019, p. 462, § 1-8/SB 214; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted former paragraph (21), which read: "Is a borrower in default who is not in satisfactory repayment status as defined by Code Section 20-3-295; for violations of this paragraph only, any hearing and appeal procedures conducted pursuant to Code Section 20-3-295 shall be the only such procedures required to suspend, deny, or revoke any license under this title;"; redesignated former paragraphs (22) and (23) as present paragraphs (21) and (22), respectively; and substituted "paragraphs (18) or (21)" for "paragraphs (18) or (22)" near the end of paragraph (22).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "paragraph (18)" for "paragraphs (18)" near the end of paragraph (22).

Editor's notes. — Ga. L. 2000, p. 1584, § 16, not codified by the General Assembly, provides that the amendment to this Code section is applicable with respect to notices delivered on or after July 1, 2000.

JUDICIAL DECISIONS

Evidence sufficient to support findings. — In a proceeding on revocation of an insurance agent's license, evidence that the agent withheld premium refunds and delayed payment to clients in order to pay office expenses, failed to inform clients concerning the clients' refunds, and was not diligent in servicing the agent's clients' policies was sufficient to support the Commissioner's findings that the agent violated provisions of O.C.G.A. § 33-23-21. Commissioner of Ins. v. Stryker, 218 Ga. App. 716, 463 S.E.2d 163 (1995).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 42 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 67 et seq., 124.

ALR. — Right of insurer to challenge agent's classification of risk, 29 A.L.R. 99.

Constitutionality, construction, and application of statute respecting cancelation or suspension or renewal of license of insurance agent, 154 A.L.R. 1146.

Liability of insurance agent, for exposure of insurer to liability, because of failure to cancel or reduce risk, 35 A.L.R.3d 792.

Liability of insurance agent, for exposure of insurer to liability, because of failure to fully disclose or assess risk or to report issuance of policy, 35 A.L.R.3d 821.

Liability of insurance agent, for exposure of insurer to liability, because of issuance of policy beyond authority or contrary to instructions, 35 A.L.R.3d 907.

Liability of insurance broker or agent to insured for failure to procure insurance, 64 A.L.R.3d 398.

Insurer's liability to insurance agent or broker for damages suffered as result of insurer's denial of coverage or refusal to pay policy proceeds to insured, 6 A.L.R.5th 611.

33-23-21.1. Licensing for educational borrowers in default.

The Commissioner shall not refuse to issue nor suspend or revoke a license of an applicant for or holder of a license because he or she is a borrower in default under the Georgia Higher Education Loan Program as determined by the Georgia Higher Education Assistance Corporation or has been certified by any entity of the federal government for nonpayment or default or breach of a repayment or service obligation under any federal educational loan, loan repayment, or service conditional scholarship program.

History. — Code 1981, § 33-23-21.1, enacted by Ga. L. 2019, p. 462, § 1-9/SB 214.

Effective date. — This Code section became effective July 1, 2019.

RESEARCH REFERENCES

Am. Jur. 2d. — 51 Am. Jur. 2d, Licenses and Permits, § 56 et seq.

C.J.S. — 53 C.J.S., Licenses, § 85 et seq.

33-23-22. Notice of suspension or revocation of license; hearing; appeals.

(a) Any license, other than a probationary license or inactive license as described in subsection (a) of Code Section 33-23-19, may be suspended or revoked as provided by Code Section 33-23-21 and subsection (b) of Code Section 33-23-19, and the Commissioner shall give notice of such action to the applicant for or holder of the license and any insurer or agent whom the applicant or licensee represents or who desires that the applicant or licensee be licensed. The procedure for conduct of hearings set forth in Chapter 2 of this title shall be followed in all cases except those cases pursuant to paragraph (20) of Code Section 33-23-21 which shall only require the hearings provided for in said paragraph.

(b) Appeal from any order or decision of the Commissioner made pursuant to this chapter shall be taken as provided in Chapter 2 of this title.

History. — Code 1981, § 33-23-22, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 453, § 10; Ga. L. 1998, p. 1094, § 9; Ga. L. 2001, p. 925, § 1; Ga. L. 2019, p. 462, § 1-10/SB 214.

The 2019 amendment, effective July 1, 2019, in subsection (a), substituted "described in subsection (a)" for "described in subsection (b)" near the middle of the first sentence, and, in the second sentence, deleted "or (21)" following "paragraph (20)", and substituted "in said paragraph" for "in either paragraph" near the end.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, "paragraph (20)" was substituted for "paragraph 20" in the last sentence in subsection (a).

JUDICIAL DECISIONS

Procedural safeguards must be provided if hearing takes place. — In the event a hearing takes place, the Commissioner must accord all the procedural safeguards provided as hearing requirements of the Insurance Code 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).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 42 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 67 et seq., 124.

ALR. — Constitutionality, construction, and application of statute respecting cancellation, suspension or renewal of license of insurance agent, 154 A.L.R. 1146.

33-23-23. Limitation on application after refusal or revocation of license; effect of surrender of license under written consent order.

(a) No licensee or applicant whose license or application has been refused or revoked as provided by Code Sections 33-23-21 and 33-23-22

shall be entitled to file another application for a license as an agent, agency, limited subagent, surplus lines broker, counselor, or adjuster within five years from the effective date of the refusal, revocation, or, if judicial review of such refusal or revocation is sought, within five years from the date of the final court order or decree affirming such refusal or revocation.

(b) The application when filed may be refused by the Commissioner unless the applicant shows good cause why the refusal or revocation of the license shall not be deemed a bar to the issuance of a new license.

(c) Any surrender of a license under written consent order shall have the same effect as a revocation under subsections (a) and (b) of this Code section.

History. — Code 1981, § 33-23-23, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 9; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 12/SB 113; Ga. L. 2019, p. 386, § 10/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "Any" for "By law, any" at the beginning of subsection (c).

33-23-24. Permits and licenses not transferable.

The permits of service representatives and licenses of licensees under this article shall not be transferable.

History. — Code 1981, § 33-23-24, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-25. Place of business.

Every licensed agent, limited subagent, counselor, and adjuster shall have and maintain in this state or, if a nonresident licensee, in the state of domicile, a place of business accessible to the public. The place of business shall be that wherein the licensee principally conducts transactions pursuant to the license. The address of the place of business shall be maintained by the Commissioner. All resident and nonresident licensees shall promptly notify the Commissioner in writing within 30 days of any change in the business address.

History. — Code 1981, § 33-23-25, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2006, p. 652, § 8/HB 1257; Ga. L. 2008, p. 1076, § 13/SB 113.

33-23-26. Agent's certificate of authority.

(a) Each insurer authorized to transact insurance in this state shall obtain an agent's certificate of authority for each agent representing such insurer in the selling, soliciting, or negotiating of contracts of

insurance in this state. For the purposes of this subsection, the insurer will be deemed to have obtained a certificate of authority for its designated agent immediately upon submission of the appointment request to the Commissioner; provided, however, that the initial certificate of authority for an applicant for licensure shall not become effective until the date such applicant is finally granted a license by the Commissioner.

(b) All agents' certificates of authority shall be renewed by the insurer in such form and manner as the Commissioner may prescribe by rule or regulation.

(c) The fee for each agent's certificate of authority or renewal thereof shall be as provided in Code Section 33-8-1.

(d) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with an agent shall notify the Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Commissioner, if the reason for the termination is one of the reasons set forth in Code Section 33-23-21 or the insurer has knowledge that the agent was found to have engaged in any of the activities in Code Section 33-23-21 by a court, governmental body, or self-regulatory organization authorized by law. Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the agent.

(e) If an agent's certificate of authority is terminated, the insurer promptly shall give notice of said termination and the effective date of the termination to the Commissioner and to the agent where reasonably possible. The Commissioner may also require the insurer to demonstrate to the satisfaction of the Commissioner that the insurer has made a reasonable effort to give notice to the agent.

(f) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with an agent for any reason not set forth in Code Section 33-23-21 shall notify the Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, and other data pertaining to such termination.

(g) The insurer or the authorized representative of the insurer shall promptly notify the Commissioner in a format acceptable to the Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commissioner in accordance with subsection (d) of this Code section had the insurer known of its existence.

(h) No certificate of authority shall be required for an agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(i) As to any application for an agent's certificate of authority, the Commissioner shall require as part of the application a certificate of the insurer proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the insurer or sponsoring agent is satisfied that such applicant is trustworthy and qualified to act as its agent in this state.

History. — Code 1981, § 33-23-26, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1993, p. 702, § 2; Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2008, p. 1076, § 14/SB 113.

33-23-27. Subagent's certificate of authority.

(a) Each agent licensed in this state shall obtain a certificate of authority for each subagent representing such agent in this state.

(b) Each subagent's certificate of authority shall be renewed by the agent not more than once every three years in such form and manner as specified by the Commissioner by rule or regulation.

(c) Each agent shall also be required to inform the Commissioner of any termination of or change to any certificate of authority for each subagent in such form and manner as may be prescribed by the Commissioner by rule or regulation.

(d) The fee for each subagent's certificate of authority or renewal or duplicate thereof shall be as provided by law.

(e) The subagent's certificate shall be held by the agent and shall be returned to the Commissioner upon termination of the subagent's authority along with an explanation of the reason for such termination in such form and manner as the Commissioner may specify by rule or regulation.

History. — Code 1981, § 33-23-27, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-28. Scope of subagent's authority; record of transactions.

(a) A subagent's certificate of authority shall not cover any kind of insurance for which the sponsoring agent and subagent are not licensed.

(b) A subagent or limited subagent shall not have power to bind an insurer.

(c) All business transacted by a subagent under such subagent's license or limited subagent shall be in the name of the agent by whom the subagent or limited subagent is employed; and the agent shall be responsible for all the acts or omissions of the subagent or limited subagent within the scope of his or her employment.

(d) A record of each transaction shall be maintained jointly by the agent and the subagent or limited subagent.

History. — Code 1981, § 33-23-28, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 6; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 15/SB 113; Ga. L. 2019, p. 386, § 11/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "maintained jointly by the agent" for "maintained by both the agent" in subsection (d).

33-23-29. Authority of agent to act as adjuster; nonresident adjusters; reciprocal agreements.

(a) On behalf of and as authorized by an insurer for which he or she is licensed as agent, an agent may from time to time act as an adjuster and investigate and report upon claims without being required to be licensed as an adjuster.

(b) No license by this state shall be required:

(1) Of a nonresident independent adjuster for the adjustment in this state of a single loss or of losses arising out of a catastrophe common to all such losses; or

(2) Of a nonresident adjuster who regularly adjusts in another state and who is licensed in such other state, if such state requires a license, to act as adjuster in this state for emergency insurance adjustment work for a period not exceeding 60 days and performed for an employer that is an insurance adjuster licensed by this state or that is a regular employer of one or more insurance adjusters licensed by this state, provided that such employer shall furnish to the Commissioner a notice in writing immediately upon the beginning of the emergency insurance adjustment work.

(c) An individual residing in another state may be licensed by the Commissioner as a nonresident adjuster under the following circumstances and in the following manner:

(1) Upon written application and payment of the required license fee and without requiring a written examination, the Commissioner shall issue a license to an individual to act as a nonresident adjuster if the individual is licensed in his or her home state as an adjuster;

(2) The required fee for the license shall be the fee provided by law or the sum which is charged as a license fee for nonresident adjusters by the state of the applicant's residence, whichever is greater; and

(3) Applicants whose home state does not require a license to transact business may be licensed in this state, provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from such applicant's resident state demonstrating the lack of licensing requirements in such state and such state's reciprocity with residents of this state.

(d) The Commissioner shall issue a license to an individual to act as a nonresident adjuster if, by the laws of the state of the applicant's residence, residents of this state may be licensed as nonresident adjusters in the same manner.

(e) The Commissioner is authorized to enter into reciprocal agreements with the appropriate official of any other jurisdiction for the purpose of implementing this Code section.

(f) No resident of Canada may be licensed as a nonresident independent adjuster unless such person has obtained a resident or home state independent adjuster license.

History. — Code 1981, § 33-23-29, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 16/SB 113; Ga. L. 2012, p. 1040, § 9/SB 203; Ga. L. 2012, p. 1350, § 8/HB 1067; Ga. L. 2019, p. 386, § 12/SB 133.

The 2019 amendment, effective July 1, 2019, in paragraph (b)(2), in the first sentence, substituted "that is" for "who is" in two places, substituted "such employer" for "the employer", and deleted the former second sentence, which read: "The Commissioner may by rule or regulation establish criteria and procedures for adjusters operating under this Code section."

33-23-29.1. Licensing of nonresident counselors.

(a) An individual residing in another state may be licensed by the Commissioner as a nonresident counselor under the following circumstances and in the following manner:

(1) Upon written application and payment of the required license fee and without requiring a written examination, the Commissioner shall issue a license to an individual to act as a nonresident counselor if the individual is licensed in his or her home state as a counselor;

(2) Applicants whose home state does not require a license to transact business as a counselor may be licensed in this state provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from the applicant's resident home state demonstrating the lack of a licensing requirement and such state's reciprocity with residents of this state; and

(3) The required fee for the license shall be the fee provided by law or the sum which is charged as a license fee for nonresident

counselors by the state of the applicant's residence, whichever is greater.

(b) The Commissioner shall issue a license to an individual to act as a nonresident counselor if, by the laws of the state of the applicant's residence, residents of this state may be licensed as nonresident counselors in the same manner.

(c) The Commissioner is authorized to enter into reciprocal agreements with the appropriate official of any other jurisdiction for the purpose of implementing this Code section.

History. — Code 1981, § 33-23-29.1, enacted by Ga. L. 2001, p. 925, § 1; Ga. L. 2005, p. 60, § 33/HB 95.

33-23-30. Restrictions on signing by agents.

An agent shall not sign in blank any policy to be issued outside of such agent's office. An agent shall not give power of attorney to or otherwise authorize anyone to sign the agent's name to policies unless the person so authorized is directly employed by the agent and no other person, and the person has no office files, equipment, or address in regard to the insurance business other than those in the office of the agent. Nothing in this Code section shall prohibit an agent from authorizing an insurer represented by such agent to reproduce mechanically or electronically such agent's signature on policies, certificates, endorsements, riders, or other insurance contract documents.

History. — Code 1981, § 33-23-30, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 7; Ga. L. 2001, p. 925, § 1.

Law reviews. — For annual survey on administrative law, see 61 Mercer L. Rev. 1 (2009).

33-23-31. Risk situs; service on nonresidents; venue of action.

(a) A risk shall be deemed to have a situs in this state if the insurance is upon or in regard to property having a permanent situs in this state or movable property which is actually in this state or is principally used or kept in this state or on persons resident in this state.

(b) Each nonresident by obtaining a license in this state or by doing business in this state shall be deemed to have consented that any notice provided in this chapter and any summons, notice, or process in connection with any action or proceeding in any state or federal court in this state, which notice, summons, or process grows out of or is based upon any business or acts done or omitted to be done in this state, may be sufficiently served upon such nonresident by serving the same upon the Commissioner. Service shall be made by leaving with the office of the Commissioner a copy of the notice, summons, or process with a fee.

The fee for such service shall be as provided by law. Such service shall be sufficient service upon the nonresident, provided that notice of the service and a copy of the notice, summons, or process shall be immediately sent by registered or certified mail or statutory overnight delivery by the plaintiff or by the Commissioner to the residence of the nonresident addressed to the nonresident. The nonresident's return receipt and the affidavit of compliance with the notice, summons, or process made by the plaintiff or the plaintiff's attorney or by the Commissioner shall be appended to the notice, summons, or process and filed with the case in the court where it is pending or filed with the Commissioner if in regard to a proceeding provided under this chapter. Venue of such an action shall be in the county of the residence of a plaintiff in the action, if the plaintiff resides in this state; otherwise venue shall be in Fulton County. The place of residence of a licensed nonresident placed on file by him or her with the Commissioner shall be deemed to be his or her place of residence until the nonresident places on file with the Commissioner a written notice stating another place of residence. As used in this subsection, the term "process" shall include a petition or complaint attached thereto.

History. — Code 1981, § 33-23-31, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 12; Ga. L. 1998, p. 1091, § 2; Ga. L. 1999, p. 878, § 8; Ga. L. 2000, p. 1589, § 3; Ga. L. 2001, p. 925, § 1; Ga. L. 2019, p. 386, § 13/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (b), in the second sentence, inserted "with the office of the Commissioner" in the middle, and deleted "in the hands of the Commissioner" at the end, and inserted "or complaint" in the last sentence.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to this Code section is applicable with respect to notices delivered on or after July 1, 2000.

Law reviews. — 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).

RESEARCH REFERENCES

ALR. — Right of insurer to challenge agent's classification of risk, 28 A.L.R. 99.

33-23-32. Countersigning by resident agents not required generally; exceptions; commissions.

Except when required in retaliation pursuant to Code Section 33-3-26, insurance contracts on risks or property located or having a situs in this state need not be countersigned by an agent duly licensed in accordance with Code Section 33-23-5; but, if a licensed nonresident agent participates in the effectuation of such contract and a countersignature is so required, the countersigning agent licensed in accordance with Code Section 33-23-5 shall be entitled to the same commis-

sion as allowed by the state of residence of the licensed nonresident but, in any event, to not more than 50 percent of the commission. Nothing contained in this Code section shall be construed to require a company to make additional compensation in the way of commissions or otherwise to a person who is paid on a salary basis.

History. — Code 1981, § 33-23-32, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 13; Ga. L. 1999, p. 878, § 9; Ga. L. 2001, p. 925, § 1.

33-23-33. Duty of licensees to provide current information of names and addresses.

(a) Every licensee under this chapter shall keep the Commissioner advised of:

(1) The office address of the licensee;

(2) The residence address of the licensee;

(3) The name and address of each insurer that the licensee represents directly or indirectly;

(4) The name and address of each agency of which the licensee is proprietor, partner, officer, director, or employee or which the licensee represents;

(5) Every trade name of such agency; and

(6) The names of all partners and members of any firm or association and the corporate name of any corporation owning or operating such agency as such information changes.

(b) Any change in the information required by subsection (a) of this Code section shall be transmitted to the Commissioner within 30 days of such change on forms prescribed by the Commissioner.

(c) The Commissioner shall prescribe by rule or regulation the form and manner by which such information will be transmitted.

History. — Code 1981, § 33-23-33, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 10; Ga. L. 2001, p. 925, § 1; Ga. L. 2019, p. 386, § 14/SB 133.

The 2019 amendment, effective July 1, 2019, substituted the present provisions of subsection (a) for the former provisions, which read: "Every licensee under this chapter shall keep the Commissioner advised of: the office address of the licensee; the residence address of the licensee; the name and address of each insurer that the licensee represents directly or indirectly; the name and address of each agency of which the licensee is proprietor, partner, officer, director, or employee or which the licensee represents; every trade name of such agency; and the names of all partners and members of any firm or association and the corporate name of any corporation owning or operating the agency as such information changes."

33-23-34. Records of transactions.

(a) Every agent, limited subagent, counselor, and adjuster under this chapter shall keep at the address as shown on his or her license or at the insurer's regional or home office situated in this state a record of all transactions consummated under such license. The record shall be in organized form and shall include:

(1) In the case of an agent or limited subagent, a record of each insurance contract procured or issued together with the names of the insurers and insureds, the amount of premium paid or to be paid, and a statement of the subject of the insurance; and the names of any other licensees from whom business is accepted and of persons to whom commissions or allowances of any kind are promised or paid;

(2) In the case of an adjuster, a record of each investigation or adjustment undertaken or consummated and a statement of any fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment; and

(3) Such other and additional information as may be customary or as may be reasonably required by the Commissioner.

(b) All records as to any particular transaction shall be kept for a term of five years beginning immediately after the completion of the transaction or the term of the contract, whichever is greater, provided that records of losses adjusted by an independent adjuster may be kept at the office of the insurer for whom the adjuster acted.

(c) In the case of agents or limited subagents, the maintaining of the records required by this Code section at the insurance agency licensed under this chapter for which agency the transaction was undertaken shall be deemed to comply with the requirements of subsection (a) of this Code section.

History. — Code 1981, § 33-23-34, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 11; Ga. L. 1999, p. 878, § 10; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 17/SB 113.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "whom" was substituted for "who" in paragraph (a)(1).

33-23-35. Reporting and disposition of premiums.

(a) An agent, limited subagent, or any other representative of an insurer or of any other person in the effectuation of an insurance contract shall report to the insurer or its agent the premium for the contract and the amount shall be shown in the contract. Each willful violation of this subsection shall constitute a misdemeanor.

(b) All funds representing premiums received or return premiums due the insured by any agent or subagent shall be accounted for in the licensee's fiduciary capacity, shall not be commingled with the licensee's personal funds, and shall be promptly accounted for and paid to the insurer, insured, or agent as entitled to such funds. Nothing contained in this Code section shall be deemed to require any agent or subagent to maintain a separate bank deposit for the funds of each principal, if the funds so held for each principal are reasonably ascertainable from the books of accounts and records of the agent or subagent.

(c) Any violation of this Code section shall constitute grounds or cause for action by the Commissioner, including, but not limited to, probation, suspension, or revocation of the license. Each and every act by a licensee shall also constitute grounds for fines and penalties, which amounts shall be set by rule or regulation of the Commissioner. Any willful violation of this Code section shall constitute a misdemeanor unless such amounts involved exceed $1,000.00, whereby such violation shall constitute a felony.

History. — Code 1981, § 33-23-35, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 18/SB 113; Ga. L. 2019, p. 386, § 15/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "$1,000.00" for "$500.00" in the third sentence of subsection (c).

Cross references. — Theft by conversion, § 16-8-4.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code Section 33-23-79 are included in the annotations to this Code section.

Insurance premium deposited to bank account of agent represented "trust funds" in possession of the agent on behalf of the insured and the bank's setoff against the account in the amount of an unpaid loan to the agent was improper. Bank of Spalding County v. Pound, 213 Ga. App. 324, 444 S.E.2d 375 (1994).

Assignment of unearned return premiums to financing company creates fiduciary duty. — When the contract entered into by an insured and a premium finance company provided for the assignment of any and all unearned return premiums and dividends to the financing company, the assignment created a fiduciary relationship between the parties pursuant to subsection (b) of former § 33-23-79 (see O.C.G.A. § 33-23-35(b)), and the failure on the part of the insured to pay a returned premium to the financing company, for whatever reason, was a breach of this fiduciary duty such that the debt for this amount was nondischargeable in bankruptcy. National Premium Budget Plan Corp. v. Nicholson, 55 Bankr. 645 (Bankr. N.D. Ga. 1985) (decided under former O.C.G.A. § 33-23-79).

Prompt accounting for refunds. — In a proceeding on revocation of an insurance agent's license, evidence that the agent waited between 48 and 57 days after depositing checks before sending premium refunds to clients supported a finding that the refunds were not "promptly accounted for" as required by O.C.G.A. § 33-23-35. Commissioner of Ins. v. Stryker, 218 Ga. App. 716, 463 S.E.2d 163 (1995).

Fiduciary relationship between broker and insurer. — When parties A, B and C arrange that C will provide in-

surance to A, and A will give B money for the purpose of paying C, B owes fiduciary duties to both A and C; accordingly, the fact that the parties' relationship arises from a contract does not preclude the possibility of a tort claim if the elements of the claim are otherwise established. Unified Servs., Inc. v. Home Ins. Co., 218 Ga. App. 85, 460 S.E.2d 545 (1995).

Fiduciary status of agents. — Bankruptcy debtors who administered employment benefit plans were fiduciaries for purposes of nondischargeability of debts to the plans under 11 U.S.C. § 523(a)(4) as licensed insurance agents, since O.C.G.A. § 33-23-35(b) created an express statutory trust, and the debtors' administration of the plans through a corporation did not abrogate the debtors' fiduciary status as individuals under O.C.G.A. § 33-23-1. Nat'l Air Traffic Controllers Assoc. v. Davenport (In re Davenport), No. 05-76748-MHM, 2007 Bankr. LEXIS 3725 (Bankr. N.D. Ga. Sept. 6, 2007).

Cited in Herring v. Standard Guar. Ins. Co., 238 Ga. 261, 232 S.E.2d 544 (1977); Seibels, Bruce & Co. v. England, 63 Bankr. 76 (Bankr. N.D. Ga. 1986); Hubbard v. Stewart, 651 F. Supp. 294 (M.D. Ga. 1987); Surety Group, Inc. v. Ragsdale, 197 Ga. App. 437, 398 S.E.2d 718 (1990); Moseley v. Coastal Plains Gin Co., 199 Ga. App. 99, 404 S.E.2d 123 (1991).

33-23-36. Inquiry into illegal or improper conduct.

The Commissioner may upon his or her own motion and shall upon a written complaint signed by a citizen of this state and filed with the Commissioner inquire into any alleged illegal or improper conduct of any licensee or inquire into the question of whether a licensee is untrustworthy or not competent or not qualified to act as a licensee under this chapter. No finding or decision adverse to any person in regard to whom the inquiry is conducted shall be made by the Commissioner until after notice and hearing as provided in Chapter 2 of this title.

History. — Code 1981, § 33-23-36, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-37. Licensing of surplus lines broker; application; bond; written examination.

(a) Nothing in this chapter shall prevent the placing of surplus lines of insurance when authorized and permitted under this title.

(b) Any person, while licensed as a resident agent as to property, casualty, and surety insurance and who is deemed by the Commissioner to be competent and trustworthy, may be licensed as a surplus lines broker as follows:

(1) Application to the Commissioner for the license shall be on forms furnished by the Commissioner;

(2) The license fee shall be in an amount as provided in Code Section 33-8-1;

(3) Each license shall be issued on a biennial basis and shall expire on the last day of the licensee's birth month and may be renewed by

filing an application and paying the prescribed fee in accordance with this Code section;

(4) Prior to the issuance of the license or any renewal of the license, the applicant shall file a bond with the Commissioner or his or her successor in office, for the benefit of any person injured by the violation of the conditions provided in this paragraph. The bond shall be executed by the applicant as principal and by a corporate surety authorized to do business in this state and shall be in the penal sum of $50,000.00, conditioned that the applicant will comply with the following:

(A) Place insurance only in compliance with Code Section 33-5-25;

(B) Remit promptly the taxes provided in Code Section 33-5-31;

(C) Account to any person requesting him or her to obtain insurance for funds or premiums collected in connection with such insurance; and

(D) Otherwise conduct business in accordance with this title.

The bond shall not be terminated unless prior to such termination 30 days' written notice is filed with the Commissioner; and

(5) Each applicant for a license to act as a surplus lines broker shall submit to a personal written examination to determine his or her competence, unless the applicant is licensed as a surplus lines broker in his or her home state.

History. — Code 1981, § 33-23-37, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 623, § 4/SB 251; Ga. L. 2012, p. 37, § 3/HB 477; Ga. L. 2019, p. 386, § 16/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "except as provided in paragraph (3.1) of this subsection" at the end of paragraph (b)(3), and deleted former paragraph (b)(3.1), which read: "All licenses that expire on December 31, 2012, shall be transitioned to a biennial term, provided that, during the transition, the Commissioner may, as provided by rule or regulation, renew such licenses for a term greater or shorter than the biennial term and may prorate the license renewal fees;".

Cross references. — Licensing of surplus line brokers generally, § 33-5-22.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, a colon was substituted for a semicolon at the end of the introductory language of paragraph (b)(4).

33-23-38. Placing insurance beyond scope of license or with nonlicensed insurers prohibited; restrictions on sharing commissions; penalty for violation.

(a) No agent or limited subagent shall place any insurance or receive any remuneration in regard to any insurance of a classification outside the scope of such agent's or limited subagent's license, nor shall the

agent or limited subagent share a commission except with an agent licensed pursuant to this article; with an agency that has as its proprietor or as a partner in the agency or as an officer or employee of the agency one or more agents licensed in regard to insurance that is within the scope of his or her agency; or with an agent or agency having a residence or situs in another state and a license from such other state for the transaction of insurance in that state.

(b) Except as otherwise provided in this title, no person shall solicit or be instrumental in placing insurance upon any risk having a situs in this state except with an insurer admitted to do insurance business in this state.

(c) A violation of this Code section shall authorize, among other penalties, the revocation of the violator's license as an agent or subagent.

History. — Code 1981, § 33-23-38, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 19/SB 113.

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 1C Am. Jur. Pleading and Practice Forms, Agency, § 149.

33-23-39. Placing of insurance through unlicensed agent prohibited; exception relating to construction project bid bonds.

No insurer shall issue, make, write, place, or cause to be made, written, placed, or issued any contract of insurance, indemnity, or suretyship covering risks or property located or having a situs in this state or covering any liability created by or arising under the laws of this state, except through an agent or agents licensed pursuant to this article, except that bid bonds issued by any surety insurer in connection with any public or private building or construction project may be issued without regard to this Code section or as provided for in subparagraph (h)(2)(F) of Code Section 33-23-4.

History. — Code 1981, § 33-23-39, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

33-23-40. Contracts issued by unauthorized persons not rendered unenforceable.

Any contract of insurance issued by a person prohibited by this chapter from so issuing it shall not be rendered unenforceable by reason

of the violation of this chapter, but all persons knowingly participating in the violation shall be subject to the provisions of Chapter 2 of this title.

History. — Code 1981, § 33-23-40, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1999, p. 878, § 11; Ga. L. 2001, p. 925, § 1; Ga. L. 2019, p. 386, § 17/SB 133.

The 2019 amendment, effective July 1, 2019, revised punctuation in the middle, and substituted "subject to the provisions of Chapter 2 of this title" for "guilty of a misdemeanor" at the end.

33-23-41. Liability and penalties for unauthorized acts.

Any person who in this state acts, purports to act, or holds himself or herself out as an agent, limited subagent, counselor, or adjuster or as an employee of an agent, limited subagent, counselor, or adjuster of or for an insurer that has not obtained from the Commissioner a certificate of authority then in effect to do business in this state as required by this article or who has not obtained a certificate of authority as required by this article and any person who in this state collects or forwards any premium or portion of the premium for or to the insurer shall pay a sum equal to the state, county, and municipal taxes and license fees required to be paid by the insurance companies legally doing business in this state. It is the Commissioner's duty to report violators of this Code section to the district attorney for the county in which the violations occurred. Violators of this Code section shall also be personally liable to the same extent as the insurer upon every contract of insurance made by the insurer with reference to a risk having a situs in this state, if the violator participated in the solicitation, negotiation, or making of the contract or in any endorsement to the contract, in any modification of the contract, or in the collection or forwarding of any premium or portion of the premium relating to such contract. This Code section shall have no application to a contract of insurance entered into in accordance with Chapter 5 of this title.

History. — Code 1981, § 33-23-41, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 20/SB 113; Ga. L. 2019, p. 386, § 18/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "this article" for "this title" in the middle of the first sentence.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under Ga. L. 1960, pp. 289, 451 are included in the annotations for this Code section.

Agent for unauthorized insurer is liable for penalty for refusal to pay claim. — Agent's liability is the same as the insurer's, and the liability for attorney's fees and damages for refusal to pay a

claim attaches to the agent as it does to the insurer. 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) (decided under Ga. L. 1960, pp. 289, 451).

State Board of Workers' Compensation lacks authority to adjudicate issue of insurance agent's liability. — Even if a particular insurance agent may be held liable under O.C.G.A. § 33-23-41 or some other provision of the Georgia Insurance Code, it does not follow that the State Board of Workers' Compensation is the proper forum for adjudicating the issue; thus, contrary to the argument of an employee who filed a claim for workers' compensation, the State Board was not authorized to hold an insurance agent who sold the employer an accident group policy instead of a workers' compensation policy personally liable under O.C.G.A. § 33-23-41 for compensating the employee. Gulf States Underwriters of La., Inc. v. Bennett, 260 Ga. App. 699, 580 S.E.2d 550 (2003).

Cited in Kelley v. Montgomery, 108 Ga. App. 271, 132 S.E.2d 857 (1963); Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions under former Code 1933, § 56-506 are included in the annotations for this Code section.

Agent prohibited from representing insurer without certificate of authority. — This section clearly prohibits an agent from representing any insurance company of this or any other state or foreign government until the company fully complies with the insurance laws of this state and receives from the Insurance Commissioner a proper certificate of authority to do business herein. 1945-47 Op. Att'y Gen. p. 361 (decided under former Code 1933, § 56-506).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 109 et seq.

C.J.S. — 44 C.J.S., Insurance, § 70.

33-23-42. Performing acts for unauthorized insurer.

Any person who performs any of the acts or things specified in this chapter for any insurance company or agent of said company without such company's having first received a certificate of authority from the Commissioner as required by law shall be punished as for a misdemeanor and shall also pay a sum equal to the state, county, and municipal taxes and license fees required to be paid by insurance companies legally doing business in this state. It shall be the duty of the Commissioner to report any violation of this Code section to the district attorney or prosecuting attorney of the circuit or county which has jurisdiction.

History. — Code 1981, § 33-23-42, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, §§ 56-501, 56-502, and Ga. L. 1953, Jan.-Feb. Sess., p. 497, § 2 are included in the annotations for this Code section.

Advertising prohibited for unlicensed insurer soliciting business by mail. — Radio stations and other advertising media domiciled in Georgia are prohibited from advertising for an insurance company not licensed by the Georgia Insurance Department to do business in this state, but doing a direct by mail solicitation from its home office through leads procured by such advertising. 1958-59 Op. Att'y Gen. p. 196 (decided under former Code 1933, §§ 56-501, 56-502, and Ga. L. 1953, Jan.-Feb. Sess., p. 497, § 2).

33-23-43. Authority of adjusters; penalty for violation.

(a) An adjuster licensed as both an independent and a public adjuster shall not represent both the insurer and the insured in the same transaction.

(b) An adjuster shall have authority under his or her license only to investigate, settle, or adjust and report to his or her principal upon claims arising under insurance contracts on behalf of insurers only if licensed as an independent adjuster or on behalf of insureds only if licensed as a public adjuster.

(c) No public adjuster, at any time, shall knowingly:

(1) Misrepresent to an insured that he or she is required to hire an independent or public adjuster to help the insured meet his or her obligations under his or her policy;

(2) Accept or agree to accept any money or other compensation from an attorney or any person acting on behalf of an attorney which the adjuster knows or should reasonably know is payment for the suggestion or advice by the adjuster to seek the services of the attorney or for the referral of any portion of a person's claim to the attorney;

(3) Hire or procure another to do any act prohibited by this subsection;

(4) Advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of goods or services. As used in this paragraph, the term "promise to pay or rebate" includes:

(A) Granting any allowance or offering any discount against the fees to be charged, including, but not limited to, an allowance or discount in return for displaying a sign or other advertisement at the insured's premises; or

(B) Paying the insured or any person directly or indirectly associated with the claim any form of compensation, gift, prize,

bonus, coupon, credit, referral fee, or other item of monetary value for any reason;

(5) Misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or as an independent adjuster, unless appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster shall not charge a claimant a fee for adjusting a claim when he or she is appointed by the insurer for that specific claim or purpose and the appointment is accepted by the public adjuster;

(6) Solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence as defined in the insured's insurance contract;

(7) Have a direct or indirect financial interest in any aspect of a claim other than the salary, fee, commission, or other consideration established in a written contract with the insured which shall incorporate all of the conditions and provisions set out in Code Section 33-23-43.1;

(8) Charge to or collect from an insured any amount, other than reasonable compensation for services rendered based on time spent and expenses incurred, in any transaction where the insurer either pays or commits in writing to pay the policy limit or limits for all coverage under the insured's policy within three business days after the loss is reported to the insurer;

(9) Misrepresent to an insured or insurer that he or she is an attorney authorized by law to provide legal advice and services or that a policy covers a loss or losses outside the scope of the coverage provided by the insurance contract;

(10) Permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required; or

(11) Hire or procure another to do any act prohibited by this subsection.

(d) For purposes of subsection (c) of this Code section, the term "public adjuster" shall include licensed public adjusters as defined by Code Section 33-23-1, persons representing themselves to be public adjusters who are not properly licensed by the Commissioner, and persons committing any act under paragraph (4) of subsection (c) of this Code section.

(e) Any person who violates any provision of subsection (c) of this Code section shall be guilty of a misdemeanor and such violation shall be grounds for suspension or revocation of licenses under this chapter.

History. — Code 1981, § 33-23-43, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 613, § 2/HB 423; Ga. L. 2014, p. 181, § 4/HB 610; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2019, p. 386, § 19/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "claim" for "property" in the middle of subparagraph (c)(4)(B).

33-23-43.1. Requirements for public adjuster contracts.

(a) Public adjusters shall ensure that all contracts for their services are in writing, prominently captioned and titled "Public Adjuster Contract," and contain the following:

(1) Legible full name of the public adjuster signing the contract, as specified on the license issued by the Department of Insurance, and attestation language that the public adjuster is fully bonded pursuant to state law;

(2) Permanent home state business address and contact information of the public adjuster, including email address;

(3) The public adjuster's Department of Insurance license number and a statement that the license is valid and in full force and effect as of the date the contract is signed;

(4) The insured's full name and street address;

(5) A description of the loss and its location, if applicable;

(6) A description of services to be provided to the insured;

(7) Signatures of the public adjuster and the insured;

(8) The date the contract was signed by the public adjuster, and the date the contract was signed by the insured;

(9) A statement of the fee, compensation, or other considerations that the public adjuster is to receive for services, including a listing of typical costs and expenses for which the public adjuster is to be reimbursed; and

(10) A statement prominently captioned in a minimum 12 point font that contains the following:

(A) Any direct or indirect interest in or compensation by any construction firm, salvage firm, building appraisal firm, storage company, or any other firm or business entity that performs any work in conjunction with damages incident to any loss which the adjuster has been contracted to adjust;

(B) Any direct or indirect participation in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the adjuster or disclosure of any other activities

that may be reasonably construed as a conflict of interest, including a financial interest in any salvage, repair, construction, or restoration of any business entity that obtains business in connection with any claims that the public adjuster has a contract or agreement to adjust; and

(C) Any direct or indirect compensation of value in connection with an insured's specific loss other than compensation from the insured for service as a public adjuster.

(b) Public adjuster contracts may not contain a contract term that:

(1) Restricts an insured's right to initiate and maintain direct communications with his or her attorney, the insurer, the insurer's adjuster, the insurer's attorney, or any other person regarding settlement of the insured's claim;

(2) Vests the public adjuster with the right to initiate direct communications with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim without specific written authorization from the insured;

(3) Allows the public adjuster's percentage fee to be collected when money is due from an insurance company but not paid or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company rather than as a percentage of each check issued by an insurance company;

(4) Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster; or

(5) Precludes or restricts an insured from pursuing any civil remedies relating to his or her claim.

(c) All public adjuster contracts shall be construed to contain, by operation of law:

(1) A provision granting the insured a right to rescind the contract within three business days after the date the contract was signed, so long as the rescission is in writing and mailed or delivered to the public adjuster at the address stated in the contract within three business days. For purposes of this subsection, rescission of the contract shall be considered delivered or mailed if it is delivered by electronic transmittal to the e-mail address or facsimile specified in the contract for such communications;

(2) A provision that if the insured exercises the right to rescind the contract, anything of value given by the insured under the contract shall be returned to the insured within 15 business days following the receipt by the public adjuster of the rescission notice; and

(3) A provision requiring that, prior to initiating any contact with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim, a public adjuster must provide the insurer a notification letter signed by the insured confirming that the insured has authorized the public adjuster to communicate directly with the insurer, the insurer's adjuster, or the insurer's attorney on behalf of the insured.

(d) All public adjuster contracts shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the Commissioner of Insurance.

History. — Code 1981, § 33-23-43.1, enacted by Ga. L. 2014, p. 181, § 5/HB 610; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2019, p. 386, § 20/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, in paragraph (c)(2), substituted "contract shall" for "contract will" in the middle, and substituted "rescission" for "cancellation" near the end.

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "email" for "e-mail" in paragraph (a)(2).

33-23-43.2. Standard of conduct for public adjusters.

(a) A public adjuster is obligated, under his or her license, to serve with objectivity and complete loyalty to the interest of his or her client alone and to render to the insured such information, counsel, and service within the public adjuster's knowledge, understanding, and opinion that will best serve the insured's insurance claim needs and interest.

(b) A public adjuster shall faithfully observe all of the terms and provisions of the public adjuster contract as prescribed in Code Section 33-23-43.1.

History. — Code 1981, § 33-23-43.2, enacted by Ga. L. 2014, p. 181, § 5/HB 610.

33-23-44. Rules and regulations.

(a) The Commissioner may establish rules and regulations with respect to:

(1) The classification of applicants according to the kinds of insurance to be effected by them if licensed;

(2) The scope, type, and conduct of written examinations to be given pursuant to this chapter and the times and places within this state for holding the examinations;

(3) Classification and scope of authority of any license authorized under this chapter; and

(4) Any other purpose required or necessary for the implementation or enforcement of this chapter.

(b) The Commissioner shall establish by rule or regulation a license for persons exempted under Code Section 33-23-18 that is distinct from other agent licenses.

History. — Code 1981, § 33-23-44, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1996, p. 705, § 14; Ga. L. 2001, p. 925, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 19 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 42, 53 et seq., 67 et seq., 105 et seq.

33-23-45. Limitation on applicability of article.

Reserved. Repealed by Ga. L. 2019, p. 386, § 21/SB 133, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1981, § 33-23-45, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 12; Ga. L. 2001, p. 925, § 1.

33-23-46. Compensation of licensed counselors; disclosure; exceptions.

(a) For purposes of this Code section, the term:

(1) "Affiliate" means a person that controls, is controlled by, or is under common control with the producer.

(2) "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable pursuant to a written agreement, but shall not mean de minimis gifts of less than $45.00 in value.

(3) "Compensation from the customer" shall not include:

(A) Any fee or similar expense provided in subparagraph (C) of paragraph (6) of Code Section 33-6-5;

(B) Any amount or fee paid by or to the producer that does not exceed an amount established by the Commissioner; or

(C) A premium or fee billed by the producer solely on behalf of an insurer.

(4) "Documented acknowledgment" means the customer's written consent obtained prior to the customer's initial purchase of insurance. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, consent documented by the producer shall be acceptable.

(b)(1) Where any insurance producer licensed as counselor, as defined by this chapter, or any affiliate of such producer receives any compensation from or charges any other fee to the customer, neither that producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for placement of insurance for that customer unless the producer has, prior to the customer's purchase of insurance:

(A) Obtained the customer's documented acknowledgment that such compensation will be received by the producer or affiliate; and

(B) Disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the producer shall disclose in readable language the method for calculating such compensation and, if possible, a reasonable estimate of the amount.

(2) Notwithstanding paragraph (1) of this subsection, an insurance producer who is not licensed as a counselor, as defined in this chapter, may not accept or receive any compensation from the customer for placement of insurance.

(c) A person shall not be considered a customer for purposes of this Code section if the person is merely:

(1) A participant or beneficiary of an employee benefit plan; or

(2) Covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the insurance producer or affiliate.

(d) This Code section shall not apply to:

(1) A person licensed as an insurance producer who acts only as an intermediary between an insurer and the producer, such as a managing general agent, a sales manager, or a wholesale broker;

(2) A reinsurance intermediary;

(3) The renewal or any other continuation of the policy; or

(4) A producer whose sole compensation for the placement is derived from commissions, salaries, and other remuneration from the insurer.

(e) The Commissioner may promulgate rules and regulations as necessary to implement the provisions of this Code section.

History. — Code 1981, § 33-23-46, enacted by Ga. L. 2005, p. 563, § 6/HB 407.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "customer" was substituted for "'customer'" in subsection (c); "a" was inserted preceding "wholesale broker" in paragraph (d)(1); and "Code section" was substituted for "chapter" in subsection (e).

ARTICLE 2

LICENSING OF ADMINISTRATORS

Editor's notes. — Ga. L. 1992, p. 2830, § 2, effective July 1, 1992, redesignated former Article 3 of this chapter as Article 2 thereof.

33-23-100. Definitions; exemptions; applicability of Code Sections 33-24-59.5 and 33-24-59.14.

(a) As used in this article, the term:

(1) "Administrator" means any business entity that, directly or indirectly, collects charges, fees, or premiums; adjusts or settles claims, including investigating or examining claims or receiving, disbursing, handling, or otherwise being responsible for claim funds; or provides underwriting or precertification and preauthorization of hospitalizations or medical treatments for residents of this state for or on behalf of any insurer, including business entities that act on behalf of a single or multiple employer self-insurance health plan or a self-insured municipality or other political subdivision. Licensure is also required for administrators who act on behalf of self-insured plans providing workers' compensation benefits pursuant to Chapter 9 of Title 34. For purposes of this article, each activity undertaken by the administrator on behalf of an insurer or the client of the administrator is considered a transaction and is subject to the provisions of this title.

(2) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(3) "Standard financial quarter" means a three-month period ending on March 31, June 30, September 30, or December 31 of any calendar year.

(b) Notwithstanding the provisions of subsection (a) of this Code section, the following are exempt from licensure so long as such entities are acting directly through their officers and employees:

(1) An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of such employer;

(2) A union on behalf of its members;

(3) An insurance company licensed in this state or its affiliate unless the affiliate administrator is placing business with a nonaffiliate insurer not licensed in this state;

(4) An insurer which is not authorized to transact insurance in this state if such insurer is administering a policy lawfully issued by it in and pursuant to the laws of a state in which it is authorized to transact insurance;

(5) A life or accident and sickness insurance agent or broker licensed in this state whose activities are limited exclusively to the sale of insurance;

(6) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(7) A trust established in conformity with 29 U.S.C. Section 186 and its trustees, agents, and employees acting thereunder;

(8) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees and employees acting thereunder or a custodian and its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(9) A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;

(10) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided that such company does not adjust or settle claims;

(11) A person who adjusts or settles claims in the normal course of his or her practice or employment as an attorney and who does not collect charges or premiums in connection with life or accident and sickness insurance coverage or annuities;

(12) An insurance company licensed in this state or its affiliate if such insurance company or its affiliate is solely administering limited benefit insurance. For the purpose of this paragraph, the term "limited benefit insurance" means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance and specifically shall include accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease insurance; or

(13) An association that administers workers' compensation claims solely on behalf of its members.

(c) A business entity claiming an exemption shall submit an exemption notice on a form provided by the Commissioner. This form must be signed by an officer of the company and submitted to the department by December 31 of the year prior to the year for which an exemption is to be claimed. Such exemption notice shall be updated in writing within 30 days if the basis for such exemption changes. An administrator claiming an exemption pursuant to paragraphs (3) and (4) of subsection (b) of this Code section shall be subject to the provisions of Code Sections 33-24-59.5 and 33-24-59.14.

(d) Obtaining a license as an administrator does not exempt the applicant from other licensing requirements under this title.

(e) Obtaining a license as an administrator subjects the applicant to the provisions of Code Sections 33-24-59.5 and 33-24-59.14.

(f) An administrator shall be subject to Code Sections 33-24-59.5 and 33-24-59.14 unless the administrator provides sufficient evidence that the self-insured health plan failed to properly fund the plan to allow the administrator to pay any outside claim.

History. — Code 1981, § 33-23-100, enacted by Ga. L. 1991, p. 1403, § 1; Ga. L. 2005, p. 563, § 7/HB 407; Ga. L. 2011, p. 595, § 4/HB 167.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "from" was deleted following "or premiums" in paragraph (a)(1) and "that" was inserted following "provided" in paragraph (b)(10).

Editor's notes. — Ga. L. 2011, p. 595, § 1/HB 167, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Insurance Delivery Enhancement Act of 2011.'"

JUDICIAL DECISIONS

Preemption. — Because self-funded plans would have different timeliness obligations in different states if amended state prompt-pay legislation went into effect, ERISA preempted the challenged provisions as relating to benefit plans, regardless of whether risk pooling was affected for saving clause purposes; ERISA's deemer clause applied. America's Health Ins. Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014).

33-23-101. Licensing of administrators; filing fee; refusal, suspension, or revocation of license; notice and hearing; reissuance of revoked license; appeal; probationary licenses; additional qualifications for license; restrictions on licensees; penalties.

(a) No business entity shall act as or hold itself out to be an administrator in this state, other than an adjuster licensed in this state for the kinds of business for which it is acting as an administrator, unless such business entity holds a license as an administrator issued by the Commissioner. The license shall be renewed on an annual basis and in such manner as the Commissioner may prescribe by rule or

regulation. Failure to hold such license shall subject the administrator to the fines and other appropriate penalties as provided in Chapter 2 of this title.

(b) An application for an administrator's license or an application for renewal of such license shall be accompanied by a filing fee to be prescribed by rule or regulation of the Commissioner.

(c) A license may be refused or a license duly issued may be suspended or revoked or the renewal of such license refused by the Commissioner if the Commissioner finds that the applicant for or holder of the license:

(1) Has violated any provision of this title or of any other law of this state relating to insurance as defined in this chapter or relating to another type of insurance;

(2) Has intentionally misrepresented or concealed any material fact in the application for the license;

(3) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(4) Has misappropriated, converted to his or her own use, or illegally withheld money belonging to an insurer or an insured or beneficiary;

(5) Has committed fraudulent or dishonest practices;

(6) Has materially misrepresented the terms and conditions of insurance policies or contracts;

(7) Has failed to comply with or has violated any proper order, rule, or regulation issued by the Commissioner;

(8) Is not in good faith carrying on business as an administrator;

(9) Has failed to obtain for initial licensure or retain for annual renewal an adequate net worth as prescribed by order, rule, or regulation of the Commissioner; or

(10) Has shown lack of trustworthiness or lack of competence to act as an administrator.

(d) If the Commissioner moves to suspend, revoke, or nonrenew a license for an administrator, the Commissioner shall provide notice of that action to the administrator and the administrator may invoke the right to an administrative hearing in accordance with Chapter 2 of this title.

(e) No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if

judicial review of such revocation is sought, within five years from the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

(f) Appeal from any order or decision of the Commissioner made pursuant to this article shall be taken as provided in Chapter 2 of this title.

(g)(1) The Commissioner shall have the authority to issue a probationary license to any applicant under this article.

(2) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

(3) The Commissioner, at his or her discretion, shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period.

(h) The Commissioner may impose, by rule or regulation, additional reasonable qualifications necessary to obtain a license as an administrator.

(i) An administrator's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. An administrator may not contract or subcontract any of its negotiated services to any unlicensed business entity unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement.

(j) The Commissioner may, at his or her discretion, assess a penalty or a fine against any business entity acting as an administrator without a license for each transaction in violation of this article.

(k) A licensed administrator is not permitted to market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.

History. — Code 1981, § 33-23-101, enacted by Ga. L. 1991, p. 1403, § 1; Ga. L. 2000, p. 1589, § 3; Ga. L. 2005, p. 563, § 8/HB 407; Ga. L. 2019, p. 386, § 22/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "this article" for "this chapter" at the end of paragraph (g)(1) and subsection (j).

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to this Code section is applicable with respect to notices delivered on or after July 1, 2000.

33-23-102. Bond and surety of applicant; liability insurance; remained licenses.

(a) Every applicant for an administrator's license shall file with the application and shall thereafter maintain in force a bond in favor of the Commissioner executed by a corporate surety insurer authorized to transact insurance in this state. The terms and type of the bond, including, but not limited to, total aggregate liability on the bond, shall be established by the rule or regulation of the Commissioner.

(b) The bond shall remain in force until the surety is released from liability by the Commissioner or until the bond is canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel the bond upon 30 days' advance notice, in writing, filed with the Commissioner.

(c) Every applicant for an administrator's license shall obtain and shall thereafter maintain in force errors and omissions coverage or other appropriate liability insurance, written by an insurer authorized to transact insurance in this state, in an amount of at least $100,000.00.

(d) The coverage required in subsection (c) of this Code section shall remain in force for a term of at least one year and shall contain language that includes that the insurer may cancel the insurance upon 60 days' advance notice filed with the Commissioner. Other terms and conditions relating to the errors and omissions policy may be imposed on the applicant as the Commissioner deems appropriate by rule or regulation.

(e) In the event a licensed administrator fails to renew, surrenders, or otherwise terminates its license, it must retain both the bond and the errors and omissions coverage for a period of not less than one year after the licensee has failed to renew, surrendered, or otherwise terminated its license.

History. — Code 1981, § 33-23-102, enacted by Ga. L. 1991, p. 1403, § 1; Ga. L. 1996, p. 919, § 8; Ga. L. 2005, p. 563, § 9/HB 407; Ga. L. 2013, p. 141, § 33/HB 79.

33-23-103. Examination of administrators by Commissioner.

Administrators shall be subject to market conduct and financial examinations by the Commissioner. Any cost involved with the examinations shall be borne by the administrator.

History. — Code 1981, § 33-23-103, enacted by Ga. L. 1991, p. 1403, § 1; Ga. L. 2005, p. 563, § 10/HB 407.

33-23-104. Establishing requirements and procedures affecting administrators.

Requirements and procedures for written agreements, payments to administrators, maintenance of information, approval of advertising, underwriting provisions, premium collection, payment of claims, claim adjustment or settlement, notifications, and other matters involving administrators may be established by rule or regulation of the Commissioner.

History. — Code 1981, § 33-23-104, enacted by Ga. L. 1991, p. 1403, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, the comma was deleted following "administrators" near the end of this Code section.

33-23-105. Rules and regulations for implementation of article.

The Commissioner may promulgate rules and regulations which are necessary to implement the provisions of this article and to ensure the safe and proper operation of administrators of this state.

History. — Code 1981, § 33-23-105, enacted by Ga. L. 1991, p. 1403, § 1.

ARTICLE 3

INSURANCE NAVIGATORS

Editor's notes. — Ga. L. 2013, p. 780, § 2/HB 198, not codified by the General Assembly, provides that this article: "shall become applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia." Notification was received on October 1, 2013.

Administrative rules and regulations. — Navigator, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Regulations Regarding Agents, Subagents, Counselors, Adjusters, Surplus Lines Brokers, and Agencies, § 120-2-3-.48.

Prelicensing course and provider approval, Official Compilation of the Rules and Regulations of the State of Georgia, Commissioner of Insurance, Regulations Regarding Agents, Subagents, Counselors, Adjusters, Surplus Lines Brokers, and Agencies, § 120-2-3-.08.

Law reviews. — For note, "Charting the Middle Course: An Argument for Robust But Well-Tailored Health Care Discrimination Protection for the Transgender Community," see 52 Ga. L. Rev. 225 (2017).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 544 et seq.
C.J.S. — 46 C.J.S., Insurance, § 1341.

33-23-200. Legislative findings; licensing of health insurance navigators.

The General Assembly finds that the provisions of the federal Patient Protection and Affordable Care Act may cause the formation of health insurance exchanges operating in Georgia under federal law and employing navigators or navigator entities whose role will be to direct individuals and companies to health insurance policies. The General Assembly further finds that licensing and regulation of such navigators or navigator entities to ensure that they are trained and knowledgeable in the subject matter of individual and group health insurance plans and insurance coverage is necessary to avoid substantial risk to the health, safety, and welfare of the residents of this state.

History. — Code 1981, § 33-23-200, enacted by Ga. L. 2013, p. 780, § 1/HB 198.

33-23-201. Definitions.

As used in this article, the term:

(1) "Exchange" means a state, federal, or partnership exchange or marketplace operating in Georgia pursuant to Section 1311 of the federal act.

(2) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and regulations or guidance issued under those acts.

(3) "Navigator" means an individual, including assistors, application counselors, or other persons, authorized pursuant to the federal act to provide insurance advice and guidance to uninsured individuals and groups seeking health insurance coverage. For the purposes of this article, if an organization or business entity serves as a navigator, an individual performing navigator duties for that organization or business entity shall be considered to be acting in the capacity of a navigator.

(4) "Patient navigator" means an individual who offers assistance to patients, families, and caregivers to help overcome health care system barriers and to facilitate timely access to quality medical and

psychosocial care as defined by the health care community he or she serves.

History. — Code 1981, § 33-23-201, enacted by Ga. L. 2013, p. 780, § 1/HB 198.

U.S. Code. — The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, referred to in this Code section, are codified throughout the United States Code and primarily in T. 42.

33-23-202. Licensing and requirements therefor.

(a) No navigator shall provide advice, guidance, or other assistance with regard to health benefit plans as a navigator under the provisions of the federal act unless licensed in accordance with this article.

(b) The Commissioner shall not issue a license to any applicant who does not meet or conform to the following qualifications or requirements:

(1) The applicant shall establish to the satisfaction of the Commissioner that he or she has the background, experience, knowledge, and competency in the subject matter that will enable him or her to deliver accurate information and advice to individuals and groups in this state seeking to obtain health insurance coverage under the provisions of the federal act;

(2) The applicant shall have successfully completed not less than 35 hours of instruction in health benefit insurance, the exchange provisions of the federal act, the medical assistance program provided for by Article 7 of Chapter 4 of Title 49, and the PeachCare for Kids Program provided for by Article 13 of Chapter 5 of Title 49 satisfactory to the Commissioner through a training program approved by the Commissioner;

(3) The applicant shall pass such examination as shall be required by the Commissioner unless such applicant is exempted by the Commissioner based on the applicant's experience and qualifications and pursuant to regulations adopted by the Commissioner;

(4) An applicant shall be not less than 18 years of age and of good moral character and must submit in a form approved by the Commissioner such information, including without limitation criminal history and regulatory background information, as the Commissioner may require; and

(5) An applicant for a renewal license shall have completed continuing education classes approved by the Commissioner.

History. — Code 1981, § 33-23-202, enacted by Ga. L. 2013, p. 780, § 1/HB 198.

33-23-203. Violations; limitation on solicitations; navigator compensation, responsibilities, and limitations.

(a) Violation of any provision of this title or the federal act, including any act or omission that would be a ground for denial, suspension, or revocation of the license of an agent as defined in Article 1 of this chapter, shall be a ground for denial, suspension, or revocation of a license under this article.

(b) No navigators shall solicit any person or business that is currently insured under an existing health benefit plan.

(c) No navigator shall receive any commission, compensation, or anything of value from any insurer, health benefit plan, business, or consumer for providing advice or services specifically authorized to be provided as a navigator pursuant to the provisions of the federal act. Navigators shall be compensated for advice or services rendered pursuant to the provisions of the federal act only as provided for by the federal act.

(d) Navigators shall provide factually accurate information to uninsured persons and businesses regarding the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal act.

(e) Notwithstanding any other provision of law, licensing as a navigator pursuant to the provisions of this article shall not constitute licensing as an agent or administrator as defined in Articles 1 and 2 of this chapter. No person providing advice or services as a navigator under the provisions of the federal act shall be compensated for such advice or services as the holder of a license issued pursuant to Article 1 or 2 of this chapter; provided, however, that the provisions of this subsection shall not prohibit the holder of a license issued pursuant to such articles from being compensated for advice or services rendered as such a licensee and not as a navigator. Navigators licensed pursuant to the provisions of this article shall not, except as specifically authorized by the provisions of the federal act:

(1) Engage in any activities that would require licensing pursuant to the provisions of Article 1 or 2 of this chapter unless licensed thereunder;

(2) Provide advice concerning the benefits, terms, and features of a particular health benefit plan or offer advice about which health benefit plan is better or worse for a particular individual or business,

except in the capacity of a licensee pursuant to the provisions of Article 1 or 2 of this chapter; or

(3) Recommend a particular health benefit plan or advise individuals or businesses about which health benefit plan to choose, except in the capacity of a licensee pursuant to the provisions of Article 1 or 2 of this chapter.

History. — Code 1981, § 33-23-203, enacted by Ga. L. 2013, p. 780, § 1/HB 198.

U.S. Code. — Section 36B of the Internal Revenue Code of 1986, referred to in this Code section, is codified at 26 U.S.C. § 36B.

33-23-204. Adoption of rules and regulations.

The Commissioner shall be authorized to adopt rules and regulations to effect the implementation of this article.

History. — Code 1981, § 33-23-204, enacted by Ga. L. 2013, p. 780, § 1/HB 198.

33-23-205. Applicability.

The provisions of this article shall not apply to patient navigators as defined in paragraph (4) of Code Section 33-23-201.

History. — Code 1981, § 33-23-205, enacted by Ga. L. 2013, p. 780, § 1/HB 198.

CHAPTER 24

INSURANCE GENERALLY

Article 1

General Provisions

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Editor's notes. — Ga. L. 1989, p. 492, § 1, designated Code Sections 33-24-1 through 33-24-51 as Article 1.

Administrative rules and regulations. — Regulations regarding insurance contract, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Insurance Department, Chapter 120-2-10.

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 law of insurance, see 38 Mercer L. Rev. 247 (1986). For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999).

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).

Cited in Pennsylvania Thresherman & Farmers Mut. Cas. Ins. Co. v. Gardner, 107 Ga. App. 472, 130 S.E.2d 507 (1963).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Insurer's Wrongful Refusal to Settle Within Policy Limits, 6 POF2d 247.

Insurer's Breach of Covenant of Good Faith and Fair Dealing — First Party Claims, 31 POF2d 323.

Civil Conspiracy to Deny First-Party Insurance Benefits, 49 POF2d 473.

Insurance Bad-Faith Actions — "Advice —of-Counsel" Defense, 16 POF3d 419.

Punitive Damages Against an Insurer for the Bad-Faith Handling of a First-Party Claim, 18 POF3d 323.

Insured's Proof That Pollution Exclusion Clause Does Not Bar Coverage for Environmental Claims, 38 POF3d 477.

Insurer's Failure to Investigate Claim in Good Faith, 46 POF3d 289.

Loss by Storm Damage Under Property Insurance, 49 POF3d 501.

ALR. — Subsequent denial of liability following promise or negotiations as affecting contractual limitation for action upon insurance policy, 3 A.L.R. 218.

Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

What rights are waived by insurer who pays money into court, 15 A.L.R. 1260.

Reasonableness of insurer's demand for production of books or papers as regards time or place of production, 63 A.L.R. 510.

Incontestable clause of statute or policy as applicable to claims other than for death benefits, 94 A.L.R. 1133; 121 A.L.R. 1437; 147 A.L.R. 1015.

Full faith and credit provisions as affecting insurance contracts, 114 A.L.R. 250; 119 A.L.R. 483; 173 A.L.R. 1138.

Theory of waiver as applicable where provisions of policy or acts of insurer are inconsistent with statutory requirements, 9 A.L.R.2d 1436.

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.

Construction and effect of arrangement under which insurance premiums are paid automatically via insurer's draft on insured's bank account, 45 A.L.R.3d 1349.

Liability of insurer for damages resulting from delay in passing upon application for health insurance, 18 A.L.R.4th 1115.

Liability to refund local taxes as within coverage of liability insurance, 21 A.L.R.4th 895.

Applicability of other insurance benefits exclusion, from coverage of hospital or health and accident policy, to governmental insurance benefits to which insured would have been entitled by prior subscription, 29 A.L.R.4th 361.

Coverage and exclusions of liability or indemnity policy on physicians, surgeons, and other healers, 33 A.L.R.4th 14.

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.

Construction and application of pollution exclusion clause in liability insurance policy, 39 A.L.R.4th 1047.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance, 75 A.L.R.4th 763.

Event triggering liability insurance coverage as occurring within period of time covered by liability insurance policy where injury or damage is delayed — Modern cases, 14 A.L.R.5th 695.

ARTICLE 1

GENERAL PROVISIONS

Law reviews. — For note on 1995 amendments and enactments of Code sections in this article, see 12 Georgia St. U.L. Review 264 and 268 (1995).

33-24-1. Definitions.

As used in this chapter, the term:

(1) "Policy" means the written contract of or written agreement for or effecting insurance. The term includes all clauses, riders, endorsements, and papers attached or issued and delivered for attachment to the contract or agreement and made a part of the contract or agreement.

(2) "Premium" means the consideration for insurance, by whatever name called. Any assessment or any membership, policy, survey, inspection, service, or similar fee or charge in consideration for an insurance contract is deemed part of the premium. The term "premium" shall not include any amount deposited and held for the account of the insured which is returnable upon cancellation of the insurance contract and upon which no commission has been paid.

(3) "Uniform Electronic Transactions Act" means Chapter 12 of Title 10.

History. — Code 1933, §§ 56-2402, 56-2403, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1995, p. 1011, § 3; Ga. L. 2014, p. 829, § 3/HB 645.

Cross references. — "Direct response insurance business" defined, § 33-24-52.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, the comma was deleted after the word "assessment" in the second sentence in paragraph (2).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Civil Code 1873, § 2794; former Civil Code 1895, § 2089; former Civil Code 1910, §§ 2404, 2470; and former Code 1933, §§ 56-213, 56-801, repealed by Ga. L. 1960, p. 289, enacting this title, are included in the annotations for this Code section.

Issuance of endorsement adding automobile is issuance of 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 the terms of former Code 1933, § 56-407A (see O.C.G.A. § 33-7-11). Gulf Am. Fire & Cas. Co. v. McNeal, 115 Ga. App. 286, 154 S.E.2d 411 (1967).

Contract of insurance, to be binding, must be in writing. Hartford Fire Ins. Co. v. Garrett, 60 Ga. App. 816, 5 S.E.2d 276 (1939) (decided under former Code 1933, § 56-213).

Contracts of insurance must be in writing. Underwriters' Agency v. Seabrook, 49 Ga. 563 (1873) (decided under former Civil Code 1973, § 2794).

Law of this state expressly requires a contract of fire insurance to be in writing, and such contract is not valid unless the contract is in writing. Athens Mut. Ins. Co. v. Evans, 132 Ga. 703, 64 S.E. 993 (1909), later appeal, 136 Ga. 584, 71 S.E. 892 (1911); Sparks v. National Union Fire Ins. Co., 23 Ga. App. 38, 97 S.E. 462 (1918) (decided under former Civil Code 1910, §§ 2404, 2470).

If a fidelity insurance business is carried on by a domestic company, its policies must be in writing. 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, § 2470).

When the insurer is a resident or nonresident corporation, a contract of fidelity insurance must be in writing, under the laws of this state. 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, § 2470).

Whether contract is issued on cash or credit basis. — Rule that a policy of insurance shall be in writing and signed by the insurer applies to contracts issued upon a cash basis as well as to those issued upon a credit basis, if such there may be. 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, § 2470).

Contract cannot be partly in parol. — As the law of this state requires that a contract for fire insurance shall be in writing, such a contract cannot be made partly in writing and partly in parol. Athens Mut. Ins. Co. v. Evans, 132 Ga. 703, 64 S.E. 993 (1909), later appeal, 136 Ga. 584, 71 S.E. 892 (1911); Sparks v. National Union Fire Ins. Co., 23 Ga. App. 38, 97 S.E. 462 (1918) (decided under former Civil Code 1910, §§ 2404, 2470).

Contract of insurance cannot be partly in writing and partly in parol. Hartford Fire Ins. Co. v. Garrett, 60 Ga. App. 816, 5 S.E.2d 276 (1939) (decided under former Code 1933, § 56-213).

Contracts for insurance must be in writing and may not be partially parol. Atlanta Metro Taxicab Group, Inc. v. Bekele, 154 Ga. App. 831, 269 S.E.2d 902 (1980).

Agent's statement and alleged oral contract cannot change written contract. — Statement of the agent and an alleged contract, which is oral in nature, cannot and does not operate to affect, modify, or change a written certificate of insurance and enrollment-record card as to the effective date of the coverage. Federated Mut. Implement & Hdwe. Ins. Co. v. Barker, 123 Ga. App. 259, 180 S.E.2d 559 (1971).

Assignment must be written. — As an assignment of an insurance policy with the assent of the company is a new contract of insurance between the company and the assignee, the contract must be in writing. St. Paul Fire & Marine Ins. Co. v. Brunswick Grocery Co., 113 Ga. 786, 39 S.E. 483 (1901) (decided under former Civil Code 1895, § 2089).

To vest the legal title to a policy of life insurance in an assignee, it is essential that the assignment should be in writing. Steele v. Gatlin, 115 Ga. 929, 42 S.E. 253 (1902); Sprouse v. Skinner, 155 Ga. 119, 116 S.E. 606 (1923) (decided under former Civil Code 1910, § 2470).

Action cannot be maintained upon a parol renewal of an insurance policy. Nowell v. Mayor of Monroe, 117 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933) (decided under former Civil Code 1910, § 2470).

Dismissal — Action on a parol renewal of an insurance policy is demurrable (now subject to motion to dismiss). Roberts v. Germania Fire Ins. Co., 71 Ga. 478 (1883) (decided under former Civil Code 1873, § 2794).

Agreement to alter insurance contract must be written. — Agreement to alter a contract of fire insurance must be in writing. Simonton, Jones & Hatcher v. Liverpool, London & Globe Ins. Co., 51 Ga. 76 (1874) (decided under former Civil Code 1873, § 2794); Mitchell v. Universal Life Ins. Co., 54 Ga. 289 (1875) (decided under former Civil Code 1873, § 2794); Augusta S.R.R. v. Smith & Kilby Co., 106 Ga. 864, 33 S.E. 28 (1899) (decided under former Civil Code 1873, § 2794); Lippman v. Aetna Ins. Co., 108 Ga. 391, 33 S.E. 897, 75 Am. St. R. 62 (1899) (decided under former Civil Code 1873, § 2794); Roberts v. Germania Fire Ins. Co., 71 Ga. 478 (1883) (decided under former Civil Code 1895, § 2089).

Later-added vehicle part of original policy. — Because the insurance coverage for the vehicle the claimant was driving at the time of the accident was intended to be part of the original policy, did not constitute a new policy, and was simply added to the existing automobile coverage, the insurer was not required to notify the insured of the change in the law or to secure a separate uninsured motorist election at the time the vehicle was added to the policy. Soufi v. Haygood, 282 Ga. App. 593, 639 S.E.2d 395 (2006).

Contract may be supplemented by terms of subsequent note. — Contract for life insurance, as expressed in the policy issued by a company to an individual, may be supplemented by a subsequent contract between the parties, expressed in a promissory note given by the

insured to the insurer for a premium on the policy and providing for a termination of all rights under the policy for nonpayment of the note, although the policy contains no such provision. State Life Ins. Co. v. Tyler, 147 Ga. 287, 93 S.E. 415, answers conformed to, 21 Ga. App. 80, 94 S.E. 59 (1917) (decided under former Civil Code 1910, § 2470).

Policy or attachment must show intent to make attachment part of contract. — Complete absence or insufficiency of reference in the policy proper to the attached paper, or vice versa, so that there can be no certainty that the parties intended the attached paper to become a part of the whole contract of insurance, precludes the attachments' inclusion or construction in connection with the policy. Georgia Int'l Life Ins. Co. v. King, 120 Ga. App. 682, 172 S.E.2d 167 (1969).

Policy as including endorsement. — Standard form homeowners insurance policies covered diminished value when loss was not otherwise defined and an endorsement providing that loss did not include diminution in value was ineffective as to renewal policies absent a notice informing policyholders that coverage for diminished value was not renewed. Consistent with O.C.G.A. § 33-24-1, the endorsement was a part of the policy. Thompson v. State Farm Fire & Cas. Co., 264 F. Supp. 3d 1302 (M.D. Ga. 2017).

Condition and stipulations printed on the back of a fire insurance policy and not mentioned or referred to on the face of the policy are not part of the policy or binding on the assured. Smyly v. Globe & Rutgers Fire Ins. Co., 28 Ga. App. 776, 113 S.E. 220 (1922), rev'd on other grounds, 155 Ga. 547, 117 S.E. 819, former judgment vacated, 30 Ga. App. 620, 118 S.E. 766 (1923) (decided under former Civil Code 1910, § 2470).

Premium need not be paid in cash. — It is not essential to the validity of a policy of fire insurance, issued in renewal of one previously taken out by the insured, that the insured should pay in cash the renewal premium, provided the agent of the company, with the company's express or implied assent, pays or undertakes to become responsible to the company for such premium, in order that credit may be extended to the insured. Mechanics & Traders Ins. Co. v. Mutual Real Estate & Bldg. Ass'n, 98 Ga. 262, 25 S.E. 457 (1896) (decided under former Civil Code 1895, § 2089); Fireman's Fund Ins. Co. v. Pekor, 106 Ga. 1, 31 S.E. 779 (1898) (decided under former Civil Code 1895, § 2089).

Part performance. — Although a person who owned a taxi and claimed that the taxi was insured did not produce a written insurance policy, there was evidence that the owner had an oral agreement with an insurance company and paid premiums to the company, and that evidence supported a jury's findings that the taxi was insured by the company and that the company exercised bad faith when the company refused to settle an injured party's claim against the owner. VFH Captive Ins. Co. v. Cielinski, 260 Ga. App. 807, 581 S.E.2d 335 (2003).

Cited in Andrews v. Georgia Mut. Ins. Co., 110 Ga. App. 92, 137 S.E.2d 746 (1964); Brown v. Five Points Parking Ctr., 121 Ga. App. 819, 175 S.E.2d 901 (1970); Hawkins Iron & Metal Co. v. Continental Ins. Co., 128 Ga. App. 462, 196 S.E.2d 903 (1973); National Indemn. Co. v. Berry, 136 Ga. App. 545, 221 S.E.2d 624 (1975); Dunham v. Grange Mut. Cas. Co., 176 Ga. App. 263, 335 S.E.2d 666 (1985); Stryker v. City of Atlanta, 738 F. Supp. 1423 (N.D. Ga. 1990).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions under former Code 1933, §§ 56-2402 and 56-2410 are included in the annotations for this Code section.

Resolution delivered with policy is part thereof. — Resolution by the board of directors of a life insurance company delivered to the assured along with the policy of insurance constitutes a rider to and basic part of the policy and must be filed with the Commissioner of the Insurance Department and approved by the Commissioner before being issued by an insurance company, as is required by former Code 1933, § 56-2410 (see O.C.G.A.

§ 33-24-9(a)). 1963-65 Op. Att'y Gen. p. 304 (decided under former Civil Code 1933, §§ 56-2402 and 56-2410).

RESEARCH REFERENCES

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

C.J.S. — 44 C.J.S., Insurance, § 1 et seq. 45 C.J.S., Insurance, § 650 et seq.

ALR. — Insurance: provision against change in interest, title, or possession as affected by a deed or other instrument which was merely colorable or not delivered, 7 A.L.R. 1608.

Insurance: including tax in assessment or premium, 12 A.L.R. 765.

Oral contracts of insurance, 15 A.L.R. 995; 69 A.L.R. 559; 92 A.L.R. 232.

Date from which life insurance premium periods are to be computed, 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

When payment of insurance premiums or assessments deemed involuntary so as to permit their recovery back, 86 A.L.R. 388.

Noncompliance with statutory requirement that insurance policy contain entire contract, or that application be attached incorporated in, endorsed upon, or delivered with, the policy as affecting right of insurer to show initial fraud or misrepresentation by insured, 93 A.L.R. 374.

Acceptance by insurance agent of something other than money or insured's money obligation in payment of premium, 93 A.L.R. 654.

Unsigned riders or slips physically attached to policy, or unsigned endorsements on policy, as part of insurance contract, 128 A.L.R. 1034.

Liability of policyholders in mutual insurance companies to assessments, 137 A.L.R. 945.

Necessity of specific allegation of consideration in action upon insurance policy, 153 A.L.R. 1406.

Effect of stamped or printed matter outside of body of insurance policy, 168 A.L.R. 555.

Consideration for rider, endorsement, or other modification of insurance policy to change risks covered, 52 A.L.R.2d 826.

Construction of insurance agency or brokerage contract dealing with computation of commissions on renewal premiums, 78 A.L.R.2d 760.

Insurance: sufficiency of insurer's compliance with statutory requisites as to attaching copy of application to, or making it part of policy, 18 A.L.R.3d 760.

33-24-2. Applicability of chapter.

This chapter applies to all insurance policies and to annuities and pure endowment contracts as defined in Code Section 33-28-1 except:

(1) Reinsurance;

(2) Policies or contracts not issued for delivery in this state or delivered in this state, except as provided in subsection (e) of Code Section 33-24-9;

(3) Ocean marine and foreign trade insurances; and

(4) Title insurance, except as to the following provisions:

(A) Code Section 33-24-5;

(B) Code Section 33-24-9;

(C) Code Section 33-24-10;

(D) Code Section 33-24-13;

(E) Code Section 33-24-16; and

(F) Code Section 33-24-19.

History. — Code 1933, § 56-2401, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1990, p. 8, § 33.

33-24-3. Insurable interest; personal insurance.

(a) An insurable interest, with reference to personal insurance, is an interest based upon a reasonable expectation of pecuniary advantage through the continued life, health, or bodily safety of another person and consequent loss by reason of such person's death or disability or a substantial interest engendered by love and affection in the case of individuals closely related by blood or by law.

(b) An individual has an unlimited insurable interest in his or her own life, health, and bodily safety and may lawfully take out a policy of insurance on his or her own life, health, or bodily safety and have the policy made payable to whomsoever such individual pleases, regardless of whether the beneficiary designated has an insurable interest.

(c) The trustee of a trust established by an individual settlor has an insurable interest in the life of that individual settlor and has the same insurable interest in the life of any other individual as does such individual settlor. The trustee of a trust has the same insurable interest in the life of any other individual as does any beneficiary of the trust with respect to proceeds of insurance on the life of such individual or any portion of such proceeds that are allocable to such beneficiary's interest in such trust. If multiple beneficiaries of a trust have an insurable interest in the life of the same individual, the trustee of such trust has the same aggregate insurable interest in such individual's life as such beneficiaries with respect to proceeds of insurance on the life of such individual or any portion of such proceeds that is allocable in the aggregate to such beneficiaries' interest in the trust.

(d) A corporation, foreign or domestic, has an insurable interest in the life of any individual:

(1) Holding at least 10 percent of the issued and outstanding shares of such corporation; or

(2) In whom the shareholders holding a majority of the issued and outstanding shares have an insurable interest, whether arising out of their status as shareholders of the corporation or otherwise,

and in the life or physical or mental ability of any of its directors, officers, or employees or the directors, officers, or employees of any of its

subsidiaries or any other person whose death or physical or mental disability might cause financial loss to the corporation; or, pursuant to any contractual arrangement with any shareholder concerning the reacquisition of shares owned by him or her at the time of his or her death or disability, on the life or physical or mental ability of that shareholder for the purpose of carrying out such contractual arrangement; or, pursuant to any contract obligating the corporation as part of compensation arrangements or pursuant to a contract obligating the corporation as guarantor or surety, on the life of the principal obligor. The trustee of a trust established by a corporation for the sole benefit of the corporation has the same insurable interest in the life or physical or mental ability of any person as does the corporation. The trustee of a trust established by a corporation providing life, health, disability, retirement, or similar benefits to employees of the corporation or its affiliates and acting in a fiduciary capacity with respect to such employees, retired employees, or their dependents or beneficiaries has an insurable interest in the lives of employees for whom such benefits are to be provided. As used in this subsection, the term "employee" shall include any and all directors, officers, employees, or retired employees. The term "employee" shall include any former employee, but only for the purpose of replacing existing life insurance that will be surrendered in exchange for new life insurance in an amount not exceeding the insurance being surrendered.

(e) The insurable interest of a corporation or trustee which has been established pursuant to subsection (d) of this Code section shall be conveyed automatically to another corporation or to the trustee of a trust established by such other corporation for its sole benefit which has acquired by purchase, merger, or otherwise all or part of the first corporation's business. A corporation or the trustee of a trust established by such corporation for its sole benefit may exchange any policy of insurance issued to itself or to another corporation or the trustee of a trust established by such other corporation for its sole benefit from which the exchanging corporation has acquired by purchase, merger, or otherwise all or part of such other corporation's business for a new policy of insurance issued to itself without establishing a new insurable interest at the time of such exchange.

(f) A shareholder in a corporation has an insurable interest in the life of any other shareholder pursuant to any contractual arrangement between or among such shareholders concerning the purchase by surviving shareholders of shares owned by a deceased or disabled shareholder, for the purpose of carrying out such contractual arrangement.

(g) A partnership, limited liability company, business trust, or other business entity established under the laws of any state or of the United

States shall have the same insurable interests as a corporation, as set forth in subsections (d) and (e) of this Code section, including, without limitation, insurable interests in such entity's partners, members, or holders of other equity ownership interests and in officers, directors, employees, and those of any subsidiaries of any such entity. The partners of a partnership, the owners of a limited liability company, and the owners of equity interests in any form of business entity have the same insurable interest in the lives of the other partners, members, or equity interest owners as do shareholders of corporations.

(h) An insurable interest must exist at the time the contract of personal insurance becomes effective but need not exist at the time the loss occurs.

(i) Any personal insurance contract procured or caused to be procured upon another individual is void unless the benefits under the contract are payable to the individual insured or such individual's personal representative or to a person having, at the time when the contract was made, an insurable interest in the individual insured. In the case of a void contract, the insurer shall not be liable on the contract but shall be liable to repay to the person or persons who have paid the premiums all premium payments without interest.

(j) A charitable institution as defined under Sections 501(c)(3), 501(c)(6), 501(c)(8), and 501(c)(9) of the Internal Revenue Code of 1986 shall have an insurable interest in the life of any donor.

(k) The insurable interests set forth in this Code section are not exclusive but are cumulative of and not in lieu of insurable interests existing in common law and not expressly set forth in this Code section.

History. — Code 1933, § 56-2404, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1988, p. 317, § 1; Ga. L. 1989, p. 1109, § 1; Ga. L. 1991, p. 1123, §§ 1, 2; Ga. L. 1993, p. 1721, § 3; Ga. L. 1995, p. 776, § 2; Ga. L. 2003, p. 482, § 1; Ga. L. 2006, p. 869, § 1/HB 1484; Ga. L. 2019, p. 386, § 23/SB 133.

The 2019 amendment, effective July 1, 2019, deleted the former second and third sentences of subsection (k), which read: "No part of this Code section specifically recognizing any insurable interest shall create any presumption or implication that such insurable interest did not exist prior to July 1, 2006. To the contrary, an insurable interest shall be presumed with respect to any life insurance policy issued prior to July 1, 2006, to any person whose insurable interest is recognized in this Code section."

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Civil Code 1895, § 2114, former Civil Code 1910, §§ 2496, 2498, and former Code 1933, §§ 56-901, 56-903, repealed by Ga. L. 1960, p. 289, enacting this title, are included in the annotations for this Code section.

Person with no insurable interest cannot procure insurance on another's life. — Person who has no insurable interest in the life of another person can-

not procure and maintain a policy of insurance on the life of such person, naming the first person as the beneficiary. Gulf Life Ins. Co. v. Davis, 52 Ga. App. 464, 183 S.E. 640 (1936) (decided under former Code 1933, §§ 56-901, 56-903).

Contract of insurance entered into between a person named as beneficiary therein and an insurance company, insuring another in whose life the beneficiary has no insurable interest, is void from the contract's inception, being a wagering contract and against public policy. Wilson v. Progressive Life Ins. Co., 61 Ga. App. 617, 7 S.E.2d 44 (1940) (decided under former Code 1933, §§ 56-901, 56-903).

Void policy does not invalidate second valid policy to another. — Insurance company may not take advantage of the company's own illegal and void contract to escape liability on a legal and binding one; hence the issuance of a first insurance contract on an orphaned child's life to the child's great-aunt, who had no insurable interest therein, did not invalidate a second policy, issued to the child's grandfather. Wilson v. Progressive Life Ins. Co., 61 Ga. App. 617, 7 S.E.2d 44 (1940) (decided under former Code 1933, §§ 56-901, 56-903).

One has an insurable interest in life of one's spouse under subsection (a) of this section. Beiter v. Decatur Fed. Sav. & Loan Ass'n, 222 Ga. 516, 150 S.E.2d 687 (1966).

Relationship of sibling is close enough to qualify for an insurable interest under subsection (a) of this section. United Ins. Co. of Am. v. Hadden, 126 Ga. App. 362, 190 S.E.2d 638 (1972).

One has no insurable interest in life of one's brother-in-law merely because of the existence of such relationship. Chandler v. Mutual Life & Indus. Ass'n, 131 Ga. 82, 61 S.E. 1036 (1908) (decided under former Civil Code 1895, § 2114).

Relationship of uncle and nephew will not support an insurable interest. Doody Co. v. Green, 131 Ga. 568, 62 S.E. 984 (1908) (decided under former Civil Code 1895, § 2114).

Adult children. — When a parent brought suit to recover the benefits under a policy of life insurance insuring the life of an adult son, the trial court erred in only partially denying the insurer's motion for summary judgment by holding that the insurer had waived the statutory requirement prohibiting the issuance of a valid life insurance policy without the written consent of the insured. Under circumstances not qualifying for an exception pursuant to O.C.G.A. § 33-24-6(a)(1)-(4), the policy was void ab initio, and unenforceable by the courts; written consent of the insured may not be waived. Time Ins. Co. v. Lamar, 195 Ga. App. 452, 393 S.E.2d 734 (1990).

Insurable interest may be based upon pecuniary expectation instead of kinship. — Insurable interest is not necessarily dependent upon marital relation or kinship by affinity or consanguinity. In a broad sense it may be said that anyone has an insurable interest in the life of another when one feels sufficient interest in another's welfare, for any reason, either to substantially assist the other during the other's life, or to make the other a gift after death, which one perhaps may not be able to do during life. Grand Lodge Knights of Pythias v. Barnard, 9 Ga. App. 71, 70 S.E. 678 (1911); McFarland v. Robertson, 137 Ga. 132, 73 S.E. 490 (1911), later appeal, 142 Ga. 266, 82 S.E. 643 (1914); Cherokee Life Ins. Co. v. Banks, 15 Ga. App. 65, 82 S.E. 597 (1914) (decided under former Civil Code 1019, § 2496).

As a general rule, a reasonable expectation of pecuniary gain or advantage through the continued life of another person and consequent loss by reason of that person's death creates an insurable interest. National Life & Accident Ins. Co. v. Parker, 67 Ga. App. 1, 19 S.E.2d 409 (1942) (insurable interest in stepson shown as matter of law) (decided under former Code 1933, §§ 56-401, 56-903).

One partner has insurable interest in life of other. — As the continuance of a partnership affords a reasonable expectancy of advantage and benefit to one partner, a partner had an insurable interest in the life of the copartner, and as the beneficiary named in the policy issued on the life of such copartner, was entitled to receive and retain the entire proceeds thereof. Rush v. Howkins, 135 Ga. 128, 68 S.E. 1035 (1910) (decided under former Civil Code 1895, § 2114).

Creditor has limited insurable interest in life of debtor. — Creditor has, for the purpose of indemnifying the creditor against loss, but for no other, an insurable interest in the life of a debtor, but this interest cannot exceed in amount that of the indebtedness to be secured. Such indebtedness may, however, include the cost of taking out and keeping up the insurance, if made a charge against the debtor, or the debtor's estate, or upon the proceeds of the policy when collected. Exchange Bank v. Loh, 104 Ga. 446, 31 S.E. 459, 44 L.R.A. 372 (1898) (decided under former Civil Code 1895, § 2114).

Conditions permitting employer to have insurable interest in employee. — Employer does not have an insurable interest in the life of an employee solely because of the relationship of employer and employee, but in order for such to appear it must be shown that the employer had a substantial economic interest in the life of the employee; that is, that by virtue of the relationship the employer might be reasonably expected to reap a substantial pecuniary benefit through the continued life of such employee, and to sustain consequent loss upon the employee's death. Turner v. Davidson, 188 Ga. 736, 4 S.E.2d 814 (1939) (decided under former Code 1933, §§ 56-901, 56-903).

Mere fact that at the time policy was issued employee was under contract to an employer for a period of approximately one year does not, standing alone, disclose an insurable interest of the employer in the life of the employee. Turner v. Davidson, 188 Ga. 736, 4 S.E.2d 814 (1939) (decided under former Code 1933, §§ 56-901, 56-903).

For an employer to have an insurable interest in the life of an employee, it should appear from the nature and character of the employment and the services rendered, their importance to the business conducted, and the character and particular ability of the employee, that the employee's death would be reasonably expected to result in substantial pecuniary loss to the employer. Turner v. Davidson, 188 Ga. 736, 4 S.E.2d 814 (1939) (decided under former Code 1933, §§ 56-901, 56-903).

When an employer has a substantial economic interest in the life of an employee, that is, when the employer might be reasonably expected to reap a substantial pecuniary benefit through the continued life of such employee, and sustain consequent loss upon the employee's death, a policy of insurance taken out by the employer in good faith to protect the employer's interest in the employee should be upheld. Turner v. Davidson, 188 Ga. 736, 4 S.E.2d 814 (1939) (decided under former Code 1933, §§ 56-901, 56-903).

Performance of ordinary duties by employee is not enough. — Small and insignificant economic readjustment which would normally follow the death of an employee performing ordinary duties requiring no special skill or knowledge would not give the employer an insurable interest in the life of the employee. Turner v. Davidson, 188 Ga. 736, 4 S.E.2d 814 (1939) (decided under former Code 1933, §§ 56-901, 56-903).

One may insure own life and assign to another not having insurable interest. — Meaning of this section is that one may insure one's own life without qualification, but that one may not insure the life of another unless one has an interest in the continuance of the life of that other. Necessarily, in the first instance, the amount of the policy is to be paid someone other than the insured because ordinarily under the contract the amount is not payable until one's death. Union Fraternal League v. Walton, 109 Ga. 1, 34 S.E. 317, 77 Am. St. R. 350, 46 L.R.A. 424 (1899), later appeal, 112 Ga. 315, 37 S.E. 389 (1900) (decided under former Civil Code 1895, § 2114).

One has a right to procure an insurance policy on one's own life and to assign it to another who has no insurable interest in the insured's life, provided it be not done by way of cover for a wagering contract. Quillian v. Johnson, 122 Ga. 49, 49 S.E. 801 (1905); Atlanta Sav. Bank v. Downing, 122 Ga. 692, 51 S.E. 38 (1905); Rylander v. Allen, 125 Ga. 206, 53 S.E. 1032, 6 L.R.A. (n.s.) 128, 5 Ann. Cas. 355 (1906); Sprouse v. Skinner, 155 Ga. 119, 116 S.E. 606 (1923); Hawkes v. Mobley, 174 Ga. 481, 163 S.E. 494 (1932); United Ins. Co. of Am. v. Hadden, 126 Ga. App. 362, 190 S.E.2d 638 (1972).

Person has an unlimited insurable interest in his or her own life, and when there is no intent to enter into a wagering contract, and classes of beneficiaries are not restricted, one may lawfully take out a policy of insurance on one's life and have the insurance made payable to whomsoever one pleases, regardless of whether the beneficiary so designated has an insurable interest in the insured's life. Quinton v. Millican, 196 Ga. 175, 26 S.E.2d 435 (1943).

One may make policy on one's life payable to paramour. — Regular life insurance policy, issued to a person on the person's own life and in favor of a paramour, may, if not otherwise invalid, be collected by the paramour, and when the paramour is designated by name, although the words "whose relationship to me is that of wife" are added, the paramour rather than the lawful spouse is entitled to the proceeds. Quinton v. Millican, 196 Ga. 175, 26 S.E.2d 435 (1943) (decided under former Code 1933, §§ 56-901, 56-903).

Assignment of policy to attending physician held not invalid. — Assignment of a life insurance policy to a physician who is rendering professional services to the assignor, by an agreement that the physician will continue to render the services to the assignor and the assignor's spouse so long as both of them shall remain in life, when the policy had an infinitesimal cash surrender value and was about to lapse for nonpayment of the premium, and the assignment is bona fide and not the result of fraud, is not as a matter of law a wagering contract and invalid and unenforceable. Hall v. Simmons, 50 Ga. App. 634, 179 S.E. 272 (1935) (decided under former Code 1933, §§ 56-901, 56-903).

"To be paid to assignee" construed. — Ruling which interprets the words "to be paid to an assignee" to import that such assignee need not have an insurable interest is not construction, but is judicial amendment. Mutual Life Ins. Co. v. Lane, 151 F. 276 (C.C.E.D. Ga.), aff'd, 157 F. 1002 (5th Cir. 1907), cert. denied, 208 U.S. 617, 28 S. Ct. 569, 52 L. Ed. 647 (1908) (decided under former Civil Code 1895, § 2114).

Liability in naming person with no insurable interest as beneficiary. — Insurer can incur no liability for increasing risk to life of insured by issuing to insured a policy designating as beneficiary a person with no insurable interest in the insured's life if the policy is procured with knowledge of and at the behest of the insured. Burton v. John Hancock Mut. Life Ins. Co., 164 Ga. App. 592, 298 S.E.2d 575 (1982).

If duty of reasonable care not to increase risk of harm to insured in connection with issuance of life insurance policies does exist under Georgia law, such duty could arise only when insurance company issues a policy that both is prohibited by statute or common law and increases risk of danger to the insured's person. Burton v. John Hancock Mut. Life Ins. Co., 164 Ga. App. 592, 298 S.E.2d 575 (1982).

Insurance company can breach no common law or statutory duty owed to insured by failing to inquire into insured's motive or intent in applying for insurance and naming as beneficiary a person with no insurable interest. Burton v. John Hancock Mut. Life Ins. Co., 164 Ga. App. 592, 298 S.E.2d 575 (1982).

Cited in Employers' Fire Ins. Co. v. Pennsylvania Millers Mut. Ins. Co., 116 Ga. App. 433, 157 S.E.2d 807 (1967); Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970); First of Ga. Ins. Co. v. Josey, 129 Ga. App. 14, 198 S.E.2d 381 (1973); Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205 (5th Cir. 1977); Georgia Mut. Ins. Co. v. Cook, 151 Ga. App. 328, 259 S.E.2d 717 (1979).

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Common law definition not broadened. — General Assembly, in defining "insurable interest" in this section, did not intend to broaden the common law defini-

tion. 1963-65 Op. Att'y Gen. p. 469.

Insurable interest may be based on kinship or pecuniary advantage. — Language, "a substantial interest engendered by love and affection in the case of individuals closely related by blood or by law," as used in subsection (a) of this Code section, was intended to embrace the common law concept of an insurable interest recognized in individuals closely related by blood or by law; that is to say that the relationships of husband and wife, father and mother, son and daughter, and vice versa would constitute an insurable interest by virtue of their relationship alone, without showing a pecuniary interest or advantage; also, others closely related by blood or law would come within this same classification in cases of special circumstances in which they are substituted for one of the individuals creating this same close relationship; all other persons, in order to show an insurable interest, must satisfy the first part of this section relating to a pecuniary advantage. 1963-65 Op. Att'y Gen. p. 469.

Aunt or grandmother must have financial relationship for insurable interest. — Aunt does not have sufficient insurable interest in the life of her infant niece or nephew, there being no financial dependency between them, to entitle the aunt to apply for and obtain a policy of life insurance upon the life of such niece or nephew, and under the same circumstances, a grandmother may not apply for such insurance. 1963-65 Op. Att'y Gen. p. 469.

Lifetime owner of policy with right to change beneficiary must have insurable interest. — When the applicant, the lifetime owner of the policy, has control of the policy and therefore may change beneficiaries at any time during the life of the insured without regard to any consent being given by the previous beneficiary or the insured, such lifetime owner must satisfy the requirements of subsection (c) of former Code 1933 § 56-2405 (see O.C.G.A. § 33-24-3) with reference to insurable interest as well as former Code 1933 § 56-2407 (see O.C.G.A. § 33-24-6) with reference to consent of the insured. In order to satisfy subsection (c), the benefits of the policy must be payable to the individual insured or the insured's personal representative, or to a person having, at the time when such contract was made, an interest in the individual insured; in order to satisfy former Code 1933, § 56-2407, such lifetime owner, in order to come within the exception, must have an insurable interest in the life of the minor whose life is insured. The wording of "no life insurance … contract upon an individual … shall be made or effectuated …" clearly would include the applicant who is the lifetime owner regardless of whether such applicant or owner is the named beneficiary in the policy. 1963-65 Op. Att'y Gen. p. 469.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 757 et seq.

C.J.S. — 44 C.J.S., Insurance, § 334 et seq.

ALR. — Effect on insurance contract of wagering assignment thereof, 5 A.L.R. 837; 53 A.L.R. 1403.

Who are "blood relatives" within statute or rules as to beneficiaries of insurance in mutual benefit societies, 10 A.L.R. 864.

Insurance: insurable interest of fiancé or fiancee, 17 A.L.R. 580.

Right of insolvent to insure life for benefit of relatives, 31 A.L.R. 51; 34 A.L.R. 838.

Effect of erroneous designation of beneficiary of insurance as "wife," 32 A.L.R. 1481.

Divorce decree as affecting a change of ownership or interest within policy of insurance, 48 A.L.R. 1232.

Insurable interest in life of co-obligor, 50 A.L.R. 366.

Divorce of insured and beneficiary as affecting the latter's right in life insurance, 52 A.L.R. 386; 175 A.L.R. 1220.

Constitutionality, construction, and application of statutes relating to insurance on life of one person for benefit of another who has no insurable interest, 108 A.L.R. 449.

Life policy or collateral agreement un-

der which benefits on death of one member of a group or class of policyholders who has no insurable interest in lives of one another are to be shared surviving members, as contrary to public policy as a wagering contract, 121 A.L.R. 725.

Insurable interest of employer in respect of injury or death of employee for which he is not legally responsible, 122 A.L.R. 1189.

Insurable interest of employer in life of employee, 125 A.L.R. 408.

Immoral relations between insured and beneficiary as affecting liability of insurer or rights in respect of proceeds policy, 173 A.L.R. 716.

Life insurance: right to raise question of lack of insurable interest, 175 A.L.R. 1276.

Rights and remedies under contract by party to procure insurance on his own life, 12 A.L.R.2d 983.

Insurable interest of partner or partnership in life of partner, 70 A.L.R.2d 577.

Insured's ratification, after loss, of policy procured without his authority, knowledge, or consent, 52 A.L.R.3d 235.

Payment of premiums by corporation on corporate officer's life insurance policy as affecting right to policy, 56 A.L.R.3d 1086.

Divorce: provision in decree that one party obtain or maintain life insurance for benefit of other party or child, 59 A.L.R.3d 9.

Insurable interest of brother or sister in life of sibling, 60 A.L.R.3d 98.

Estoppel of, or waiver by, issuer of life insurance policy to assert defense of lack of insurable interest, 86 A.L.R.4th 828.

Insurable interest of foster child or stepchild in life of foster or step parent, or vice versa, 35 A.L.R.5th 781.

33-24-4. Insurable interest; property insurance.

(a) As used in this Code section, the term "insurable interest" means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.

(b) No insurance contract on property or of any interest therein or arising therefrom shall be enforceable except for the benefit of persons having, at the time of the loss, an insurable interest in the things insured.

History. — Orig. Code 1863, § 2745; Code 1868, § 2753; Code 1873, § 2795; Code 1882, § 2795; Civil Code 1895, § 2090; Civil Code 1910, § 2472; Code 1933, § 56-812; Code 1933, § 56-2405, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 24/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted former subsection (c), which read: "The measure of an insurable interest in property is the extent to which the insured might be damnified by loss, injury, or impairment of such interest in such property."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "section, the term 'insurable interest'" for "section, 'insurable interest'" in subsection (a).

Law reviews. — For survey article on domestic relations, see 34 Mercer L. Rev. 113 (1982). For annual survey of insurance law, see 42 Mercer L. Rev. 259 (1990).

For comment on American Equitable Assurance Co. v. Pioneer Coop. Fire Ins. Co., 100 R.I. 375, 216 A.2d 139 (1966), as to effect of transfer of insured property to third party absent a clause in the policy prohibiting alienation, see 17 Mercer L. Rev. 483 (1966).

JUDICIAL DECISIONS

Analysis

General Consideration
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General Consideration

Test of insurable interest is whether insured will suffer direct pecuniary loss. — Test of insurable interest in property is whether insured has such a right, title, or interest therein, or relation thereto, that the insured will be benefited by the property's preservation and continued existence or suffer a direct pecuniary loss from the property's destruction or injury by the peril insured against. New Jersey Ins. Co. v. Rowell, 157 Ga. 360, 121 S.E. 414, answer conformed to, 32 Ga. App. 16, 123 S.E. 38 (1924), later appeal, 33 Ga. App. 552, 126 S.E. 892 (1925); Farmers Mut. Fire Ins. Co. v. Pollock, 52 Ga. App. 603, 184 S.E. 383 (1936).

It is enough if the assured holds such a relation to the property that the property's destruction by the peril insured against involves pecuniary loss to the assured. New Jersey Ins. Co. v. Rowell, 157 Ga. 360, 121 S.E. 414, answer conformed to, 32 Ga. App. 16, 123 S.E. 38 (1924), later appeal, 33 Ga. App. 552, 126 S.E. 892 (1925).

Title is not the sole test for determining an insurable interest. It may be a special or limited interest, disconnected from any title, lien, or possession, whereby the holder of the interest will suffer loss by the interest's destruction, etc., and that will entitle the holder to protect the interest by insurance; but the holder must have some lawful interest. Gordon v. Gulf Am. Fire & Cas. Co., 113 Ga. App. 755, 149 S.E.2d 725 (1966).

When by virtue of a quitclaim deed to his ex-wife as well as by their divorce decree itself, a husband was divested of equitable title to their residential property, he retained an equitable interest in it because of his continuing liability on and payment of a note given with a deed to secure a loan for improvements on the property. Republic Ins. Co. v. Martin, 182 Ga. App. 390, 355 S.E.2d 694 (1987).

When a daughter had acquired an insurable interest in residential property by a quitclaim deed to her from her mother, the daughter had an equitable interest, in addition to that of her mother, arising from her obligation on a note under a deed to secure a loan for improvements and from her occupancy of the residence. Republic Ins. Co. v. Martin, 182 Ga. App. 390, 355 S.E.2d 694 (1987).

Insured must have lawful interest in property. — While title may not always be the determinative factor, the insured must have some lawful interest in property before the insured can have an insurable interest in the property, although that interest may be slight or contingent, legal or equitable. Splish Splash Waterslides, Inc. v. Cherokee Ins. Co., 167 Ga. App. 589, 307 S.E.2d 107 (1983).

Mere possession insufficient. — Mere possession of property, although giving the possessor certain rights against a trespasser, is in and of itself not sufficient to constitute an insurable interest. Splish Splash Waterslides, Inc. v. Cherokee Ins. Co., 167 Ga. App. 589, 307 S.E.2d 107 (1983).

"Security deed" and promissory note creates insurable interest. — Vendor who had given a "security deed" to fire-damaged property, and who had remained liable on a promissory note to bank-mortgagee, had an insurable interest in the property. Cherokee Ins. Co. v. Gravitt, 187 Ga. App. 179, 369 S.E.2d 779 (1988).

Lessee has insurable interest in leased property. New Jersey Ins. Co. v. Rowell, 157 Ga. 360, 121 S.E. 414, answer conformed to, 32 Ga. App. 16, 123 S.E. 38 (1924), later appeal, 33 Ga. App. 552, 126 S.E. 892 (1925).

No insurable interest in lease assignee unless lease effectively assigned. — Mere intruder or trespasser on the land of another has no insurable interest in that real estate or the buildings thereon. Consequently, a lease assignee can claim no insurable interest in realty buildings unless the lease in question has been effectively assigned. Splish Splash Waterslides, Inc. v. Cherokee Ins. Co., 167 Ga. App. 589, 307 S.E.2d 107 (1983).

Right to remove trade fixtures does not provide an independent basis for finding that one has an insurable interest in property when the right to remove such fixtures has ended with the cessation of the right of possession, unless the landlord acquiesces in continual possession. Splish Splash Waterslides, Inc. v. Cherokee Ins. Co., 167 Ga. App. 589, 307 S.E.2d 107 (1983).

Nature of insurable interest. — It is not necessary that the policy shall specifically insure or define in terms the nature of the insurable interest of the assured, especially when there is no fraud or deception, and the company through the company's agent is informed as to the facts of such "interests." Hagan v. Hudson Ins. Co., 48 Ga. App. 558, 173 S.E. 477 (1934).

If interest is expressly referred to, company is estopped from questioning it. — When the insurer, with full knowledge of the interest of the assured, recognizes it as insurable by issuing a policy which expressly refers to the nature of such interest, it will not be permitted, as a general rule, to question the sufficiency of such interest, and the principle of estoppel will apply. Hagan v. Hudson Ins. Co., 48 Ga. App. 558, 173 S.E. 477 (1934).

Cited in Townsend v. Morris, 222 Ga. 242, 149 S.E.2d 464 (1966); Great Am. Ins. Co. v. Lipe, 116 Ga. App. 169, 156 S.E.2d 490 (1967); Reserve Ins. Co. v. Associates Disct. Corp., 116 Ga. App. 792, 159 S.E.2d 97 (1967); Nationwide Mut. Fire Ins. Co. v. Jenkins, 389 F.2d 373 (5th Cir. 1967); Greenbriar Shopping Ctr., Inc. v. Lorne Co., 310 F. Supp. 303 (N.D. Ga. 1969); Liberty Nat'l Bank & Trust Co. v. Interstate Motel Developers, Inc., 346 F. Supp. 888 (S.D. Ga. 1972); Trust Co. v. Thompson, 133 Ga. App. 866, 212 S.E.2d 498 (1975); Huckaby v. Georgia Farm Bureau Mut. Ins. Co., 140 Ga. App. 493, 231 S.E.2d 378 (1976); American Reliable Ins. Co. v. Woodward, 143 Ga. App. 652, 239 S.E.2d 543 (1977); Canal Ins. Co. v. P & J Truck Lines, 145 Ga. App. 545, 244 S.E.2d 81 (1978); Georgia Mut. Ins. Co. v. Cook, 151 Ga. App. 328, 259 S.E.2d 717 (1979); Allstate Ins. Co. v. Ammons, 160 Ga. App. 257, 286 S.E.2d 765 (1981); Leader Nat'l Ins. Co. v. Smith, 162 Ga. App. 612, 292 S.E.2d 456 (1982); James v. Pennsylvania Gen. Ins. Co., 167 Ga. App. 427, 306 S.E.2d 422 (1983); Crews v. Allstate Ins. Co., 188 Ga. App. 646, 373 S.E.2d 782 (1988); Jet Air, Inc. v. National Union Fire Ins. Co., 189 Ga. App. 399, 375 S.E.2d 873 (1988); Georgia Farm Bureau Mut. Ins. Co. v. Brewer, 202 Ga. App. 127, 413 S.E.2d 770 (1991); Conex Freight Sys. v. Ga. Ins. Insolvency Pool, 254 Ga. App. 92, 561 S.E.2d 221 (2002).

Parties With Insurable Interest

Secondary liability on lease for coal auger gave debtor insurable interest in the coal auger even though it did not have title to the property. Bryan v. Commercial Union Ins. Co. (In re Mr. Mach., Inc.), 29 Bankr. 339 (Bankr. N.D. Ga. 1983).

Guarantor of loan has insurable interest in financed vehicle. — Appellant, who guaranteed a loan from a commercial loan from a bank to appellee, had an insurable interest in the truck which was financed through that loan to appellee. Whitaker v. Ranow, 173 Ga. App. 746, 327 S.E.2d 855 (1985).

Purchaser of chattel, subsequently destroyed, cannot recover from prior owner's insurer. — Party who purchased chattel had an insurable interest in that chattel but as the purchaser had no policy of insurance, the purchaser could not recover from the prior owner's insurer when the chattel was totally destroyed. Roach v. Georgia Farm Bureau Mut. Ins. Co., 173 Ga. App. 229, 325 S.E.2d 797 (1984).

Implied trust in favor of insured when property conveyed. — When the jury was authorized to find that an implied trust resulted in favor of the insured when the insured conveyed the property

Parties With Insurable Interest (Cont'd)

involved to the insured's brother, the insured had an insurable interest in the house at the time of the house's destruction by fire, even though the property was no longer titled in the insured's name. Georgia Farm Bureau Mut. Ins. Co. v. Smith, 179 Ga. App. 399, 346 S.E.2d 848 (1986).

Partner has an insurable interest in the firm property which will support a policy taken out thereon for the partner's own benefit. Georgia Farm Bureau Mut. Ins. Co. v. Mikell, 126 Ga. App. 640, 191 S.E.2d 557 (1972).

Partner has an insurable interest in the firm's property because the partner has an actual, lawful, and substantial economic interest in the property's preservation. Georgia Farm Bureau Mut. Ins. Co. v. Mikell, 126 Ga. App. 640, 191 S.E.2d 557 (1972).

Insurable interest of partnership. — Insurable interest in the property of a partnership exists in both the partnership and the partners. Georgia Farm Bureau Mut. Ins. Co. v. Mikell, 126 Ga. App. 640, 191 S.E.2d 557 (1972).

Presumption that only named partner's interest is covered. — Partner who insures a partnership property in the partner's own name without any stipulation or understanding that the insurance is for the benefit of the firm or a co-partner is presumed to have insured only the named partner's own interest in the property. Georgia Farm Bureau Mut. Ins. Co. v. Mikell, 126 Ga. App. 640, 191 S.E.2d 557 (1972).

Partnership may show insurance is for partnership's benefit. — Insurance apparently made for an individual partner may be shown to have been for the benefit of the partnership when the parties deal on that basis, or when the entity entitled to the insurance so authorizes or ratifies the action. Georgia Farm Bureau Mut. Ins. Co. v. Mikell, 126 Ga. App. 640, 191 S.E.2d 557 (1972).

Mortgagee has insurable interest. — Mortgagee or one succeeding to the interest or rights of a mortgagee in the mortgaged property has an insurable interest therein. Farmers Mut. Fire Ins. Co. v. Pollock, 52 Ga. App. 603, 184 S.E. 383 (1936) (decided under former Code 1933, § 56-812).

Bankruptcy court found that under the security deed the credit company held a valid security interest in the destroyed property and the security deed provided sufficient language to grant the credit company a security interest in the proceeds of the collateral, including any insurance proceeds. Altegra Credit Co. v. Ford Motor Credit Co. (In re Brantley), 286 B.R. 918 (Bankr. S.D. Ga. 2002).

Person succeeding to mortgagee's rights has insurable interest. — When plaintiff's spouse held a mortgage against the property, and when the mortgage was not paid spouse, gave spouses interest in the mortgage and mortgaged property to the plaintiff and the plaintiff paid the expenses of the foreclosure, and while the sheriff's deed was made to the spouse and not to the plaintiff, as the plaintiff had directed, it was intended to have been made to the plaintiff, and the plaintiff thought it was so made until action was brought, and the plaintiff's spouse did not claim any interest in or title to the property, but it belonged to the plaintiff, subject to an outstanding security deed, the plaintiff having exclusive and sole possession and had rented the property out to the plaintiff's tenants, the plaintiff had an interest, legal or equitable, in the insured property, such as could be made the subject matter of a fire insurance policy. Farmers Mut. Fire Ins. Co. v. Pollock, 52 Ga. App. 603, 184 S.E. 383 (1936).

Parties holding bond for title may be regarded as owners, even when the purchase money is not all paid. Southern Ins. & Trust Co. v. A. Lewis & Bros., 42 Ga. 587 (1871).

Abandoned spouse has insurable interest in home owned by other spouse. — When a married person is deserted by the other spouse and by such desertion is left in the exclusive possession and control of the dwelling house in which they previously lived together, and the abandoned spouse continues thereafter to occupy the house as the spouse's home, paying the taxes thereon and removing with spouse's own funds a mort-

gage which the other spouse had placed against it, the first spouse has an insurable interest therein, notwithstanding the legal title to the property may be in the other spouse. Aetna Ins. Co. v. Foster, 43 Ga. App. 658, 159 S.E. 882 (1931).

One has insurable interest as "trustee" for property partly owned by spouse. — When a policy of fire insurance was issued to a married person, designated generally as "trustee," and another, the married person, if the other spouse was part owner of the property covered by the policy, has such an insurable interest therein as would authorize the former for the latter's benefit to join with the other person insured in an action upon the policy. Southern Mut. Ins. Co. v. Turnley, 100 Ga. 296, 27 S.E. 975 (1897).

Estranged spouse who relinquished title to property to the other spouse retained an insurable interest in the property. Brown v. Ohio Cas. Ins. Co., 239 Ga. App. 251, 519 S.E.2d 726 (1999).

Parent may execute insurance contract for minor children. — In the absence of an express statutory prohibition, a parent as the natural guardian of the parent's minor children, and being endowed with the children's custody, control, and management has the legal right to execute a contract of insurance in the children's behalf. Georgia Mut. Ins. Co. v. Nix, 113 Ga. App. 735, 149 S.E.2d 494 (1966).

When insurer knows who has title, policy is valid. — This section simply provides that a contract of insurance shall be unenforceable "except for the benefit of persons" having an insurable interest in the thing insured; and when it is alleged that the defendant insurance company, through the agent issuing the policy, had actual knowledge that title to the insured property was in the plaintiff's son, the policy will be construed as a valid contract of insurance covering the property of the son, issued to the father as trustee, and he can recover therefor for the benefit of his son. Georgia Mut. Ins. Co. v. Nix, 113 Ga. App. 735, 149 S.E.2d 494 (1966).

Both owner and contractor may insure property under construction. — Owner may insure the owner's interest in the property under construction, and contractors may indemnify themselves against loss during the same period of time, and both policies will be payable, in the event of a fire, to the extent of loss of each insured under that insured's separate policy. American Ins. Co. v. Bateman, 125 Ga. App. 189, 186 S.E.2d 547 (1971); Insurance Co. of N. Am. v. Fowler, 148 Ga. App. 509, 251 S.E.2d 594 (1978).

As contractor has insurable interest, builder's risk policy may cover. — When the subject matter of insurance is a builder's risk policy, whether for construction, alteration, or repair, the building contractor who has entered into such a contract has an insurable interest in the building. Unless when such risk is deemed to have commenced is decided by the wording of the policy, it is normally while "under construction." E.C. Long, Inc. v. Brennan's of Atlanta, Inc., 148 Ga. App. 796, 252 S.E.2d 642 (1979).

Cargo carrier had insurable interest in cargo owned by third party. — Because it had liability to the owner of cargo for loss to the cargo during transportation under the Carmack Amendment to the Interstate Commerce Act, 49 U.S.C. § 14706(a)(1), a cargo carrier had an insurable interest in cargo it was transporting for an owner. Certain Underwriters at Lloyds, London v. DTI Logistics, Inc., 300 Ga. App. 715, 686 S.E.2d 333 (2009).

Parties Without Insurable Interest

Simple creditor has no insurable interest in debtor's property. — Simple contract creditor, without a lien either statutory or contract, without a jus in re or jus in rem, owning a mere personal claim against a debtor, has no insurable interest in the property of the debtors. Northwestern Nat'l Ins. Co. v. Southern States Phosphate & Fertilizer Co., 20 Ga. App. 506, 93 S.E. 157 (1917).

Bona fide purchaser of stolen property has no insurable interest therein. — Bona fide possession of stolen property does not give the holder any sort of title whatever, such as would come up to the rule governing an insurable interest; nor does the possessor's bona fide possession of stolen property constitute such an exclusive and undisputed claim as would entitle the possessor to be called

Parties Without Insurable Interest (Cont'd)

the "sole and exclusive" owner. Not only has the real owner a contrary claim, but an uncontestable claim, and the fact that the owner is unable to assert it until the whereabouts of the property has been located does not render the claim of the bona fide holder in possession either undisputed or uncontested. Giles v. Citizens Ins. Co., 32 Ga. App. 207, 122 S.E. 890 (1924).

One who purchases stolen property, though in good faith, can acquire no title — hence no lawful interest. Gordon v. Gulf Am. Fire & Cas. Co., 113 Ga. App. 755, 149 S.E.2d 725 (1966).

Alienation of property, standing alone, effectively renders the policy unenforceable, and furthermore, if the insured was divested of all interest and right under the policy by an outright assignment, the insured could not thereafter claim an interest or maintain an action to recover under the policy in the insured's name. Curtis v. Girard Fire & Marine Ins. Co., 190 Ga. 854, 11 S.E.2d 3 (1940) (bill of sale to secure debt).

Life tenant's insurable interest terminates at tenant's death. — Policy of fire insurance issued to one who has only a life estate in the property insured is inoperative as to loss occurring after the life tenant's death since the termination of the life estate by the life tenant's death terminates the life tenant's insurable interest in the property. Garnett v. Royal Ins. Co., 23 Ga. App. 432, 98 S.E. 363 (1919) (decided under former Civil Code 1910, § 2472).

Mere possession or license to use an outbuilding standing alone was insufficient to create an insurable interest in the outbuilding. Sapp v. Georgia Farm Bureau Mut. Ins. Co., 206 Ga. App. 209, 424 S.E.2d 871 (1992).

Individual failed to show an interest in a grantee corporation. — Individual who was a sole shareholder of a corporation did not have an insurable interest in property that was quitclaimed to a corporation, absent any showing that the individual had an interest in the grantee corporation or that the two corporations were the same. Muhammad v. Allstate Ins. Co., 313 Ga. App. 531, 722 S.E.2d 136 (2012).

Policy Provisions

Company cannot name amount and then contend insured's interest is limited. — Insurance company may not, with full knowledge of the interest being insured, contract to insure and collect assessments on a named amount, and then in the event of loss contend that insured's interest is limited to the value of the rental of the leasehold for the remainder of the term. Farmers' Mut. Fire Ins. Co. v. Harris, 50 Ga. App. 75, 177 S.E. 65 (1934).

Total payable under all interests and policies need not equal market value. — There is no rule of law that when various interests and various insurance policies are involved, the total payable under all the policies must necessarily be equivalent to the market value of the property. American Ins. Co. v. Bateman, 125 Ga. App. 189, 186 S.E.2d 547 (1971).

Insurable interest requirement does not dispense with sole ownership condition in policy. — While under the section an insurable interest is defined as some interest in the property or event insured, and a slight or contingent interest is sufficient, whether legal or equitable, such insurable interest is not to be taken as synonymous with the sole and unconditional ownership required by the terms of the policy. Nor does the rule as to an insurable interest dispense with the contractual requirement as to liens upon the property constituting the subject matter of the risk. Alliance Ins. Co. v. Williamson, 36 Ga. App. 497, 137 S.E. 277, cert. denied, 36 Ga. App. 825, (1927).

Fire insurance policy beneficiary. — Policy of fire insurance was issued to A individually, purporting to insure a described building. There was nothing in the policy to indicate that A's interest was other than individual. The policy contained a stipulation that the policy should be void "if the interest of the insured be other than unconditional or sole ownership, or if the subject of insurance be a building on ground not owned by the in-

sured in fee simple." After loss an action was brought upon the policy by A as trustee for A's children, A alleging that A held title to the property in trust for A's children. It was held that A's pleading was properly dismissed. Fox v. Queen Ins. Co., 124 Ga. 948, 53 S.E. 271 (1906).

Requires exclusive and undisputed use under claim of right. — Insured will be deemed to have "sole and unconditional" ownership whenever, under a claim of right, the insured has the exclusive and undisputed use, possession, and enjoyment of the property. Giles v. Citizens Ins. Co., 32 Ga. App. 207, 122 S.E. 890 (1924).

Equitable title satisfies sole ownership condition. — When one spouse has an equitable interest in the house, which interest is recognized by the other spouse, the equitable interest, together with the legal title held by the other spouse, constitutes a complete fee simple title in the house and premises in the insured, and sufficiently meets the requirements of the policy that the property insured be on premises owned by the insured in fee simple, that the interest of the insured therein be truly stated, and that the ownership of the insured be sole and unconditional. Hurley v. National-Ben Franklin Fire Ins. Co., 46 Ga. App. 515, 167 S.E. 917 (1933).

Perfect equitable title in the insured to property covered by a policy of fire insurance satisfies the condition in the policy that the policy "shall be void, if the interest of the insured be other than unconditional and sole ownership; or if the subject of insurance be a building on ground not owned by the insured in fee simple." Norwich Union Fire Ins. Soc'y Ltd. v. Sawyer, 57 Ga. App. 739, 196 S.E. 223 (1938).

Bill of sale to secure debt voids policy. — Bill of sale to secure debt was an alienation of the property insured and rendered void the policy under the terms of the policy. Curtis v. Girard Fire & Marine Ins. Co., 190 Ga. 854, 11 S.E.2d 3 (1940).

Agent's knowledge estops company from setting up noncompliance with condition. — If the agent of the insurance company knew at the time of issuance of the policy the real facts as to ownership, the policy would nevertheless be binding since the company would be estopped by reason of such knowledge from setting up the noncompliance of the insured with the sole and unconstitutional ownership provision of the policy. Blackstock v. Jefferson Ins. Agency, 23 Ga. App. 642, 99 S.E. 142 (1919).

Change of vehicle number without owner's knowledge does not void policy. — While it is true that a plaintiff cannot recover in an action on a fire insurance policy except by showing that the property in the plaintiff's possession at the time the policy was issued was the same as that described in the policy, still when the insured is the actual owner of the property which is the subject matter of the contract of insurance, and has an insurable interest therein, the mere fact that the original factory number of the motor of an insured automobile may have been changed without the owner's knowledge would not of itself render the contract of insurance null and void with reference to the insurance on the car actually dealt with by the contracting parties. Giles v. Citizens Ins. Co., 32 Ga. App. 207, 122 S.E. 890 (1924).

Practice and Procedure

Ownership or insurable interest must be alleged in action on policy. — By virtue of this section, in an action upon a policy fire insurance, it is incumbent upon the plaintiff to allege that the property destroyed by fire belonged to the plaintiff, or that the plaintiff had some insurable interest therein, at the time of the fire. When the plaintiff's pleading contains no such allegation, no cause of action is set forth. Northwestern Nat'l Ins. Co. v. Southern States Phosphate & Fertilizer Co., 20 Ga. App. 506, 93 S.E. 157 (1917).

Assignee of policy must allege such interest. — Assignment of the policy as collateral security will not enable the assignee to maintain an action, unless it is alleged that at the time of the fire the assignee had an interest in the property insured. Northwestern Nat'l Ins. Co. v. Southern States Phosphate & Fertilizer Co., 20 Ga. App. 506, 93 S.E. 157 (1917).

Practice and Procedure (Cont'd)

Possessor of personalty is presumed owner. — Possessor of personal property is presumed to be the property's owner, until the contrary appears. In an action against an insurance company upon a policy insuring property as belonging to the policyholder, when the company sets up the defense that the policyholder is not the owner of the property, the burden is upon the company to disprove the policyholder's ownership. Giles v. Citizens Ins. Co., 32 Ga. App. 207, 122 S.E. 890 (1924).

Proof of possession makes prima facie case. — On the trial of a case by an insured under a fire insurance policy against the insurer to recover for the loss by fire of property alleged to have been covered by the policy, if it is incumbent upon the plaintiff to show that the plaintiff's title to the property was sole and unconditional, or that the plaintiff had such title to the property as would entitle the plaintiff to recover as the owner having an insurable interest in the property, it is only necessary for the plaintiff to make a prima facie case of the required ownership, which the plaintiff may do by showing that the policy covered the property damaged and that the plaintiff was in possession of the property claiming to be the owner thereof. National Union Fire Ins. Co. v. Tatum, 56 Ga. App. 740, 193 S.E. 799 (1937).

Evidence sufficient to show ownership and waiver of sole ownership condition. — Evidence was sufficient to authorize the inference that property covered by an insurance policy belonged to the insured, and that no person other than the insured had any right, title, or interest in the property, unless it was a creditor of the insured for whose benefit the policy was issued, and to whom, as a person entitled to possession of the policy, the defendant had delivered the policy, and that the insurer at the time had knowledge of whatever right, title, and interest in the property may have been in the creditor, and therefore had waived the provision in the policy that the policy, unless otherwise provided for by agreement, or by endorsement on the policy or addition to it, would be void if the interest of the insured were other than unconditional and sole ownership. National Union Fire Ins. Co. v. Tatum, 56 Ga. App. 740, 193 S.E. 799 (1937).

Proper form for instructing on insurable interest. — When the judge charged the jury that in the judge's opinion A had an insurable interest; it was held that this was an improper mode of presenting the case. The judge ought to have called the attention of the jury to the facts, and then stated: "If you believe, etc., etc., then in the opinion of the court, under the law, you will find that he had an insurable interest." Southern Ins. & Trust Co. v. A. Lewis & Bros., 42 Ga. 587 (1871).

OPINIONS OF THE ATTORNEY GENERAL

Leasehold interest coupled with a right or option to purchase or otherwise acquire the leased property upon expiration of the lease agreement is an "insurable interest" which may be protected by the lessee. 1963-65 Op. Att'y Gen. p. 404.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 933 et seq.

C.J.S. — 44 C.J.S., Insurance, § 317 et seq.

ALR. — Insurance: effect of violation of warranty or condition of sole and unconditional ownership as regards one or more of several items of property covered by policy, 5 A.L.R. 808.

Right of reinsurer to question the insurable interest or eligibility of beneficiary, 18 A.L.R. 1163.

Insurance: effect of provision declaring loss, in case of mortgagee's interest, subject to all the terms and conditions of the policy, 19 A.L.R. 1449; 56 A.L.R. 850.

Insurable interest in landlord in crops raised by tenant, or in chattels or fixtures placed on the premises by the latter, 45 A.L.R. 863.

Tenant by entirety as sole and unconditional owner within insurance policy, 48 A.L.R. 353.

Levy of process, or seizure and possession of officer thereunder, as change of interest, title, or possession, avoiding insurance policy, 48 A.L.R. 1021.

Divorce decree as effecting a change of ownership or interest within policy of insurance, 48 A.L.R. 1232.

Reacquisition or extinguishment of title or interest as affecting provision in fire insurance policy against change of title, interest, or possession, or against encumbrance, 52 A.L.R. 843.

Right in proceeds of insurance taken out by warehouseman on goods stored, 53 A.L.R. 1409.

Vendee or vendor under executory contract as having exclusive ownership or interest, within the meaning of condition in insurance policy requiring interest of insured to be that of "unconditional and sole ownership," or the like, 60 A.L.R. 11.

Condition vendor or vendee of personal property as sole and unconditional owner within an insurance policy, 61 A.L.R. 661.

Voidability of deed to insured as affecting his status as sole and unconditional owner, 64 A.L.R. 757.

Insurable interest of husband or wife in other's property, 68 A.L.R. 362; 27 A.L.R.2d 1059.

Extent of recovery by insured who has only a partial or limited interest in the insured property, 68 A.L.R. 1344.

Property insurance taken out by, or endorsed to, receiver in bankruptcy or trustee in bankruptcy, 74 A.L.R. 1347.

Right of mortgagee to benefit of insurance taken out by, or in name of, receiver, trustee, or assignee for creditors of own of equity of redemption, 94 A.L.R. 1387.

Default on part of vendee in land contract as change in title, interest, or possession within provision of insurance policy in that regard, 97 A.L.R. 769.

Insurer's right of subrogation to mortgagee where it is not liable to mortgagor as subordinate to mortgagee's right as regards amount of mortgage debt remaining unpaid after application of proceeds of insurance, 106 A.L.R. 679.

Validity of insurance property possessed in violation of law or used for unlawful purpose, 132 A.L.R. 125.

Mortgagee's knowledge or acceptance of mortgagee clause before loss, as condition of his right to benefit of it, 132 A.L.R. 355.

Conditional sale as affecting provision in insurance policy against change of title, interest, or possession, 133 A.L.R. 785.

Fire insurance: sole and unconditional ownership provision as applicable where insured's title is defective, but in itself subject to no inherent limitation or condition affecting his exclusive ownership, 133 A.L.R. 1344.

Waiver or estoppel regarding sole and unconditional ownership clause, where both insurer and insured are aware of the uncertainty as to the title, 140 A.L.R. 1235.

Insurable interest predicated upon invalid or unenforceable contract, 9 A.L.R.2d 181.

Validity and construction of provision of automobile policy against encumbrances, 16 A.L.R.2d 736.

Condemnation proceedings as affecting insurable interest of property owner, 29 A.L.R.2d 888.

33-24-5. Persons having capacity to contract for insurance; purchase of insurance by or for minors; rescission, avoidance, or repudiation of contracts by minors.

(a) Any person of competent legal capacity may contract for insurance.

(b) A minor not less than 15 years of age as determined at his nearest birthday may, notwithstanding his minority, contract for annuities, endowments, life insurance, and accident and sickness insurance on his own life or body or the life or body of any person in whom he has an insurable interest. A minor shall, notwithstanding his minority, be

deemed competent to exercise all rights and powers with respect to or under any contract or policy for annuities, endowments, life insurance, and accident and sickness insurance on his own life or body or on the person of another as though of full legal age, and may surrender his interest in the annuities, endowments, life insurance, and accident and sickness insurance and give a valid discharge for any benefit accruing or money payable under the contract or policy. The minor shall not, by reason of his minority, be entitled to rescind, avoid, or repudiate the contract or to rescind, avoid, or repudiate any exercise of a right or privilege under the contract, except that the minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by promissory note or otherwise, any consideration or premium on any such contract or policy. Any contract or policy for annuities, endowments, life insurance, and accident and sickness insurance procured by or for a minor under this subsection shall be made payable either to the minor or his estate or to a person having an insurable interest in the life of such minor.

(c) A minor not less than 15 years of age as determined at his nearest birthday may, notwithstanding such minority, contract for insurance on other subjects of insurance in which he has an insurable interest. A minor shall be bound by any settlement made in connection with any insurance contract so issued. The minor shall not, by reason of his minority, be entitled to rescind, avoid, or repudiate the contract or to rescind, avoid, or repudiate any exercise of a right or privilege under the contract, except that a minor, not otherwise emancipated, shall not be bound by any unperformed agreement to pay, by promissory note or otherwise, any premium on any insurance contract.

History. — Code 1933, § 56-2406, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1990, p. 8, § 33.

Law reviews. — For article recommending more consistency in age requirements of laws pertaining to the welfare of minors, see 6 Ga. St. B.J. 189 (1969).

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Minority does not prohibit contracting insurance. — When a 16-year-old child requested that the child's vehicle be added to the parents' existing coverage, and when the child was a named insured under the policy, the child's minority in and of itself did not prohibit the child from contracting insurance. Buffington v. State Auto. Mut. Ins. Co., 192 Ga. App. 389, 384 S.E.2d 873, cert. denied, 192 Ga. App. 901, 384 S.E.2d 873 (1989).

Federal law controls servicemember's right to choose beneficiary of GI insurance. — When state law conflicts with the right granted by Congress to a servicemember to name in the first instance a beneficiary of the servicemember's own choosing, state law must yield. Davenport v. Servicemen's Group Life Ins. Co., 119 Ga. App. 685, 168 S.E.2d 621 (1969).

Minor servicemember may designate beneficiary. — Minor service-

member may exercise the right granted by the Federal Servicemember's Group Life Insurance Act to designate a beneficiary of the servicemember's choosing for such insurance, this section to the contrary notwithstanding. Davenport v. Servicemen's Group Life Ins. Co., 119 Ga. App. 685, 168 S.E.2d 621 (1969).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 205.

C.J.S. — 44 C.J.S., Insurance, § 461 et seq.

ALR. — Insanity of insured as excusing lack of, or delay in, notice or proof of accident or disability, 142 A.L.R. 852.

Capacity of minor insured to effect a change of beneficiary, 14 A.L.R.2d 375.

33-24-6. Consent of insured to insurance contract; exceptions; reliance by insurer on statements in application.

(a) No life or accident and sickness insurance contract upon an individual, except a contract of group life insurance or of group or blanket accident and sickness insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies for a life or accident and sickness insurance contract or consents in writing to the contract, except in the following cases:

(1) A spouse may effectuate insurance upon the other spouse;

(2) Any person having an insurable interest in the life of a minor or any person upon whom a minor is dependent for support and maintenance may effectuate insurance upon the life of or pertaining to the minor;

(3) An application for a family policy may be signed by either parent, by a stepparent, or by husband or wife;

(4) A publicly owned corporation may effectuate insurance upon its employees in whom it has an insurable interest;

(5) A corporation not described in paragraph (4) of this subsection may effectuate insurance upon its employees in whom it has an insurable interest, and a trustee of a trust established by a corporation providing life, health, disability, retirement, or similar benefits may effectuate insurance upon employees for whom such benefits are to be provided if the insurance contract or contracts held by such corporation or trustee cover at least two employees. For purposes of this paragraph, any employee of a group of corporations consisting of a parent corporation and its directly or indirectly owned subsidiaries shall be considered to be an employee of each corporation within that group; or

(6) A corporation described in paragraph (4) or (5) of this subsection or the trustee of a trust established by such corporation for its

sole benefit may exchange any policy which was issued to itself on the life of an employee or retiree of the corporation, or which was issued to another corporation or the trustee of a trust established by such other corporation for its sole benefit on the life of an employee or retiree of such other corporation, and the exchanging corporation has acquired by purchase, merger, or otherwise all or part of such other corporation's business for a new policy of insurance on such individual's life issued to the exchanging corporation.

(b)(1) If a contract of life insurance is issued as authorized in paragraph (4) or (5) of subsection (a) of this Code section, the insurer shall be required to give written notice of such life insurance in accordance with paragraph (3) of this subsection and provide the employees an opportunity to refuse to participate. For all contracts of life insurance issued or delivered for issuance in this state pursuant to paragraph (4) or (5) of subsection (a) of this Code section, the written consent of each individual proposed to be insured shall be obtained prior to the issuance of a policy on such individual. Written consent shall include an acknowledgment that the corporation may maintain life insurance coverage on such individual after such individual's employment with the corporation has terminated.

(2) If a contract of life insurance is issued as authorized in paragraphs (1) or (2) of subsection (a) of this Code section, the insurer shall be required to give written notice of such life insurance in accordance with paragraph (3) of this subsection.

(3) At the time of the issuance or delivery of the contract of insurance, notice of the issuance of the policy shall be delivered to the insured in person or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the home, business, or other address of record of the insured. The insurer may obtain a receipt provided by the United States Postal Service as evidence of mailing such notice or obtain such other evidence of mailing as prescribed or accepted by the United States Postal Service. The insurer shall not be required to provide the notice set forth in this subsection with respect to any application for credit life insurance; any insured who is older than the age of majority and who has signed or otherwise acknowledged the application in writing; any application for insurance covering the life of a minor; or any application for a contract of life insurance with a face amount of less than $10,000.00.

(c) An insurer shall be entitled to rely upon all statements, declarations, and representations made by an applicant for insurance relative to the insurable interest which such applicant has in the insured; and no insurer shall incur any legal liability except as set forth in the policy, by virtue of any untrue statements, declarations, or representations so relied upon in good faith by the insurer.

(d) As used in paragraphs (4), (5), and (6) of subsection (a) of this Code section, the term "employee" shall include any and all directors, officers, employees, or retired employees. The term "employee" shall include any former employee, but only for the purpose of replacing existing life insurance that will be surrendered in exchange for new life insurance in an amount not exceeding the insurance being surrendered.

History. — Code 1933, § 56-2407, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1987, p. 389, § 1; Ga. L. 1990, p. 132, § 1; Ga. L. 1990, p. 1000, § 1; Ga. L. 1993, p. 1721, § 4; Ga. L. 1995, p. 776, § 3; Ga. L. 2003, p. 482, § 2; Ga. L. 2009, p. 635, § 1/HB 80; Ga. L. 2019, p. 386, § 25/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "after July 1, 2003," following "issuance in this state" in the middle of the second sentence of paragraph (b)(1).

Law reviews. — For note, "Misrepresentations and Nondisclosures in the Insurance Application," see 13 Ga. L. Rev. 876 (1979).

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Common law required insured's knowledge or consent. — There existed at common law a general rule establishing a public policy against the issuance of a policy of life insurance without the knowledge or consent of the person insured. It was deemed that to allow the insuring of the life of a person without the person's knowledge or consent could be a contributing factor toward the commission of a crime and could create a substantial risk to the unknowing insured person. Wren v. New York Life Ins. Co., 59 F.R.D. 484 (N.D. Ga. 1973), aff'd, 493 F.2d 839 (5th Cir. 1974).

Knowledge or consent as deterrent to crime. — To allow the insuring of the life of a person without that person's knowledge or consent could be a contributing factor toward the commission of a crime and could create a substantial risk to the unknowing insured person. Wren v. New York Life Ins. Co., 493 F.2d 839 (5th Cir. 1974).

Section requires insured's application or consent in writing. — While the public policy at common law dealt with "knowledge or consent," the Georgia General Assembly has been even more restrictive by providing that the insured must either apply for the insurance or consent thereto in writing. Wren v. New York Life Ins. Co., 59 F.R.D. 484 (N.D. Ga. 1973), aff'd, 493 F.2d 839 (5th Cir. 1974).

Verbal authorization of written consent does not comply. — Purpose of this section is to put consent beyond all question by requiring the consent to be in writing. The very purpose and specific requirement of the section would be rendered meaningless if one could meet its terms by alleging written consent to have been verbally authorized, something that the deceased insured would hardly be in a position to dispute. Wren v. New York Life Ins. Co., 493 F.2d 839 (5th Cir. 1974).

Telephone communication which allegedly gives one the right to sign an application for insurance, which is subsequently signed by that party, does not constitute the consent in writing by the insured as required by this section. Wren v. New York Life Ins. Co., 59 F.R.D. 484 (N.D. Ga. 1973), aff'd, 493 F.2d 839 (5th Cir. 1974).

Consent of insured is not required for placement of group insurance. Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205 (5th Cir. 1977).

Trusted group policy, in which the individual applies for the coverage of the individual's choice and each application undergoes separate underwriting, as in individual insurance, does not constitute a "group" policy for purposes of O.C.G.A. § 33-24-6. Delaware Am. Int'l Life Ins. Co. v. Wood, 630 F. Supp. 364 (N.D. Ga. 1984).

Insurance coverage is void ab initio when insured neither signed application nor consented in writing to the issuance of the coverage. Wood v. New York Life Ins. Co., 631 F. Supp. 3 (N.D. Ga. 1984).

When a parent brought suit to recover the benefits under a policy of life insurance insuring the life of the parent's adult child, the trial court erred in only partially denying the insurer's motion for summary judgment by holding that the insurer had waived the statutory requirement prohibiting the issuance of a valid life insurance policy without the written consent of the insured. Under circumstances not qualifying for an exception pursuant to O.C.G.A. § 33-24-6(a)(1)-(4), the policy was void ab initio, and unenforceable by the courts; written consent of the insured may not be waived. Time Ins. Co. v. Lamar, 195 Ga. App. 452, 393 S.E.2d 734 (1990).

Issuance of void policy. — Plaintiff's complaint stated a viable fraud claim based on alleged misrepresentation by the defendant in knowingly issuing a void insurance policy with the purpose of deceiving the plaintiff, on the plaintiff's reasonable reliance on the appearance that the policy issued was valid and enforceable, and on the resulting harm to the plaintiff, including the loss of use of funds paid as premiums for the void policy. Loney v. Primerica Life Ins. Co., 231 Ga. App. 815, 499 S.E.2d 385 (1998).

Insurer is not barred by incontestability clauses from arguing that policies are void ab initio because the proposed insured, who was then an adult, neither signed the applications nor consented in writing to the issuance of the coverage as required by subsection (a) of O.C.G.A. § 33-24-6. Guarantee Trust Life Ins. Co. v. Wood, 631 F. Supp. 15 (N.D. Ga. 1984).

Running of the incontestability clause is not a bar to an action under subsection (a) of O.C.G.A. § 33-24-6. Wood v. New York Life Ins. Co., 631 F. Supp. 3 (N.D. Ga. 1984).

Contracts of insurance written on the franchise plan bear the same legal consequences as any individually written policy, and, therefore, require the signature of the individual insured, exactly the same as under an individual policy. Wood v. New York Life Ins. Co., 255 Ga. 300, 336 S.E.2d 806 (1985); Connecticut Gen. Life Ins. Co. v. Wood, 631 F. Supp. 9 (N.D. Ga. 1984).

Insurer is entitled to rely on the statements of an applicant as true under subsection (b) (now subsection (c)), and incurs no legal liability except as set forth in the policy by virtue of any untrue statements, declarations, or representations relied on by the insurer. Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970).

Ambiguous questions in application. — Questions as to applicant's status as smoker calling for "yes" or "no" answers were ambiguous and answers thereto were construed favorably to the insured. Jackson Nat'l Life Ins. Co. v. Snead, 231 Ga. App. 406, 499 S.E.2d 173 (1998).

Conflicting and disputed evidence on the issue of the falsity of the insured's representation on an application created issues of fact that were properly presented to the jury. Jackson Nat'l Life Ins. Co. v. Snead, 231 Ga. App. 406, 499 S.E.2d 173 (1998).

Cited in Hairston v. John Hancock Mut. Life Ins. Co., 320 F. Supp. 643 (N.D. Ga. 1970); National Indem. Co. v. Berry, 136 Ga. App. 545, 221 S.E.2d 624 (1975).

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No consent by parent not guardian of child's property. — Parent of a minor child, who may be assumed to be the guardian of the person of the child but not the qualified guardian of the child's property, may not execute the written consent on behalf of the child mentioned in this section. 1963-65 Op. Att'y Gen. p. 469.

Applicant with right to change beneficiary must have insurable interest in life of minor insured. — When the applicant, the lifetime owner of the policy, has control of the policy and therefore may change beneficiaries at any time during the life of the insured without regard to any consent being given by the previous

beneficiary or the insured, such lifetime owner must satisfy the requirements of subsection (c) of former Code 1933 § 56-2404 (see O.C.G.A. § 33-24-3) with reference to an insurable interest as well as former Code 1933, § 56-2404 (see O.C.G.A. § 33-34-6) with reference to consent of the insured. In order to satisfy subsection (c) of former Code 1933, § 56-2404, the benefits of the policy must be payable to the individual insured or the insured's personal representative, or to a person having, at the time when such contract was made, an interest in the individual insured; in order to satisfy former Code 1933, § 56-2404 such lifetime owner, in order to come within the exception, must have an insurable interest in the life of the minor whose life is insured. The wording of "no life insurance … contract upon an individual … shall be made or effectuated," clearly would include the applicant who is the lifetime owner regardless of whether such applicant or owner is the named beneficiary in the policy. 1963-65 Op. Att'y Gen. p. 469.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 196 et seq., 358 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 479, 480.

ALR. — Liability in respect of premium where policy is rejected by applicant or prospect, 41 A.L.R. 644.

Divorce of insured and beneficiary as affecting the latter's right in life insurance, 52 A.L.R. 386; 175 A.L.R. 1220.

Right of insurance company, in view of its public interest, to reject applications for insurance (including validity, construction and application of statutes in that regard), 123 A.L.R. 139.

Rights and remedies against insurer, of one upon whose life it has, without his or her consent, issued a policy of life insurance to another, 127 A.L.R. 113.

"Family" insurance, 152 A.L.R. 1169.

Insured's responsibility for false answers inserted by insurer's agent in application following correct answers by insured, or incorrect answers suggested by agent, 26 A.L.R.3d 6.

Insured's ratification, after loss, of policy procured without his authority, knowledge, or consent, 52 A.L.R.3d 235.

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.

Estoppel of, or waiver by, issuer of life insurance policy to assert defense of lack of insurable interest, 86 A.L.R.4th 828.

33-24-6.1. Prerequisites for replacement life insurance exceeding insurance being surrendered.

Notwithstanding the provisions of subsection (d) of Code Section 33-24-3, subsection (d) of Code Section 33-24-6, or paragraph (11) of Code Section 33-27-3 which relate to the replacement of existing life insurance, any new life insurance may exceed the insurance being surrendered:

(1) When an entity has a proper interest pursuant to subsection (d) or (e) of Code Section 33-24-3 and the authority to effectuate life insurance pursuant to the provisions of paragraph (4), (5), or (6) of subsection (a) of Code Section 33-24-6; and

(2)(A) To the extent application of the cash surrender value from the old insurance as a premium under the new life insurance contract requires a larger amount of insurance to qualify as life insurance or to be not treated as a modified endowment contract for federal income tax purposes;

(B) To otherwise comply with applicable federal law; or

(C) When, upon cessation of premium payments, a former employee or trustee elects under the policy to use the cash value available under the policy to restructure the term, face amount, or investment options under the policy, even though such restructuring may result in an increase in the amount of the insurance.

History. — Code 1981, § 33-24-6.1, enacted by Ga. L. 1997, p. 683, § 3; Ga. L. 2006, p. 869, § 2/HB 1484.

33-24-7. Statements and descriptions in applications or in negotiations deemed representations and not warranties; effect of misrepresentations upon recovery under policies.

(a) All statements and descriptions in any application for an insurance policy or annuity contract or in negotiations for such, by or in behalf of the insured or annuitant, shall be deemed to be representations and not warranties.

(b) Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless:

(1) Fraudulent;

(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(3) The insurer in good faith would either not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the premium rate as applied for or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been known to the insurer as required either by the application for the policy or contract or otherwise.

History. — Code 1933, § 56-2409, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Law reviews. — For survey article on insurance, see 34 Mercer L. Rev. 177 (1982). 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 annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004). For survey article on construction law, see 60 Mercer L. Rev. 59 (2008). For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010). For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014). For article, "The Peculiarities of Georgia Insurance Law," see 24 Ga. St. B.J. 18 (April 2019).

For note, "Misrepresentations and Nondisclosures in the Insurance Application," see 13 Ga. L. Rev. 876 (1979).

For comment on Jefferson Std. Life Ins. Co. v. Henderson, 37 Ga. App. 704, 141 S.E. 498 (1928), see 1 Ga. L. Rev. 53 (1929). For comment on Stillson v. Prudential Ins. Co., 202 Ga. 79, 42 S.E.2d 121

(1947), see 10 Ga. B.J. 225 (1947). For comment on National Life & Accident Ins. Co. v. Camp, 77 Ga. App. 667, 49 S.E.2d 670 (1948), see 11 Ga. B.J. 349 (1949). For comment criticizing State Farm Mut. Auto. Ins. Co. v. Reese, 116 Ga. App. 59, 156 S.E.2d 529 (1967), see 19 Mercer L. Rev. 277 (1968).

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Analysis

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General Consideration

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1867, §§ 2670 to 2672; former Civil Code 1895, §§ 2097 to 2099; former Ga. L. 1906, p. 107; former Civil Code 1910, §§ 2471, 2479, 2480, 2481; former Ga. L. 1912, p. 119, § 21; and former Code 1933, §§ 56-820 to 56-822, 56-904, repealed by Ga. L. 1960, p. 289, enacting this title, are included in the annotations for this Code section.

Legislative intent. — In enacting this section, the General Assembly had in mind the probability of an insured, due to forgetfulness because of its lack of importance, stating in the application that the insured had not consulted a physician, when in fact the insured had consulted a physician and received treatment for a cold that had long since disappeared entirely. By this section it was intended to make sure that the family of such an insured should not be denied the insurance money solely because of such innocent and harmless oversight. National Life & Accident Ins. Co. v. Preston, 68 Ga. App. 614, 23 S.E.2d 526 (1942), aff'd, 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, § 56-822).

Section declares former law. — Provision, that no statements, covenants, or representations contained in applications for insurance shall ever be held or construed to be warranties, but shall be held to be representations only was merely declaratory of the former law as repeatedly construed by the Supreme Court as was the provision declaring in effect that in order for any statement or representation to be material, it must change the character and nature of the risk as contemplated in the policy; nor was the former law changed in any way with respect to fraud and good faith. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, § 56-822).

O.C.G.A. § 33-24-7 does not apply to insurance policies covered by O.C.G.A. § 33-24-45. Sentry Indem. Co. v. Sharif, 248 Ga. 395, 282 S.E.2d 907 (1981); Georgia Farm Bureau Mut. Ins. Co. v. Phillips, 251 Ga. 244, 304 S.E.2d 725 (1983).

No-fault automobile insurance policy issued under Georgia law could not be voided retrospectively as provided by O.C.G.A. § 33-24-7 even in situations when the insured had made material misrepresentations in securing the policy. Sentry Indem. Co. v. Sharif, 248 Ga. 395, 282 S.E.2d 907 (1981).

Insurance law not applicable to suretyship contract. — Insurance law was not applicable in a case involving liability under a suretyship contract; thus, O.C.G.A. § 33-24-7 did not apply to excuse a surety from liability based on fraud of the principal. 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).

Automobile liability policy cannot be voided retrospectively under O.C.G.A. § 33-24-7. — Automobile insurance policy providing basic third-party liability insurance and basic personal injury protection benefits (no-fault) issued pursuant to Georgia law cannot be voided retrospectively under this section. Pearce v. Southern Guar. Ins. Co., 246 Ga. 33, 268 S.E.2d 623 (1980).

Because an insurer could not rely upon O.C.G.A. § 33-24-7 and cases construing

General Consideration (Cont'd)

the statute, the insurer could not retrospectively void the liability portion of the applicant's policy even if the applicant failed to fully disclose all information or made material misrepresentations when applying for the policy. Liberty Ins. Corp. v. Ferguson, 263 Ga. App. 714, 589 S.E.2d 290 (2003).

Application cannot be impeached separately. — When the application is attached to and made a part of the policy, the beneficiary suing on the policy cannot separately impeach the application as thus integrated therein; the application must stand or fall as a part of the policy, and if the application falls so does the policy, for the insured is committed to the representations set forth in the application. Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, § 56-820).

In order to prevail on the insurer's claim that the insurer rightfully rescinded insurance pursuant to O.C.G.A. § 33-24-7, the insurer must show first that the application contained misrepresentations, omissions, concealment of facts, or incorrect statements; and second, the insurer must prove: (1) that such omissions were fraudulent; (2) that the omissions were material either to the acceptance of the risk or to the hazard assumed by the insured; or (3) that the insurer in good faith would not have issued the policy, or would not have issued a policy in as large an amount or at the premium rate applied for, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been known. Ochoa v. Principal Mut. Ins. Co., 144 F.R.D. 418 (N.D. Ga. 1992).

Immediate tender of premium not required for recession. — In a case involving O.C.G.A. § 33-24-7(b), a life insurance company did not waive the company's right to rescind the policy by waiting to refund the premium paid under the policy until eighteen months after the company had received permission from the district court to interplead the premium. Immediate tender of a premium is not required by the law of Georgia in order to rescind a policy. Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC, 555 F.3d 1331 (11th Cir. 2009).

Impact of misrepresentation on application. — Trial court's denial of a directed verdict in favor of the insurer was reversed on the issue of whether the policy was void based upon misrepresentations in the application because the undisputed evidence showed that the use of a certified public accountant audit and a requirement that checks be countersigned were material to the insurer's decision to issue crime coverage to the insured and that the insurer would not have issued the policy if the insurer had known the true facts. Ga. Cas. & Sur. Co. v. Valley Wood, Inc., 336 Ga. App. 795, 783 S.E.2d 441 (2016).

Fraud will void policy. — When a material statement in an application for insurance is fraudulent and is made to induce the acceptance of the risk, the policy or contract of insurance is void ab initio. Metropolitan Life Ins. Co. v. Shaw, 30 Ga. App. 97, 117 S.E. 106 (1923) (decided under former Civil Code 1910, § 2480).

Fraud in the procurement would void the entire policy. Wooten v. Life Ins. Co., 93 Ga. App. 665, 92 S.E.2d 567 (1956) (decided under former Code 1933, § 56-824).

Willful concealment of material fact will void policy. — When an applicant for life insurance willfully conceals from the insurer the fact of a previous illness, such concealment will void the policy if the disease was of such a character as to enhance the risk. The fact that the insured may have died a short while after the policy was insured, from a disease with which the insured was not affected when the policy was issued, does not conclusively show that the fact of the previous illness was not material, within the meaning of the rule above mentioned. Aetna Life Ins. Co. v. Conway, 11 Ga. App. 557, 75 S.E. 915 (1912) (decided under former Civil Code 1910, §§ 2479, 2480, 2481).

While failure to state a material fact will not void a policy unless such failure is fraudulent, a willful concealment of such a fact, which would enhance the risk, will

void the policy. Mutual Life Ins. Co. v. Bolton, 22 Ga. App. 566, 96 S.E. 442 (1918) (decided under former Civil Code 1910, §§ 2479, 2480, and 2481); Pilgrims Health & Life Ins. Co. v. Smith, 41 Ga. App. 287, 152 S.E. 592 (1930) (decided under former Civil Code 1910, §§ 2479, 2480, and 2481); Phillips v. New York Life Ins. Co., 173 Ga. 135, 159 S.E. 696 (1931) (decided under former Civil Code 1910, § 2479).

When the insured has made false and fraudulent statements as to matters that are material to the risk, or fraudulently concealed such matters from the insurer, for the purpose of obtaining the insurance, and has thereby induced the insurer to issue the policy, the policy is void, not as a matter of contract, but because it has been procured by fraud. National Life & Accident Ins. Co. v. Dorsey, 69 Ga. App. 734, 26 S.E.2d 654 (1943) (decided under former Code 1933, § 56-820).

When the evidence shows a misstatement willfully made or a material fraudulent concealment in answers to questions made in an application for insurance not attached to the policy, a verdict in favor of the insurer will be demanded. Gulf Life Ins. Co. v. Moore, 90 Ga. App. 791, 84 S.E.2d 696 (1954) (decided under former Code 1933, § 56-820).

Good faith is defense to failure to state such fact. — When a man insured his life for the benefit of a woman represented as his wife and the truth of the case was that the marriage was void by reason of the reputed wife having a former lawful husband living at the time of the second marriage, it was held that the policy is not void by reason of the illegality of the last marriage, unless it further appears that the husband and wife knew of the illegality of the marriage at the time of issuance of the policy and failed to inform the company of the fact. Equitable Life Assurance Soc'y v. Paterson, 41 Ga. 338, 5 Am. R. 535 (1870) (decided under former Code 1867, §§ 2670 to 2672).

While good faith is no defense when there is an untrue answer or misrepresentation of a material fact, good faith is a defense when there is simply a failure to state a material fact in an insurance application which is attached to and made a part of the policy, or a concealment of such fact as would enhance the risk. In such instance, it is necessary that there be a fraudulent failure to state a material fact or willful concealment thereof by the applicant. Gilham v. National Life & Accident Ins. Co., 104 Ga. App. 459, 122 S.E.2d 164 (1961).

With respect to an insurance applicant's failure to state material facts or the concealment of such facts in the application for insurance, the rule is thus: the mere failure to state a material fact or the concealment of such fact, when not done willfully and fraudulently, will not void a policy of insurance. Gilham v. National Life & Accident Ins. Co., 104 Ga. App. 459, 122 S.E.2d 164 (1961).

When there is a mere failure to state a material fact, or the concealment of a material fact, the good faith of the applicant is relevant in that the failure or concealment must be fraudulent or willful. Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970); Hairston v. John Hancock Mut. Life Ins. Co., 320 F. Supp. 643 (N.D. Ga. 1970).

Key language of paragraph (b)(3) of O.C.G.A. § 33-24-7 is that the insurer must demonstrate the insurer's good faith before the insurer can rescind the policy. Nappier v. Allstate Ins. Co., 766 F. Supp. 1166 (N.D. Ga. 1991), aff'd, 961 F.2d 168 (11th Cir. 1992).

Applies to incorrect statements and suppression of material fact. — Court could not uphold a policy holder's argument that there was no evidence that it made a material misrepresentation to the insurer during the underwriting process—only that it suppressed the fact that an executive was sued after the insurer's issuance of a conditional binder. O.C.G.A. § 33-24-7 applies to incorrect statements, and suppression of a material fact which a party is under an obligation to communicate constitutes fraud. Langdale Co. v. Nat'l Union Fire Ins. Co., 110 F. Supp. 3d 1285 (N.D. Ga. 2014).

Willfully misrepresenting material fact is legal fraud. — While it is true that the representations as made in an unattached application cannot be treated as "a part of the policy or contract" and are

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not to be taken as covenants or warranties, still, if such statements furnished the actual basis on which the policy was issued, and the statements were knowingly and willfully false with the intent by the applicant to defraud the insurer, the insurer may ordinarily set up such facts as a means for avoiding the policy, not under and by virtue of the terms of the contract, but because the insurance is thus shown to have been fraudulently procured. Metropolitan Life Ins. Co. v. Bugg, 48 Ga. App. 363, 172 S.E. 829 (1934) (decided under former Civil Code 1910, § 2471); National Life & Accident Ins. Co. v. McKenney, 52 Ga. App. 466, 183 S.E. 659 (1936) (decided under former Code 1933).

Willful misrepresentation of a material fact if done with a view to securing insurance is a legal fraud even if not done for the purpose of prejudicing the rights of the insurance company, provided the company had no knowledge of the fact and was not estopped to assert the falsity. National Life & Accident Ins. Co. v. Fischel, 62 Ga. App. 645, 9 S.E.2d 192 (1940) (decided under former Code 1933, § 56-820).

Any representation by the insured to induce acceptance of the risk must be true or the policy is void. Manley v. Pacific Mut. Life Ins. Co., 35 F.2d 337 (5th Cir. 1929) (decided under former Civil Code 1910, §§ 2479, 2480).

Material misrepresentations void policy. — Any material representations of facts by the assured, to induce the acceptance of the risk, will void the policy if untrue. Mutual Life Ins. Co. v. Bolton, 22 Ga. App. 566, 96 S.E. 442 (1918); Phillips v. New York Life Ins. Co., 173 Ga. 135, 159 S.E. 696 (1931) (decided under former Civil Code 1910, §§ 2479 to 2481).

When there is a material misrepresentation, the policy may be voided. State Farm Mut. Auto. Ins. Co. v. Anderson, 107 Ga. App. 348, 130 S.E.2d 144, cert. dismissed, 219 Ga. 211, 132 S.E.2d 556 (1963).

In a breach of contract action filed by an insured against an insurer, the trial court did not err in granting the insurer summary judgment as to the issue of coverage as questions answered untruthfully in the application for insurance by the insured amounted to misrepresentations warranting a cancellation of the policy at issue, pursuant to O.C.G.A. § 33-24-7. T. J. Blake Trucking, Inc. v. Alea London, Ltd., 284 Ga. App. 384, 643 S.E.2d 762 (2007), cert. denied, No. S07C1101, 2007 Ga. LEXIS 505 (Ga. 2007).

Misrepresentation must be material. — In order for an insurance company, defending on the ground of false statements in the application, to have a verdict directed, it must establish that the representations were material to the risk and were untrue. Watertown Fire Ins. Co. v. Grehan, 74 Ga. 642 (1885); Aetna Life Ins. Co. v. Moore, 231 U.S. 543, 34 S. Ct. 186, 58 L. Ed. 356 (1913) (decided under former Civil Code 1910, §§ 2479 to 2482).

Questions presented for determination in a case as to whether representations of facts by the assured to induce the acceptance of the risk, if material, must be true or the policy is void are: (1) Was the representation false? and (2) Was it made in reference to a matter material to the risk? Sovereign Camp Woodmen of the World v. Beard, 26 Ga. App. 130, 105 S.E. 629, cert. denied, 26 Ga. App. 801 (1921) (decided under former Civil Code 1910, §§ 2479 to 2481).

Representations considered to be true. — Representations made in an application for insurance which is attached to and made a part of the policy are considered as covenanted to be true by the applicant, and the policy will be voided by any variation which changes the nature, extent, or character of the risk. Mutual Life Ins. Co. v. Bolton, 22 Ga. App. 566, 96 S.E. 442 (1918); Phillips v. New York Life Ins. Co., 173 Ga. 135, 159 S.E. 696 (1931) (decided under former Civil Code 1910, §§ 2479 to 2481).

Misrepresentations by agents. — When an application for insurance is actually attached to the policy of insurance, and by the terms of the contract is made a part thereof, any misrepresentation of material facts made by the agent of the insurer in the application will be imputed to the insured, and the insured will not be allowed to claim under the contract, without being held to have had knowledge of

the false statements made in the application actually attached to and forming an integral part of the contract as delivered, accepted, and sued on. Southern Sur. Co. v. Fortson, 46 Ga. App. 265, 167 S.E. 335 (1933) (decided under former Civil Code 1910, §§ 2479 to 2481).

When a policy of life insurance has been issued, misrepresentations of facts made by the insured in the application for the insurance will not void the policy unless the misrepresentations are material and change the character, extent, or nature of the risk. New York Life Ins. Co. v. Watson, 48 Ga. App. 211, 172 S.E. 602 (1934) (decided under former Civil Code 1910, §§ 2479 to 2481).

When an application for life insurance is attached to and made a part of a policy, any misrepresentation in the application which changes the nature and character of the risk as contemplated in the policy may defeat a recovery, regardless of good faith on the part of the insured. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, §§ 56-820 to 56-822).

When the application is attached to and made a part of the policy, and false statements or representations are contained in such application, as a result of which the risk is increased, a recovery on the policy may be defeated on such grounds whether the statements and representations were made in good faith or fraudulently. Metropolitan Life Ins. Co. v. Joye, 77 Ga. App. 357, 48 S.E.2d 751 (1948) (decided under former Code 1933, §§ 56-820, 56-821).

In cases when the application for insurance is attached to and becomes a part of the policy, in order to avoid the policy for a misrepresentation of the applicant made in the application, the insurer need only show that the representation was false and that it was material in that it changed the nature, extent, or character of the risk and this is true although the applicant may have made the representation in good faith, not knowing that the representation was untrue. Gilham v. National Life & Accident Ins. Co., 104 Ga. App. 459, 122 S.E.2d 164 (1961).

Material misstatements or omissions justify avoidance of a policy and denial of plaintiff beneficiary's recovery of contract proceeds as a matter of law. Nichols v. Southern Life Ins. Co., 584 F.2d 106 (5th Cir. 1978).

In order to prevail under paragraph (b)(2) of O.C.G.A. § 33-24-7, an insurer need only prove that: (1) an insured's representation was false; and (2) the representation was material in that the representation changed the nature, extent, or character of the risk. Nappier v. Allstate Ins. Co., 766 F. Supp. 1166 (N.D. Ga. 1991), aff'd, 961 F.2d 168 (11th Cir. 1992).

Insured who sought an increase in life insurance coverage and completed medical history on February 28, was hospitalized on March 28, was approved for increased coverage on March 29, and diagnosed with a brain tumor on April 1, could not receive the increased coverage. The insured's change in health rendered untrue a number of responses on the medical questionnaire and the insurance company should have been made aware of these material fact changes. The insurance company would not have increased coverage if the insured had disclosed the change in health; therefore, the company is authorized to rescind the additional life insurance coverage. Cosby v. Transamerica Occidental Life Ins. Co., 860 F. Supp. 830 (N.D. Ga. 1993), aff'd, 16 F.3d 1232 (11th Cir. 1994).

Misrepresentations are warranties when subsection (b) applies. — Statements in an application for an insurance policy will not prevent recovery under the policy unless the statements are: (1) fraudulent or (2) material to the risk or (3) unless in good faith the insurer would not have issued the policy, or would not have issued the policy for that large an amount or for that premium or covered that particular risk, had the true facts been known. Hartford Accident & Indem. Co. v. Hartley, 275 F. Supp. 610 (M.D. Ga. 1967), aff'd, 389 F.2d 91 (5th Cir. 1968).

Although this section provides that statements in the application are deemed to be representations and not warranties, misstatements or misrepresentations are treated as warranties for the purpose of preventing a recovery under the policy, when the statements come under any one of the three criteria in subsection (b) of this section, and actual knowledge of their

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falsity is not required to prevent a recovery. United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978); Davis v. John Hancock Mut. Life Ins. Co., 202 Ga. App. 3, 413 S.E.2d 224 (1991).

Material misrepresentations are warranties. — Representations when made, if material, are warranties, but the representations differ from the ordinary warranty in that the representations' falsity does not avoid the policy unless the representations are material and the variation from truth in such as to change the nature, extent, or character of the risk. Mobile Fire Dep't Ins. Co. v. Miller, 58 Ga. 420 (1877); Rosser v. Georgia Home Ins. Co., 101 Ga. 716, 29 S.E. 286 (1897); Supreme Conclave Knights of Damon v. Wood, 120 Ga. 328, 47 S.E. 940 (1904); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934); Sovereign Camp W.O.W. v. Reid, 53 Ga. App. 618, 186 S.E. 759 (1936); United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978).

Wherever an applicant for life insurance makes material representations in an application or examination, and covenants that those representations are true, and these representations are made the basis of the contract of insurance, such contract is void if the representations vary from the truth in such manner as to change the nature, extent, or character of the risk. This is true although the applicant may have made the representations in good faith, not knowing that the representations are untrue. Morris v. Imperial Ins. Co., 106 Ga. 461, 32 S.E. 595 (1899); Supreme Conclave Knights of Damon v. Wood, 120 Ga. 328, 47 S.E. 940 (1904) (decided under former Civil Code 1895, §§ 2097, 2098).

Warrantor's good faith immaterial. — It is therefore immaterial whether the warrantor acted in good faith in making the representations. Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934) (decided under former Civil Code 1910, § 2481); Sovereign Camp W.O.W. v. Reid, 53 Ga. App. 618, 186 S.E. 759 (1936) (decided under former Code 1933, §§ 56-820, 56-821); United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978).

Any material misrepresentation whereby the nature, extent, or character of the risk is changed will void the certificate, whether the statement is made in good faith or willfully and fraudulently, when the application is attached to and is made a part of the policy or when a benefit certificate in a fraternal benefit association is involved. Sovereign Camp, W.O.W. v. Batchelor, 52 Ga. App. 262, 183 S.E. 131 (1935) (decided under former Code 1933, §§ 56-820 to 56-822).

When an applicant for life insurance covenants in the application that the statements made to the medical examiner are true, and these statements are made a part of the contract of insurance and form the basis of such contract, any variation in any of them which is material, whereby the nature or extent or character of the risk is changed, will avoid the policy, whether the statement was made in good faith or willfully or fraudulently. Sovereign Camp W.O.W. v. Reid, 53 Ga. App. 618, 186 S.E. 759 (1936) (decided under former Code 1933, §§ 56-820 to 56-822).

When insured, in applying for reinstatement of life policies, furnishes false evidence which is relied on by the insurance company, the insured is guilty of fraud in law which avoids the policy whether the insured acts in good or bad faith and whether the insured intends to deceive or not. Life & Cas. Ins. Co. v. Davis, 62 Ga. App. 832, 10 S.E.2d 129 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Misrepresentation that is material to the risk will void the policy whether made in good faith or not. Kennesaw Life & Accident Ins. Co. v. Hubbard, 106 Ga. App. 556, 127 S.E.2d 845 (1962).

Affirmative representation in an application which is made a part of the policy, which, if shown to be false and material, in that it presented a false picture of the nature, extent, or character of the risk, cannot be overcome by a showing that the applicant answered in good faith, not knowing that it was untrue. Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970); Hairston

v. John Hancock Mut. Life Ins. Co., 320 F. Supp. 643 (N.D. Ga. 1970).

In order to avoid an insurance policy for a misrepresentation of the applicant made in the application, the insurer need only show that the representation was false and that the representation was material in that the representation changed the nature, extent, or character of the risk. This is true although the applicant may have acted in good faith, not knowing that a representation is untrue. Bourne v. Balboa Ins. Co., 144 Ga. App. 55, 240 S.E.2d 261 (1977).

Policy cannot be avoided upon the ground of the falsity of a representation, though warranted under the contract, unless that representation is material and the variation from the truth is such as to change the nature, extent, or character of the risk, even though an applicant may make the representation in good faith, not knowing that the representation is untrue. United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978).

Good faith irrelevant when misrepresenting material facts. — Whether an applicant's previous homeowners' policy was canceled for cause is material to an insurance company's decision to provide coverage. It is irrelevant whether an applicant acted in good faith or even had knowledge of the falsity when misrepresenting material facts in procuring insurance coverage. Nappier v. Allstate Ins. Co., 961 F.2d 168 (11th Cir. 1992).

When insureds sued an insurer for breach of contract following the rescission of the insureds' insurance policy, it was proper to instruct that even a misrepresentation given in good faith would void the policy; under O.C.G.A. § 33-24-7(b)(2) and (3), an insurer did not have to show that a representation was fraudulent, only that it was material and false, and the "to the best of my knowledge and belief" language on the application meant only that the insureds were relying upon the insureds' own knowledge, not upon that of others such as an agent. White v. Am. Family Life Assur. Co., 284 Ga. App. 58, 643 S.E.2d 298 (2007).

Good faith applicable when insurer knows information comes from others. — Actual falsity of representations materially affecting the nature and character of risk void a policy of life insurance, independently of intentional deceit. Good faith is not a reply to actual falsity, unless the representation is made on information from others, and the insurer is so informed at the time the assured proposes to contract on a basis of fact presented by the insured to the insurer. If that basis is incorrect in a material respect, there is no binding contract. Pacific Mut. Life Ins. Co. v. Manley, 27 F.2d 915 (N.D. Ga. 1928), aff'd, 35 F.2d 337 (5th Cir. 1929) (decided under former Civil Code 1910, §§ 2479, 2480).

Any verbal or written representations of facts by the assured to induce the acceptance of the risk, if material, must be true, or the policy is void; if however, the party has no knowledge, but states on the representation of others, bona fide, and so informs the insurer, the falsity of the information does not void the policy. Farmers Protective Fire Ins. Co. v. Weaver, 44 Ga. App. 752, 162 S.E. 839 (1932) (decided under former Civil Code 1910, § 2480).

Innocent coinsured barred from recovery. — When the insurer would not have issued a policy if the insurer had known the truth concerning misrepresentations by the applicant, an innocent coinsured of the applicant was also barred from recovery. Graphic Arts Mut. Ins. Co. v. Pritchett, 220 Ga. App. 430, 469 S.E.2d 199 (1995).

Insurance company is not required to prove that the insured had actual knowledge of the falsity of a misrepresentation in order to prevent a recovery. Bailey v. Interstate Life & Accident Ins. Co., 155 Ga. App. 65, 270 S.E.2d 287 (1980).

Law presumes intent to deceive when insured knowingly makes false statement. — When it is shown that a material statement in an application is false which was known to the insured at the time the insured made the application and the statement was made with a view toward obtaining the insurance, with the company having no knowledge of the statement's falsity, when the company acted upon the statement to the company's injury, the law will conclusively pre-

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sume an intent to deceive, and a case of actual fraud will be made out. Atha v. Mid-South Ins. Co., 173 Ga. App. 489, 326 S.E.2d 853 (1985).

Question posed in an insurance application must be evaluated in the light of the meaning conveyed to the insured, regardless of the true or technical meaning. Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970).

Question held to refer to habitual use of drugs or drinks. — Question in written application for life insurance, attached to and made a part of the policy, "To what extent do you now, or have you in the past, used intoxicants, morphine, cocaine, or other habit-forming drugs?" referred to the "habitual" or "customary" use of such drugs or drinks did not refer to an "occasional" or "exceptional" use of such drugs or drinks. National Life & Accident Ins. Co. v. Barnes, 61 Ga. App. 730, 7 S.E.2d 299 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Falsity of representations is waived by insurer's actual notice. — In order to work a waiver for the falsity of material representations in an application for life insurance, actual notice to the company, or some authorized agent, of the falsity of such representations is necessary, and constructive notice is insufficient to effect such waiver. Lee v. Metropolitan Life Ins. Co., 158 Ga. 517, 123 S.E. 737 (1924) (decided under former Ga. L. 1912, p. 119).

Reasonable explanations for contradictory testimony. — In a case in which an insured appealed from a trial court's order granting summary judgment to an insurer on the insured's lawsuit to recover damages in connection with the loss of the insured's home and the home's contents due to a fire, the appellate court directed the trial court on remand to determine whether the insured presented reasonable explanations for the insured's contradictory testimony. Sikes v. Great Lakes Reinsurance (UK) PLC, 321 Ga. App. 136, 741 S.E.2d 263 (2013).

Constructive knowledge insufficient. — If the agent had actual knowledge of the fact which by a stipulation in the contract would render the contract void, the insurer could not set up such facts as a defense. But before the knowledge of the agent could work a waiver on the part of the principal, the knowledge must have been actual. Constructive knowledge would not be sufficient for that purpose. Interstate Life & Accident Co. v. Bess, 35 Ga. App. 723, 134 S.E. 804 (1926) (decided under former Civil Code 1910, §§ 2479 to 2481).

Neither the obtaining of an examination of an applicant nor the failure to obtain one will work either a waiver or an estoppel in the absence of a showing that the true facts were known to the insurance company when the company accepted the application and delivered the policy. Kennesaw Life & Accident Ins. Co. v. Hubbard, 106 Ga. App. 556, 127 S.E.2d 845 (1962) (decided under former Code 1933, § 56-908).

Agent's actual knowledge is imputed to insurer. — When the agent who filled out the application and delivered the policy to the insured had actual knowledge of such incorrect statements in the application, the insurer will be held to have had notice thereof and to be estopped from asserting the invalidity of the policy because of such incorrect statements in the application. Southern Sur. Co. v. Fortson, 46 Ga. App. 265, 167 S.E. 335 (1933) (decided under former Civil Code 1910, §§ 2479 to 2481).

Knowledge of material facts on the part of an agent of an insurance company is notice to the company, and, if with this notice the company issues a policy, it is estopped in equity from deriving benefit from any stipulation in the policy which might have availed it if it had been ignorant of the facts. National Life & Accident Ins. Co. v. Pollard, 66 Ga. App. 895, 19 S.E.2d 557 (1942) (decided under former Code 1933, §§ 56-820 to 56-822).

When an insured makes a false statement on an application for insurance of which the agent of the insurance company has actual knowledge, this knowledge is imputed to the insurer, who is thereafter estopped from urging this defense. Allstate Ins. Co. v. Anderson, 121 Ga. App. 582, 174 S.E.2d 591 (1970).

Agent's knowledge of insured's medical problem must be specific. — To avoid an insurance company's reliance on misrepresentation as a defense when the insured represented on the application that the insured was in good health but when the agent knew that the insured was sick, the agent's knowledge of the medical problem must be specific rather than general, as the insurer may be willing to assume the risk of insuring someone who is generally unhealthy but not someone who suffers from a specific disease. Thus, an insurance agent's knowledge that the insured was "very sick" did not constitute knowledge that the insured previously suffered both a heart attack and a stroke and was currently being treated for lung cancer. Burkholder v. Ford Life Ins. Co., 207 Ga. App. 908, 429 S.E.2d 344 (1993).

Agent's preparation of application and willful insertion of false answer imputed to insurer. — When soliciting and forwarding applications for policies of insurance were within the scope of the duties of an agent of an insurance company and such agent undertook to prepare for another an application for insurance, and willfully inserted therein a false answer to a material question, the agent will be regarded in so doing as the agent of the company and not of the applicant, and the agent's knowledge of the falsity of the answer will be imputed to the company. Ocean Accident & Guarantee Corp. v. Howell, 46 Ga. App. 69, 166 S.E. 678 (1932); Jarriel v. Preferred Risk Mut. Ins. Co., 155 Ga. App. 136, 270 S.E.2d 238 (1980).

Agent's knowledge imputed to insurer when application does not restrict agent's authority. — When fraud or collusion is not shown, and when an application for insurance, although attached to and made a part of the policy, contains no restrictions on the authority of the soliciting agent, the insurer is estopped to deny knowledge of facts recited by the applicant to the insurer's agent and therefore imputable to the insurer as to the falsity of representations contained in the application, and is presumed to have waived the misrepresentations actually inserted therein by such agent. 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) (decided under former Code 1933, § 56-820).

Although a limitation on the authority of the agent to waive the provisions of the insurance contract when it appears on the face of the application for insurance makes any effort of the agent to waive provisions ineffective, when such limitation does not appear on the application, a similar limitation of the agent's authority occurring in the policy itself refers only to acts of the agent subsequent to the issuance of the policy. 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) (decided under former Code 1933, § 56-820).

Even though there is a material misrepresentation in an application which is attached to the policy such as would be sufficient to avoid the policy under this section, and even though there is a limitation on the authority of the agent in the policy to waive any provisions of either, unless there is a limitation on the authority of the agent in the application itself sufficient to put the proposed insured on notice of the limitation on the authority of the agent, the general rule applies that the knowledge of the agent is the knowledge of the principal. Allstate Ins. Co. v. Anderson, 121 Ga. App. 582, 174 S.E.2d 591 (1970).

Insurer liable when applicant prevented from ascertaining agent's misrepresentation. — Although the application was, by the application's terms, a part of the contract of insurance, and was signed by the person to whom the policy was subsequently issued, if the latter was fraudulently misled and deceived by the agent as to the contents of the application in the respect indicated, and was in fact ignorant that it contained the false answer in question, the company will not be allowed to avoid the policy on the ground of a false warranty in relation to that answer. Ocean Accident & Guarantee Corp. v. Howell, 46 Ga. App. 69, 166 S.E. 678 (1932) (decided under former Civil Code 1910, §§ 2479 to 2482).

When a soliciting agent of an insurance company undertook to prepare for another

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an application for insurance and willfully and fraudulently, without the knowledge of the applicant, inserted in the application false answers to material questions, which were contrary to truthful answers given by the applicant, and the agent, after inserting such false answers, willfully read the application to the applicant in such a manner as to indicate that the answers were written as given by the applicant, and the applicant then signed the application, the insurance company will not be permitted to avoid the policy on the ground that the application, which was attached to the policy, contained a clause limiting the agent's authority. Stillson v. Prudential Ins. Co., 202 Ga. 79, 42 S.E.2d 121 (1947), commented on in, see 10 Ga. B.J. 225 (1947); (decided under former Code 1933, §§ 56-820 to 56-822).

If one in fact makes truthful answers to an agent who nevertheless mistakenly or fraudulently records the answers otherwise on the application, and the applicant is for some reason prevented from ascertaining the discrepancy and signs the application, the company will be estopped from avoiding liability for misrepresentation. Jessup v. Franklin Life Ins. Co., 117 Ga. App. 389, 160 S.E.2d 612 (1968).

Insertion of false answers by agent of limited authority. — An application for insurance which contains false answers that are material to the risk, inserted by the agent of the company issuing the policy but under such circumstances as do not prevent the signer from being bound thereby, which application is attached to and made a part of the policy issued, does not, when the application itself expressly limits the authority of the agent taking the application, constitute such notice to the company issuing the policy as amounts to notice and estoppel on the company's part. The applicant, by the receipt of and reliance on the policy, is estopped from pleading or proving the fraud of the agent in taking the application and making the false answers, the application containing the provision "that the company is not bound by any knowledge of or statements by or to any agent unless written thereon." National Accident & Health Ins. Co. v. Davis, 50 Ga. App. 391, 178 S.E. 320 (1935) (decided under former Code 1933, §§ 56-820 to 56-822).

When an applicant signs the application in a completed state, the applicant is bound by the answers to the questions appearing on the application, even though the insurer's agent filled out the application. Jefferson Std. Life Ins. Co. v. Bridges, 147 Ga. App. 5, 248 S.E.2d 5 (1978).

Agent's knowledge will be imputed to insured. — When an application for insurance is actually attached to the policy of insurance and by the terms of the contract is made a part thereof, any misrepresentation of material facts made by the agent of the insurer in the application will be imputed to the insured, and the insured will not be allowed to claim under the contract, without being held to have had knowledge of the false statements made in the application actually attached to and forming an integral part of the contract as delivered, accepted and sued on. Southern Sur. Co. v. Fortson, 44 Ga. App. 329, 161 S.E. 679 (1931) (decided under former Civil Code 1910, §§ 2479 to 2482).

When application is signed in blank, insured is bound by false answers. — When an application is signed in blank and authority given by the applicant to the agent of the company to fill out the application from information given the agent, any false answers inserted in the application which is attached to and made a part of the policy issued, unless inserted by a misleading device or artifice perpetrated by such agent, will be binding on the applicant; those who can read must read, and are bound by writings signed by themselves, unless such signature was procured through fraud. National Accident & Health Ins. Co. v. Davis, 50 Ga. App. 391, 178 S.E. 320 (1935) (decided under former Code 1933, §§ 56-820 to 56-822).

An applicant is prima facie charged with knowledge of the contents of an application signed by the applicant, but this may be rebutted. Jessup v. Franklin Life Ins. Co., 117 Ga. App. 389, 160 S.E.2d 612 (1968).

Estoppel from proving agent's fraud. — When the insured had notice of the limitations on the agent's authority and signed an application without reading the application, the insured placed it in the power of the agent to commit a fraud by inserting false answers in the application which was made a part of the policy of insurance issued and delivered to the insured and on which the insured relied. In such a case the insured is estopped from pleading or proving the fraud of the agent in the assertion of false answers. National Accident & Health Ins. Co. v. Davis, 50 Ga. App. 391, 178 S.E. 320 (1935) (decided under former Code 1933, §§ 56-820 to 56-822).

Reading of application after policy issued excused. — If the insured and beneficiary are not bound originally by the contract between the parties limiting the authority of the agent when false answers are inserted by the agent and the reading of the application is thus excused, there is no duty on the insured or beneficiary to examine the application after the policy is issued. The insurance company would have to show actual knowledge of the false answers after delivery of the policy in order to show such fraud as would avoid the contract. Barber v. All Am. Assurance Co., 89 Ga. App. 270, 79 S.E.2d 48 (1953) (decided under former Code 1933, § 56-908).

It would be unreasonable to say that the insured or beneficiary is excused in the first instance from reading the application, and then to charge the insured or beneficiary with the duty of reading the application after the policy was delivered. Barber v. All Am. Assurance Co., 89 Ga. App. 270, 79 S.E.2d 48 (1953) (decided under former Code 1933, § 56-908).

Insurer may plead fraud without repaying premiums. — In an action on an insurance policy, the defense that the contract of insurance is void because the contract was obtained by fraud practiced on the insurer by the insured may be pled without repaying or offering to repay the premiums or any part thereof received by the insurer on the policy. Columbian Nat'l Life Ins. Co. v. Mulkey, 146 Ga. 267, 91 S.E. 106 (1916); Stansall v. Columbian Nat'l Life Ins. Co., 27 Ga. App. 537, 109 S.E. 297, cert. denied, 27 Ga. App. 836 (1921), later appeal, 32 Ga. App. 87, 122 S.E. 733 (1924) (decided under former Civil Code 1910, §§ 2479 to 2481).

Spouse's misinformation concerning insured sufficient to bar recovery on policy. — Spouse's incorrect responses to questions on a major medical insurance policy application about the insured's prior hospitalizations constituted misstatements sufficient to preclude recovery under the policy even if made in good faith. Oakes v. Blue Cross Blue Shield of Columbus, Inc., 170 Ga. App. 335, 317 S.E.2d 315 (1984).

Insurer estopped from asserting misrepresentations as defense. — Insurer is estopped from asserting misrepresentations as a defense when the insurer's agent, having been given true information, writes down false answers. Liberty Nat'l Life Ins. Co. v. Houk, 157 Ga. App. 540, 278 S.E.2d 120 (1981), aff'd, 248 Ga. 111, 281 S.E.2d 583 (1983).

When an insured with muscular dystrophy had a keen mind and full knowledge of the condition when a life insurance application was filled out, the argument that the insured believed that the insured was in good health and free from physical defects is without merit. Wood v. National Benefit Life Ins. Co., 631 F. Supp. 6 (N.D. Ga. 1984).

Application failed to ask for specific information. — When an insurer alleged misrepresentation on the part of an auto store for failing to disclose that the store sold freon, there was no misrepresentation for failure to disclose and the insurer had no basis for the insurer's suggestion that the risk involved in insuring freon was somehow greater than the risk involved in insuring such other, unspecified auto parts, because: (1) the application and policy referred generically to "auto parts"; (2) the application and policy contained no express reference to any particular auto part; (3) at oral argument, the insurer conceded that freon may be considered an "auto part"; (4) the insurer offered no evidence that suggested that the store informed the insurer of their dealings in certain auto parts but not in freon; and, (5) the insurer presented no evidence of the types of auto parts that the

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insurer purported to insure. JLM Enters. v. Houston Gen. Ins. Co., 196 F. Supp. 2d 1299 (S.D. Ga. 2002).

Summary judgment proper when insurer showed representation of business was false. — Because an insurer carried the insurer's burden of showing that the representation of an insured's business was false, and that the representation was material in that the representation changed the nature, extent, or character of the insurance coverage risk, the trial court did not err in granting the insurer summary judgment. Marchant v. Travelers Indem. Co., 286 Ga. App. 370, 650 S.E.2d 316 (2007).

Insurer's affidavit insufficient for summary judgment. — In a dispute involving a fire insurance policy and the insurer's claim that the insured made a material misrepresentation that the home was the insured's primary residence and occupied by the insured, when in fact the insured stayed there only periodically but allowed a friend and the friend's family to live there, the insurer's affidavit that the insurer would not have issued the policy had the insurer known the true facts was insufficient to support a grant of summary judgment. 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).

Cited in Hubbard v. Kennesaw Life & Accident Ins. Co., 110 Ga. App. 870, 140 S.E.2d 237 (1965); State Farm Mut. Auto. Ins. Co. v. Reese, 116 Ga. App. 59, 156 S.E.2d 529 (1967); Reserve Ins. Co. v. Associates Dist. Corp., 116 Ga. App. 792, 159 S.E.2d 97 (1967); Globe Life & Accident Ins. Co. v. Still, 376 F.2d 611 (5th Cir. 1967); Pitts v. Life Ins. Co., 137 Ga. App. 658, 224 S.E.2d 776 (1976); Morris v. State Farm Mut. Auto. Ins. Co., 143 Ga. App. 617, 239 S.E.2d 187 (1977); McGhee v. Independent Life & Accident Ins. Co., 146 Ga. App. 310, 246 S.E.2d 349 (1978); Taylor v. Time Ins. Co., 583 F.2d 743 (5th Cir. 1978); Southern Guar. Ins. Co. v. Pearce, 607 F.2d 146 (5th Cir. 1979); Hicks v. American Interstate Ins. Co., 158 Ga. App. 220, 279 S.E.2d 517 (1981); Sentry Indem. Co. v. Sharif, 156 Ga. App. 828, 280 S.E.2d 354 (1981); Empire Fire & Marine Ins. Co. v. Jackson, 159 Ga. App. 585, 284 S.E.2d 99 (1981); Casey Enters., Inc. v. American Hdwe. Mut. Ins. Co., 655 F.2d 598 (5th Cir. 1981); Jones v. Delta Life Ins. Co., 161 Ga. App. 532, 288 S.E.2d 885 (1982); Pennsylvania Life Ins. Co. v. Tanner, 163 Ga. App. 330, 293 S.E.2d 520 (1982); Sawyer v. Citizens & S. Nat'l Bank, 164 Ga. App. 177, 296 S.E.2d 134 (1982); Cummings v. Prudential Ins. Co. of Am., 542 F. Supp. 838 (S.D. Ga. 1982); Bailey v. Interstate Life & Accident Ins. Co., 165 Ga. App. 611, 302 S.E.2d 374 (1983); James v. Pennsylvania Gen. Ins. Co., 167 Ga. App. 427, 306 S.E.2d 422 (1983); Jones v. United Ins. Co. of Am., 177 Ga. App. 102, 338 S.E.2d 532 (1985); Celtic Life Ins. Co. v. Monroe, 220 Ga. App. 38, 467 S.E.2d 360 (1996); Progressive Preferred Ins. Co. v. Aguilera, 243 Ga. App. 442, 533 S.E.2d 448 (2000); C. Ingram Co. v. Phila. Indem. Ins. Co., 303 Ga. App. 548, 694 S.E.2d 181 (2010).

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Objective standard applied. — O.C.G.A. § 33-24-7 represented the legislature's decision to extend a measure of protection to those who apply for insurance, the judicial response to that legislative policy being the adoption of an objective standard — a type of standard traditionally applied by a jury to facts found by it — to define the prudent insurer and materiality. There was no similar legislative or judicial recognition on behalf of an insured who filed a sworn proof of loss stating the insured's interest in the property was 100 percent, when in fact the insured had conveyed the property to a parent to prevent the insured's spouse from claiming it in divorce proceedings. Such was a material misrepresentation as a matter of law, voiding the coverage. Woods v. Independent Fire Ins. Co., 749 F.2d 1493 (11th Cir. 1985).

In a case involving O.C.G.A. § 33-24-7(b), the life insurance policy beneficiaries unsuccessfully argued that determining the materiality of the deceased's misrepresentations required that the district court consider the actual conduct of the insurance company when the company approved the deceased's life in-

surance policy. The test for materiality under O.C.G.A. § 33-24-7(b)(2) was the objective standard of conduct of a prudent insurer, not a subjective standard about the actual conduct of a particular insurance company. Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC, 555 F.3d 1331 (11th Cir. 2009).

Risks revolve around insured's personal characteristics. — Insurance policies are of the nature of personal contracts. The insurer is selective of those risks which revolve around the character, integrity, and personal characteristics of those whom the insurer will insure. Republic Ins. Co. v. Chapman, 146 Ga. App. 719, 247 S.E.2d 156 (1978).

Parties cannot make immaterial matters material by contract. — Mere immaterial matters do not void the policy even though the policy declares the matters to be warranties and the parties themselves cannot contract to make immaterial matters material. Aetna Life Ins. Co. v. Moore, 231 U.S. 543, 34 S. Ct. 186, 58 L. Ed. 356 (1913) (decided under former Civil Code 1910, §§ 2479 to 2482).

Insurer cannot assert factor is material without apprising insured. — Insurance company cannot assert that a factor is material to the risk about which it has neither made inquiry or apprised its prospective insured. Georgia Farm Bureau Mut. Ins. Co. v. First Fed. Sav. & Loan Ass'n, 152 Ga. App. 16, 262 S.E.2d 147 (1979).

Objectively false statement on application. — Requiring an attorney to disclose every adverse ruling on the attorney's application would be unreasonable; however, when an attorney chose to voluntarily dismiss a client's action, refiled the action in another court, and, as a result, lost the case because the action was barred by the statute of limitations, the attorney's answering "no" to questions on an application as to the attorney's knowledge of any acts that could result in a professional liability claim was an objectively false statement and the statement was material. Home Indem. Co. v. Toombs, 910 F. Supp. 1569 (N.D. Ga. 1995).

Material misrepresentation of business practices by agent on application. — Based on evidence from an insurance underwriter that the underwriter would have rejected an application for crime coverage if the application had accurately stated that the insured did not audit with a certified public accountant and did not require countersignatures on checks, these misrepresentations were material under O.C.G.A. § 33-24-7(b) and entitled the insurer to void coverage, although an independent agent, not the insured, submitted the application. Georgia Casualty & Surety Company v. Valley Wood, Inc., 336 Ga. App. 290, 785 S.E.2d 1 (2016).

Material representation is one that would influence a prudent insurer in determining whether or not to accept the risk or in fixing the amount of the premium in the event of such acceptance. Empire Life Ins. Co. v. Jones, 14 Ga. App. 647, 82 S.E. 62 (1914) (decided under former Civil Code 1910, §§ 2479 to 2482); Lee v. Metropolitan Life Ins. Co., 158 Ga. 517, 123 S.E. 737 (1924) (decided under former Civil Code 1910, §§ 2479 to 2482); Phillips v. New York Life Ins. Co., 173 Ga. 135, 159 S.E. 696 (1931) (decided under former Civil Code 1910, §§ 2479 to 2482); Ocean Accident & Guarantee Corp. v. Howell, 46 Ga. App. 69, 166 S.E. 678 (1932) (decided under former Civil Code 1910, §§ 2479 to 2482); New York Life Ins. Co. v. Watson, 48 Ga. App. 211, 172 S.E. 602 (1934) (decided under former Code 1933, §§ 56-820 to 56-822); Bankers Health & Life Ins. Co. v. Brown, 49 Ga. App. 294, 175 S.E. 387 (1934) (decided under former Code 1933, §§ 56-820 to 56-822); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934) (decided under former Code 1933, §§ 56-820 to 56-822); Firemen's Ins. Co. v. Parmer, 51 Ga. App. 916, 181 S.E. 880 (1935) (decided under former Civil Code 1910, §§ 2479 to 2482); Bankers Health & Life Ins. Co. v. Hamilton, 56 Ga. App. 569, 193 S.E. 477 (1937) (decided under former Civil Code 1910, §§ 2479 to 2482); Bankers Health & Life Ins. Co. v. Glisson, 61 Ga. App. 583, 7 S.E.2d 32 (1940) (decided under former Civil Code 1910, §§ 2479 to 2482); Metropolitan Life Ins. Co. v. Marshall, 65 Ga. App. 696, 16 S.E.2d 33 (1941) (decided under former Code 1933, §§ 56-820 to 56-822); Bourne

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v. Balboa Ins. Co., 144 Ga. App. 55, 240 S.E.2d 261 (1977) (decided under former Code 1933, §§ 56-820 to 56-822); Sentry Indem. Co. v. Brady, 153 Ga. App. 168, 264 S.E.2d 702 (1980) (decided under former Code 1933, §§ 56-820 to 56-822).

Materiality of a concealment or representation of fact depends, not on the ultimate influence of the fact upon the risk or its relation to the cause of loss, but on the immediate influence upon the party to whom the communication is made, or is due, in forming that party's judgment at the time of effecting the contract. Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934) (decided under former Civil Code 1910, §§ 2479 to 2482); Firemen's Ins. Co. v. Parmer, 51 Ga. App. 916, 181 S.E. 880 (1935) (decided under former Civil Code 1910, §§ 2479 to 2482); Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, §§ 56-820 to 56-922); Bankers Health & Life Ins. Co. v. Glisson, 61 Ga. App. 583, 7 S.E.2d 32 (1940) (decided under former Code 1933, §§ 56-820 to 56-922); Commercial Cas. Ins. Co. v. Jeffers, 69 Ga. App. 52, 24 S.E.2d 815 (1943) (decided under former Code 1933, § 56-908).

Test, in determining whether questions contained in an application for insurance are material, is whether knowledge or ignorance of the facts sought to be elicited thereby would materially influence the action of the insurer. Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934) (decided under former Civil Code 1910, §§ 2479 to 2482); Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, §§ 56-820 to 56-822); Commercial Cas. Ins. Co. v. Jeffers, 69 Ga. App. 52, 24 S.E.2d 815 (1943) (decided under former Code 1933, § 56-908).

Misrepresentations referred to in this section are those which constitute actual fraud, or any other misrepresentations which are material to the risk; and the phrase "material misrepresentations" as here used means misrepresentations of such character that the knowledge or ignorance of the fact sought to be elicited would thereby influence the action of a prudent insurer in forming the insurer's judgment as to whether to accept the risk and what premium to charge, and such that the character and nature of the risk contemplated in the policy were changed from what they would have been if the representations had been true. Commercial Cas. Ins. Co. v. Jeffers, 69 Ga. App. 52, 24 S.E.2d 815 (1943) (decided under former Code 1933, § 56-908).

Material misrepresentation is one which would be consideration in an insurer's decision to issue a policy. Continental Cas. Co. v. Synalloy Corp., 667 F. Supp. 1523 (S.D. Ga. 1983), aff'd, 826 F.2d 1024 (11th Cir. 1987).

Insurer prevailed on a beneficiary's breach of contract and bad faith claims because the insured made a material misrepresentation under O.C.G.A. § 33-24-7 by the failure to disclose a driving under the influence conviction within five years of the issuance of the life insurance policy and the insured would not have received the rating and premium offered by the insurer if the conviction had been disclosed. Dracz v. Am. Gen. Life Ins. Co., 427 F. Supp. 2d 1165 (M.D. Ga. 2006).

Materiality of a representation is not measured by the ultimate cause of loss, but is determined by the influence such knowledge has on assuming the risk at the outset. Jessup v. Franklin Life Ins. Co., 117 Ga. App. 389, 160 S.E.2d 612 (1968).

Loss unconnected to misrepresentation. — Though the loss should arise from causes totally unconnected with the material fact concealed or misrepresented, the policy is void, because a true disclosure of the fact might have led the company to decline the insurance altogether, or to accept it only at a higher premium. Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, §§ 56-820 to 56-822).

As the evidence showed that an insurer would not have reinstated a homeowner's policy if the insurer knew the insureds planned to reinstall a diving board, the insureds, by providing a photo showing

the board had been removed, made a material misrepresentation to the insurer. Under O.C.G.A. § 33-24-7(b), the fact that the insureds' subsequent loss was unrelated to the use of the diving board was irrelevant in determining that the insureds' misrepresentation as to board's permanent removal voided coverage. Pope v. Mercury Indem. Co., 297 Ga. App. 535, 677 S.E.2d 693 (2009).

Increase in risk. — Test as to whether a misrepresentation will defeat a recovery is not whether the matter represented shall have actually contributed to the contingency or event on which the policy is to become payable, but whether it changed the nature and character of the risk and increased it as against the insurer under the particular policy, and by increase in risk is meant an increase that is at least substantial. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, § 56-908); National Life & Accident Ins. Co. v. Atha, 69 Ga. App. 825, 26 S.E.2d 675 (1943) (decided under former Code 1933, § 56-908); Metropolitan Life Ins. Co. v. Joye, 77 Ga. App. 357, 48 S.E.2d 751 (1948) (decided under former Code 1933, § 56-908).

Nature, extent, or character of risk must be changed. — Misstatement in an application for insurance must in some way change the nature, extent, or character of the risk in order to void the policy; the court after citing this section, said any variation by which the nature, extent, or character of the risk is changed, will constitute a breach of that covenant, and will void the policy, but it is not any and every variation from the representations contained in the application, that will constitute a breach of the covenant of warranty and void the policy. The variation must be such as to change the nature or extent, or character of the risk, in order to void the policy. If the insured should state in the insured's application for a fire policy, in answer to the question as to what was the insured's age, that the insured was 30 years old, when in fact the insured was 31, it would be a variation, but not such a variation as would change the nature, or extent, or character of the risk of the insurance company. Mobile Fire Ins. Co. v. Miller, 58 Ga. 420 (1877) (decided under former Civil Code 1873, § 2802); Rosser v. Georgia Home Ins. Co., 101 Ga. 716, 29 S.E. 286 (1897) (decided under former Civil Code 1895, § 2097).

Policy cannot be avoided upon the ground of the falsity of a representation, though warrantied, unless that representation is material, and the variation from truth is such as to change the nature, extent, or character of the risk. Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934) (decided under former Civil Code 1910, §§ 2479 to 2482).

Variation from the truth, to be material, must be such as to change the nature, extent, or character of the risk. Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, §§ 56-820 to 56-822).

Material misrepresentation as to a known fact will avoid a policy if such misrepresentation changes the character, extent, or nature of the risk. Mutual Benefit Health & Accident Ass'n v. McCranie, 178 F.2d 745 (5th Cir. 1949) (decided under former Code 1933, § 56-908).

In the case of fire and life insurance applications, a misrepresentation is material if the misrepresentation changes the character, nature, or extent of the risk. State Farm Mut. Auto. Ins. Co. v. Anderson, 107 Ga. App. 348, 130 S.E.2d 144, cert. dismissed, 219 Ga. 211, 132 S.E.2d 556 (1963).

In order to void a policy of insurance for a misrepresentation in the application, the insurer must show that the representation was false and that the representation was material in that the representation changed the nature, extent, or character of the risk. Sentry Indem. Co. v. Brady, 153 Ga. App. 168, 264 S.E.2d 702 (1980).

Representations as to previous health of the insured are in general material when not only life, but future health, are to be insured. Even though a misrepresentation relates to a time several years prior to the application, it is material, unless it is very clear that the ill health was due to a transient cause, and left no bad effects. Mental derangement,

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because of its obscurity, especially might well be traced back indefinitely. Pacific Mut. Life Ins. Co. v. Manley, 27 F.2d 915 (N.D. Ga. 1928), aff'd, 35 F.2d 337 (5th Cir. 1929) (decided under former Civil Code 1910, §§ 2479, 2480).

Health and age of insured. — When in an application made for the insurance policy, which was issued by an insurance company and subsequently taken up by another company, it was stated that the insured was 53 years of age and was sound physically and not suffering from any disease, but the evidence showed that at the time of the application the insured was over 60 years of age and was suffering from cancer, which in a few months caused the insured's death, it was held that these representations were material to the risk, and the representations' falsity was unknown to the original company at the time the policy sued on was substituted for the policy in the original company. Maddox v. Southern Mut. Life Ins. Ass'n, 6 Ga. App. 681, 65 S.E. 789 (1909); Southern Life Ins. Co. v. Hill, 8 Ga. App. 857, 70 S.E. 186 (1911) (decided under former Ga. L. 1906, p. 107).

Provisions of this section are applicable in a suit on a policy of life insurance when the insurer pleads fraud in the procurement of the policy and alleges in defense of such suit that the applicant for insurance made in the application which was attached to and formed a part of the policy, untrue and incorrect statements relative to previous illnesses and relative to whether or not the applicant had been previously treated by a physician. Metropolitan Life Ins. Co. v. Marshall, 65 Ga. App. 696, 16 S.E.2d 33 (1941) (decided under former Code 1933, §§ 56-821, 56-822).

Misrepresentation of true state of the insured's health and medical history by the insured entitled the insurer to refuse the administrator's claim for proceeds of a mortgage life insurance policy. Davis v. Integon Life Ins. Corp., 645 F.2d 494 (5th Cir. 1981).

Failure to disclose psychological issues. — Failure to disclose the fact that the insured had undergone a neuropsychiatric evaluation constituted a material misrepresentation since, if the resulting diagnosis had been known, the insurer would have been required to either charge a higher premium or decline to issue the policy; further, it was immaterial whether the insured acted in good faith in completing the application, and likewise immaterial that the insured died from an unrelated cause. Hopkins v. Life Ins. Co., 218 Ga. App. 591, 462 S.E.2d 467 (1995).

If risk is increased. — Whether a misrepresentation relates to health or to some other fact or condition, the final test is whether there was an increase in risk. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, §§ 56-820 to 56-822).

Failure to disclose condition diagnosed as cancer. — When the insured had been diagnosed with carcinoma of the esophagus, the insured's failure to disclose the fact of "attendance by a physician for a condition diagnosed as cancer" (through periodic checkups to see if previously diagnosed cancer had recurred) upon the insurance application amounted to a material misrepresentation, even though the cancer was in remission at the time the application was completed. Lee v. Chrysler Life Ins. Co., 204 Ga. App. 550, 419 S.E.2d 727, cert. denied, 204 Ga. App. 922, 419 S.E.2d 727 (1992).

Cancer diagnosis and insurance application timeline. — To the extent defendant life insurance company claimed an insured's failure to disclose health problems was a material misrepresentation absolving the company of liability under O.C.G.A. § 33-24-7(b), the jury was to decide fault, and issues as to whether the insured learned the insured had cancer until after the insured was told the policy was approved precluded summary judgment against the plaintiff, the trustee of a family trust, who sought proceeds of the life insurance policy that insured the life of the trustee's mother, the insured.

Nixon v. Lincoln Nat'l Ins. Co., 2005 U.S. App. LEXIS 7935 (11th Cir. May 5, 2005) (Unpublished).

Failure to disclose that an insured suffered from muscular dystrophy was material to the risk assumed by any company providing life insurance. Wood v. National Benefit Life Ins. Co., 631 F. Supp. 6 (N.D. Ga. 1984).

A history of progressively disabling muscular dystrophy is material to the risk assumed by the insurance company providing life insurance. Northwestern Nat'l Life Ins. Co. v. Wood, 631 F. Supp. 22 (N.D. Ga. 1984).

Omitted heart disease history. — Trial court did not err in granting summary judgment to an insurer because the uncontroverted evidence established conclusively that the insurer would not have issued the subject policy had the insurer been aware of the insured's omitted and mistated medical history of heart disease material to a legitimate acceptance of risk on behalf of the insurer. Taylor v. Georgia Int'l Life Ins. Co., 207 Ga. App. 341, 427 S.E.2d 833 (1993).

Misrepresentations as to applicant's history of medical problems. — When the record showed that an applicant for insurance had been hospitalized just four months prior to signing the application for treatment of chronic obstructive pulmonary disease, and that during the three years prior to the date of the application the applicant had been treated on numerous occasions by a physician for respiratory problems including asthma and bronchitis, the evidence showed that the insurer would not have issued the policy if the insurer had been aware of the applicant's extensive history of medical problems; because the evidence demanded a finding that misrepresentations were made on the application of insurance which were material as a matter of law, recovery under the policy was precluded. Smith v. Integon Life Ins. Corp., 195 Ga. App. 481, 393 S.E.2d 741 (1990).

Since the misrepresentation as to the insured's medical history about the insured's medical condition was clearly material to the risk, the trial court did not err in granting summary judgment to the insurer. Jennings v. Life Ins. Co., 212 Ga. App. 140, 441 S.E.2d 479 (1994).

Applicant's taking of medicine prescribed for a circulatory system disease constituted treatment of a circulatory disease within the meaning of an insurance application and the applicant's failure to report the treatment was a material misrepresentation. Brown v. JMIC Life Ins. Co., 222 Ga. App. 670, 474 S.E.2d 645 (1996).

Material misrepresentation in insurance application. — When the evidence shows that the insurer would not have issued the policy if the insurer had been aware of the true facts, the evidence demands a finding that the omissions or misrepresentations were material to the acceptance of the risk. Ga. Cas. & Sur. Co. v. Valley Wood, Inc., 336 Ga. App. 795, 783 S.E.2d 441 (2016).

Fact or condition which either contributes to or hastens death. — This section says nothing about stating a fact or condition which either contributes to death or hastens death's coming, but the test prescribed is increase in the risk. It is expectancy and not ultimate fact that controls; risk, not loss. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, § 56-908).

When although the defendant did not know that the disease or trouble with the defendant's palate was cancer, so that the defendant's answer that the defendant had never suffered with a disease denominated cancer insofar as the defendant knew, was truthful, nevertheless the evidence demanded a finding that the defendant's representation that the defendant had had no other illness except childhood illnesses was untrue, that the defendant knew that the representation was untrue, and that the misrepresentation was material. National Life & Accident Ins. Co. v. Atha, 69 Ga. App. 825, 26 S.E.2d 675 (1943) (decided under former Code 1933, § 56-904).

Misstatements may be material to risk although an insured did not die of the disease with reference to which it is contended false answers were made. Mutual Benefit Health & Accident Ass'n v. McCranie, 178 F.2d 745 (5th Cir. 1949) (decided under former Code 1933, §§ 56-820, 56-821).

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Meaning of statement that insured is in "good health." — Statement in an application for reinstatement of a policy of insurance, rendered necessary by the insurance's lapse, that the insured is in "good health," is not to be construed as a warranty that the insured's health is absolutely perfect, but only that the insured's health is practically the same as it was when the policy was issued. Massachusetts Benefit Life Ass'n v. Robinson, 104 Ga. 256, 30 S.E. 918, 42 L.R.A. 261 (1898) (decided under former Civil Code 1895, § 2097).

When life insurance applicant concealed information about treatment for drug and alcohol use and the evidence is uncontroverted that this nondisclosure was material to the risk, the insurer was entitled to void the policy under the provisions of subsection (b) of O.C.G.A. § 33-24-7. Life Ins. Co. v. Helmuth, 182 Ga. App. 750, 357 S.E.2d 107, cert. denied, 182 Ga. App. 910, 357 S.E.2d 107 (1987).

Representations in the application and in the medical blank or form occupy the same status and have the same effect. Kennesaw Life & Accident Ins. Co. v. Hubbard, 106 Ga. App. 556, 127 S.E.2d 845 (1962) (decided under former Code 1933, § 56-908).

Untrue statements to medical examiner may avoid policy. — When an applicant for life-insurance covenants in the application that the statements made to the medical examiner are true, and these statements are made a part of the contract of insurance and form the basis of the contract, any variation in any of them which is material, whereby the nature or extent or character of the risk is changed, will void the policy whether the statements are made in good faith or fraudulently. Southern States Life Ins. Co. v. Morris, 24 Ga. App. 746, 102 S.E. 179 (1920); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934) (decided under former Civil Code 1910, §§ 2479 to 2482).

Statements as to consultations with and treatment by physicians are always considered material because the means are thereby furnished for the company to check the information and good faith of the applicant as to the nature and extent of the applicant's ailments. So it is ground for cancelling a life insurance policy that insured in the application stated that the insured had not been treated by physicians for an ailment, when it appeared that six years before the insured had a condition of acute mania, had been confined in hospitals, and been treated for recurrent severe headaches. Pacific Mut. Life Ins. Co. v. Manley, 27 F.2d 915 (N.D. Ga. 1928), aff'd, 35 F.2d 337 (5th Cir. 1929) (decided under former Civil Code 1910, §§ 2479, 2480).

If risk is substantially increased. — While a false statement as to consultation or treatment for a slight or trivial ailment may not without more be considered as a material misrepresentation, so as to avoid the policy, yet the illness need not be shown to have been serious, the true criterion being as in case of misrepresentations as to other matters, substantial increase in risk. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943); Metropolitan Life Ins. Co. v. Joye, 77 Ga. App. 357, 48 S.E.2d 751 (1948) (decided under former Code 1933, §§ 56-820 to 56-822).

When the insured made a false representation as to consultation of a physician and treatment with radium for a lesion or sore on the insured's lip, known as a "keratosis" and regarded generally in the medical profession as precancerous (in that it may or may not develop into a cancer), the matter so misrepresented substantially increased the risk as contemplated in the policy, notwithstanding some of the evidence may have tended to show that the particular condition had apparently healed at the time the representation was made and had no connection with the cause of the insured's death of cancer of the mouth. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, §§ 56-820 to 56-822).

Failure of an application for life insurance to disclose the fact that the applicant had been treated for an ailment within the period of time mentioned in the application, to be a defense to the insurance

company in an action on the policy, must be such as to substantially enhance the risk as contemplated in that particular policy; however, it need not be shown that the misrepresented facts actually or probably contributed to maturing the benefits of the policy, in whole or in part, earlier than would have been the case if the representations had been true. Metropolitan Life Ins. Co. v. Milton, 74 Ga. App. 160, 38 S.E.2d 885 (1946) (decided under former Code 1933, §§ 56-820, 56-821).

Misstatement as to liquor consumed. — When an insured was not an excessive drinker, and the insured's death was not caused by the insured's use of intoxicants, the insured's misstatement of the kind or quantity of liquors consumed daily, or the insured's failure to state certain facts with reference thereto not material to the risk, was no defense to the policy, nor ground for voiding the policy. Royal Union Mut. Life Ins. Co. v. Wynn, 177 F. 289 (C.C.N.D. Ga. 1910), aff'd, 185 F. 1007 (5th Cir. 1911) (decided under former Civil Code 1895, §§ 2097 to 2099).

Representation that applicant has never been rejected by any company, association, or agents is material to the risk and is not true if the applicant has withdrawn an application at the suggestion of the medical adviser and with the knowledge that the company to whom the application was made was about to reject the application. Aetna Life Ins. Co. v. Moore, 231 U.S. 543, 34 S. Ct. 186, 58 L. Ed. 356 (1913) (decided under former Civil Code 1910, § 2479).

Reply in the negative, in a signed application for life insurance, to a question whether the applicant had ever been previously rejected for life insurance or whether the applicant had ever failed to receive a contract of life insurance for the full amount and kind applied for, is a representation materially affecting the nature, extent, and character of the risk of the insurer, and will avoid the policy and contract, when the evidence is undisputed that, prior to such application, another company or association had in fact refused to issue a life insurance policy, for which the applicant for the latter policy had then applied, and that the company or association to which the applicant last applied relied upon such representation in its application. Sovereign Camp W.O.W. v. Reid, 53 Ga. App. 618, 186 S.E. 759 (1936) (decided under former Code 1933, §§ 56-820, 56-821).

Prior losses and cancellation or refusal of insurance are material. — Questions in an application for insurance pertaining to prior losses and cancellation or refusal of any prior insurance are material to the risk, and false answers to such questions prevent a recovery under the policy. Brannon v. Allstate Ins. Co., 120 Ga. App. 467, 171 S.E.2d 319 (1969).

Insurance company is entitled to rescind a certificate of insurance when the application failed to disclose when asked, that a previous application for insurance had been declined. Northwestern Nat'l Life Ins. Co. v. Wood, 631 F. Supp. 22 (N.D. Ga. 1984).

Other insurance is material. — Policy of accident and health insurance will be avoided when the applicant has made in the application false statements as to matters material to the risk such as the applicant's monthly income, or the existence vel non of other insurance. Southern Sur. Co. v. Fortson, 46 Ga. App. 265, 167 S.E. 335 (1932) (decided under former Civil Code 1910, §§ 2479 to 2481).

When an insurance policy is issued, based on statements made in the written application which is attached to and made a part of the policy, and limitation is placed therein on the authority of the agent to change, waive, or modify the terms of the policy, and the insured makes an answer that no other application has been taken out or that no other policy has been issued, on the insured's life, or for injury, or for illness, when as a matter of fact another policy in another company has been issued, or another application has been taken out, the policy is void. Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, §§ 56-820, 56-821).

When an application contained a statement that "No application will be approved when the building or contents to be insured are already insured," the applicant's misrepresentation as to the existence of other insurance on property in

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question involved a material fact, thus negating the insurer's liability for loss. Washington v. Interstate Fire Ins. Co., 163 Ga. App. 15, 293 S.E.2d 485 (1982).

Misrepresentations as to previous cancellations. — In an action for recovery under a fire insurance policy, the affidavit of an insurer that the insurer would not have issued the policy if the insurer had known the truth about three previous cancellations entitled the insurer to summary judgment even though the insurer had actual knowledge of one of the cancellations as a matter of law. Graphic Arts Mut. Ins. Co. v. Pritchett, 220 Ga. App. 430, 469 S.E.2d 199 (1995).

Lack of title to some of insured property may be material. — Supreme Court's answer to a question certified by the Court of Appeals to the effect that under a contract of fire insurance insuring several articles of personal property, and providing that "This entire policy shall be void if the interest of the insured be other than unconditional and sole ownership," if the insured did not hold title to a part of the property insured, the insured could not recover for the destruction of the property to which the insured held title on the theory that the contract was divisible, does not preclude the Court of Appeals from determining the "materiality" of the fact that the plaintiff did not hold title to some of the property, either as that term may be used to refer to representations in the contract of insurance, or to the doctrine de minimis non curat lex, if either of these principles is otherwise applicable to the facts of the case. Liverpool & London & Globe Ins. Co. v. Stuart, 193 Ga. 437, 18 S.E.2d 681 (1942) (decided under former Code 1933, § 56-821).

Lack of material misrepresentation, incorrect statement, or omission. — Insurer improperly rescinded a directors and officers insurance policy with an insured because the insurer failed to prove that the insured made any material misrepresentation, incorrect statement, or omission, either in the application or at the sole meeting between the insured and the insurer, sufficient to satisfy O.C.G.A. § 33-24-7 or Georgia common law governing fraudulent procurement. Exec. Risk Indem. v. AFC Enters., 510 F. Supp. 2d 1308 (N.D. Ga. 2007), aff'd, 279 Fed. Appx. 793 (11th Cir. 2008).

Misrepresentation as to encumbrances. — Misrepresentation that the property insured is not encumbered is material and falls within the provisions of this section. Globe & Rutgers Fire Ins. Co. v. Smyly, 155 Ga. 547, 117 S.E. 819, former judgment vacated, 30 Ga. App. 620, 118 S.E. 766 (1923) (decided under former Civil Code 1910, §§ 2479 to 2481).

Under a proper construction of the exclusion clause regarding the existence of prior liens, it must refer to such an encumbrance of the property as was, if not placed on the property by the applicant, at least known to the applicant, or it will not void the applicant's interest in the policy. Canal Ins. Co. v. P & J Truck Lines, 145 Ga. App. 545, 244 S.E.2d 81, overruled on other grounds, United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978).

Misrepresentations as to value. — Misrepresentations by the assured, whether fraudulent or otherwise, as to the value of the property insured, but which do not in any manner affect the risk, will not, except in case of "valued" policies, avoid a policy of insurance. Rosser v. Georgia Home Ins. Co., 101 Ga. 716, 29 S.E. 286 (1897) (decided under former Civil Code 1895, §§ 2097 to 2099); Firemen's Ins. Co. v. Parmer, 51 Ga. App. 916, 181 S.E. 880 (1935) (decided under former Civil Code 1910, § 2480).

Misrepresentation by an assured as to the actual cost price of an automobile in a fire insurance policy issued thereon, when the policy provides for payment of damages to be ascertained by the actual value of the property at the time of the loss is not such a material misrepresentation as will avoid the policy. Firemen's Ins. Co. v. Parmer, 51 Ga. App. 916, 181 S.E. 880 (1935) (decided under former Civil Code 1910, § 2480).

Misrepresentation as to net worth and income. — If an insured's application drastically misrepresented the insured's net worth and income, and plaintiff insurer's expert testified no insurer would have issued the $7 million life in-

surance policy for estate planning purposes had the insurer known the insured's net worth was $160,000 and income was $7,200, rescission was proper under O.C.G.A. § 33-24-7(b)(2) and the insurer was granted summary judgment against the defendants, the participants in the "estate planning" insurance program covering the deceased elderly insured. Am. Gen. Life Ins. Co. v. Schoenthal Family, L.L.C., 248 F.R.D. 298 (N.D. Ga. 2008), aff'd, 555 F.3d 1331 (11th Cir. 2009).

In a case involving O.C.G.A. § 33-24-7(b), the beneficiaries argued unsuccessfully that the life insurance company denied the claim in bad faith. The deceased's objectively material misrepresentations in the deceased's application as to the deceased's income and net worth constituted a reasonable ground for the insurance company to contest the claim, and bad faith claims failed as a matter of law if the insurer had any reasonable ground to contest the claim. Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC, 555 F.3d 1331 (11th Cir. 2009).

Misrepresentation as to existence of circumstances that could reasonably give rise to professional liability claim. — Defendant attorney's numerous and substantial payments to a credit card from the real estate closing trust account of the other defendant, the attorney's law firm, allowed plaintiff insurer to rescind its professional liability policy under O.C.G.A. § 33-24-7(b)(2) because the attorney had stated in the insurance application that the attorney knew of no circumstance that could reasonably give rise to a professional liability claim. Medmarc Cas. Ins. Co. v. Reagan Law Group, P.C., 525 F. Supp. 2d 1334 (N.D. Ga. 2007).

Failure to disclose extended employee coverage. — When it was clear that had the insurer known that the employee leasing agreement was intended to cover the subcontractor's employees, it would not have issued the policy, such coverage was material to the risk assumed by the insurer and demanded a finding that no coverage existed, such that the insurer was not estopped to deny protection for the subcontractor's employees. American Resources Ins. Co. v. Conner, 209 Ga. App. 885, 434 S.E.2d 737 (1993).

Traffic citations. — Misrepresentation as to the applicant's two traffic citations was material since it was the insurer's practice to decline to insure "sporty or performance" cars, such as the applicant's Porsche, when the driver was a new policy holder who had even one accident or traffic citation in the preceding five years. Haugseth v. Cotton States Mut. Ins. Co., 192 Ga. App. 853, 386 S.E.2d 725 (1989).

Expert's opinion refused. — In an action on a health insurance policy brought by a parent for benefits for injuries to a child, the court refused to accept, as trier of fact, an expert's opinion concerning the materiality of the representation made by the plaintiff that the plaintiff's child maintained no other health insurance. Hall v. Time Ins. Co., 663 F. Supp. 599 (M.D. Ga. 1987), rev'd on other grounds, 854 F.2d 440 (11th Cir. 1988).

Based upon an insured's material misrepresentation in the insurance application, an insurer may retrospectively void a commercial insurance policy that includes motor vehicle liability coverage as long as the cancellation of the policy does not leave an injured third party without available liability insurance in an amount equal to the minimum statutory requirements. FCCI Ins. Group v. Rodgers Metal Craft, Inc., No. 4:06-CV-107 (CDL), 2008 U.S. Dist. LEXIS 57649 (M.D. Ga. July 28, 2008).

Expert testimony admitted. — In a case involving O.C.G.A. § 33-24-7(b), the life insurance policy beneficiaries unsuccessfully argued that the insurance company's expert's testimony was unreliable because experience alone could never form the basis for expert testimony. The district court did not abuse the court's discretion when the court determined that the expert's education and experience qualified the expert to testify as an expert about insurance industry standards since the expert had ample knowledge and experience about the subject; inter alia, the expert had obtained masters and doctoral degrees in risk management and insurance, the expert had taught classes in risk management and insurance, including underwriting in general and financial underwriting in particular at the college level, and the expert had coauthored a

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leading college-level textbook on life insurance that included chapters on financial underwriting. Am. Gen. Life Ins. Co. v. Schoenthal Family, LLC, 555 F.3d 1331 (11th Cir. 2009).

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Affirmative defense. — Omissions in the insured's policy application was an affirmative defense that was required to be pled and, by waiting until trial to assert the defense, plaintiff waived the defense. Hamilton v. Mecca, Inc., 930 F. Supp. 1540 (S. D. Ga. 1996).

Declaratory judgment limited to declaring policy void or not void. — In an insurer's declaratory judgment seeking a determination that a policy was void due to the insured's misrepresentations in the application, O.C.G.A. § 33-24-7(b), the trial court erred by, rather than simply declaring the policy void, requiring the insurer to elect whether to affirm or rescind the policy and repay the premiums if rescinding. Georgia Casualty & Surety Company v. Valley Wood, Inc., 345 Ga. App. 30, 812 S.E.2d 94 (2018).

Parol evidence to show knowledge of insurer's agent admitted. — When the agent of an insurance company omitted to insert in a policy on a stock of general merchandise permission to the assured to keep kerosene oil and powder in the same building with such stock, parol evidence was admissible to show knowledge of such keeping by the agent. Mobile Fire Dept. Ins. Co. v. Miller, 58 Ga. 420 (1877) (decided under former Code 1867, §§ 2670 to 2672).

Evidence of notice to the company's agent that the plaintiff had a hernia was admissible, not to establish a waiver of the terms of the policy, but to meet the defense of fraudulent concealment and thereby prevent the avoidance of the whole contract. Travelers Ins. Co. v. Thornton, 119 Ga. 455, 46 S.E. 678 (1904) (decided under former Civil Code 1895, § 2099).

Evidence showing concealment or failure to state fact was not willful is admissible. — Before a failure to state a material fact in an application for insurance, which is attached to and forms a part of the policy, will void the policy, the omission must have been fraudulent, and, before the concealment of such a fact as would enhance the risk will void the policy, the omission must have been willfully made by the applicant, and in a suit on a policy of insurance, when the insurer depends upon the ground of the failure of the applicant to state a material fact in the application or of the applicant's concealment of a fact which would enhance the risk, evidence is admissible which tends to show that the applicant, in failing to state such material fact, did not fail to do so fraudulently, or in concealing a fact which enhances the risk assumed by the insurer, did not do so willfully. Life & Cas. Ins. Co. v. Blackburn, 59 Ga. App. 479, 1 S.E.2d 450 (1939) (decided under former Code 1933, § 56-822).

Evidence of insured's good character if fraud in issue. — When an effort is made to impeach a contract of insurance upon the ground that the contract was issued in consequence of the perpetration of a fraud by the assured upon the insurer, evidence of the good character of the assured is admissible to support the assured's bona fides in the transactions. Metropolitan Life Ins. Co. v. Marshall, 65 Ga. App. 696, 16 S.E.2d 33 (1941) (decided under former Code 1933, §§ 56-821, 56-822).

Information given by deceased to insurer as to medical history. — When the sole issue was whether the policy was procured by false and fraudulent statements of the applicant as to the applicant's health and previous illness and the deceased had given the company information which enabled the company to ascertain the deceased's medical history, this information could be considered by the jury on the issue of whether the deceased intended to defraud the company in taking out the policy. National Life & Accident Ins. Co. v. Bonner, 58 Ga. App. 876, 200 S.E. 319 (1938) (decided under former Code 1933, §§ 56-820 to 56-822).

Attached document must be proved to be intended part of policy for consideration. — Document physically attached to the policy must also be shown to have been intended as a part of the policy, or a part of the application which is also

attached to and expressly recited to be a part of the policy, before the document may be considered. Georgia Int'l Life Ins. Co. v. King, 120 Ga. App. 682, 172 S.E.2d 167 (1969); Capital City Ins. Co. v. Rick Taylor Timber Co., 918 F. Supp. 1558 (S.D. Ga. 1995), aff'd, 106 F.3d 417 (11th Cir. 1997).

Unincorporated statement relevant on fraud but not material misrepresentation. — When delivery of a life insurance policy was by the company conditioned on the signing of a statement of insurability by the insured, but the statement did not purport to amend the application, and neither the application nor the contract proper made reference thereto, any question of whether the application contained a misstatement material to the risk is relevant to the question of fraud in the inception, but is not a ground for cancellation under this section. Georgia Int'l Life Ins. Co. v. King, 120 Ga. App. 682, 172 S.E.2d 167 (1969); Capital City Ins. Co. v. Rick Taylor Timber Co., 918 F. Supp. 1558 (S.D. Ga. 1995), aff'd, 106 F.3d 417 (11th Cir. 1997).

Rule applies to unattached application. — When the application is not attached to the policy, the company may not treat the application as a part of the contract or introduce the application in evidence as such, or to show that certain statements were contracted or warranted to be true; but the company could plead and prove that the insured had made false and fraudulent statements as to the insured's health, and that the company was thus fraudulently induced to issue the policy and that the policy was therefore void, not as a matter of contract, but because of fraudulent procurement. National Life & Accident Ins. Co. v. Pollard, 66 Ga. App. 895, 19 S.E.2d 557 (1942) (decided under former Code 1933, §§ 56-820 to 56-822).

Although an unattached application cannot be admitted for the purpose of showing a breach of the contract, since the application forms no part of the contract, still, when the defense is that the policy was fraudulently procured by reason of false and fraudulent representations material to the risk, the application is admissible, not as a part of the contract, and not for the purpose of showing that the policy was void under the contract, but to show that the policy was fraudulently procured. National Life & Accident Ins. Co. v. Atha, 69 Ga. App. 825, 26 S.E.2d 675 (1943) (decided under former Code 1933, § 56-904).

Rate book admissible to show misrepresentation was material. — When an action was brought on a policy of life insurance containing the following provision: "If the age of the insured is incorrectly stated, the amount payable under this policy shall be the insurance which the actual premiums would have purchased at the true age of the insured," the age stated in the policy was 55 years, and the defendant pleaded fraud in the procurement of the policy, alleging that in fact the insured was more than 70 years of age, and uninsurable, it was held that the rate book of the company was admissible for the purpose of showing that there was no rate on a person 70 years of age, and that the misrepresentation was material. Johnson v. American Nat'l Life Ins. Co., 134 Ga. 800, 68 S.E. 731 (1910) (decided under former Civil Code 1895, § 2095 and former Ga. L. 1906, p. 107).

Burden on defendant in action on policy to show material misrepresentations. — In an action upon an insurance policy, the burden of showing that the representations made by the insured in the application were material and untrue is on the defendant, and such questions are generally issues of fact for determination by the jury. New York Life Ins. Co. v. Watson, 48 Ga. App. 211, 172 S.E. 602 (1934) (decided under former Civil Code 1910, § 2479).

Burden of showing the misrepresentations made in the application were untrue and material is upon the insurance company, when the action is defended upon the ground that the insured made misrepresentations of facts material to the risk in the application for insurance. Metropolitan Life Ins. Co. v. Milton, 74 Ga. App. 160, 38 S.E.2d 885 (1946) (decided under former Code 1933, §§ 56-820, 56-821); National Life & Accident Ins. Co. v. Camp, 77 Ga. App. 667, 49 S.E.2d 670 (1948), commented on in, see 11 Ga. B.J. 349 (1949).

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Did insurer rely on false information. — Trial court erred by dismissing husband and wife's lawsuit claiming breach of an insurance contract for failure to pay the insureds' claim because, although the husband's application for insurance contained false information, there was a question about whether the insurance company relied on that information in making the company's decision to issue an insurance policy and whether the insurance company had waived the company's right to rescind the contract. Lively v. S. Heritage Ins. Co., 256 Ga. App. 195, 568 S.E.2d 98 (2002).

Evidence sufficient to support finding of no material misrepresentation. — Jury was authorized to find that the insured's answer in an application for an accident insurance with reference to a previous disability from accident was true in that the evidence did not demand the finding that the disability occurred within the time mentioned in the question and that the answer was not such a material misrepresentation as would avoid the policy. National Accident & Health Ins. Co. v. Childs, 62 Ga. App. 633, 9 S.E.2d 108 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Jury was authorized to find that the insured's untrue answer in the insured's application for accident insurance as to infirmity or deformity was not a material misrepresentation such as would avoid the policy. National Accident & Health Ins. Co. v. Childs, 62 Ga. App. 633, 9 S.E.2d 108 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Evidence sufficient to support finding of no willful or fraudulent concealment. — Jury question was presented as to whether or not the conduct of the insured in making application for insurance was fraudulent, the evidence being consistent with the insured's good faith, and authorizing the finding that the insured did not knowingly and fraudulently conceal or misrepresent the insured condition in making application for insurance. Bankers Health & Life Ins. Co. v. Hamilton, 56 Ga. App. 569, 193 S.E. 477 (1937) (decided under former Ga. L. 1906, p. 107 and former Code 1933, §§ 56-821, 56-822).

When the evidence was sufficient to show that the answers given by the parent of an insured in applying for life insurance on the life of a child were made in good faith, that if the insured was afflicted with epilepsy as the insurance company contended, the parent did not know it, and that the agent who took the application was acquainted with the insured, and being in a position to get first-hand knowledge of the insured's health, gave it as the agent's opinion, both in an endorsement on the application and in the agent's testimony on the trial, that the applicant was in good health, and was a good risk, the jury was authorized to find that there was no willful concealment or fraudulent intent by the plaintiff parent. National Life & Accident Ins. Co. v. Dorsey, 69 Ga. App. 734, 26 S.E.2d 654 (1943) (decided under former Code 1933, §§ 56-820 to 56-822, 56-904).

Failure of the insured to supply information as to health problems when no inquiry is made by the insurer or the insurer's agents and neither the certificate or master policy of insurance inform the insured that certain illnesses are not covered will not raise a defense of fraud or material misrepresentation in a suit on a credit life insurance policy. Block v. Voyager Life Ins. Co., 251 Ga. 162, 303 S.E.2d 742 (1983).

Evidence sufficient to support finding that insurer was estopped by knowledge. — When company issued policy of industrial life insurance upon an application which contained information that the insured was 21 years of age, was six feet one inch in height, but weighed only 146 pounds, that the insured had "bronchitis", and that a certain named doctor attended the insured (the insured having told the agent of the company the insured had had "bronchiectasis" while the agent put "bronchitis" in the application, and medical testimony disclosing that the terms are usually confused and used interchangeably by laymen), and the company sought to avoid liability upon the ground of fraud in the procurement, in that the insured misrepresented the condition of the insured's health, the jury was

authorized to find that the company had knowledge of the insured's physical condition, or at least had sufficient knowledge to put the company upon inquiry as to the soundness of the insured's health, and having issued the policy and received the weekly premiums, the company was estopped from deriving any benefit from a stipulation in the policy which might have availed the company if the company had been ignorant of the facts. National Life & Accident Ins. Co. v. Pollard, 66 Ga. App. 895, 19 S.E.2d 557 (1942) (decided under former Code 1933, §§ 56-820 to 56-822).

Case of actual fraud made out. — When it is shown that a material statement made in an application for insurance was false, that the statement's falsity was known to the insured at the time the statement was made, that the statement was made with a view to procuring insurance, that the company had no notice of the statement's falsity, and that the company acted upon the statement to the company's injury, the law will conclusively presume an intent to deceive, and a case of actual fraud will be made out, although the insured may not have really intended to prejudice the rights of the company. National Life & Accident Ins. Co. v. Atha, 69 Ga. App. 825, 26 S.E.2d 675 (1943) (decided under former Code 1933, § 56-904); State Farm Mut. Auto. Ins. Co. v. Anderson, 107 Ga. App. 348, 130 S.E.2d 144, cert. dismissed, 219 Ga. 211, 132 S.E.2d 556 (1963); Hartford Accident & Indem. Co. v. Hartley, 275 F. Supp. 610 (M.D. Ga. 1967), aff'd, 389 F.2d 91 (5th Cir. 1968).

Evidence not requiring finding answer was untrue. — When the deceased drank at separate, infrequent intervals and on such occasions to excess, but was not a habitual drinker, and there was no evidence that the deceased ever drank between these "sprees," the evidence did not demand a finding that the answer "an occasional drink" to a question in the application as to what extent the deceased used intoxicants was untrue. National Life & Accident Ins. Co. v. Barnes, 61 Ga. App. 730, 7 S.E.2d 299 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Verdict must be for insurer if uncontroverted facts show materially fraudulent concealment. — When uncontroverted facts show misstatements or materially fraudulent concealment in answer to questions in an application for life insurance, a verdict in favor of the insurer must be rendered. Mutual Benefit Health & Accident Ass'n v. McCranie, 178 F.2d 745 (5th Cir. 1949) (decided under former Code 1933, §§ 56-820, 56-821).

No explanation for delay in asserting rescission. — Trial court properly granted summary judgment to the insured on the insurer's counterclaim for rescission because the insurer offered no explanation for why the insurer failed to announce the insurer's intent to rescind the policies until December 2013, in response to the insured's suit filed against the insurer and Georgia law is clear that if a party to a contract seeks to avoid the contract on the ground of fraud or mistake, the party must, upon discovery of the facts, at once announce their purpose and adhere to the purpose. American Safety Indemnity Co. v. Sto Corp., 342 Ga. App. 263, 802 S.E.2d 448 (2017).

Insurer's void policy defense waived. — Although an application for workers' compensation insurance incorrectly stated that the employees did not travel out of state or perform any work above 15 feet, and the insurer claimed the insurer would not have issued the policy if the application had been correct, the insurer waived the insurer's void policy defense under O.C.G.A. § 33-24-7 when, upon discovering the inaccuracies, the insurer told the employer that coverage would continue for 90 days, and a claim occurred during that period. Grange Mutual Casualty Company v. Bennett, 350 Ga. App. 608, 829 S.E.2d 834 (2019), cert. denied, No. S19C1418, 2020 Ga. LEXIS 32 (Ga. 2020).

Jury issues. — When an insured was in apparent good health at the time of applying for insurance, but died of tuberculosis some six and one-half months thereafter, it was a question for the jury whether the insured was in sound health at the time of the issuance of the policy. National Life & Accident Ins. Co. v. McKenney, 52 Ga. App. 466, 183 S.E. 659

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(1936) (decided under former Code 1933, §§ 56-820 to 56-822).

Statements made in an application for life insurance will not, if false, void the policy issued thereon, unless the statements were material and operated to change the nature or character of the risk. This materiality, when not indisputably established by the evidence, is a matter for determination by a jury. Metropolitan Life Ins. Co. v. Marshall, 65 Ga. App. 696, 16 S.E.2d 33 (1941) (decided under former Code 1933, §§ 56-820 to 56-822); Metropolitan Life Ins. Co. v. Milton, 74 Ga. App. 160, 38 S.E.2d 885 (1946) (decided under former Code 1933, §§ 56-820 to 56-822).

When the deceased, who was illiterate in 1932 stayed in the hospital two days, and was dismissed with a diagnosis of hypertension, arteriosclerosis, and mild diabetes which could be controlled by treatment, but was hard working and active, and enjoyed good health during the time between the two-day stay at the hospital in 1932 and the spring of 1940, under the circumstances the question whether the deceased willfully and fraudulently procured an insurance policy in May 1939 by a representation which was known by the deceased to be false, was a question for the jury. National Life & Accident Ins. Co. v. Boyd, 66 Ga. App. 722, 19 S.E.2d 210 (1942) (decided under former Code 1933, §§ 56-820 to 56-822).

Issue as to material misrepresentation is ordinarily a matter for jury determination. Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970).

With respect to the issue of the materiality of the misrepresentation of no illness or diseases on an insurance application, it is proper to submit such a question to a jury when there is a conflict of evidence as to whether a child's illness or disease had been in existence at the time the application was filled out. United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978).

When it is not clear from the evidence whether a child had been taken to a physician or physicians for nonroutine medical attention, i.e., treatment for illness or disease, the issues of the falsity and materiality of a representation that one had not, on an insurance application, are properly submitted to the jury. United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978).

As a rule, the question of materiality of the misrepresentation is one for the jury. Only when the evidence excludes every reasonable inference except that the misrepresentations were material should the court determine materiality on the court's own. Nappier v. Allstate Ins. Co., 766 F. Supp. 1166 (N.D. Ga. 1991), aff'd, 961 F.2d 168 (11th Cir. 1992).

Unless every reasonable inference but one is excluded. — Truth and materiality of representations are generally questions of fact for determination by the jury; but when all the testimony relating to a question of fact excludes every reasonable inference but one, the issue becomes an issue of law for determination by the court. Phenix Ins. Co. v. Fulton, 80 Ga. 224, 4 S.E. 866 (1887) (decided under former Code 1867, §§ 2670 to 2672); Empire Life Ins. Co. v. Jones, 14 Ga. App. 647, 82 S.E. 62 (1914) (decided under former Civil Code 1910, §§ 2479 to 2481); Connecticut Mut. Life Ins. Co. v. Mulkey, 142 Ga. 358, 82 S.E. 1054 (1914) (decided under former Civil Code 1910, §§ 2479 to 2481); Mutual Life Ins. Co. v. Bolton, 22 Ga. App. 566, 96 S.E. 442 (1918) (decided under former Civil Code 1910, §§ 2479 to 2481); Stansall v. Columbian Nat'l Life Ins. Co., 27 Ga. App. 537, 109 S.E. 297, cert. denied, 27 Ga. App. 836 (1921), later appeal, 32 Ga. App. 87, 122 S.E. 733 (1924) (decided under former Civil Code 1910, §§ 2479 to 2481); Jefferson Std. Life Ins. Co. v. Henderson, 37 Ga. App. 704, 141 S.E. 498 (1928), for comment, see 1 Ga. L. Rev. No. 3, p. 53 (1929); Phillips v. New York Life Ins. Co., 173 Ga. 135, 159 S.E. 696 (1931) (decided under former Civil Code 1910, §§ 2479 to 2481); Mutual Benefit Health & Accident Ass'n v. Marsh, 60 Ga. App. 431, 4 S.E.2d 84 (1939) (decided under former Code 1933, §§ 56-820, 56-821).

Whether misrepresentations are material is ordinarily a question for the jury, but when the evidence excludes every reasonable inference except that they were

material, no issue is presented upon that point for determination by the jury. Bankers Health & Life Ins. Co. v. Glisson, 61 Ga. App. 583, 7 S.E.2d 32 (1940) (decided under former Code 1933, §§ 56-820 to 56-822); Jefferson Std. Life Ins. Co. v. Bridges, 147 Ga. App. 5, 248 S.E.2d 5 (1978); United Family Life Ins. Co. v. Shirley, 242 Ga. 235, 248 S.E.2d 635 (1978); Bailey v. Interstate Life & Accident Ins. Co., 155 Ga. App. 65, 270 S.E.2d 287 (1980).

Issue as to material misrepresentation should ordinarily be submitted to the jury; yet, when the evidence as a whole excludes every reasonable inference but one, the court may so rule as a matter of law. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943) (decided under former Code 1933, §§ 56-820 to 56-822).

Issue as to material misrepresentations in an insurance application, like questions as to negligence, proximate cause, and similar matters, should ordinarily be submitted to the jury. Only when the evidence as a whole excludes every reasonable inference but one may the court so rule as a matter of law. Gilham v. National Life & Accident Ins. Co., 104 Ga. App. 459, 122 S.E.2d 164 (1961).

Summary judgment based on incorrect statement of good health. — Insured's representation that the insured was of good health, when an incorrect statement, is ground for granting an insurer's motion for summary judgment. Bridges v. World Serv. Life Ins. Co., 134 Ga. App. 923, 216 S.E.2d 714 (1975) (but see United Family Life Ins. Co. v. Shirley, 144 Ga. App. 722, 242 S.E.2d 274 (1978)).

Whether insurance agent's actions misleading found to be question of fact. — Whether an agent's actions in indicating to the insured that the insured only had to sign and not fill in an insurance application were sufficiently misleading to allow an insured to escape the consequences of the agent's insertion of untruthful answers on an application was a question of fact not susceptible to summary judgment. O'Kelly v. Southland Life Ins. Co., 167 Ga. App. 455, 305 S.E.2d 873 (1983).

Charging section is harmless when defense is actual fraud. — It would not be harmful to the insurer to give in charge a part or all of this section when the sole defense is actual fraud. Interstate Life & Accident Co. v. Bess, 35 Ga. App. 723, 134 S.E. 804 (1926) (decided under former Civil Code 1910, §§ 2479 to 2481).

Charge on sufficiency of proof of fraud. — To sustain a charge of fraud as to answers made in an application for insurance which is not attached to the policy the proof must be clear, cogent, convincing and certain, and it was not error for the trial court to charge the jury accordingly. Gulf Life Ins. Co. v. Moore, 90 Ga. App. 791, 84 S.E.2d 696 (1954) (decided under former Code 1933, §§ 56-820 to 56-822).

Charge on knowledge of pregnancy proper when supported by evidence of appearance. — It was not error for the court to charge the jury that if the agent of the company had actual knowledge that the insured was pregnant at the time of her application the plaintiff could recover despite the fact that she misrepresented the fact of her pregnancy, when evidence, if credible, authorized the finding that the insured's condition and appearance showed that she was pregnant. National Life & Accident Ins. Co. v. Fischel, 62 Ga. App. 645, 9 S.E.2d 192 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Charge requiring fraudulent intent is error as to material misrepresentation. — In the absence of facts constituting waiver or estoppel, an insurance policy is voided by a willful misrepresentation of a material fact in an application for insurance made with a view to obtaining a policy of insurance, which is acted upon by an insurance company in issuing a policy, even though the applicant for the insurance did not make the misrepresentation for the purpose of prejudicing the rights of the insurance company; hence, a charge making intention to defraud prerequisite to the voiding of the policy was error. National Life & Accident Ins. Co. v. Fischel, 62 Ga. App. 645, 9 S.E.2d 192 (1940) (decided under former Code 1933, §§ 56-820 to 56-822).

Insurer was not entitled to summary judgment under paragraph (b)(3) of O.C.G.A. § 33-24-7 because the

Procedure (Cont'd)

insurer failed to present any evidence showing that the insurer would not have issued a policy if the insurer had known of a misrepresentation by the insured regarding a prior cancellation. Nappier v. Allstate Ins. Co., 766 F. Supp. 1166 (N.D. Ga. 1991), aff'd, 961 F.2d 168 (11th Cir. 1992).

Rescission under paragraph (b)(3) of O.C.G.A. § 33-24-7(b)(3) was inappropriate in an action against the defendants, the participants in an "estate planning" insurance program covering the deceased elderly insured, because one of the plaintiff insurer's experts used contradictory underwriting standards regarding testimony that the policy would not have been issued if the truth regarding the insured's financial condition had been known. Am. Gen. Life Ins. Co. v. Schoenthal Family, L.L.C., 248 F.R.D. 298 (N.D. Ga. 2008), aff'd, 555 F.3d 1331 (11th Cir. 2009).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1007 et seq.

ALR. — Insurance: incorrect statement of age, 1 A.L.R. 459; 160 A.L.R. 295.

Insurance: effect of violation of warranty or condition of sole and unconditional ownership as regards one or more of several items of property covered by policy, 5 A.L.R. 808.

Statements by applicant for life insurance as to use of intoxicating liquor, 26 A.L.R. 1279.

Effect on insurance of mere failure to disclose encumbrance on property, 28 A.L.R. 801.

Applicability of statute limiting effect of representations and warranties in contract of insurance, to provision that policy shall not take effect unless delivered to assure while in good health, 29 A.L.R. 656.

Effect of erroneous designation of beneficiary of insurance as "wife," 32 A.L.R. 1481.

Construction and effect of statute specifically directed against securing life insurance by fraud or upon life of person not in insurable condition, 40 A.L.R. 624.

Criterion of health for purposes of warranty or condition in insurance contract, 40 A.L.R. 662; 100 A.L.R. 362.

Right of insurer to insist upon representations not in fact made by insured nor incorporated in the application when signed by him, 43 A.L.R. 527.

Materiality, in application for accident insurance, of statements as to other insurance or indemnity thereunder, 55 A.L.R. 742.

Insurance: warranties and conditions precedent distinguished, 59 A.L.R. 611.

Avoidance of renewed fire policy for breach of warranty or representation first made in original application or policy, 62 A.L.R. 823.

Insurance: misrepresentation or nondisclosure not clearly otherwise material to the risk, but which influenced or might have influenced insurer in accepting risk as within statutory or policy provision exonerating insured from effect of misrepresentations other than those material to or increasing the risk, 73 A.L.R. 304.

Admissibility as against the beneficiary of life or accident insurance of statements or declarations by the insured outside his application, 86 A.L.R. 146.

Provisions of insurance policy as to watchman, and warranties and representations in that regard, 87 A.L.R. 1074.

Binding effect of application not signed by insured, 91 A.L.R. 1127.

Disability feature of insurance contract as subject of rescission apart from life insurance feature, 91 A.L.R. 1470.

Noncompliance with statutory requirement that insurance policy contain entire contract, or that application be attached incorporated in, endorsed upon, or delivered with, the policy as affecting right of insurer to show initial fraud or misrepresentation by insured, 93 A.L.R. 374.

Representations and warranties in credit insurance, 97 A.L.R. 1468.

Continued acceptance of insurance premiums or dues as basis of waiver of, or estoppel to assert, misrepresentation or breach affected by alternative obligation which survived misrepresentation or breach, 101 A.L.R. 1138.

Materiality of false representation, in application for policy of insurance, as to whether applicant has consulted physicians, 131 A.L.R. 617.

Opinion or expert testimony as to materiality of misrepresentation in application for insurance or as to increased risk or as to practice or usage of insurance companies regarding acceptance or rejection of certain class of risk, 135 A.L.R. 411.

Age adjustment clause of policy as affected by incontestable clause or statute against avoidance of policy because of misrepresentation, 135 A.L.R. 445.

Impairment of insured's health or physical condition not contributing to his death or disability as affecting insurer's liability, 148 A.L.R. 912.

Misstatement in description of automobile as affecting automobile policy, 149 A.L.R. 531.

Insurance: misstatement as to income of insured, 150 A.L.R. 1364.

Construction and application of provision of statute designed to prevent avoidance of automobile liability policy by reason of violation of its exclusions or conditions, or other terms, 1 A.L.R.2d 822.

Waiver of, or estoppel to assert, provision of policy respecting location of personal property covered thereby, 4 A.L.R.2d 868.

Judgment avoiding indemnity or liability policy for fraud as barring recovery from insurer by or on behalf of third person, 18 A.L.R.2d 891.

Misrepresentation by applicant for automobile liability insurance as to ownership of vehicle as material to risk, 33 A.L.R.2d 948.

Materiality of false statements by applicant for automobile insurance as to license revocations or suspensions or traffic violations, 89 A.L.R.2d 1027.

Obligee's concealment or misrepresentation concerning previous defalcation as affecting liability on fidelity bond or contract, 4 A.L.R.3d 1197.

Misrepresentation or misstatement as to insured's marital status, or as to his relationship to beneficiary, as ground for avoiding liability under life insurance policy, 14 A.L.R.3d 931.

Fraud, false swearing, or other misconduct of insured as affecting right of innocent mortgagee or loss payee to recover on property insurance, 24 A.L.R.3d 435.

Reformation of property insurance policy to correctly identify the person or interest insured, 25 A.L.R.3d 580.

Reformation of property insurance policy to correctly identify property insured, 25 A.L.R.3d 1232.

Insured's responsibility for false answers inserted by insurer's agent in application following correct answers by insured, or incorrect answers suggested by agent, 26 A.L.R.3d 6.

Insured's statement, in application for life or health insurance or its reinstatement, that he is in good health, as absolute representation of, or more statement of his good-faith belief in, his good health, 26 A.L.R.3d 1061.

Insured's misrepresentation or misstatement as to his name or marital status as ground for avoiding liability insurance, 27 A.L.R.3d 849.

What constitutes "serious illness," "serious disease," or equivalent language used in insurance application, 28 A.L.R.3d 1255.

Representations as to age or identity of persons who will drive vehicle, or as to extent of their relative use, as avoiding coverage under automobile insurance policy, 29 A.L.R.3d 1139.

Modern status of rules regarding materiality and effect of false statement by insurance applicant as to previous insurance cancellations or rejections, 66 A.L.R.3d 749.

Automobile insurance: concealment or nondisclosure of physical defects or conditions as avoiding coverage, 72 A.L.R.3d 804.

Misrepresentation or concealment by insured or agent avoiding liability by title insurer, 17 A.L.R.4th 1077.

Rescission or cancellation of insurance policy for insured's misrepresentation or concealment of information concerning human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), or related health problems, 15 A.L.R.5th 92.

Negligent misrepresentation as "accident" or "occurrence" warranting insurance coverage, 58 A.L.R.5th 483.

Rescission of directors' and officers' liability insurance policy, 29 A.L.R.6th 189.

33-24-8. Admissibility in evidence of applications in actions between insurer and insured.

As to kinds of insurance other than life insurance, no application for insurance signed by or on behalf of the insured shall be admissible in evidence in any action between the insured and the insurer arising out of the policy applied for if the insurer, at expiration of 30 days after receipt by the insurer of written demand by or on behalf of the insured for a copy of the application, has failed to furnish to the insured a copy of the application reproduced by any legible means.

History. — Code 1933, § 56-2408, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Application which is basis of suit not excludable. — Insurance application which is both the gravamen of a complaint that the application did not comply with Jones v. State Farm Auto. Ins. Co., 156 Ga. App. 230, 274 S.E.2d 623 (1980), and the "best evidence" in support thereof, cannot be the subject of a motion for exclusion at trial pursuant to O.C.G.A. § 33-24-8. Georgia Farm Bureau Mut. Ins. Co. v. Coffman, 169 Ga. App. 192, 311 S.E.2d 854 (1983) (see O.C.G.A. § 33-34-5 and notes thereto).

RESEARCH REFERENCES

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, § 1987 et seq.

ALR. — Liability in respect of premium where policy is rejected by applicant or prospect, 41 A.L.R. 644.

Admissibility as against the beneficiary of life or accident insurance of statements or declarations by the insured outside his application, 86 A.L.R. 146.

Failure to attach copy of application as affecting right to set up breach of condition in policy itself, 87 A.L.R. 194.

Binding effect of application not signed by insured, 91 A.L.R. 1127.

33-24-9. Approval or disapproval of forms.

(a) No basic insurance policy or annuity contract form or application form where written application is required and is to be made a part of the policy or contract or printed rider or endorsement form or form of renewal certificate shall be delivered or issued for delivery in this state unless the form has been filed with and approved by the Commissioner. This subsection shall not apply to surety bonds or to specially rated inland marine risks nor to policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or which related to the manner of distribution of benefits or to the reservation of rights and benefits under life or accident and sickness insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder.

(b) Every filing shall be made not less than 90 days in advance of any delivery. At the expiration of 90 days the form filed shall be deemed approved unless prior thereto it has been approved or disapproved by the Commissioner. Approval of any form by the Commissioner shall constitute a waiver of any unexpired portion of the waiting period. The Commissioner may extend by not more than an additional 90 days the period within which he may approve or disapprove any form by giving notice of the extension before expiration of the initial 90 day period. At the expiration of the period as so extended and in the absence of prior approval or disapproval, any form shall be deemed approved. The Commissioner may at any time, after notice and for cause shown, withdraw any approval after notice and hearing as provided in Code Sections 33-2-17 through 33-2-23 and 33-2-26 through 33-2-28.

(c) Any order of the Commissioner disapproving any form or withdrawing a previous approval shall state in reasonable detail the grounds for that action.

(d) The Commissioner may by order, in exceptional cases, exempt from the requirements of this Code section for so long as he deems proper any insurance document or form or type of insurance document or form as specified in the order to which, in his discretion, this Code section may not practicably be applied or the filing and approval of which are, in his discretion, not desirable or necessary for the protection of the public.

(e) This Code section shall apply also to any form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of that jurisdiction informs the Commissioner that the form is not subject to approval or disapproval by the official and upon the Commissioner's order requiring the form to be submitted to him for approval or disapproval. The standards applicable to forms for domestic use shall apply to such forms.

(f) Each filing made pursuant to this Code section shall be accompanied by a fee or fees as provided in Code Section 33-8-1.

History. — Code 1933, § 56-2410, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1973, p. 499, § 5; Ga. L. 1992, p. 2725, § 27.

Law reviews. — For article, "The Chevron Two-Step in Georgia's Administrative Law," see 46 Ga. L. Rev. 871 (2012).

JUDICIAL DECISIONS

Insurance providing coverage for aerial pesticide contractors is of a unique character and is thereby expressly covered by the exclusionary language of subsection (a) of O.C.G.A. § 33-24-9. Kelly v. Lloyd's of London, 255 Ga. 291, 336 S.E.2d 772 (1985).

Assault and battery exclusions. — Failure of an insurer to file and obtain administrative approval of an assault and

battery exclusion in a liability insurance policy did not render the exclusion void and unenforceable. Penn Am. Ins. Co. v. Miller, 228 Ga. App. 659, 492 S.E.2d 571 (1997).

Cited in Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972); State Farm Mut. Auto. Ins. Co. v. Bates, 542 F. Supp. 807 (N.D. Ga. 1982); Cincinnati Ins. Co. v. Page, 188 Ga. App. 876, 374 S.E.2d 768 (1988).

OPINIONS OF THE ATTORNEY GENERAL

Group coverage of domestic partnerships violative of public policy. — Municipal ordinances which create the status of domestic partnership are violative of constitutional and statutory provisions precluding municipal legislation relating to legal status and relationship; thus, group health insurance coverage provided pursuant to such ordinances is violative of the public policy of this state. 1993 Op. Att'y Gen. No. 93-26.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 19 et seq., 31.

C.J.S. — 44 C.J.S., Insurance, 478 et seq.

ALR. — Right of insured or beneficiary to enforce a policy provision more favorable to him than the standard policy; or to have policy reformed so as to include such a provision, 113 A.L.R. 773.

Validity, construction, and effect of approval or disapproval by Insurance Commissioner (or similar official) of policy, 119 A.L.R. 877.

33-24-10. Grounds for disapproval of forms.

The Commissioner shall disapprove any form filed under Code Section 33-24-9 or withdraw any previous approval of such form only:

(1) If it is in any respect in violation of or does not comply with this title;

(2) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract;

(3) If it has any title, heading, or other indication of its provisions which is misleading;

(4) If it is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible or not easily legible to persons of normal vision;

(5) If it contains provisions which are unfair or inequitable or contrary to the public policy of this state or would, because the provisions are unclear or deceptively worded, encourage misrepresentation; or

(6) If the benefits provided in any medicare supplement insurance policy described in Code Section 33-24-29 are unreasonable in relation to the premium charged.

History. — Code 1933, § 56-2411, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1980, p. 1266, § 3; Ga. L. 2019, p. 386, § 26/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "described" for "defined" in the middle of paragraph (6).

Editor's notes. — Ga. L. 1980, p. 1266, § 5, not codified by the General Assembly, provides that the amendment to paragraph (6) shall be applicable to "any medicare supplement policy delivered or issued for delivery" in Georgia "on or after November 1, 1980."

JUDICIAL DECISIONS

Cited in Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972); Strickland v. Gulf Life Ins. Co., 240 Ga. 723, 242 S.E.2d 148 (1978); Whitehead v. Lumbermen's Mut. Cas. Co., 543 F. Supp. 967 (N.D. Ga. 1982); Universal Scientific, Inc. v. Safeco Ins. Co. of Am., 174 Ga. App. 768, 331 S.E.2d 611 (1985); Penn Am. Ins. Co. v. Miller, 228 Ga. App. 659, 492 S.E.2d 571 (1997).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 19 et seq., 31.

C.J.S. — 44 C.J.S., Insurance, §§ 479, 480.

ALR. — Right of insured or beneficiary to enforce a policy provision more favorable to him than the standard policy; or to have policy reformed so as to include such a provision, 113 A.L.R. 773.

Validity, construction, and effect of approval or disapproval by Insurance Commissioner (or similar official) of policy, 119 A.L.R. 877.

Validity and construction of statutes relating to style or prominence with which provisions must be printed in insurance policy, 36 A.L.R.3d 464.

33-24-10.1. Standard or uniform claim form.

The Commissioner is authorized to establish by rule or regulation a standard or uniform claim form to be supplied by insurers to their insureds for the purpose of filing claims under policies or contracts of accident and sickness insurance. The Commissioner shall file and maintain on file in the office of the Commissioner a true copy of the standard or uniform claim form designated as such and bearing the Commissioner's authenticating signature and the date of filing.

History. — Code 1981, § 33-24-10.1, enacted by Ga. L. 1992, p. 1184, § 1; Ga. L. 2019, p. 386, § 27/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on and after January 1, 1994," following "supplied by insurers" in the middle of the first sentence.

33-24-11. Waiver by Commissioner of use of standard or uniform provisions in policies or contracts; approval of use of substitute provisions.

(a) The Commissioner may waive the required use of a particular provision in a particular insurance policy form or annuity or endowment contract form if the Commissioner finds such provision unnecessary for the protection of the insured or inconsistent with the purposes

of the policy and if the policy is otherwise approved by the Commissioner.

(b) Unless otherwise provided in this title, no policy shall contain any provision inconsistent with or contradictory to any standard provision used or required to be used, but the Commissioner may approve any substitute provision which is not less favorable in any particular to the insured or beneficiary than the standard provisions or optional standard provisions otherwise required.

(c) In lieu of the standard provisions required by this title for contracts for particular kinds of insurance, substantially similar standard provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the Commissioner.

History. — Code 1933, § 56-2412, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 28/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (a), substituted "the Commissioner finds such provision" for "he finds the provision" in the middle, and substituted "the Commissioner" for "him" at the end.

JUDICIAL DECISIONS

Any provisions of policy of insurance, made for insurer's benefit, may be waived either expressly or impliedly by the company's actions. Barnum v. Sentry Ins., 160 Ga. App. 213, 286 S.E.2d 445 (1981).

Insurer estopped from denying liability when agent has actual knowledge of ownership of property. — When a policy of insurance is issued when the agent has full and actual knowledge of the ownership of the property, the insurer waives the insurer's rights under the policy and is estopped to claim an avoidance of responsibility under the contract as written because of noncompliance with the conditions as to ownership which would preclude coverage under the terms of the contract. Barnum v. Sentry Ins., 160 Ga. App. 213, 286 S.E.2d 445 (1981).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 19 et seq., 31.

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

ALR. — Right of insured or beneficiary to enforce a policy provision more favorable to him than the standard policy; or to have policy reformed so as to include such a provision, 113 A.L.R. 773.

Validity of option provisions in life insurance policy which vary from (or add to, or exclude) statutory provisions, 115 A.L.R. 1389.

33-24-12. Noncomplying conditions or provisions; cancellation of contracts covering uninsurable subjects.

(a) Any insurance policy, rider, or endorsement issued and otherwise valid which contains any condition or provision not in compliance with the requirements of this title shall not be rendered invalid due to the noncomplying condition or provision but shall be construed and applied in accordance with such conditions and provisions as would have

applied had the policy, rider, or endorsement been in full compliance with this title.

(b) Any insurance contract delivered or issued for delivery in this state covering a subject or subjects of insurance resident, located or to be performed in this state and which, pursuant to this title, the insurer may not lawfully insure under the contract shall be cancelable at any time by the insurer, any provisions of the contract to the contrary notwithstanding; and the insurer shall promptly cancel the contract in accordance with the Commissioner's request for cancellation. No illegality or cancellation shall be deemed to relieve the insurer of any liability incurred by it under the contract while in force or to prohibit the insurer from retaining the pro rata earned premium on the contract. This Code section shall not relieve the insurer from any penalty otherwise incurred by the insurer under this title on account of any violation.

History. — Code 1933, § 56-2418, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2019, p. 386, § 29/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "after January 1, 1961," following "endorsement issued" near the beginning of subsection (a).

JUDICIAL DECISIONS

Grafting of statutory law into noncomplying policy. — When an insurer issues a policy with provisions not in compliance with the law, the contract will not be rendered void but the provisions of the statute will be grafted into the policy. Flewellen v. Atlanta Cas. Co., 250 Ga. 709, 300 S.E.2d 673 (1983).

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).

Failure to send required notice. — Standard form homeowners insurance policies covered diminished value when loss was not otherwise defined and an endorsement providing that loss did not include diminution in value was ineffective as to renewal policies absent a notice informing policyholders that coverage for diminished value was not renewed. The failure to send the notice was not excusable under O.C.G.A. § 33-24-12 or under case law addressing mere technical violations. Thompson v. State Farm Fire & Cas. Co., 264 F. Supp. 3d 1302 (M.D. Ga. 2017).

Cited in Pearce v. Southern Guar. Ins. Co., 246 Ga. 33, 268 S.E.2d 623 (1980); Penn Am. Ins. Co. v. Miller, 228 Ga. App. 659, 492 S.E.2d 571 (1997); Ga. Farm Bureau Mut. Ins. Co. v. Rockefeller, 343 Ga. App. 36, 805 S.E.2d 660 (2017).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 238 et seq., 259 et seq.

ALR. — What constitutes "other insurance" within meaning of insurance policy

provisions prohibiting insured from obtaining other insurance on same property, 7 A.L.R.4th 494.

33-24-13. Execution of policies; use of facsimile signatures.

Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer. A facsimile signature of any executing individual may be used in lieu of an original signature.

History. — Code 1933, § 56-2416, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 878, § 12.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Civil Code 1895, § 2089, former Civil Code 1910, § 2470, and former Code 1933, § 56-801, repealed by Ga. L. 1960, p. 289, enacting this title, are included in the annotations for this Code section.

Requirement of written signed policy applies to cash or credit policy. — Rule that a policy of insurance shall be in writing and signed by the insurer applies to contracts issued upon a cash basis as well as to those issued upon a credit basis, if such there may be. 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, § 2470).

Execution must be by authorized person. — Writing in the form of a policy of fire insurance will not constitute a valid contract of insurance when the writing is not, at the time the contract therein purports to go into effect, executed by one authorized to execute contracts in behalf of the alleged insurer. Planters & Peoples Mut. Fire Ass'n v. De Loach, 113 Ga. 802, 39 S.E. 466 (1901), later appeal, 122 Ga. 385, 50 S.E. 141 (1905) (decided under former Civil Code 1895, § 2089).

Agent filling blanks need not have written authority. — It is not essential to the validity of a policy that the company's agent, who filled blanks in the policy, should have been clothed with written authority. Smith v. Farmers Mut. Ins. Ass'n, 111 Ga. 737, 36 S.E. 957 (1900) (decided under former Civil Code 1895, § 2089).

Agent may temporarily delegate agent's authority to write policies. — If a local agent of a fire insurance company who is authorized by the principal to procure insurance, write and countersign policies, collect premiums, and deliver the policies to the insured, directs the agent's clerk during the agent's temporary absence to issue policies and sign the name of the agent thereto and collect premiums, and the clerk follows such direction, the writing of the policy and signing of the name of the agent thereto under these circumstances will be deemed the act of the agent and binding upon the company. Atlas Assurance Co. v. Kettles, 144 Ga. 306, 87 S.E. 1 (1915) (decided under former Civil Code 1910, § 2470).

Insurer cannot complain agent writing policies also represented insureds. — If an insurance company, knowing or from the surrounding circumstances being reasonably aware that the company's local agent is acting or assuming to act for the customers of the agency in applying for policies of insurance in the customers' names on the customers' property, and without depending on the skill, advice, or loyalty of the agent in the transaction, but acting upon its own judgment as to the desirability of the particular risks, authorizes the agent to write the policies, the company will not be allowed to complain that such local agent was also

the agent of the opposite parties to the contracts, but the company will be held bound on the policies so written. Todd v. German-American Ins. Co., 2 Ga. App. 789, 59 S.E. 94 (1907) (decided under former Civil Code 1895, § 2089).

Acceptance of premium held not to estop insurer from defense execution not authorized. — Mere acceptance by the person described in a writing in the form of a policy of fire insurance as the insurer of a sum of money as an assessment or premium will neither have the effect of rendering valid the unexecuted writing, nor of estopping the alleged insurer from making the defense that the writing was not executed by anyone authorized to act in the insurer's behalf, when it appears that the assessment or premium was accepted in ignorance of the fact that the writing was not executed by one authorized at the time of the writing's delivery to act in behalf of the insurer, and that upon the discovery of this fact the insurer promptly repudiated the act of the person who had delivered the writing and returned to the person claiming to be insured all the money which the insurer or the insurer's authorized agent had received from the alleged insured. Planters & Peoples Mut. Fire Ass'n v. De Loach, 113 Ga. 802, 39 S.E. 466 (1901), later appeal, 122 Ga. 385, 50 S.E. 141 (1905) (decided under former Civil Code 1895, § 2089).

Place for signature. — Usual and proper place for the signature is at the end of the matter which the signature attests. But, in strict law, it will suffice if, with the intent to constitute a signing, the signature is inserted in the writing at another place. Delaware Ins. Co. v. Pennsylvania Fire Ins. Co., 126 Ga. 380, 55 S.E. 330, 7 Ann. Cas. 1134 (1906), later appeal, 130 Ga. 643, 61 S.E. 492 (1908) (decided under former Civil Code 1895, § 2089).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 225 et seq.

C.J.S. — 44 C.J.S., Insurance, § 482.

33-24-14. (See Editor's notes.) Delivery of policies; applicability of Uniform Electronic Transactions Act; additional mailings.

(a)(1) Subject to the insurer's requirement as to payment of premiums, every policy shall be mailed or delivered to the insured or to the person entitled to the policy within a reasonable period of time after its issuance except where a condition required by the insurer has not been met by the insured.

(2) A policy required to be delivered under this subsection may be delivered by electronic transmittal in accordance with Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," or by electronic posting if that policy is posted electronically, provided that:

(A) The insured has agreed to accept delivery by electronic posting;

(B) The insurer makes the policy accessible as long as the policy is in force;

(C) After the expiration of the policy, the insurer archives its expired policies for a period of five years and makes them available upon request;

(D) The insurer provides the following information in or simultaneously with each declarations page provided at the time of issuance of the initial policy and any renewals of that policy:

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

(ii) A method by which the insured may obtain, upon request and without charge, a paper copy of such insured's policy; and

(iii) The Internet address where the insured's policy and endorsement are posted; and

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

(b) In the event the original policy is delivered or is required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle or aircraft, in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to the vehicle or aircraft is insured, a duplicate of the policy setting forth the name and address of the insurer, the insurance classification of the vehicle or aircraft, the type of coverage, the limits of liability, the premiums for the respective coverages, and the duration of the policy or memorandum of the policy containing the same information shall be delivered by the vendor, mortgagee, or pledgee to each vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of the duplicate policy or memorandum.

(c) The provisions of Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," apply to this title, and nothing in this Code section shall be construed to limit its applicability.

(d) In addition to any mailing which may be legally accomplished pursuant to Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," any other required mailing may be performed electronically if the following conditions are met:

(1) The Code section which requires a mailing specifically notes that mailing may be accomplished pursuant to this subsection;

(2) The insured agrees to receive mailings electronically by signing a statement which reads:

"I AGREE TO RECEIVE ALL MAILINGS AND COMMUNICATIONS ELECTRONICALLY. SUCH ELECTRONIC MAILING OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES";

provided, however, that the Commissioner may approve the use of substantially similar language;

(3) If the statement in paragraph (2) of this subsection is physically signed by the insured, then the statement must be in a separate document and written in all capital letters in at least 12 point font, or on a substantially similar form approved by the Commissioner. If the statement is signed electronically, then it must be signed according to a procedure which has been approved by the Commissioner; provided, however, that the Commissioner shall approve a procedure for obtaining a signature only if that procedure is designed to ensure that the statement is not presented in a misleading or confusing manner;

(4) If the insurer becomes aware that the insured's email address at which such party has consented to receive notices or documents is no longer valid, the insurer shall send the notice or document as required by other applicable law;

(5) The insurer must retain a record pursuant to Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," of the mailing, including proof of the date of mailing and the address to which the mailing was sent. Such record must be retrievable for a period of five years after the date of such mailing and, if requested, must be transmitted to the Commissioner in a reasonable time;

(6) The insured may withdraw his or her consent to receive mailings electronically;

(7) All conditions have been met under Chapter 12 of Title 10, the "Uniform Electronic Transactions Act," so that the mailing could be accomplished electronically, unless the law requiring the mailing imposes a specific type of delivery method;

(8) All conditions have been met under the federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001, et seq. This Code section shall not modify, limit, or supersede Section 101(c) of such Act or authorize electronic delivery of any of the notices described in Section 103(b) of such Act; and

(9) No insurance company shall cancel, refuse to issue, or refuse to renew any policy because the applicant or insured refuses to agree to receive mailings electronically pursuant to this subsection.

History. — Code 1933, § 56-2421, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2014, p. 829, § 4/HB 645; Ga. L. 2017, p. 774, § 33/HB 323; 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 "e-mail" in paragraph (d)(4).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2014, "apply" was substituted for "applies" in subsection (c).

Editor's notes. — For application of this statute in 2020, see Executive Orders 06.11.20.01, 06.29.20.02, 07.15.20.01, 07.31.20.02, 08.15.20.01, and 08.31.20.02.

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

JUDICIAL DECISIONS

In light of the similarity of the statutory provisions, decisions under former Civil Code 1910, § 2470, and former Code 1933, § 56-801, repealed by Ga. L. 1960, p. 289, enacting this title, are included in the annotations for this Code section.

Delivery in reasonable time is included in every insurance contract. — Every contract for insurance includes, in addition to the requirements of reasonable risk imposed by the insurer prior to issuance of the contract, payment of the requisite premium by the insured, and issuance of the policy by the insurer, the additional act of delivery of the policy of insurance to the insured or other person entitled thereto within a reasonable period of time. Matthews v. National Life & Accident Ins. Co., 141 Ga. App. 368, 233 S.E.2d 442 (1977).

Receipt by agent to deliver is delivery to insured. — Receipt by an agent from the agent's insurance company of a policy to be unconditionally delivered by the agent to the applicant is, in law, tantamount to a delivery to the insured, although the agent never parts with possession of the policy, and although the policy's delivery to the applicant is by contract made essential to the policy's validity. Southern Life Ins. Co. v. Kempton, 56 Ga. 339 (1876) (decided under former law); Fireman's Fund Ins. Co. v. Pekor, 106 Ga. 1, 31 S.E. 779 (1898) (decided under former law); Metropolitan Life Ins. Co. v. Thompson, 20 Ga. App. 706, 93 S.E. 299 (1917) (decided under former Civil Code 1910, § 2470).

Manual delivery of the policy is not necessary when the policy had been issued by the company and simply retained by the agent for the agent's individual protection until reimbursed by the insured. Metropolitan Life Ins. Co. v. Thompson, 20 Ga. App. 706, 93 S.E. 299 (1917), later appeal, 23 Ga. App. 421, 98 S.E. 399 (1919), later appeal, 25 Ga. App. 125, 103 S.E. 424 (1920) (decided under former Civil Code 1910, § 2470).

Delivery is not necessary to make contract effective. — While a policy of insurance is required to be in writing, delivery is not necessary if, in other respects the contract is consummated. Home Ins. Co. v. Head, 35 Ga. App. 143, 132 S.E. 238 (1926), later appeal, 36 Ga. App. 379, 138 S.E. 275 (1927) (decided under former Civil Code 1910, § 2470); South Ga. Farmers Fire Ins. Ass'n v. Smith, 46 Ga. App. 12, 166 S.E. 423 (1932) (decided under former Civil Code 1910, § 2470).

If consideration paid, although risk has been increased. — When the contract of insurance has been agreed upon by the insurance company and insured has paid the consideration therefor, it is a good contract, a valid policy, whether the policy was delivered to the insured or was still in the hands of the agent. The insured is entitled to the policy and the agent had no right in law to withhold it. The knowledge of the agent that the insured had violated one of the conditions of the policy by increasing the risk of the company would not authorize the agent to refuse to deliver the policy upon the insured's demand. Massachusetts Mut. Life Ins. Co. v. Boswell, 20 Ga. App. 446, 93 S.E. 95 (1917) (decided under former Civil Code 1910, § 2470).

Unless policy requires delivery. — When an insurance company has accepted an application for insurance and has is-

sued the policy, actual delivery is not essential to the consummation of a contract of insurance, unless expressly provided for in the application or the policy. When both the application and the policy are silent as respects actual delivery of the policy being essential to a consummation of the contract, the contract becomes consummated upon the retention by the company of the notes and the issuance of the policy and mailing the policy to the company's local agent for delivery to the applicant. Tarver v. Swann, 36 Ga. App. 461, 137 S.E. 126 (1927) (decided under former Civil Code 1910, § 2470).

Parol agreement requiring actual delivery for consummation held ineffective. — When an application for insurance, which, upon the consummation of the contract of insurance, became a part of the contract, provided that the company should "not be bound by any act done or statement made by or to any agent, or other person, which is not contained in this application," an agreement not contained in the application or the policy, made between the applicant and the local agent, when the application and notes were signed, to the effect that the contract of insurance would not be consummated until actual delivery of the policy to the applicant, and that upon failure to make such actual delivery the applicant would not be bound upon the notes, did not become part of the contract. Tarver v. Swann, 36 Ga. App. 461, 137 S.E. 126 (1927) (decided under former Civil Code 1910, § 2470).

Insurance contracts are considered made at the contract's place of delivery. Canal Ins. Co. v. Aldrich, 489 F. Supp. 157 (S.D. Ga. 1980).

Burden of proving custom as to consummating renewals. — When a contract of insurance is not delivered, an agent whose duty it is to keep the property of the agent's principal insured is under obligation to see that, in other respects, the contract is consummated, and on being sued for a breach of duty, the burden of proving that it was in fact consummated is on the agent. If one seeks to show this by evidence of a local custom whereby it was the practice of insurance companies to renew any policy about to expire by sending out a new policy shortly before the expiration of the former one and presenting a bill for the premium within a month or two after such expiration, the burden is on the agent to establish that this custom was complied with in the particular instance. Thomas v. Funkhouser, 91 Ga. 478, 18 S.E. 312 (1893) (decided under former Code 1882, § 2794).

When the insured had prior knowledge, the insurance company could rely on an exclusion contained in the policy, even though the policy was not delivered until after the loss occurred. Williams v. Fallaize Ins. Agency, Inc., 220 Ga. App. 411, 469 S.E.2d 752 (1996).

Motorist's parent's deletion of the motorist's vehicle from the parent's insurance policy was properly relied on by an insurer in the insurer's denial of coverage of a driver, arising from a motor vehicle collision with the motorist, although the insurer failed to prove that the insurer provided the parent with a written copy of the endorsement within a reasonable period of time of the issuance thereof, as required by O.C.G.A. § 33-24-14, as the parent had notice of the endorsement because the motorist made the request to change the policy coverage; the decrease in premium was consideration for deletion of the coverage. Danforth v. Gov't Emples. Ins. Co., 282 Ga. App. 421, 638 S.E.2d 852 (2006), cert. denied, No. S07C0473, 2007 Ga. LEXIS 143 (Ga. 2007).

Cited in Broome v. Mutual of Omaha Ins. Co., 119 Ga. App. 443, 167 S.E.2d 607 (1969).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 227 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 497, 498.

ALR. — Date from which life insurance premium periods are to be computed, 32 A.L.R. 1253; 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

What amounts to a "delivery" or an "actual delivery" to insured within express

provision of insurance policy, 53 A.L.R. 492; 145 A.L.R. 1434.

Right of insurer to show that delivery of policy was conditional, 95 A.L.R. 472.

Constructive delivery of policy ready for delivery to insured upon compliance with certain conditions which he agreed to perform but had not performed prior to the loss, 123 A.L.R. 907.

Rights and remedies arising out of delay in passing upon application for insurance, 32 A.L.R.2d 487.

Transmission of insurance policy to insurance agent as satisfying provision requiring delivery to insured, 19 A.L.R.3d 953.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms, 78 A.L.R.4th 9.

33-24-15. When policies or contracts become effective.

A policy of insurance or an annuity or endowment contract shall run from midday of the date of the policy or contract; and the time shall be calculated accordingly if the policy or contract is to be in force for a specified period of time unless the hour and minute of attachment of liability is specified.

History. — Orig. Code 1863, § 2773; Code 1868, § 2781; Code 1873, § 2823; Code 1882, § 2823; Civil Code 1895, § 2119; Civil Code 1910, § 2501; Code 1933, § 56-910; Code 1933, § 56-2429, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Section is inapplicable if contract fixes time. — This section is not applicable when the parties to the contract make provision as to the time of the commencement of the risk. Metropolitan Life Ins. Co. v. Thompson, 20 Ga. App. 706, 93 S.E. 299 (1917), later appeal, 23 Ga. App. 421, 98 S.E. 399 (1919), 25 Ga. App. 125, 103 S.E. 424 (1920).

Section is part of policy if contract is silent. — If no time for the commencement of the risk is fixed in the contract of insurance, the provisions of this section are to be read into the policy as a term thereof, and the policy runs from midday of the date thereof. Metropolitan Life Ins. Co. v. Thompson, 20 Ga. App. 706, 93 S.E. 299 (1917), later appeal, 23 Ga. App. 421, 98 S.E. 399 (1919), 25 Ga. App. 125, 103 S.E. 424 (1920) (decided under former Civil Code 1910, § 2501); Pilgrim Health & Life Ins. Co. v. Milledge, 107 Ga. App. 77, 129 S.E.2d 80 (1962).

Policy cannot be basis for action on loss before policy's date. — Policy of life insurance bearing a given date, and purporting to insure for the future only, cannot be made the basis of an action to recover for a loss occurring on a prior date. Pilgrim Health & Life Ins. Co. v. Milledge, 107 Ga. App. 77, 129 S.E.2d 80 (1962).

Equitable power is needed to reform date. — Policy of insurance bearing a given date, and purporting to insure for the future only, cannot be made the basis of an action to recover for a loss occurring upon a prior date; and if for any reason such policy is subject to reformation as to date, the policy can be reformed only in a court having the power to grant affirmative equitable relief in such matters. Fowler v. Preferred Accident Ins. Co., 100 Ga. 330, 28 S.E. 398 (1897).

Cited in Sorrow v. Southland Ins. Co., 112 Ga. App. 446, 145 S.E.2d 608 (1965); Robertson v. Southland Life Ins. Co., 130 Ga. App. 807, 204 S.E.2d 505 (1974).

RESEARCH REFERENCES

ALR. — Date from which life insurance premium periods are to be computed, 32 A.L.R. 1253; 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

Death of insured or other loss pending application not effectively granted, for reinstatement of life or accident insurance, after lapse, 105 A.L.R. 478; 164 A.L.R. 1057.

Due date of premium or date of expiration of grace period as commencement of period of extended insurance, 106 A.L.R. 1276.

Antedating policy of insurance as affecting liability for loss that had already occurred, 132 A.L.R. 1325.

Inclusion or exclusion of first or last day in computing period of time prescribed by insurance contract, 137 A.L.R. 1155.

Temporary life, accident, or health insurance pending approval of application or issuance of policy, 2 A.L.R.2d 943.

Stipulated period of time coverage of insurance policy as affected by countersigning subsequent to specified commencement date, 22 A.L.R.2d 984.

Rights and remedies arising out of delay in passing upon application for insurance, 32 A.L.R.2d 487.

Computation of time with respect to fractions of days, in determining duration and termination of risk under accident, health, or hospital policy, 38 A.L.R.2d 768.

Effective date of life, health or accident insurance policy, as between premium date stated in policy and later date either of approval, acceptance, or delivery of policy, or of payment of premium, 44 A.L.R.2d 472; 37 A.L.R.3d 933.

Calculation of newborn child's age for purposes of life insurance policy requiring that specified age be reached before coverage begins, 37 A.L.R.3d 1448.

Event triggering liability insurance coverage as occurring within period of time covered by liability insurance policy where injury or damage is delayed — Modern cases, 14 A.L.R.5th 695.

33-24-16. Construction of policies.

Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application made a part of the policy.

History. — Orig. Code 1863, § 2748; Code 1868, § 2756; Code 1873, § 2798; Code 1882, § 2798; Civil Code 1895, § 2093; Civil Code 1910, § 2475; Code 1933, § 56-815; Code 1933, § 56-2419, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For annual survey article on evidence law, see 52 Mercer L. Rev. 303 (2000).

For note, "Conflicts of Interest in the Liability Insurance Setting," 13 Ga. L. Rev. 973 (1979).

For comment on Maddox v. Life & Cas. Ins. Co., 79 Ga. App. 164, 53 S.E.2d 235 (1949), see 12 Ga. B.J. 83 (1949). For comment on Aetna Life Ins. Co. v. Sanders, 127 Ga. App. 352, 193 S.E.2d 173 (1972), see 24 Mercer L. Rev. 967 (1973).

JUDICIAL DECISIONS

Analysis

General Considerations
Construction of Words or Phrases
Construction in Favor of Insured

General Considerations

Contract of insurance should be construed to carry out the true intention of the parties; every other rule of construction of contracts, including insurance contracts, is subservient to this one. Penn Mut. Life Ins. Co. v. Marshall, 49 Ga. App. 287, 175 S.E. 412 (1934); Public Indem. Co. v. Yearwood, 50 Ga. App. 646, 179 S.E. 232 (1935); Golden v. National Life & Accident Ins. Co., 189 Ga. 79, 5 S.E.2d 198 (1939); National Life & Accident Ins. Co. v. Wilson, 106 Ga. App. 504, 127 S.E.2d 306 (1962); Andrews v. Georgia Mut. Ins. Co., 110 Ga. App. 92, 137 S.E.2d 746 (1964); Imperial Enters., Inc. v. Fireman's Fund Ins. Co., 535 F.2d 287 (5th Cir. 1976); National Hills Shopping Ctr., Inc. v. Liberty Mut. Ins. Co., 551 F.2d 655 (5th Cir. 1977).

Supreme Court has no power to alter provisions of insurance contract or to declare a liability under a state of facts which the parties never agreed should fix it. Golden v. National Life & Accident Ins. Co., 189 Ga. 79, 5 S.E.2d 198 (1939).

When the terms and conditions of an insurance policy are unambiguous, the court must declare the contract as made by the parties. Genone v. Citizens Ins. Co., 207 Ga. 83, 60 S.E.2d 125 (1950).

Contract of insurance should be construed so as to carry out the true intention of the parties. Macon-Bibb County Hosp. Auth. v. Continental Ins. Co., 196 Ga. App. 399, 396 S.E.2d 50 (1990).

Omitted form paragraphs serve to explain intent of parties. — Omitted form paragraphs are parts of a written document and serve to explain the intent of the parties, just as typewritten or handwritten statements serve to clarify or to change the sense of printed paragraphs. Ranger Ins. Co. v. Culberson, 454 F.2d 857 (5th Cir. 1971), cert. denied, 407 U.S. 916, 92 S. Ct. 2440, 32 L. Ed. 2d 691 (1972).

Contract law controls over parties' motives. — Insurance is a matter of contract and it is contract law rather than the underlying motives of the contracting parties that is ultimately controlling. National Sec. Fire & Cas. Co. v. London, 180 Ga. App. 198, 348 S.E.2d 580 (1986).

Insurance contracts governed by same rules of construction as other contracts. — Insurance contracts are governed by the same rules of construction or interpretation for the purpose of ascertaining the intention of the parties as apply to other contracts. Genone v. Citizens Ins. Co., 207 Ga. 83, 60 S.E.2d 125 (1950); Kytle v. Georgia Farm Bureau Mut. Ins. Co., 128 Ga. App. 109, 195 S.E.2d 787 (1973).

Insurance policy is a contract and has the same attributes and requirements as any other contract. Grange Mut. Cas. Co. v. King, 174 Ga. App. 716, 331 S.E.2d 41 (1985).

Construction of insurance contract is, like any contract, ordinarily a matter for the court. Fidelity Bankers Life Ins. Co. v. Renew, 121 Ga. App. 883, 176 S.E.2d 103 (1970).

Contract of insurance as a whole must be looked to in arriving at the construction of any part. Cotton States Mut. Ins. Co. v. Hutto, 115 Ga. App. 164, 154 S.E.2d 375 (1967).

Court must interpret an insurance policy in the policy's entirety, including any amplification, extension, or modification by a rider or endorsement. B.L. Ivey Constr. Co. v. Pilot Fire & Cas. Co., 295 F. Supp. 840 (N.D. Ga. 1968).

Contract must be viewed as a whole and in light of usual rules of construction of contracts generally. National Hills Shopping Ctr., Inc. v. Liberty Mut. Ins. Co., 551 F.2d 655 (5th Cir. 1977).

Court cannot construe policy so as to create or avoid liability. — It is the function of the court to construe a contract of insurance as the contract is written, and the court by construction cannot create a liability not assumed by the insurer, nor make a new contract for the parties, nor one different from that plainly intended, nor add words to the contract either to create or avoid liability. Pilot Life Ins. Co. v. Morgan, 94 Ga. App. 394, 94 S.E.2d 765 (1956).

When parties to a business transaction mutually agree that insurance will be provided as a part of the bargain, such agreement must be construed as providing mutual exculpation to the bargaining parties who must be deemed to have

agreed to look solely to the insurance in the event of loss and not to liability on the part of the opposing party. Turner v. Clark & Clark, 158 Ga. App. 79, 279 S.E.2d 323 (1981).

When there is a conflict between endorsement and policy, terms of endorsement must apply, for it is a general principle of wide application in Georgia that when an endorsement or rider and a policy conflict, the former controls the latter, since it is a later expression of intent. B.L. Ivey Constr. Co. v. Pilot Fire & Cas. Co., 295 F. Supp. 840 (N.D. Ga. 1968).

Policy as including endorsement. — Standard form homeowners insurance policies covered diminished value when loss was not otherwise defined and an endorsement providing that loss did not include diminution in value was ineffective as to renewal policies absent a notice informing policyholders that coverage for diminished value was not renewed. Consistent with O.C.G.A. § 33-24-16, the endorsement was a part of the policy. Thompson v. State Farm Fire & Cas. Co., 264 F. Supp. 3d 1302 (M.D. Ga. 2017).

Court's role in interpreting pollution policy exclusion. — In an action brought by a lessor against a former lessee, a dry cleaning corporation, for indemnification for remediation expenses incurred in cleaning up the contaminated shopping center property vacated by the lessee, the trial court properly refused to examine a Pollution Liability Exclusion Endorsement in a vacuum and, rather, considered that language in concert with other policy language addressing coverage of property damage arising out of the discharge of pollutants and thereby found that an umbrella policy provided coverage for quick, abrupt, and accidental discharges of pollutants. The trial court properly determined that the inconsistent language of the Pollution Liability Exclusion and an Amendatory Endorsement were ambiguous as the Amendatory Endorsement narrowed the scope of Pollution Liability Exclusion by exempting from it discharges that were quick, abrupt, and accidental; but the Pollution Liability Exclusion Endorsement broadened the scope of Exclusion by extending the exclusion to any discharge. State Farm Fire & Cas. Co. v. Walnut Ave. Partners, LLC, 296 Ga. App. 648, 675 S.E.2d 534 (2009).

Application for insurance becomes part of insurance contract itself when the application is attached to the policy of insurance. West v. Rudd, 242 Ga. 393, 249 S.E.2d 76 (1978).

When an application for insurance is attached to or made part of an insurance contract by reference, the contract must be construed according to the terms contained therein as amplified, extended, or modified by the application. West v. Rudd, 242 Ga. 393, 249 S.E.2d 76 (1978).

Beneficiary named in application controls over omission of any beneficiary in policy. — When an application for a policy of life insurance designates a named person as the beneficiary of the policy, and a policy is issued which does not contain the name of any beneficiary, the person named in the application is to be treated as the beneficiary of the contract. West v. Rudd, 242 Ga. 393, 249 S.E.2d 76 (1978).

"Duplicate" insurance policy rendered the original contract of insurance void, and evidence showed that it was the intent of both parties to include the same table of guaranteed values found in the original policy within the terms of the "new" policy. Brannen v. Gulf Life Ins. Co., 201 Ga. App. 241, 410 S.E.2d 763 (1991).

Cited in Liberty Mut. Ins. Co. v. Mead Corp., 219 Ga. 6, 131 S.E.2d 534 (1963); Wells v. Metropolitan Life Ins. Co., 107 Ga. App. 826, 131 S.E.2d 634 (1963); Hartford Accident & Indem. Co. v. Hulsey, 220 Ga. 240, 138 S.E.2d 310 (1964); Travelers Indem. Co. v. Watson, 111 Ga. App. 98, 140 S.E.2d 505 (1965); Grigsby v. Houston Fire & Cas. Ins. Co., 113 Ga. App. 572, 148 S.E.2d 925 (1966); Morris v. Insurance Co. of N. Am., 114 Ga. App. 517, 151 S.E.2d 813 (1966); Aetna Life Ins. Co. v. Sanders, 127 Ga. App. 352, 193 S.E.2d 173 (1972); Hawkins Iron & Metal Co. v. Continental Ins. Co., 128 Ga. App. 462, 196 S.E.2d 903 (1973); Blue Cross of Georgia/Atlanta, Inc. v. Grenwald, 148 Ga. App. 486, 251 S.E.2d 585 (1978); Dunham v. Grange Mut. Cas. Co., 176 Ga. App. 263, 335 S.E.2d 666 (1985); S & T Timber, Inc. v. Southern Gen. Ins. Co., 198 Ga. App. 18, 400 S.E.2d

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379 (1990); McMillon v. Empire Fire & Marine Ins. Co., 209 Ga. App. 378, 433 S.E.2d 429 (1993); Canal Indem. Co. v. E.M.C. Motors, Inc., 227 Ga. App. 84, 488 S.E.2d 126 (1997); Cotton States Mut. Ins. Co. v. Coleman, 242 Ga. App. 531, 530 S.E.2d 229 (2000); Gentry Mach. Works, Inc. v. Harleysville Mut. Ins. Co., 621 F. Supp. 2d 1288 (M.D. Ga. 2008).

Construction of Words or Phrases

Words used in insurance policies, as in all other contracts, bear their usual and common significance, and their ordinary meaning. Pilot Life Ins. Co. v. Morgan, 94 Ga. App. 394, 94 S.E.2d 765 (1956) (decided under former Code 1933, § 56-815); National Life & Accident Ins. Co. v. Wilson, 106 Ga. App. 504, 127 S.E.2d 306 (1962) (decided under former Code 1933, § 56-815); Kytle v. Georgia Farm Bureau Mut. Ins. Co., 128 Ga. App. 109, 195 S.E.2d 787 (1973).

Language of insurance contract should be construed in the contract's entirety, should receive a reasonable construction, and should not be extended beyond what is fairly within the contract's terms; when the language is unambiguous and but one reasonable construction of the contract is possible, the court must expound it as made. New York Life Ins. Co. v. Thompson, 45 Ga. App. 638, 165 S.E. 847 (1932), aff'd, 177 Ga. 898, 172 S.E. 3 (1933); Penn Mut. Life Ins. Co. v. Marshall, 49 Ga. App. 287, 175 S.E. 412 (1934); Daniel v. Jefferson Std. Life Ins. Co., 52 Ga. App. 620, 184 S.E. 366 (1936); Genone v. Citizens Ins. Co., 207 Ga. 83, 60 S.E.2d 125 (1950); Gill v. Federal Life & Cas. Co., 86 Ga. App. 455, 71 S.E.2d 683 (1952); Great Am. Ins. Co. v. Lipe, 116 Ga. App. 169, 156 S.E.2d 490 (1967); Ranger Ins. Co. v. Columbus-Muscogee Aviation, Inc., 130 Ga. App. 742, 204 S.E.2d 474 (1974); Lester v. Great Cent. Ins. Co., 138 Ga. App. 353, 226 S.E.2d 149 (1976).

"The insured" defined. — Meaning of "the insured" as such term is used in the employee exclusion provision of an insurance policy, see Ryder Truck Rental, Inc. v. St. Paul Fire & Marine Ins. Co., 540 F. Supp. 66 (N.D. Ga. 1982).

"Relative" defined. — When the insured and the insured's spouse had a child living when the spouse died, the relationship created by affinity in marriage between the insured and the insured's spouse's sibling survived the spouse's death; thus, the sibling, who resided in the insured's home, remained a "relative" of the insured for purposes of the insured's auto insurance contract. Rutledge v. Auto-Owners Ins. Co., 249 Ga. App. 361, 548 S.E.2d 86 (2001).

"Business auto policy" may be, in effect, "personal" policy. — By including an endorsement in a "business auto" policy issued to an "individual" business which provides that, if the named insured is an individual, the words "named insured" include the named insured's spouse if a resident of the same household, the intent is to make what would otherwise be a "business auto policy" issued to an "individual" business in effect a "personal" policy for at least some coverages afforded thereunder. Purcell v. Allstate Ins. Co., 168 Ga. App. 863, 310 S.E.2d 530 (1983).

Words in business liability policy to be given ordinary meaning. — Under a business liability policy, the parties are presumed to have in contemplation the nature and character of the business, and to have foreseen the usual course and manner of conducting the business; thus, in construing a policy of insurance so as to arrive at the true intention of the parties, the ordinary legal and literal meaning of the words must be given effect when it is possible to do so without destroying the substantial purpose and effect of the contract. Travelers Indem. Co. v. Nix, 644 F.2d 1130 (5th Cir. 1981).

Bad faith not found. — 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).

Construction in Favor of Insured

Policies generally to be construed in favor of insured. — While a contract of insurance should be construed so as to carry out the true intention of the parties, policies of insurance will be liberally construed in favor of the object to be accomplished, and provisions therein will be strictly construed against the insurer; and if a policy or contract of insurance is fairly susceptible of more than one construction, the interpretation most favorable to the insured will be given effect. Metropolitan Life Ins. Co. v. Evans, 54 Ga. App. 830, 189 S.E. 369 (1936); McLendon v. Carolina Life Ins. Co., 71 Ga. App. 557, 31 S.E.2d 429 (1944); Hulsey v. Interstate Life & Accident Ins. Co., 207 Ga. 167, 60 S.E.2d 353 (1950); Gill v. Federal Life & Cas. Co., 86 Ga. App. 455, 71 S.E.2d 683 (1952); North British & Mercantile Ins. Co. v. Mercer, 211 Ga. 161, 84 S.E.2d 570 (1954); Pilot Life Ins. Co. v. Morgan, 94 Ga. App. 394, 94 S.E.2d 765 (1956); Hartford Accident & Indem. Co. v. Hulsey, 109 Ga. App. 169, 135 S.E.2d 494, rev'd on other grounds, 220 Ga. 240, 138 S.E.2d 692 (1964); Float-Away Door Co. v. Continental Cas. Co., 372 F.2d 701 (5th Cir. 1966), cert. denied, 389 U.S. 823, 88 S. Ct. 58, 19 L. Ed. 2d 76 (1967); Ranger Ins. Co. v. Columbus-Muscogee Aviation, Inc., 130 Ga. App. 742, 204 S.E.2d 474 (1974); Allstate Ins. Co. v. Harris, 133 Ga. App. 567, 211 S.E.2d 783 (1974); Lester v. Great Cent. Ins. Co., 138 Ga. App. 353, 226 S.E.2d 149 (1976); Cincinnati Ins. Co. v. Gwinnett Furn. Mart, Inc., 138 Ga. App. 444, 226 S.E.2d 283 (1976).

It is a cardinal principle of insurance law that a policy or contract of insurance is to be construed liberally in favor of the insured and strictly as against the insurer since the policies are prepared by the company's experts and legal advisers acting in the interest of the company, and the insured has no voice in the selection and arrangement of the words employed. Kytle v. Georgia Farm Bureau Mut. Ins. Co., 128 Ga. App. 109, 195 S.E.2d 787 (1973).

When the language of the insurance policy is ambiguous, the policy must be construed most strongly against the insurer and in favor of the insured, the policy having been issued for the purpose intended. Hutsell v. U.S. Life Title Ins. Co., 157 Ga. App. 845, 278 S.E.2d 730 (1981).

Insurer is presumed to have intended that the clause most favorable to the insured be effective or else the insurer would not have inserted the clause in the policy the insurer issued, and the insured is presumed to have chosen and intended to accept that which is most favorable to the insured; there being a conflict in the policy as written and amended or endorsed, an issue of material fact remains for determination as to the coverage and as to the intentions of the parties with reference to the contract of insurance. Hutsell v. U.S. Life Title Ins. Co., 157 Ga. App. 845, 278 S.E.2d 730 (1981).

Construction in favor of insured must not be unreasonable or strained. — Since insurance policies are contracts of adhesion penned by the insurer, when ambiguity is present, construction of the policy is in favor of the insured, although the construction must not be unreasonable or strained. Imperial Enters., Inc. v. Fireman's Fund Ins. Co., 535 F.2d 287 (5th Cir. 1976).

While an ambiguous insurance contract will be liberally construed in favor of the insured, one which, when construed reasonably and in the contract's entirety, unambiguously and lawfully limits the insurer's liability cannot be expanded beyond what is fairly within the contract's plain terms. City of Albany v. Hartford Accident & Indem. Co., 141 Ga. App. 594, 234 S.E.2d 109 (1977); National Hills Shopping Ctr., Inc. v. Liberty Mut. Ins. Co., 551 F.2d 655 (5th Cir. 1977).

Insurance policies are construed so as to avoid forfeitures. Imperial Enters., Inc. v. Fireman's Fund Ins. Co., 535 F.2d 287 (5th Cir. 1976).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 540 et seq., 559 et seq.

C.J.S. — 45 C.J.S., Insurance, § 583.

ALR. — Pro rata provisions of insurance policy as affected by insolvency or receivership of other insurer or invalidity of other policy, 56 A.L.R. 472.

Constitutionality of compulsory arbitration or appraisal provision of standard policy, 77 A.L.R. 619.

When one deemed to have attained or passed age specified in insurance policy, 84 A.L.R. 389.

Custom or practice as regards duration of insurance risk as supplying omission in written policy in that regard, 85 A.L.R. 1334.

Election or request contemplated by policy as condition of right, option, or benefit extended thereby as predicable upon language or content of the application, 108 A.L.R. 882.

Election of option under insurance policy where person otherwise entitled to make it is dead, incompetent, or an infant, 112 A.L.R. 1063; 127 A.L.R. 454; 136 A.L.R. 1045.

Right of insured or beneficiary to enforce a policy provision more favorable to him than the standard policy; or to have policy reformed so as to include such a provision, 113 A.L.R. 773.

Kind of insurance or insurer contemplated by provision in policy of life, health, or accident insurance, or by a question in application therefor, in regard to other or additional insured or prior application therefor, 119 A.L.R. 765.

Right of insurer to reformation of policy or other relief because of its own error, not due to misrepresentation by insured, in computing premiums, indemnity, or other benefits or options under policy, 125 A.L.R. 1058.

Conflict of laws as regards effect of divorce, or other change in the relation of insured and beneficiary, upon rights beneficiary under insurance policy, 125 A.L.R. 1287.

Unsigned riders or slips physically attached to policy, or unsigned endorsements on policy, as part of insurance contract, 128 A.L.R. 1034.

Validity and enforceability of agreement, between insurer and beneficiary of insurance electing to leave proceeds in insurer's hands, as to ultimate disposition of proceeds, 138 A.L.R. 1483.

Mutual rescission, waiver, ratification, or estoppel, as regards insurer's attempt to rescind policy of insurance or particular provisions thereof, 152 A.L.R. 95.

Extension or other subsequent agreement as affected by provision of policy or statute (or qualification thereof) that policy, together with the application if endorsed thereon or attached thereto, shall constitute or shall contain the entire contract, 152 A.L.R. 384.

Full faith and credit provision as affecting insurance contract, 173 A.L.R. 1138.

Fraud or misrepresentation by insured's agent after loss as within provision avoiding policy for fraud or attempted fraud of insured, 24 A.L.R.2d 1220.

Insurer's admission of liability, offers of settlement, negotiations, and the like, as waiver of, or estoppel to assert, contractual limitation provision, 29 A.L.R.2d 636.

Doctrine of estoppel or waiver as available to bring within coverage of insurance policy risks not covered by its terms or expressly excluded therefrom, 1 A.L.R.3d 1139.

Choice of law in construction of insurance policy originally governed by law of one state as affected by modification, renewal, exchange, replacement, or reinstatement in different state, 3 A.L.R.3d 646.

Construction of express insurance policy provision restricting insurer's right to cancel or otherwise terminate coverage, 19 A.L.R.3d 1429.

Notice or proof of loss under one policy as notice or proof of loss under another provision of same policy or another policy issued by same insurer, 29 A.L.R.3d 856.

Who is "employed or engaged in the automobile business" within exclusionary clause of liability policy, 55 A.L.R.4th 261.

Liability insurance: what is "claim" under deductibility-per-claim clause, 60 A.L.R.4th 983.

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.

Who is an "executive officer" of insured within meaning of liability insurance policy, 1 A.L.R.5th 132.

33-24-16.1. Clarification of term "actual charge" or "actual fee".

(a) The term "actual charge" or "actual fee," when used in an individual or group specified disease insurance policy, shall mean the amount actually paid by or on behalf of an insured person and accepted as full payment by a health care provider or other designated person for the goods or services provided.

(b) The General Assembly finds and declares that the provisions of subsection (a) of this Code section are intended to clarify the correct interpretation of the defined terms for instances in which the particular insurance policy does not otherwise contain a definition.

History. — Code 1981, § 33-24-16.1, enacted by Ga. L. 2006, p. 767, § 2/SB 385; Ga. L. 2019, p. 386, § 30/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "current" following "clarify the" in the middle of subsection (b).

33-24-17. Assignment of policies.

A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or accident and sickness policy issued under the terms of which the beneficiary may be changed upon the sole request of the policy owner may be assigned either by pledge or by transfer of title by an assignment executed by the policy owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

History. — Code 1933, § 56-2423, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, § 56-903, are included in the annotations for this Code section.

No-assignment clause should not be applied ritualistically and mechanically to forfeit coverage; rather, the court should consider the voluntariness of the assignment and the increased risk or hazard assumed by the insurer. Imperial Enters., Inc. v. Fireman's Fund Ins. Co., 535 F.2d 287 (5th Cir. 1976).

Nonassignment clause did not prevent assignment that did not change insurer's risk. — Because an insurance broker paid normal premiums on behalf of the insured in anticipation of a refund,

and the insured promised that the refund would be paid directly to the broker despite language in the insurance contracts that refunds would be paid to the insured and despite a non-assignment clause, the insured validly assigned the insured's right to a refund to the broker; the non-assignment clause was permissible under O.C.G.A. § 33-24-17, but the court would not apply the clause to preclude the assignment because the assignment did not increase the insurer's risk. Watson Ins. Agency, Inc. v. Chipman-Union, Inc. (In re Chipman-Union, Inc.), 330 B.R. 851 (Bankr. M.D. Ga. 2005).

Policy of life insurance is chose in action and assignable by insured as security for a debt under former Code 1933, § 85-1803 (see O.C.G.A. § 44-12-22), prior to the insured's death. Baldwin v. Atlanta Joint Stock Land Bank, 189 Ga. 607, 7 S.E.2d 178 (1940) (decided under former Code 1933, § 56-903).

Policy of life insurance is a chose in action and may be assigned by the insured as security for a debt, and generally the effect of such an assignment is to vest legal title to the policy in the assignee to the amount of the debt secured. Parramore v. Williams, 215 Ga. 179, 109 S.E.2d 745 (1959) (decided under former Code 1933, § 56-903).

Effect of insurer's failure to honor assignment. — Assignment for valuable consideration, with notice to the debtor, imposes on the debtor an equitable and moral obligation to pay the assignee. Thus, an insurance company which had notice of an assignment of proceeds, but nevertheless paid all benefits to the insureds rather than the assignee, was liable to the assignee. Santiago v. Safeway Ins. Co., 196 Ga. App. 480, 396 S.E.2d 506, cert. denied, 196 Ga. App. 909, 396 S.E.2d 506 (1990).

Beneficiary divested of interest by assignment of policy subject to payment of debt. — Beneficiary, having only a divestible interest which is not a vested right, is, in effect, divested of this interest by the assignment of an insurance policy subject to payment of a debt. Ruis v. Bank of Albany, 213 Ga. 41, 96 S.E.2d 580 (1957) (decided under former Code 1933, § 56-903).

General rule of assignment with respect to present beneficiary. — When the insured names a third person as beneficiary in a policy of life insurance, the general rule as to the assignment of the policy is that, if the insured reserved the right in the policy to change the beneficiary, the insured may assign the policy without the consent of such beneficiary, but if no such reservation is made, the assignment cannot be legally made unless the consent of the beneficiary is obtained. Baldwin v. Atlanta Joint Stock Land Bank, 189 Ga. 607, 7 S.E.2d 178 (1940) (decided under former Code 1933, § 56-903).

Interest in policy of original beneficiary and insured after absolute assignment. — Assignment of insurance policy "for value received" which recites that the policy "is an absolute assignment," is an absolute assignment as against the original beneficiary, and the insured under such an assignment would have no interest in the policy after assignment. Parramore v. Williams, 215 Ga. 179, 109 S.E.2d 745 (1959) (decided under former Code 1933, § 56-903).

Since the rights of the beneficiary and the rights of the debtor were subjected by the assignment of the insurance policies to the full amount of the debt secured by the assignment of the policies (which debt exceeded the value of the policies), they had no further interest in such policies and no rights to assert as to these policies in receivership proceedings. Parramore v. Williams, 215 Ga. 179, 109 S.E.2d 745 (1959) (decided under former Code 1933, § 56-903).

When an insurer has, by the insurer's own conduct and actions, consistently demonstrated a decision to regard a policy as assigned and to treat one, other than the named insured, as the assignee thereof and has thereby waived the insurer's own requirement, as between the insurer and that party, that the assignment be in writing, the insurer has consented to the assignment and may not avoid the

assignment's obligations thereunder by urging the lack of a formal written assignment between the assignee and assignor. State Farm Fire & Cas. Co. v. Mills Plumbing Co., 152 Ga. App. 531, 263 S.E.2d 270 (1979).

Recognizing assignee's claim of right without looking to underlying transaction. — Insurer was entitled to provide for the insurer's discharge from liability by paying life insurance proceeds to an assignee of policy, notwithstanding claim by executor that the indebtedness secured by the policy was less than the amount of the policy. Pittman v. Maxwell, 175 Ga. App. 138, 332 S.E.2d 683 (1985).

Parent transferring automobile title may still have insurable interest. — Parent may have an insurable interest as to liability coverage for an automobile, notwithstanding the parent's transferring the title to that vehicle to the parent's child, such that a no-assignment clause should not be applied ritualistically and mechanically to forfeit coverage. James v. Pennsylvania Gen. Ins. Co., 167 Ga. App. 427, 306 S.E.2d 422 (1983).

OPINIONS OF THE ATTORNEY GENERAL

Insurance Code does not prohibit assignment of conversion privilege under policy of group life insurance. 1969 Op. Att'y Gen. No. 69-2.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 774 et seq.

C.J.S. — 45 C.J.S., Insurance, § 730.

ALR. — Validity as against creditors of change of beneficiary of insurance policy from estate to individual, 6 A.L.R. 1173; 106 A.L.R. 596.

Insurance: assignment of life or benefit policy for valuable consideration as change of beneficiary, 38 A.L.R. 109.

Rights as between mortgagor and insurance company where policy avoided as to mortgagor, but not as to mortgagee, 52 A.L.R. 278.

Divorce of insured and beneficiary as affecting the latter's right in life insurance, 52 A.L.R. 386; 175 A.L.R. 1220.

Right of life insured to assign policy without beneficiary's consent, 60 A.L.R. 191.

Right of lessor or lessee or his privies to benefit of insurance taken out by other or his privies, 66 A.L.R. 864.

Rights and remedies of beneficiary after death of insured who had pledged policy to secure debt, 71 A.L.R. 1437; 111 A.L.R. 628; 160 A.L.R. 1389.

Assignment of policy insuring life of minor, 95 A.L.R. 205.

Assignment of claim for loss under fire insurance policy as affecting the furnishing of proofs of loss, 101 A.L.R. 1300.

Avoidance on ground of fraud, mistake, duress, or mental incompetency of otherwise validly effected change of beneficiary of insurance policies, 105 A.L.R. 950.

Construction, application, and effect of provision of life insurance policy as to filing of assignment, or duplicate, with insurer, 111 A.L.R. 709.

Assignment by assured of policy of indemnity or liability insurance, or of rights thereunder, 122 A.L.R. 144.

Assignment of policy of life insurance as affecting subsequent attempt to change beneficiary, 125 A.L.R. 1097.

Rights, in respect of proceeds of policy of life insurance, as between beneficiary and one to whom policy has been assigned otherwise than as collateral, 138 A.L.R. 1357.

National Service Life Insurance Act, 153 A.L.R. 1413; 155 A.L.R. 1445; 156 A.L.R. 1445; 157 A.L.R. 1445; 158 A.L.R. 1445.

Duty of insurer to investigate mental competency of insured to assign policy, or to designate or change designation of beneficiary, or as to fraud or undue influence in that regard, 162 A.L.R. 547.

Change of beneficiary in old line insurance policy as affected by failure to comply with requirements as to manner of making change, 19 A.L.R.2d 5.

Validity of assignment of life insurance policy to one who has no insurable interest in insured, 30 A.L.R.2d 1310.

Transfer or pledge of fire insurance policy as collateral security for debt as within policy provisions prohibiting or restricting assignment of policy, 31 A.L.R.2d 1199.

Testamentary nature of life insurance trust, 53 A.L.R.2d 1112.

Right of one who pays medical or similar expenses of injured person under life care, or similar, contract to recover the cost thereof from tortfeasor, 78 A.L.R.2d 822.

Law governing assignment of life insurance policy or of rights thereunder, 97 A.L.R.2d 1399.

Obligation of insurer to give assignee of life policy notice of premiums due, 68 A.L.R.3d 360.

Coverage under all-risk insurance, 30 A.L.R.5th 170.

33-24-18. Contents of insurance policies and annuity contracts generally.

(a) The written instrument in which a contract of insurance is set forth is the policy.

(b) Every policy shall specify:

(1) The names of the parties to the contract;

(2) The subject of the insurance;

(3) The risks insured against;

(4) The time when the insurance under the policy takes effect and the period during which the insurance is to continue;

(5) The premium; and

(6) The conditions pertaining to the insurance.

(c) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.

(d) Subsections (b) and (c) of this Code section shall not apply to surety contracts or to group insurance policies.

(e) All policies and annuity contracts issued by admitted insurers and the forms of the policies and annuity contracts filed with the Commissioner shall have printed thereon an appropriate designating letter or figure or combination of letters or figures or terms identifying the respective forms of policies or contracts. Whenever any change is made in any form, the designating letters, figures, or terms thereon shall be correspondingly changed.

(f) All policies and annuity contracts shall contain such standard or uniform provisions as are required by the applicable provisions of this title pertaining to contracts of particular kinds of insurance.

(g) A policy may contain additional provisions which are not inconsistent with this title and which are:

(1) Required to be inserted by the laws of the insurer's domicile;

(2) Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract; or

(3) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.

History. — Code 1933, §§ 56-2413, 56-2414, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 31/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "admitted insurers" for "domestic insurers" near the beginning of the first sentence of subsection (e).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Civil Code 1910, §§ 2022, 2089, 2470, and 2499, and former Code 1933, §§ 56-213, 56-801, and 56-911, are included in the annotations for this Code section.

Insurance contract must be wholly in writing and not partly in parol. Jacobs v. Merchants Fire Assurance Corp., 99 F.2d 655 (5th Cir. 1938), cert. denied, 306 U.S. 654, 59 S. Ct. 643, 83 L. Ed. 1052 (1939) (decided under former Code 1933, § 56-213).

Contract of insurance must be in writing in order to be valid, and is not enforceable when the contract is partly in writing and partly in parol. Electric City Lumber Co. v. New York Underwriters' Ins. Co., 43 Ga. App. 355, 158 S.E. 620 (1931) (decided under former Civil Code 1910, §§ 2022, 2089).

Contract for fire insurance cannot be made partly in writing and partly in parol. Newark Fire Ins. Co. v. Smith, 176 Ga. 91, 167 S.E. 79 (1932) (decided under former Civil Code 1910, § 2470).

Writing must express the essentials of the insurance contract. Jacobs v. Merchants Fire Assurance Corp., 99 F.2d 655 (5th Cir. 1938), cert. denied, 306 U.S. 654, 59 S. Ct. 643, 83 L. Ed. 1052 (1939) (decided under former Code 1933, § 56-213).

Contract of fire insurance is invalid if the contract is silent as to duration of risk. J.T. Knight & Son v. Superior Fire Ins. Co., 80 F.2d 311 (5th Cir. 1935), cert. denied, 298 U.S. 654, 56 S. Ct. 674, 80 L. Ed. 1381 (1936) (decided under former Code 1933, § 56-213).

Fidelity insurance policies must be in writing. — If a fidelity insurance business is carried on by a domestic company, its policies must be in writing as required by former Civil Code 1910, § 2499 (see O.C.G.A. § 33-24-18) and former Civil Code 1910, §§ 2404 and 2470 (see O.C.G.A. §§ 33-24-1 and 33-24-13). Nowell v. Mayor of Monroe, 177 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933).

Whether the insurer is a resident or nonresident corporation, a contract of fidelity insurance must be in writing. Nowell v. Mayor of Monroe, 177 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933).

Rule that a policy of insurance shall be in writing and signed by the insurer applies to contracts issued upon a cash basis as well as to those issued upon a credit basis. Nowell v. Mayor of Monroe, 177 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933).

Action cannot be maintained upon a parol renewal of an insurance policy. Nowell v. Mayor of Monroe, 177 Ga. 648, 171 S.E. 136, answer conformed to, 47 Ga. App. 665, 171 S.E. 143 (1933).

Requirement that contract be in writing unalterable by custom. — While insurance companies are bound to know customs of places where the companies transact business and are assumed to have made the companies' contracts with

reference thereto, and while the custom of any business or trade is binding between contracting parties when it is of such universal practice as to justify the conclusion that it became by implication a part of the contract, the statutory requisite that contracts of insurance be in writing, setting forth all material elements of a contract of insurance before such a contract is enforcible, may not be obliterated by custom. Peninsular Life Ins. Co. v. Downard, 99 Ga. App. 509, 109 S.E.2d 279 (1959) (decided under former Code 1933, §§ 56-801, 56-911).

Contract for fire insurance which expresses no time for risk to continue is too vague and uncertain to be treated as complete; such a contract is not "consummated." Newark Fire Ins. Co. v. Smith, 176 Ga. 91, 167 S.E. 79 (1932) (decided under former Civil Code 1910, § 2470).

When an instrument declared on as a contract of fire insurance is silent as to the duration of the risk and when the defendant is insisting that the alleged contract is invalid because the period of the risk is not stated in the writing, it is not permissible for the plaintiff to supply this element by allegation and proof of a general custom covering such matter. Newark Fire Ins. Co. v. Smith, 176 Ga. 91, 167 S.E. 79 (1932) (decided under former Civil Code 1910, § 2470).

Insurance contract which does not say what risks are insured against is insufficient. Jacobs v. Merchants Fire Assurance Corp., 99 F.2d 655 (5th Cir. 1938), cert. denied, 306 U.S. 654, 59 S. Ct. 643, 83 L. Ed. 1052 (1939) (decided under former Code 1933, § 56-213).

Parol evidence as to what was said by parties at time of execution. — If the writing is unambiguous, parol evidence as to what was said by the parties at the time the writing was executed will not be admitted to vary or alter the terms of the writing. Mitchener v. Union Cent. Life Ins. Co., 185 Ga. 194, 194 S.E. 530 (1937); Fowler v. Liberty Nat'l Life Ins. Co., 73 Ga. App. 765, 38 S.E.2d 60 (1946) (decided under former Code 1933, §§ 56-801, 56-911).

Memorandum or binder petition is not effective as a contract of insurance if such elements of the contract as the period of the risk and the premium to be paid are understood between the parties to the contract, though not stated in any writing between the parties. J.T. Knight & Son v. Superior Fire Ins. Co., 80 F.2d 311 (5th Cir. 1935), cert. denied, 298 U.S. 654, 56 S. Ct. 674, 80 L. Ed. 1381 (1936) (decided under former Code 1933, § 56-213).

Policy cancelled in accordance with policy's terms at time of accident. — When there is evidence that at the time of an automobile collision a policy of insurance which had previously covered the automobile had been cancelled in accordance with the policy's terms, a verdict finding no liability on the policy is authorized. Carroll v. Garlington-Hardwick Co., 79 Ga. App. 708, 54 S.E.2d 441 (1949) (decided under former Code 1933, § 56-213).

Cited in Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 171 et seq.

Am. Jur. Proof of Facts. — Avoiding the "Business Pursuits" Exclusion — 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.

C.J.S. — 44 C.J.S., Insurance, § 394 et seq. 46A C.J.S., Insurance, § 2233 et seq.

ALR. — Validity of option provisions in life insurance policy which vary from the statutory provisions, 26 A.L.R. 103; 115 A.L.R. 1389.

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.

Date from which life insurance premium periods are to be computed, 32

A.L.R. 1253; 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

Criterion of health for purposes of warranty or condition in insurance contract, 40 A.L.R. 662; 100 A.L.R. 362.

"Permanent disability" within insurance policy as confined to disability lasting until death, 40 A.L.R. 1386; 97 A.L.R. 126.

Incontestable clause as affecting failure to comply with provisions as to proofs of loss, 41 A.L.R. 382.

Validity and enforceability of contractual stipulation for payment of additional amount in case of delay in payment of insurance dues, premiums, or assessments, 41 A.L.R. 979.

Purchase of property by mortgagee or holder of mortgage securities as breach of condition against sale or change of title in insurance policy with mortgage clause, 45 A.L.R. 597.

Provision in accident insurance policy in relation to train wreck, 51 A.L.R. 1331.

Right to proceeds of insurance where loss occurs after mortgage foreclosure sale, but during redemption period, 52 A.L.R. 898.

Provision for prorating as applicable where buildings owned by the same person having a wall in common are covered by different policies, 54 A.L.R. 88.

Validity, construction, and effect of stipulation in application or policy of insurance waiving privilege as to communication to or testimony by physician, 54 A.L.R. 412.

Construction and effect of provisions as to age, or employment as affected by age, in policy insuring employer against liability, 59 A.L.R. 300.

Meaning of "personal representative," "lawful representative," or term of similar import, in insurance policy bond, or other contract, 59 A.L.R. 838.

Construction and effect of provisions in automobile insurance policies as to location or place of keeping, 61 A.L.R. 312.

Reasonableness of insurer's demand for production of books or papers as regards time or place of production, 63 A.L.R. 510.

Outstanding interest in one to whom loss is payable as ground of forfeiture under condition on insurance policy respecting title or encumbrances, 65 A.L.R. 913.

Rider or provision protecting insured during interim or short-term period as affecting inception of risk under main policy of life insurance, 71 A.L.R. 1378.

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. 1378.

Automobile insurance: policy obtained by mortgagee or conditional vendor of car as other or additional insurance with clause against such insurance in policy obtained by mortgagor or conditional vendee and vice versa, 76 A.L.R. 1174.

Constitutionality of compulsory arbitration or appraisal provision of standard policy, 77 A.L.R. 619.

War risk life and disability insurance, 81 A.L.R. 933.

Incontestable clause as affecting provisions of policy exempting insurer or limiting its liability while insured is engaged in particular occupation, 85 A.L.R. 317.

Custom or practice as regards duration of insurance risk as supplying omission in written policy in that regard, 85 A.L.R. 1334.

Time of operation of suicide clause as affected by reinstatement of policy, 98 A.L.R. 344.

Consequential damages suffered by one person on account of bodily injuries to or death of another as within coverage of indemnity or liability policy or bond, 105 A.L.R. 1024.

Change in, renewal of, or substitution for original policy of life insurance as affecting time limitation prescribed by original policy in respect of defenses available to insurer, 110 A.L.R. 1139.

Adjustment of loss by agreement between mortgagor and insurer as affecting mortgagee under loss payable clause, 111 A.L.R. 697.

Equity jurisdiction for cancelation of insurance policy upon ground within incontestable clause prior to termination of period, 111 A.L.R. 1275.

Election of option under insurance policy where person otherwise entitled to make it is dead, incompetent, or an infant, 112 A.L.R. 1063; 127 A.L.R. 454; 136 A.L.R. 1045.

Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

Right of insured or beneficiary to enforce a policy provision more favorable to him than the standard policy; or to have policy reformed so as to include such a provision, 113 A.L.R. 773.

What constitutes a "riot," "civil commotion," etc., within provisions of insurance policy, 121 A.L.R. 250.

Liability or indemnity insurance: clause with respect to notice of accident, claim, etc., or with respect to forwarding papers, 123 A.L.R. 950; 18 A.L.R.2d 443.

Sufficiency of bookkeeping to satisfy condition of insurance policy, 125 A.L.R. 350.

Applicability of option provisions to double indemnity and disability features of life or accident insurance, 128 A.L.R. 552.

Validity of provisions for extended or paid-up insurance loan and surrender value of endowment provisions in life policies with assessment feature, 128 A.L.R. 639.

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.

Grace period for payment of insurance premiums as applicable to premium notes, extension agreements, or supplemental agreements for instalment payments, 131 A.L.R. 744.

Insurer's right of subrogation to insured's claim against wrongdoer as affected by existence of defense, or possibility of defense, to action on policy, 138 A.L.R. 1170.

Notice to insured of insufficiency to meet premiums of cash or loan value, reserve, or dividends, 140 A.L.R. 683.

Provision in fire insurance policy against other insurance as applied to property owned jointly or by cotenants, 143 A.L.R. 425.

Scope and application of exceptions as regards carrying passengers in policies of automobile insurance, 147 A.L.R. 632.

Suspension of contestable period of incontestable clause of life insurance policy pending appointment of personal representative of insured or of beneficiary, 157 A.L.R. 1204.

Provision of life insurance policy limiting insurer's liability number under specified conditions to return of premium as subject to waiver or estoppel by reason of agent's knowledge of breach of condition respecting insured's health, 163 A.L.R. 691.

Increase or renewal of mortgage debt without insurer's consent as violation of policy provision as to mortgages or encumbrances, 163 A.L.R. 1402.

Insurance: facility of payment clause, 166 A.L.R. 10.

Disability from use of intoxicants or drugs as within meaning of disability provision of insurance policy, 166 A.L.R. 833.

"Violation of law" clause in life or accident policy as requiring causative connection between violation of law by insured and his death or injury, 166 A.L.R. 1118.

Compliance with requirements of insurance policy as to proof of death by accident, 170 A.L.R. 1262.

Who is member of insured's "family" or "household" within coverage of property insurance policy, 1 A.L.R.2d 561.

Temporary life, accident, or health insurance pending approval of application or issuance of policy, 2 A.L.R.2d 943.

Automobile liability insurance: permission or consent to employee's use of car within meaning of omnibus coverage clause, 5 A.L.R.2d 600.

Incontestable clause as applicable to suit to reform insurance policy, 7 A.L.R.2d 504.

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.

Liability insurance: clause with respect to notice of accident or claim, etc., or with respect to forwarding suit papers, 18 A.L.R.2d 443.

Construction of clause of automobile liability policy excluding coverage in case of "commercial" use, 18 A.L.R.2d 719.

Requirement of disability policy as to proof of disability before reaching specified age as barring recovery where disabil-

ity occurs before, but proof is made after, attainment of such age, 18 A.L.R.2d 1061.

Stipulated period of time coverage of insurance policy as affected by countersigning subsequent to specified commencement date, 22 A.L.R.2d 984.

Revival of theft provision of insurance policy suspended for breach of condition or warranty, 31 A.L.R.2d 849.

What constitutes "jewelry" within coverage or exceptions of personal property insurance policy, 40 A.L.R.2d 871.

Insured's discontinued breach of warranty relating to use or keeping of prohibited articles as barring recovery on fire policy, 44 A.L.R.2d 1048.

Amount recoverable under loss of member or vision clauses of accident insurance, 44 A.L.R.2d 1233.

Liability for additional annual or periodic life insurance premium where insured dies on premium due date, 45 A.L.R.2d 1264.

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.

Apportionment of liability between automobile liability insurers one or more of whose policies provide against any liability if there is other insurance, 46 A.L.R.2d 1163.

Automobile insurance: omnibus clause exception relating to public garages, sales agencies, service stations, and the like, 47 A.L.R.2d 556.

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.

Clause in health and accident, or similar, policy reducing amount of, or terminating, periodic payments after insured reaches specified age, as applicable to disability incurred before such age was reached, 53 A.L.R.2d 552.

Mortgage, lien, or other encumbrance as constituting increase of hazard so as to avoid fire or other property insurance policy, 56 A.L.R.2d 422.

Test or criterion of "actual cash value" under insurance policy insuring to extent of actual cash value at time of loss, 61 A.L.R.2d 711.

Motor vehicle theft policy: clause with respect to notice of loss, 66 A.L.R.2d 1280.

Time of disability or death with regard to termination of coverage under group policy, 68 A.L.R.2d 150.

Coverage and exceptions in beauty shop liability policy, 77 A.L.R.2d 1258.

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.

Construction of terms "in transit," "transportation," and the like, within coverage or exclusion clauses of insurance policy, 80 A.L.R.2d 445.

Payments on other than annual basis as satisfying provision for increase of insurance benefits based on payment of premiums in advance, 83 A.L.R.2d 696.

Fracture or loss of member, or loss of sight, contemplated by accident policy or provision insuring against specific injury, 87 A.L.R.2d 481; 51 A.L.R.4th 156.

Provisions of burglary or theft policy as to "visible marks" or "visible evidence," 99 A.L.R.2d 129.

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.

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.

Liability insurance: "accident" or "accidental" as including loss resulting from ordinary negligence of insured or his agent, 7 A.L.R.3d 1262.

Dividends as preventing lapse of policy for nonpayment of premiums, 8 A.L.R.3d 862.

Construction and application of provision in liability policy limiting the amount of insurer's liability to one person, 13 A.L.R.3d 1228.

Construction of incontestable clause applicable to disability insurance, 13 A.L.R.3d 1383.

Time within which demand for appraisal of property loss must be made, under insurance policy providing for such appraisal, 14 A.L.R.3d 674.

Property insurance, or public liability insurance, as covering, in absence of express provision, after-acquired premises or realty, or subsequent additions to described realty, 18 A.L.R.3d 795.

Provisions of burglary or theft policy requiring losses evidenced by "physical damage to premises," 22 A.L.R.3d 1305.

Continuance or resumption of work as affecting finding of total or permanent disability within insurance coverage, 24 A.L.R.3d 8.

Property insurance: insured's ignorance of loss or casualty, cause of damage, coverage or existence of policy, or identity of insurer, as affecting or excusing compliance with requirements as to time for giving notice, making proof of loss, or bringing action against insurer, 24 A.L.R.3d 1007.

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.

Reformation of property insurance policy to correctly identify the person or interest insured, 25 A.L.R.3d 580.

Reformation of property insurance policy to correctly identify property insured, 25 A.L.R.3d 1232.

Injury or disability resulting from medical treatment for accident as proximately caused by original accident within coverage of accident or disability insurance, 25 A.L.R.3d 1386.

Construction and effect of "visible sign of injury" and similar clauses in accident provision of insurance policy, 28 A.L.R.3d 413.

Clause in life, accident, or health policy, covering missile or rocket work, 33 A.L.R.3d 694.

Recoverability, under property insurance or insurance against liability for property damage or insured's expenses to prevent or mitigate damages, 33 A.L.R.3d 1262.

Time when period provided for in suicide clause of life or accident policy begins to run, 37 A.L.R.3d 933.

Who is "executive officer" of insured within coverage of liability insurance policy, 39 A.L.R.3d 1434.

Conclusiveness of recitation, in delivered insurance policy, that initial premium has been paid, 44 A.L.R.3d 1361.

What constitutes "actual trial" under policy provision conditioning liability insurer's obligation upon determination of insured's liability by judgment after actual trial, 48 A.L.R.3d 1082.

Construction and application of clause excluding from coverage of liability policy "Completed Operations Hazards," 58 A.L.R.3d 12.

What constitutes "collapse" of a building within coverage of property insurance policy, 71 A.L.R.3d 1072.

Doctrine of unconscionability as applied to insurance contracts, 86 A.L.R.3d 862.

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.

Group insurance: construction, application, and effect of policy provision extending conversion privilege to employee after termination of employment, 32 A.L.R.4th 1037.

Partnership or joint venture exclusion in contractor's or other similar comprehensive general liability insurance policy, 57 A.L.R.4th 1155.

Who is "executive officer" of insured within liability insurance policy, 1 A.L.R.5th 132.

Uninsured and underinsured motorist coverage: enforceability of policy provision limiting appeals from arbitration, 23 A.L.R.5th 801.

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.

Construction and application of "business pursuits" exclusion provision in general liability policy, 35 A.L.R.5th 375.

Construction of incontestable clause applicable to disability insurance, 67 A.L.R.5th 513.

33-24-19. Incorporation of constituent documents in policies.

No policy shall contain any provisions purporting to make any portion of the charter, bylaws, or other constituent document of the insurer a part of the contract unless the portion is set forth in full in the policy. Any policy provision in violation of this Code section shall be invalid. This Code section shall not apply to the subscriber's agreement or power of attorney of a reciprocal insurer.

History. — Code 1933, § 56-2415, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Including or attaching constitution or bylaws of insurer issuing life insurance policy, § 33-25-2. Including or attaching constitution or bylaws of insurer issuing policy of accident and sickness insurance, § 33-29-2(a)(7).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Ga. L. 1906, p. 107, are included in the annotations for this Code section.

Section not applicable to action between policyholders. — Former Ga. L. 1906, p. 107 (see O.C.G.A. § 33-24-19) is not applicable when an action is brought by one or more policyholders to establish the liability of other policyholders to pay assessments, and to compel the policyholders to contribute to the payment of losses sustained by the complainants. Alma Gin & Milling Co. v. Peeples, 145 Ga. 722, 89 S.E. 820 (1916) (decided under former Ga. L. 1906, p. 107).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 196 et seq.

C.J.S. — 44 C.J.S., Insurance, § 486 et seq.

ALR. — Liability in respect of premium where policy is rejected by applicant or prospect, 41 A.L.R. 644.

Right of insured or beneficiary to enforce a policy provision more favorable to him than the standard policy; or to have policy reformed so as to include such a provision, 113 A.L.R. 773.

Validity of option provisions in life insurance policy which vary from (or add to, or exclude) statutory provisions, 115 A.L.R. 1389.

33-24-19.1. Certificate of insurance forms to be approved by Commissioner; definitions; required provisions of certificate.

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

(1) "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance or insurance binder, including any policy of insurance which may be referred to as a certificate, or any insurance information card or identification card issued in conjunction with a motor vehicle insurance policy.

(2) "Certificate holder" means any person, other than a policyholder, that requests, obtains, or possesses a certificate of insurance.

(3) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(4) "Insurer" means any person engaged as indemnitor, surety, or contractor who issues insurance as defined by Code Sections 33-7-3 and 33-7-6. Nothing in this Code section shall apply to or affect any offering of accident, sickness, or disability insurance by a fraternal benefit society, as provided under Code Section 33-15-60; health care plans, as provided under Chapter 20 of this title; health maintenance organizations, as provided under Chapter 21 of this title; any provisions of accident and sickness insurance policies generally, as provided under Code Sections 33-24-20 through 33-24-31; individual accident and sickness insurance, as provided under Chapter 29 of this title; or group or blanket accident and sickness insurance, as provided under Chapter 30 of this title.

(5) "Person" means any individual, partnership, corporation, association, or other legal entity, including any government or governmental subdivision or agency.

(6) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

(b) No person, wherever located, may prepare, issue, or request the issuance of a certificate of insurance unless the form has been filed with and approved by the Commissioner of Insurance. No person, wherever located, may alter or modify an approved certificate of insurance form.

(c) The Commissioner of Insurance shall disapprove a form filed under this Code section, or withdraw approval of a form, if the form:

(1) Is unjust, unfair, misleading, or deceptive, or violates public policy;

(2) Fails to comply with the requirements of subsection (d) of this Code section; or

(3) Violates any law, including any regulation adopted by the Commissioner of Insurance.

(d) Each certificate of insurance must contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend, or alter the coverage, terms, exclusions, and conditions afforded by the policies referenced herein." However, the Commissioner of Insurance may approve a form filed under this Code section that does not state that the form is provided for information purposes only, if such form contains the following or similar

statement: "This certificate of insurance does not amend, extend, or alter the coverage, terms, exclusions, and conditions afforded by the policies referenced herein."

(e) Standard certificate of insurance forms promulgated by the Association for Cooperative Operations Research and Development or the Insurance Services Office are deemed approved by the Commissioner of Insurance and are not required to be filed if the forms otherwise comply with the requirements of this Code section.

(f) No person, wherever located, shall demand or request the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains any false or misleading information concerning the policy of insurance to which the certificate makes reference.

(g) No person, wherever located, may knowingly prepare or issue a certificate of insurance that contains any false or misleading information or that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(h) No person may prepare, issue, or request, either in addition to or in lieu of a certificate of insurance, an opinion letter or other document or correspondence that is inconsistent with this Code section.

(i) This Code section shall apply to all certificate holders, policyholders, insurers, insurance producers, and certificate of insurance forms issued as evidence of insurance coverages on property, operations, or risks located in this state, regardless of where the certificate holder, policyholder, insurer, or insurance producer is located.

(j) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder new or additional rights beyond what the referenced policy of insurance expressly provides.

(k) No certificate of insurance shall contain references to contracts, including construction or service contracts, other than the referenced contract of insurance. Notwithstanding any requirement, term, or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions, and conditions of the policy itself.

(l) A certificate holder shall have a legal right to notice of cancellation, nonrenewal, or any material change, or any similar notice concerning a policy of insurance only if the person is named within the policy or any endorsement and the policy or endorsement requires

notice to be provided. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance and cannot be altered by a certificate of insurance.

(m) Any certificate of insurance or any other document or correspondence prepared, issued, or requested in violation of this Code section shall be null and void and of no force and effect.

(n) Any person who violates this Code section may be fined up to $5,000.00 per violation.

(o) The Commissioner of Insurance shall have the power to examine and investigate the activities of any person that the Commissioner reasonably believes has been or is engaged in an act or practice prohibited by this Code section. The Commissioner of Insurance shall have the power to enforce the provisions of this Code section and to impose any authorized penalty or remedy against any person who violates this Code section.

(p) The Commissioner of Insurance may adopt reasonable rules and regulations as are necessary or proper to carry out the provisions of this Code section.

History. — Code 1981, § 33-24-19.1, enacted by Ga. L. 2011, p. 434, § 1/HB 66; Ga. L. 2019, p. 386, § 32/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "nonprofit medical service corporations, as provided under Chapters 18 and 19 of this title;" following "under Code Section 33-15-60;" in the middle of the second sentence of paragraph (a)(4); and substituted "This" for "The provisions of this " at the beginning of subsection (i).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 178 et seq.

C.J.S. — 45 C.J.S., Insurance, § 605.

33-24-20. Provision in accident and sickness policies for termination of coverage of surviving spouse or as result of break in marital relationship; issuance of policy to spouse.

(a) No individual policy of accident and sickness insurance offered for sale in this state, other than a policy of credit accident and sickness insurance which provides coverage for hospital or medical expenses on either an expense incurred basis or other than on an expense incurred basis, which, in addition to covering the insured, also provides coverage to the spouse of the insured may contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of the death of the insured or of an entry of a valid decree of divorce between the parties.

(b) Every policy which contains a provision for termination of coverage of the spouse upon death of the insured or divorce shall contain a provision to the effect that, upon the death of the insured or the entry of a valid decree of divorce between the insured parties, the surviving or divorced spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 31 days following the entry of such decree and upon the payment of the appropriate premium, an individual or family policy of accident and sickness insurance then being issued by the insurer which provides coverage most nearly similar to the coverage contained in the policy which was terminated by reason of death or divorce or any other similar individual or family policy then being issued by the insurer which contains lesser coverage. Any and all probationary or waiting periods set forth in such an individual or family policy shall be considered as being met to the extent coverage was in force under the prior policy.

(c) This Code section shall also apply to blanket accident and sickness insurance policies and to policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any other similar entity.

History. — Code 1933, § 56-3004.1, enacted by Ga. L. 1980, p. 1393, § 1; Ga. L. 1981, p. 640, § 1; Ga. L. 1995, p. 745, § 2.6; Ga. L. 2017, p. 164, § 14/HB 127.

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

Editor's notes. — Ga. L. 1981, p. 640, § 3, not codified by the General Assembly, provides that this Act shall apply to policies issued, delivered, or renewed in this state on or after July 1, 1981.

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981).

33-24-21. Provision in accident and sickness policies for termination of group coverage of surviving spouse or as result of break in marital relationship; issuance of policy to spouse.

(a) No group policy of accident and sickness insurance offered for sale in this state, other than a policy of credit accident and sickness insurance which provides coverage for hospital or medical expenses on either an expense incurred basis or otherwise, which, in addition to covering the insured, also provides coverage to the spouse of the insured, may contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except by reason of the death of the insured or of any entry of a valid decree of divorce between the parties.

(b) Every policy which contains a provision for termination of coverage of the spouse upon death of the insured or divorce shall contain a provision to the effect that, upon the death of the insured or the entry

of a valid decree of divorce between the insured parties, the surviving or divorced spouse shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 31 days following the entry of such decree and upon the payment of the appropriate premium, an individual or family policy of accident and sickness insurance then being issued by the insurer which provides coverage most nearly similar to the coverage contained in the policy which was terminated by reason of death or divorce or any other similar individual or family policy then being issued by the insurer which contains lesser coverage. Any and all probationary or waiting periods set forth in an individual or family policy shall be considered as being met to the extent coverage was in force under the prior policy.

(c) This Code section shall also relate to blanket accident and sickness insurance policies and to policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any other similar entity.

History. — Code 1933, § 56-3102.1, enacted by Ga. L. 1980, p. 1393, § 2; Ga. L. 1981, p. 640, § 2; Ga. L. 1990, p. 8, § 33; Ga. L. 1995, p. 745, § 2.7; Ga. L. 2017, p. 164, § 15/HB 127.

Cross references. — Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

Editor's notes. — Ga. L. 1981, p. 640, § 3, not codified by the General Assembly, provides that this Act shall apply to policies issued, delivered, or renewed in this state on or after July 1, 1981.

33-24-21.1. Group accident and sickness contracts; conversion privilege and continuation right provisions; impact of federal legislation.

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

(1) "Assistance-eligible individual" shall have the same meaning as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009, as amended.

(2) "Creditable coverage" under another health benefit plan means medical expense coverage with no greater than a 90 day gap in coverage under any of the following:

(A) Medicare or Medicaid;

(B) An employer based accident and sickness insurance or health benefit arrangement;

(C) An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, health care corporation, or fraternal benefit society;

(D) A spouse's benefits or coverage under medicare or Medicaid or an employer based health insurance or health benefit arrangement;

(E) A conversion policy;

(F) A franchise policy issued on an individual basis to a member of a true association as defined in subsection (b) of Code Section 33-30-1;

(G) A health plan formed pursuant to 10 U.S.C. Chapter 55;

(H) A health plan provided through the Indian Health Service or a tribal organization program or both;

(I) A state health benefits risk pool;

(J) A health plan formed pursuant to 5 U.S.C. Chapter 89;

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

(3) "Eligible dependent" means a person who is entitled to medical benefits coverage under a group contract or group plan by reason of such person's dependency on or relationship to a group member.

(4) "Group contract or group plan" is synonymous with the term "contract or plan" and means:

(A) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(B) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(C) A group accident and sickness insurance policy or contract, as defined in Chapter 30 of this title.

(5) "Group member" means a person who has been a member of the group for at least six months and who is entitled to medical benefits coverage under a group contract or group plan and who is an insured, certificate holder, or subscriber under the contract or plan.

(6) "Insurer" means an insurance company, health care corporation, health care plan, or health maintenance organization.

(7) "Qualifying eligible individual" means:

(A) A Georgia domiciliary, for whom, as of the date on which the individual seeks coverage under this Code section, the aggregate of the periods of creditable coverage is 18 months or more; and

(B) Who is not eligible for coverage under any of the following:

(i) A group health plan, including continuation rights under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA);

(ii) Part A or Part B of Title XVIII of the federal Social Security Act; or

(iii) The state plan under Title XIX of the federal Social Security Act or any successor program.

(a.1) Any group member or qualifying eligible individual who is an assistance-eligible individual as provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, during the period permitted under such act whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits that it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan in accordance with paragraph (2) of subsection (c) of this Code section. Such coverage shall continue for the fractional policy month remaining, if any, at termination plus up to the maximum number of additional policy months specified in paragraph (2) of subsection (c) of this Code section upon payment of the premium to the insurer by cash, certified check, or money order, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. An assistance-eligible individual who is in a transition period as defined in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall be treated for purposes of any continuation of coverage provision as having timely paid such premium if such individual was covered under the continuation of coverage to which such premium relates for the period immediately preceding such transition period, if such individual remains eligible for such continuation of coverage, and if such individual pays the amount of such premium not later than 30 days after the date of provision of notice regarding eligibility for extended continuation of coverage. For the period that the assistance-eligible individual is eligible for the premium reduction assistance as provided in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, such premium payment shall be calculated as 35 percent of the rate for active group members including any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage.

(a.2) The rights and benefits under this Code section attributable to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, shall expire when that Act

expires. Any extension of such benefits shall require an Act of the Georgia General Assembly. Under no circumstances shall the extended benefits for assistance-eligible individuals become the responsibility of this state or any insurer after the expiration of the premium subsidy made available to individuals pursuant to Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

(b) Each group contract or group plan delivered or issued for delivery in this state, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical coverage, or any combination of these coverages, on an expense incurred or service basis, excluding contracts and plans which provide benefits for specific diseases or accidental injuries only, shall provide that members and qualifying eligible individuals whose insurance under the group contract or plan would otherwise terminate shall be entitled to continue their hospital, surgical, and major medical insurance coverage under that group contract or plan for themselves and their eligible dependents.

(c)(1) Any group member or qualifying eligible individual whose coverage has been terminated and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to such termination, shall be entitled to have his or her coverage and the coverage of his or her eligible dependents continued under the contract or plan. Such coverage must continue for the fractional policy month remaining, if any, at termination plus three additional policy months, upon payment of the premium by cash, certified check, or money order, at the option of the employer, to the policyholder or employer, at the same rate for active group members set forth in the contract or plan, on a monthly basis in advance as such premium becomes due during this coverage period. Such premium payment must include any portion of the premium paid by a former employer or other person if such employer or other person no longer contributes premium payments for this coverage. At the end of such period, the group member shall have the same conversion rights that were available on the date of termination of coverage in accordance with the conversion privileges contained in the group contract or group plan.

(2) Any group member or qualifying eligible individual who is an assistance-eligible individual has a right to elect continuation of his or her coverage and the coverage of his or her dependents at any time between May 5, 2009, and 60 days after receiving notice from the employer's insurer of the right to participate in state continuation

benefits under this Code section in accordance with Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, if:

(A) The individual was involuntarily terminated from employment or otherwise experienced a loss of coverage due to qualifying events specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended;

(B) The individual was eligible for state continuation under this Code section at the time of termination;

(C) The individual continues to be eligible for state continuation benefits under this Code section, provided that the total period of continuous eligibility shall not exceed the number of policy months equal to the maximum premium reduction period specified in Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended, as measured from the month of the qualifying event making the individual an assistance-eligible individual; and

(D) The individual or the employer of the individual contacts the insurer and informs the insurer that the individual wants to take advantage of state continuation coverage under the provisions of Section 3001 of Title III of the federal American Recovery and Reinvestment Act (P.L. 111-5), as amended.

(3) In addition to the group policy under which the group member was insured, the group member and any qualifying eligible individual shall, to the extent that such plan is offered under the group plans offered by the company, also be offered the option of continuation coverage through a high deductible health plan, or its actuarial equivalent, that is eligible for use with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code. Such high deductible health plans shall have premiums consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided.

(d)(1) A group member shall not be entitled to have coverage continued if:

(A) Termination of coverage occurred because the employment of the group member was terminated for cause;

(B) Termination of coverage occurred because the group member failed to pay any required contribution; or

(C) Any discontinued group coverage is immediately replaced by similar group coverage including coverage under a health benefits plan as defined in the federal Employee Retirement Income Secu-

rity Act of 1974, 29 U.S.C. Section 1001, et seq. Further, a group member shall not be entitled to have coverage continued if the group contract or group plan was terminated in its entirety or was terminated with respect to a class to which the group member belonged. This subsection shall not affect conversion rights available to a qualifying eligible individual under any contract or plan.

(2) A qualifying eligible individual shall not be entitled to have coverage continued if the most recent creditable coverage within the coverage period was terminated based on one of the following factors:

(A) Failure of the qualifying eligible individual to pay premiums or contributions in accordance with the terms of the health insurance coverage or failure of the issuer to receive timely premium payments;

(B) The qualifying eligible individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of coverage; or

(C) Any discontinued group coverage is immediately replaced by similar group coverage, including coverage under a health benefits plan as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. This subsection shall not affect conversion rights available to a group member under any contract or plan.

(e) If the group contract or group plan terminates while any group member or qualifying eligible individual is covered or whose coverage is being continued, the group administrator, as prescribed by the insurer, must notify each such group member or qualifying eligible individual that he or she must exercise his or her conversion rights within:

(1) Thirty days of such notice for group members who are not qualifying eligible individuals; or

(2) Sixty-three days of such notice for qualifying eligible individuals.

(f) Every group contract or group plan, other than a group accident and sickness insurance policy, contract, or plan issued in connection with an extension of credit, which provides hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred or service basis, excluding policies which provide benefits for specific diseases or for accidental injuries only, shall contain a conversion privilege provision.

(g) Eligibility for the converted policies or contracts shall be as follows:

(1) Any qualifying eligible individual whose insurance and its corresponding eligibility under the group policy, including any con-

tinuation available, elected, and exhausted under this Code section or the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than fraud or failure of the qualifying eligible individual to pay a required premium contribution to the employer or, if so required, to the insurer directly and who has at least 18 months of creditable coverage immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group based coverage covering such qualifying eligible individual and any eligible dependents who were covered under the qualifying eligible individual's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The insurer must offer qualifying eligible individuals at least two distinct conversion options from which to choose. One such choice of coverage shall be comparable to comprehensive health insurance coverage offered in the individual market in this state or comparable to a standard option of coverage available under the group or individual health insurance laws of this state. The other choice may be more limited in nature but must also qualify as creditable coverage. Each coverage shall be filed, together with applicable rates, for approval by the Commissioner. Such choices shall be known as the "Enhanced Conversion Options";

(2) Premiums for the enhanced conversion options for all qualifying eligible individuals shall be determined in accordance with the following provisions:

(A) Solely for purposes of this subsection, the claims experience produced by all groups covered under comprehensive major medical or hospitalization accident and sickness insurance for each insurer shall be fully pooled to determine the group pool rate. Except to the extent that the claims experience of an individual group affects the overall experience of the group pool, the claims experience produced by any individual group of each insurer shall not be used in any manner for enhanced conversion policy rating purposes;

(B) Each insurer's group pool shall consist of each insurer's total claims experience produced by all groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group insurance from which the qualifying eligible individual is converting. The pool shall include the experience generated under any medical expense insurance coverage offered under separate group contracts and contracts issued to trusts, multiple employer trusts, or association groups or trusts, including

trusts or arrangements providing group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, through contracts issued or issued for delivery in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement; and any other group-type coverage which is determined to be a group shall also be included in the pool for enhanced conversion policy rating purposes; and

(C) Any other factors deemed relevant by the Commissioner may be considered in determination of each enhanced conversion policy pool rate so long as it does not have the effect of lessening the risk-spreading characteristic of the pooling requirement. Duration since issue and tier factors may not be considered in conversion policy rating. Notwithstanding subparagraph (A) of this paragraph, the total premium calculated for all enhanced conversion policies may deviate from the group pool rate by not more than plus or minus 50 percent based upon the experience generated under the pool of enhanced conversion policies so long as rates do not deviate for similarly situated individuals covered through the pool of enhanced conversion policies;

(3) Any group member who is not a qualifying eligible individual and whose insurance under the group policy has been terminated for any reason, including failure of the employer to pay premiums to the insurer, other than eligibility for medicare (reaching a limiting age for coverage under the group policy) or failure of the group member to pay a required premium contribution, and who has been continuously covered under the group contract or group plan, and under any contract or plan providing similar benefits which it replaces, for at least six months immediately prior to termination shall be entitled, without evidence of insurability, to convert to individual or group coverage covering such group member and any eligible dependents who were covered under the group member's coverage under the group contract or group plan. Such conversion coverage must be, at the option of the individual, retroactive to the date of termination of the group coverage or the date on which continuation or COBRA coverage ended, whichever is later. The premium of the basic converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and classification of risks of each person to be covered under that policy and to the type and amount of coverage provided. This form of conversion coverage shall be known as the "Basic Conversion Option"; and

(4) Nothing in this Code section shall be construed to prevent an insurer from offering additional options to qualifying eligible individuals or group members.

(h) Each group certificate issued to each group member or qualifying eligible individual, in addition to setting forth any conversion rights, shall set forth the continuation right in a separate provision bearing its own caption. The provisions shall clearly set forth a full description of the continuation and conversion rights available, including all requirements, limitations, and exceptions, the premium required, and the time of payment of all premiums due during the period of continuation or conversion.

(i) This Code section shall not apply to limited benefit insurance policies. For the purposes of this Code section, the term "limited benefit insurance" means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term limited benefit insurance includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, and comprehensive major medical insurance coverage.

(j) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section. Such rules and regulations may prescribe various conversion plans, including minimum conversion standards and minimum benefits, but not requiring benefits in excess of those provided under the group contract or group plan from which conversion is made, scope of coverage, preexisting limitations, optional coverages, reductions, notices to covered persons, and such other requirements as the Commissioner deems necessary for the protection of the citizens of this state.

(k)(1) Except as provided in paragraph (2) of this subsection, this Code section shall apply to all group plans and group contracts delivered or issued for delivery in this state on or after July 1, 2009, and to group plans and group contracts then in effect on the first anniversary date occurring on or after July 1, 2009.

(2) The provisions of paragraphs (1), (2), and (3) of subsection (c) of this Code section shall apply to all group plans and group contracts in effect on September 1, 2008.

(l) As soon as practicable, but no later than June 4, 2009, the Commissioner shall develop and direct insurers to issue notices for assistance-eligible individuals regarding availability of expanded eligibility and continuation coverage assistance to be sent to the last known addresses of such assistance-eligible individuals.

(m) Nothing in this Code section shall imply that individuals entitled to continuation coverage who are not assistance-eligible individuals shall receive benefits beyond the period of coverage provided in para-

graph (1) of subsection (c) of this Code section or that assistance-eligible individuals are entitled to any continuation benefit period beyond what is provided by Section 3001 of Title III of the federal American Recovery and Reinvestment Act of 2009 or extensions to that Act which are enacted on and after May 5, 2009.

(n)(1) Upon the effective date whereupon guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, an insurer shall not be required to offer conversion and enhanced conversion rights and coverage pursuant to this Code section.

(2) Each insurer may terminate, cancel, or nonrenew all existing conversion and enhanced conversion coverage as of the date on which guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, provided that the insurer provides at least 90 days' notice prior to the discontinuance of the coverage to policyholders and to the Commissioner.

(3) An insurer may not terminate, cancel, or nonrenew any policy under this paragraph if, at the end of the 90 day cancellation period, the insured would not have at least 90 days of remaining open enrollment to obtain insurance coverage through an exchange created pursuant to the federal Patient Protection and Affordable Care Act.

History. — Code 1981, § 33-24-21.1, enacted by Ga. L. 1986, p. 688, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1997, p. 1462, § 3; Ga. L. 1998, p. 1064, § 4; Ga. L. 2002, p. 441, § 10; Ga. L. 2009, p. 737, § 1/SB 94; Ga. L. 2010, p. 87, § 1/HB 1268; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2013, p. 873, § 2/HB 389; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2017, p. 164, § 16/HB 127; Ga. L. 2019, p. 386, § 33/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "assistance-eligible" for "assistance eligible" throughout this Code section; substituted "Assistance-eligible" for "Assistance eligible" at the beginning of paragraph (a)(1); deleted "nonprofit hospital or nonprofit medical service corporation," following "health maintenance organization," in subparagraph (a)(2)(C); in subsection (a.2), substituted "Act" for "act" near the end of the first sentence and substituted "this state" for "the State of Georgia" in the middle of the second sentence; substituted "this Code section" for "this chapter" in subparagraphs (c)(2)(B) and (c)(2)(C); deleted "currently" preceding "offered under the group plans" in the middle of the first sentence of paragraph (c)(3); substituted "Termination" for "termination" at the beginning of subparagraphs (d)(1)(A) and (d)(1)(B), substituted "Any" for "any" at the beginning of subparagraph (d)(1)(C), substituted "Failure" for "failure" at the beginning of subparagraph (d)(2)(A), substituted "The" for "the" at the beginning of subparagraph (d)(2)(B), and substituted "Any" for "any" at the beginning of subparagraph (d)(2)(C); and substituted "Code section" for "chapter" near the beginning of subsection (m).

Cross references. — Renewal or continuation of coverage at option of insured, § 33-29-21. Individual health insurance coverage availability, T. 33, C. 29A. Continuation of similar coverage, § 33-30-15.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1997, "Code" was inserted preceding "section" in subparagraph (a)(6)(A) (now (a)(7)(A)), and in

paragraph (g)(1), an ending quote and a semicolon were substituted for a period and an ending quote.

Pursuant to Code Section 28-9-5, in 2009, in paragraph (c)(2), "May 5, 2009," was substituted for "the effective date of this paragraph", and in subsection (l), "June 4, 2009" was substituted for "30 days after the effective date of this subsection".

Pursuant to Code Section 28-9-5, in 2010, an extra comma was deleted following "months" in the second sentence of paragraph (c)(1).

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; and further provides that the Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

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.

Ga. L. 2013, p. 873, § 1/HB 389, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Georgia Health Insurance Enhancement Act of 2013.'"

U.S. Code. — The Patient Protection and Affordable Care Act, referred to in this Code section, are codified throughout the United States Code and primarily in T. 42.

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

For note on the 2002 amendment of this Code section, see 19 Georgia St. U.L. Review 220 (2002).

JUDICIAL DECISIONS

Cited in Brandon v. Mayfield, 215 Ga. App. 735, 452 S.E.2d 181 (1994).

33-24-21.2. Continuation of coverage under group accident and sickness plans for persons 60 years of age or older.

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

(1) "Group contract or group plan" is synonymous with the term "contract or plan" and means:

(A) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(B) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(C) A group accident and sickness insurance policy or contract, as defined in Chapter 30 of this title.

(2) "Group member" means a person who has been a member of the group for at least six months; who is entitled to medical benefits coverage under a group contract or group plan; and who is an insured, certificate holder, or subscriber under the contract or plan.

(3) "Insurer" means an insurance company, health care plan, or health maintenance organization.

(4) "Internal Revenue Code" means the federal Internal Revenue Code as defined in Code Section 48-1-2.

(5) "Plan administrator" means:

(A) The person designated as the plan administrator by the instrument under which the group contract or plan is operated; or

(B) If no plan administrator is designated, the plan sponsor.

(b)(1) A group contract or plan providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the Internal Revenue Code, shall contain a provision that a group member whose insurance under the contract or plan otherwise terminates after the expiration of the period of continuation of coverage for which the individual is eligible under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code shall be entitled to continue coverage under that group contract or plan for himself or herself and his or her eligible dependents if the group member was 60 years of age or older as of the date on which the continuation of coverage afforded under Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code commences.

(2) A group member shall not be entitled to have coverage continued under paragraph (1) of this subsection if:

(A) Termination of employment is voluntary for other than health reasons;

(B) Termination of coverage occurred because the employment of a group member was terminated for reasons which would cause a forfeiture of unemployment compensation under Chapter 8 of Title 34, the "Employment Security Law";

(C) Termination of coverage occurred because the group member failed to pay any required contribution;

(D) Any discontinued coverage is immediately replaced by similar group coverage; or

(E) The group contract or group plan was terminated in its entirety or was terminated with respect to a class to which the group member belonged.

This paragraph shall not affect conversion rights available to a group member under any contract or plan.

(c) A group contract or plan providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases which is issued, delivered, issued for delivery, or renewed in this state to provide coverage for the employees of an employer subject to the provisions of Section 4980B of the federal Internal Revenue Code, shall contain a provision that:

(1) The surviving spouse of a group member may continue coverage under the plan, at the death of the group member, with respect to the spouse and any dependent children whose coverage under the plan otherwise would terminate because of the death of the group member if the surviving spouse is 60 years of age or older at the time of the death; and

(2) The divorced spouse of a group member may continue coverage under the plan, upon dissolution of marriage with the group member, with respect to the divorced spouse and any dependent children whose coverage under the plan otherwise would terminate because of the dissolution of marriage, if the divorced spouse is 60 years of age or older at the time of the dissolution or legal separation.

(d) Each group certificate issued to each group member shall set forth the continuation right provided in subsections (b) and (c) of this Code section in a separate provision bearing its own caption. The provision shall clearly set forth a full description or the continuation right available, including all requirements, limitations, exceptions, the premium required or a brief statement concerning the method of calculation thereof, and the time of payment of all premiums due during the period of continuation.

(e) In the event and to the extent that this Code section is applicable, the election by the group member or divorced or surviving spouse to obtain continuation of coverage as provided under the provisions of Section 4980B of the Internal Revenue Code or under the provisions of Code Section 33-24-21.1 shall constitute election of continuation of coverage under this Code section without further action by the group member or surviving or divorced spouse. The provisions of Section 4980B of the Internal Revenue Code or of Code Section 33-24-21.1, whichever is applicable, regarding notice to a group member or a

divorced or surviving spouse of the right to continue coverage shall apply to the continuation of coverage provided under this Code section.

(f) If an eligible group member or the divorced or surviving spouse elects continuation of coverage under subsection (b) or (c) of this Code section:

(1) The monthly premium for the continuation shall not be greater than 120 percent of the total of the amount that would be charged if the eligible group member or the divorced or surviving spouse were a current group member and the amount that the group policyholder would contribute toward the premium if the eligible group member or the divorced or surviving spouse were a current group member;

(2) The first premium for the continuation of coverage under this Code section shall be paid by the eligible group member or the divorced or surviving spouse on the first regular due date following the expiration of the eligible person's benefits under the provisions of Code Section 33-24-21.1 or Section 4980B of the Internal Revenue Code; and

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following:

(A) The failure to pay premiums or required premium contributions, if applicable, when due, including any grace period allowed by the policy;

(B) The date that the group plan is terminated as to all group members, except that if a different group plan is made available to group members, the eligible group member or the divorced or surviving spouse shall be eligible for continuation of the same coverage under the new plan;

(C) The date on which the eligible group member or divorced or surviving spouse becomes insured under any other group health plan; or

(D) The date on which the eligible group member or the divorced or surviving spouse becomes eligible for federal medicare coverage.

(g) This Code section shall apply to any group contract or group plan which covers 20 or more employees and which is issued, delivered, issued for delivery, or renewed in this state on or after July 1, 1992, and to any group contract or group plan covering 20 or more employees then in effect on the first anniversary date occurring on or after July 1, 1992.

History. — Code 1981, § 33-24-21.2, enacted by Ga. L. 1992, p. 1969, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 2017, p. 164, § 17/HB 127.

Code Commission notes. — As enacted by Ga. L. 1992, p. 1969, § 1, this Code section contained two subsections designated as subsection (f). Pursuant to

Code Section 28-9-5, in 1992, the second subsection (f) was redesignated as subsection (g).

33-24-22. Provision in health insurance policies for coverage of newly born or adopted children.

(a) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which, under the terms of such policies, provide coverage for a family member of the insured or subscriber shall, as to the family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth. A newly born child of the insured or subscriber shall include an adopted child. The coverage for the adopted child shall be effective from the date of the placement for adoption or final decree of adoption, whichever occurs first.

(b) The coverage for newly born children or adopted children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, but need not include benefits for routine well baby care.

(c) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or the date of the placement for adoption or final adoption of a child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth, placement for adoption, or final decree of adoption, whichever is applicable, in order to have the coverage continue beyond the 31 day period.

(d) This Code section shall not apply to persons adopted as adults pursuant to the provisions of Code Section 19-8-21, relating to the adoption of adult persons.

History. — Code 1933, § 56-2441, enacted by Ga. L. 1974, p. 196, § 1; Ga. L. 1988, p. 1535, § 1; Ga. L. 1990, p. 1572, § 6; Ga. L. 1998, p. 1064, § 5; Ga. L. 2019, p. 386, § 34/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "Reserved." for the former provisions of subsection (e), which read: "The requirements of this Code section shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state on or after July 1, 1998."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former subsection (e) which was designated as reserved.

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

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

33-24-23. Provision in group policies of accident and sickness insurance for exclusion or reduction of benefits.

Notwithstanding any other provisions in this title to the contrary, no group policy of accident and sickness insurance offered for sale in this state shall be issued or renewed by any insurer transacting business in this state, or health care plan under Chapter 20 of this title, which by the terms of the group policy excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured by reason of the fact that benefits have been paid or are also payable under any blanket school accident policy regardless of who makes the premium contribution or any individually underwritten and individually issued contract or plan of insurance which provides exclusively for accident and sickness benefits and for which 100 percent of the premiums have been paid by the insured or a member of the insured's family, irrespective of the mode or channel of premium payment to the insurer or any discount received on such premium by virtue of the insured's membership in any organization or status as an employee. Any policy provision in violation of this Code section shall be void and unenforceable. Nothing in this Code section shall affect the practice of coordinating benefits between group policies issued pursuant to Chapter 30 of this title.

History. — Code 1933, § 56-2442, enacted by Ga. L. 1975, p. 443, § 1; Ga. L. 2017, p. 164, § 18/HB 127; Ga. L. 2019, p. 386, § 35/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "after April 17, 1975," following "shall be issued or renewed" near the beginning of the first sentence.

Cross references. — Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

33-24-24. Provision in group or blanket accident and sickness policies of coverage for complications of pregnancy.

(a) For the purposes of this Code section, the term:

(1) "Complications of pregnancy" means the following:

(A) Conditions requiring hospital confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; but the term shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

(B) Ectopic pregnancy which is terminated.

(2) "Group policy or group contract" means a group or blanket accident and sickness insurance policy or contract as defined in Chapter 30 of this title, a group contract of the type issued by a health care plan established under Chapter 20 of this title, or any similar group benefit plan, policy, or contract.

(3) "Major medical coverage" means coverage which provides benefits of at least 75 percent of necessary, reasonable, and customary charges for medical care, including hospitalization in semiprivate accommodations, with maximum lifetime benefits of at least $100,000.00.

(b) Each group policy or group contract issued, delivered, issued for delivery, amended, or renewed in this state which provides major medical coverage and which includes maternity benefits shall include complications of pregnancy within such major medical coverage for all persons who have been covered by the policy or contract for a period of nine months or for a period of at least 30 days immediately prior to the date conception occurs or pregnancy commences. The same coverage for complications of pregnancy shall be provided for all family members and dependents with major medical coverage under the group policy or group contract.

(c) Group policies or group contracts subject to this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to complications of pregnancy unless the provisions apply generally to all benefits provided or paid for under the group policies or group contracts.

(d) If fixed amounts for surgery are specified in any group policy or group contract subject to this Code section, the fixed amounts for surgical procedures involving complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity.

(e) If any group policy or group contract subject to this Code section provides a fixed amount for maternity benefits, complications of pregnancy shall be treated the same as an illness rather than pregnancy and a person covered by the group policy or group contract shall be entitled to benefits otherwise provided by the group policy or group contract.

(f) Nothing contained in this Code section shall be deemed to prohibit an insurer or nonprofit corporation from issuing group policies or group contracts which contain provisions providing benefits greater than the minimum benefits required by this Code section or from

issuing group policies or group contracts which contain provisions which are generally more favorable to the insured than those required by this Code section.

History. — Code 1933, § 56-2443, enacted by Ga. L. 1977, p. 1229, § 2; Ga. L. 2017, p. 164, § 19/HB 127; Ga. L. 2019, p. 386, § 36/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "after January 1, 1978," following "renewed in this state" near the middle of the first sentence of subsection (b).

Cross references. — Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

RESEARCH REFERENCES

ALR. — Insurance: pregnancy as misrepresentation or breach of warranty, 2 A.L.R. 1507.

33-24-25. Provisions in group or blanket policies excluding or reducing coverage of persons eligible for or receiving medical assistance.

No group or blanket accident and sickness policy shall contain any provision purporting to exclude or reduce coverage provided an otherwise insurable person solely for the reason that the person is eligible for or receiving medical assistance as defined in Article 7 of Chapter 4 of Title 49. Any such provision appearing in a group or blanket accident and sickness insurance policy shall be null and void.

History. — Code 1933, § 56-3105.1, enacted by Ga. L. 1978, p. 1522, § 2; Ga. L. 2017, p. 164, § 20/HB 127; Ga. L. 2019, p. 386, § 37/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "subsequent to July 1, 1978," following "insurance policy" near the end of the second sentence.

Cross references. — Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

33-24-26. Provisions limiting or restricting payment of benefits for preexisting illnesses or conditions.

No group accident and sickness insurance policy, other than policies of disability income insurance and credit accident and sickness insurance and other than policies of qualified self-insurers, shall be issued in this state, which policy limits or restricts payment of benefits for any preexisting illness or condition not otherwise excluded from the group policy for a period in excess of 12 months following the date of the issuance of the certificate covering the insured person.

History. — Code 1933, § 56-3112, enacted by Ga. L. 1978, p. 2036, § 1; Ga. L. 1995, p. 1009, § 1; Ga. L. 2017, p. 164, § 21/HB 127.

Cross references. — Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

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.

Burden of proof in action upon accident policy, or accident feature of life policy, as to whether injury or death was resulting from antecedent disease or other abnormal bodily or mental condition, 144 A.L.R. 1416.

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 900.

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.

33-24-26.1. Provisions required in group policies or contracts of disability income insurance covering preexisting conditions; restrictions on preexisting condition limitations or exclusions.

(a) A group policy or contract of disability income insurance shall not contain a definition of the term "preexisting condition" which is more restrictive than the following: preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within 12 months preceding the effective date of coverage of the insured.

(b) Any group policy or contract of disability income insurance which limits, restricts, or excludes payment of benefits for preexisting conditions shall contain a notice as provided in this subsection. The notice shall be entitled "Preexisting Conditions Limitations or Exclusions," shall appear as a separate paragraph of the policy or contract, shall appear in boldface type, and shall provide an appropriate definition or description of the term "preexisting condition" for the purposes of the policy.

(c) No policy or certificate of group disability income insurance shall be issued or delivered in this state which limits or excludes payment of benefits for a disability resulting from a preexisting condition if that disability occurs more than 24 months following the effective date of an insured's coverage under such policy.

History. — Code 1981, § 33-24-26.1, enacted by Ga. L. 1995, p. 1009, § 2; Ga. L. 2019, p. 386, § 38/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "Reserved." for the former provisions of subsection (d), which read: "This Code section shall apply to group policies or contracts of disability income insurance issued, delivered, issued for delivery, or renewed in this state on or after July 1, 1995."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modern-

ize, and correct the Code, deleted former subsection (d) which was designated as reserved.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, "preexisting" was substituted for "Preexisting" following the colon in subsection (a).

33-24-27. Provision for reimbursement for services within the lawful scope of practice of psychologists or chiropractors.

(a) As used in this Code section, the term "psychologist" means any person who is:

(1) Duly licensed as a psychologist under Chapter 39 of Title 43, which provides for the licensure of psychologists, and has a doctoral degree from an accredited educational institution and a year of supervised experience in a setting approved by the State Board of Examiners of Psychologists;

(2) Required by Georgia law to meet continuing education requirements as a condition for renewal of licensing; and

(3) Required to adhere to the American Psychological Association's Ethical Standards of Psychologists (Revised 1977).

(b) Notwithstanding any provisions in policies or contracts which might be construed to the contrary, all individual, group, or blanket policies of accident and sickness insurance and individual or group service contracts which are issued, delivered, issued for delivery, amended, or renewed in this state and which provide coverage for services which are within the lawful scope of practice of a psychologist or chiropractor duly licensed to practice in this state shall be deemed to provide that any person covered under the policies or contracts shall be entitled to receive reimbursement for services under the policies or contracts regardless of whether they are rendered by a duly licensed doctor of medicine or by a duly licensed psychologist or chiropractor.

History. — Code 1933, § 56-2445, enacted by Ga. L. 1980, p. 1249, § 1; Ga. L. 1980, p. 1279, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 2019, p. 386, § 39/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (b), deleted "from and after July 1, 1980," following "to the contrary," near the middle, deleted "or indemnity" following "individual or group service", and deleted "issued by nonprofit corporations or by health care corporations" preceding "which are issued" in the middle.

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30. Chiropractors, T. 43, C. 9.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1987, a comma was inserted following "group" in subsection (b).

Editor's notes. — Ga. L. 1980, p. 1249, § 1, superseded former Code 1933, § 56-3111.

OPINIONS OF THE ATTORNEY GENERAL

O.C.G.A. § 33-24-27 does not apply to a self-insured health insurance plan provided by Board of Regents and the University of Georgia to their employees. 1981 Op. Att'y Gen. No. 81-38.

RESEARCH REFERENCES

ALR. — What amounts to medical or surgical attendance or consultation within contemplation of contract of life or accident insurance, 63 A.L.R. 846.

33-24-27.1. Provision for reimbursement for services within the lawful scope of practice of optometrists.

Notwithstanding any provisions in such policies or contracts which might be construed to the contrary, all individual and group or blanket policies of accident and sickness insurance and individual or group service contracts or by health care corporations, pursuant to Chapter 20 of this title, which policies are issued, delivered, issued for delivery, amended, or renewed in this state and which provide coverage for services which are within the lawful scope of practice of an optometrist duly licensed to practice in this state, shall be deemed to provide that any person covered under such policies or contracts shall be entitled to receive reimbursement for such services under such policies or contracts regardless of whether they are rendered by a duly licensed doctor of medicine or by a duly licensed optometrist.

History. — Code 1933, § 56-2447, enacted by Ga. L. 1981, p. 817, §§ 1, 2; Ga. L. 2019, p. 386, § 40/SB 133.

The 2019 amendment, effective July 1, 2019, deleted the subsection (a) designation; deleted "from and after July 1, 1981," following "to the contrary," near the middle, deleted "or indemnity" following "or group service", and deleted "issued by nonprofit corporations, pursuant to Chapters 18 and 19 of this title," preceding "or by health care corporations" in the middle; and deleted former subsection (b), which read: "This Code section shall not be construed so as to impair the obligation of any policy or contract which is in existence prior to July 1, 1981."

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

OPINIONS OF THE ATTORNEY GENERAL

O.C.G.A. § 33-24-27.1 is not applicable to Board of Regents' self-insured health plan for its employees, the self-insured State Employees Health Insurance Plan, or any self-insured plan established by a state agency. 1981 Op. Att'y Gen. No. 81-67.

33-24-27.2. Provision for reimbursement for services within the lawful scope of practice of athletic trainers.

Notwithstanding any provisions in policies or contracts which might be construed to the contrary, all individual, group, or blanket policies of accident and sickness insurance and individual or group service contracts or by health care corporations which are issued, delivered, issued for delivery, amended, or renewed in this state and which provide coverage for services which are within the lawful scope of practice of an athletic trainer qualified pursuant to Code Section 43-5-8 shall be deemed to provide that any person covered under such policies or contracts shall be entitled to receive reimbursement for services under such policies or contracts regardless of whether such services are rendered by a duly licensed doctor of medicine or by an athletic trainer qualified pursuant to Code Section 43-5-8. Nothing contained in this Code section shall require an insurer to offer such coverage.

History. — Code 1981, § 33-24-27.2, enacted by Ga. L. 1999, p. 327, § 2; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 386, § 41/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted the subsection (a) designation; in the first sentence of this Code section, deleted "from and after July 1, 1999," following "to the contrary," near the middle, deleted "or indemnity" following "or group service", and deleted "issued by nonprofit corporations" preceding "or by health care corporations" in the middle; and deleted former subsection (b), which read: "This Code section shall not be construed so as to impair the obligation of any policy or contract which is in existence prior to July 1, 1999."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "Code section" for "subsection" in the last sentence of this Code section.

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, in the last sentence of this Code section, "insurer" was substituted for "insurance".

33-24-28. Termination of coverage of dependent child upon attainment of specified age.

(a) An individual hospital or medical expense insurance policy or hospital contract which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities and chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer or hospital by the policyholder or subscriber within 31 days of

the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(b) A group hospital or medical expense insurance policy or hospital contract which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities and chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity and dependency is furnished to the insurer or hospital by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(c) This Code section shall apply equally to health insurance policies issued pursuant to Chapters 29 and 30 of this title, coverage by health maintenance organizations under Chapter 21 of this title, and health care plans under Chapter 20 of this title.

History. — Code 1933, § 56-2440, enacted by Ga. L. 1972, p. 1156, § 1; Ga. L. 1995, p. 1302, § 13; Ga. L. 2009, p. 453, §§ 3-2, 3-6/HB 228; Ga. L. 2017, p. 164, § 22/HB 127; Ga. L. 2019, p. 386, § 42/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "or medical service plan" following "insurance policy or hospital" near the beginning of subsections (a) and (b); substituted "insurer or hospital by the policyholder" for "insurer, hospital, or medical service plan corporation by the policyholder" in subsection (a); and deleted "or medical service plan corporation" following "furnished to the insurer or hospital" in subsection (b).

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

33-24-28.1. Coverage of treatment of mental disorders.

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

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) An individual accident and sickness insurance policy or contract, as defined in Chapter 29 of this title; or

(B) Any similar individual accident and sickness benefit plan, policy, or contract.

(2) "Mental disorder" shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation.

(b) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental disorders, which coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if such insured's spouse and dependents are covered under such benefit plan, policy, or contract. In no event shall such an insurer be required to cover inpatient treatment for more than a maximum of 30 days per policy year or outpatient treatment for more than a maximum of 48 visits per policy year under individual policies.

(c) The optional endorsement required to be made available under subsection (b) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to the treatment of mental disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(d) Nothing in this Code section shall be construed to prohibit an insurer, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(e) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for the treatment of mental disorders that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

History. — Code 1933, § 56-2447, enacted by Ga. L. 1981, p. 896, § 1; Ga. L. 1984, p. 777, § 1; Ga. L. 1989, p. 14, § 33; Ga. L. 1998, p. 736, § 1; Ga. L. 2019, p. 386, § 43/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (b), deleted "on or after July 1, 1984," following "or renewed" in the middle of the first sentence, substituted "such insured's spouse" for "the insured's spouse" in the middle of the second sentence; and deleted "nonprofit corporation," following "prohibit an insurer," near the beginning of subsection (d).

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981). For review of 1998 legislation relating to insurance, see 15 Georgia St. U.L. Review 170 (1998).

For note, "The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation," see 44 Ga. L. Rev. 511 (2010).

RESEARCH REFERENCES

ALR. — 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.

33-24-28.2. Coverage of outpatient surgery.

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

(1) "Anesthetic" means an agent that produces insensibility to pain or touch. According to their action, such anesthetics are subdivided into the categories of general and local anesthetics.

(2) "Charges for facility services" means charges for such items as drugs and biologicals administered at the facility, trays, bandages, and casts which are furnished incidentally to a physician's services and which are commonly furnished in a physician's office.

(3) "General anesthetic" means an anesthetic that is complete and affects the entire body causing loss of consciousness when the anesthetic acts upon the brain. Such anesthetics are usually administered intravenously or through inhalation.

(4) "Licensed medical practitioner" means a medical practitioner who is currently licensed to practice medicine under Chapter 34 or 35 of Title 43 and who has agreed to submit to review by a Professional Standards Review Organization (PSRO) established, conditionally or otherwise, pursuant to Part B of Title XI of the Social Security Act (42 U.S.C. Section 1320c, et seq.), or by a medical care foundation or other recognized peer review organization, and who is approved to perform the covered procedures under a local anesthetic at an accredited hospital located within the area where the procedures are performed.

(5) "Local anesthetic" means an anesthetic affecting a local area only, the anesthetic operating upon the nerves or nerve tracts.

(6) "Medical emergency" means the sudden and unexpected onset of a condition with severe symptoms, requiring medical care which is secured immediately after the onset or within 72 hours after the onset of symptoms. The illness or condition as finally diagnosed must be one which normally would require immediate medical, not surgical, care. Sudden, unexpected, severe medical conditions or symptoms are those which are or which give evidence of being life threatening. Previously diagnosed chronic conditions in which subacute symptoms have existed over a period of time shall not be included in the definition of medical emergency unless symptoms suddenly become so severe as to require immediate medical aid. Provided they meet the requirements of this definition, conditions such as the following will qualify as medical emergencies: appendicitis, acute asthma, breathing difficulties or shortness of breath, severe bronchitis, severe onset of bursitis, severe chest pain, choking, coma, convulsions or seizures, cystitis, dermatitis or hives (resulting from internal or unknown causes), diabetic coma, severe diarrhea, drug reaction, epistaxis (nosebleed), fainting, severe fecal impaction, food poisoning, frostbite, acute attack of gall bladder, gastritis, acute gastrointestinal conditions, severe headache, suspected heart attack, hemorrhage, hysteria, insertion of catheter (for acute retention), insulin shock (overdose), kidney stone, maternity complications such as a suspected miscarriage (if policy covers maternity), sudden or severe onset of pain, pleurisy, pneumonitis, poisoning (including overdoses), pyelitis, pyelonephritis, shock, cerebral or cardiac spasms, spontaneous pneumothorax, severe stomach pains, strangulated hernia, stroke, sunstroke, swollen ring finger, tachycardia, thrombosis or phlebitis, unconsciousness, acute urinary retention, sudden onset of vision loss, or severe vomiting.

(7) "Professional fees" means charges for identifiable professional services rendered by a physician to a patient in person, which services contribute either to the diagnosis of the condition or the treatment of the patient.

(b) Every insurer authorized to issue accident and sickness benefit plans, policies, or contracts shall be required to make available, as an optional endorsement to all such policies that provide coverage for medical or surgical procedures which are required to be performed on an inpatient basis, an endorsement which provides at least the following coverages:

(1) Coverage which provides reimbursement for any covered surgical procedures performed on an outpatient basis when such procedures are performed by a licensed medical practitioner operating with the use of local anesthetic at a licensed outpatient surgical facility affiliated with a licensed hospital, at a licensed freestanding

surgical facility, at a surgical facility operated by a health maintenance organization, or at the office of a licensed medical practitioner; and

(2) Coverage which provides reimbursement for medical or surgical procedures performed on an outpatient basis in the case of a medical emergency.

(c) All payments made under the coverages provided for in this Code section shall be made in accordance with the schedule of benefits contained in the policy, if applicable, or in accordance with the usual, customary, and reasonable professional fees and charges for facility services furnished in connection with such procedures.

(d) This Code section shall also apply to policies or contracts issued by a health care plan, a health maintenance organization, a fraternal benefit society, or any other similar entity.

(e) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage specified in paragraphs (1) and (2) of subsection (b) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, health care plan, health maintenance organization, or master policyholder to provide or to make available such coverage to any certificate holder insured under such group policy, plan, or contract.

(f) Nothing in this Code section shall be construed to prohibit an insurer, health care plan, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

History. — Code 1933, § 56-2447, enacted by Ga. L. 1981, p. 991, § 1; Ga. L. 2017, p. 164, § 23/HB 127; 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)(4).

Cross references. — Contents of individual accident and sickness insurance policies, T. 33, C. 29. Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "Section" was inserted following "42 U.S.C." in paragraph (a)(4).

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 540 et seq. 44 Am. Jur. 2d, Insurance, § 972 et seq.
C.J.S. — 44 C.J.S., Insurance, §§ 573, 580 et seq., 631. 46 C.J.S., Insurance, § 1234 et seq. 46A C.J.S., Insurance, § 1783.

33-24-28.3. Policies not to exclude payment to hospitals specializing in treatment of alcoholics or drug addicts.

No policy of accident and sickness insurance, other than a policy of accident and sickness insurance issued in connection with an extension of credit, which is issued, delivered, or issued for delivery in this state by an insurer, health care plan, fraternal benefit society, or health maintenance organization authorized to transact insurance in this state and which provides specific benefits for the treatment of alcoholism or drug addiction, shall exclude the payment or reimbursement of such covered hospital or medical service benefits which would otherwise be payable to a hospital duly licensed in this state solely because such hospital specializes in the treatment of alcoholics or drug addicts and is operated primarily for the treatment of such persons.

History. — Code 1981, § 33-24-28.3, enacted by Ga. L. 1986, p. 695, § 2; Ga. L. 2017, p. 164, § 24/HB 127.

33-24-28.4. Coverage of general anesthesia and hospital or ambulatory surgical facility charges for certain dental care.

(a) As used in this Code section, the term "general anesthesia" means the use of an anesthetic that is complete and affects the entire body, causing loss of consciousness when the anesthetic acts upon the brain. Such anesthetics are usually administered intravenously or through inhalation.

(b)(1) Any individual or group plan, policy, or contract for health care services which is issued, delivered, issued for delivery, or renewed in this state by a health care insurer, health maintenance organization, accident and sickness insurer, fraternal benefit society, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes health care services to patients, insureds, or beneficiaries in this state shall be subject to the provisions of this Code section.

(2) Any entity listed in paragraph (1) of this subsection and located or domiciled outside of this state shall be subject to the provisions of this Code section if it receives, processes, adjudicates, pays, or denies any claim for health care services submitted by or on behalf of any

patient, insured, or other beneficiary who resides or receives health care services in this state.

(c) Any entity that provides a health care services plan, policy, or contract subject to this Code section shall provide coverage for general anesthesia and associated hospital or ambulatory surgical facility charges in conjunction with dental care provided to a person insured or otherwise covered under such plan if such person is:

(1) Seven years of age or younger or is developmentally disabled;

(2) An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the insured; or

(3) An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

(d) Any entity that provides a health care services plan, policy, or contract subject to this Code section may require prior authorization for general anesthesia and associated hospital or ambulatory surgical facility charges for dental care in the same manner that prior authorization is required for such benefits in connection with other covered medical care.

(e) Any entity that provides a health care services plan, policy, or contract subject to this Code section may restrict coverage under this Code section to include only procedures performed by:

(1) A fully accredited specialist in pediatric dentistry or other dentist fully accredited in a recognized dental specialty for which hospital or ambulatory surgical facility privileges are granted;

(2) A dentist who is certified by virtue of completion of an accredited program of postgraduate training to be granted hospital or ambulatory surgical facility privileges; or

(3) A dentist who has not yet satisfied certification requirements but has been granted hospital or ambulatory surgical facility privileges.

(f) This Code section shall not apply to limited benefit insurance policies as defined in paragraph (4) of subsection (e) of Code Section 33-30-12.

History. — Code 1981, § 33-24-28.4, enacted by Ga. L. 1999, p. 377, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2017, p. 164, § 25/HB 127.

Editor's notes. — Ga. L. 1999, p. 377, § 2, not codified by the General Assembly, provides that: "This Act shall apply to all plans, policies, or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 1999."

33-24-29. Coverage for treatment of mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering small groups; federal law.

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

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

(2) "Mental disorder" shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering small groups as defined in subsection (a) of Code Section 33-30-12.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental disorders, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits, but which may provide for different limits on the number of inpatient treatment days and outpatient treatment visits, as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the

dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(d)(1) The optional endorsement required to be made available under subsection (c) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages which apply to the treatment of mental disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract, except for any differing limits on inpatient treatment days and outpatient treatment visits as provided under subsection (c) of this Code section and as otherwise provided in paragraph (2) of this subsection.

(2) The optional endorsement required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental disorders, and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000.00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater.

(e)(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of

indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract.

(g) This Code section is neither enacted pursuant to nor intended to implement the provisions of any federal law.

History. — Code 1981, § 33-24-29, enacted by Ga. L. 1998, p. 736, § 2; Ga. L. 2001, p. 4, § 33; Ga. L. 2017, p. 164, § 26/HB 127; Ga. L. 2019, p. 386, § 44/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1998," following "or renewed" in the middle of the first sentence of subsection (c).

Editor's notes. — Ga. L. 1998, p. 736, § 2, repealed former Code Section 33-24-29, pertaining to medicare supplement health insurance. The former Code section was based on Ga. L. 1980, p. 1266, § 1; Ga. L. 1980, p. 1418, § 1.

On November 30, 1999, the Commissioner of Insurance reported to the General Assembly that "pursuant to O.C.G.A. Section 33-24-29(g) and O.C.G.A. Section 33-24-29.1(g), I do not find and cannot report that as an effect of the changes in coverage required by Senate Bill 620, premiums increased on average at a rate exceeding 2 percent for the period July 1, 1998 to October 1, 1999."

Law reviews. — For note, "The Parity Cure: Solving Unequal Treatment of Mental Illness Health Insurance Through Federal Legislation," see 44 Ga. L. Rev. 511 (2010).

33-24-29.1. Coverage for mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering all groups except small groups.

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

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

(2) "Mental disorder" shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering all groups except small groups as defined in subsection (a) of Code Section 33-30-12.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental disorders, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(d)(1) The optional endorsement required to be made available under subsection (c) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, including without limitation limits on the number of inpatient treatment days and outpatient treatment visits, which apply to the treatment of mental disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract, except as otherwise provided in paragraph (2) of this subsection.

(2) The optional endorsement required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental disorders, and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the

accident and sickness insurance benefit plan, policy, or contract; provided, however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000.00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater.

(e)(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract.

History. — Code 1981, § 33-24-29.1, enacted by Ga. L. 1998, p. 736, § 3; Ga. L. 2001, p. 4, § 33; Ga. L. 2017, p. 164, § 27/HB 127; Ga. L. 2019, p. 386, § 45/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1998," following "or renewed" in the middle of the first sentence of subsection (c).

Editor's notes. — On November 30, 1999, the Commissioner of Insurance reported to the General Assembly that "pursuant to O.C.G.A. Section 33-24-29(g) and O.C.G.A. Section 33-24-29.1(g), I do not find and cannot report that as an effect of the changes in coverage required by Senate Bill 620, premiums increased on average at a rate exceeding 2 percent for the period July 1, 1998 to October 1, 1999."

33-24-30. Excluding or denying coverage on basis of violation of civil air regulations.

(a) No policy of insurance issued or delivered in this state covering any loss, expense, or liability arising out of the ownership, maintenance, or use of an aircraft shall exclude or deny coverage because the aircraft is operated in violation of civil air regulations pursuant to federal, state, or local laws or ordinances.

(b) This Code section does not prohibit the use of specific exclusions or conditions in any such policy which relates to any of the following:

(1) Certification of an aircraft in a stated category by the Federal Aviation Administration;

(2) Certification of a pilot in a stated category by the Federal Aviation Administration;

(3) Establishing requirements for pilot experience; or

(4) Establishing limitations on the use of the aircraft.

(c) Any policy of insurance containing one, all, or any combination of the specific exclusions or conditions in the categories permitted in subsection (b) of this Code section shall include conspicuous notice advising the insured that the policy contains such exclusions or conditions and provide specific instructions as to what actions the insured shall undertake in order to protect and preserve his or her rights and coverages under the policy.

History. — Code 1933, § 56-2439, enacted by Ga. L. 1968, p. 1414, § 1; Ga. L. 2015, p. 824, § 1/HB 84.

Editor's notes. — Ga. L. 2015, p. 824, § 2/HB 84, not codified by the General Assembly, provides: "This Act shall be applicable to policies issued on or renewed after July 1, 2015."

Law reviews. — For annual survey on commercial transportation, see 69 Mercer L. Rev. 41 (2017).

JUDICIAL DECISIONS

Policy's terms prevail over FAA regulations. — Provision in an insurance policy requiring that only pilots with "proper [Federal Aviation Agency pilot]

certificates" may operate the aircraft, does not require exact compliance with the face of the pilot's certificate, since the policy's terms specifying the limits of the coverage, and not the Federal Aviation Agency's regulations, prevail. Ranger Ins. Co. v. Culberson, 454 F.2d 857 (5th Cir. 1971), cert. denied, 407 U.S. 916, 92 S. Ct. 2440, 32 L. Ed. 2d 691 (1972).

Endorsement of passenger coverage provision in an insurance policy prevails over a provision suspending coverage for operation of a plane "in any manner which requires a special permit or waiver from the Federal Aviation Agency (FAA)" when the plane was operated in violation of FAA regulation since the policy clearly was endorsed so as to cover just such operation. Ranger Ins. Co. v. Culberson, 454 F.2d 857 (5th Cir. 1971), cert. denied, 407 U.S. 916, 92 S. Ct. 2440, 32 L. Ed. 2d 691 (1972).

Limitation of liability based on absence of valid medical certificate. — Limitation of liability based upon absence of a valid medical certificate relates to pilot "status" and does not constitute a condition subsequent tending illegally to vitiate coverage. Boone v. Ranger Ins. Co., 152 Ga. App. 891, 264 S.E.2d 325 (1980).

Policy exclusion for losses arising out of the operation of a helicopter for which the airworthiness certificate has expired does not violate subsection (a) O.C.G.A. § 33-24-30, even though the effectiveness of that certificate is governed by compliance with federal regulations, since the basis for exclusion of coverage is the operation of the helicopter without the airworthiness certificate, not the violation of the underlying regulations. Coren v. Puritan Ins. Co., 184 Ga. App. 667, 362 S.E.2d 380, cert. denied, 184 Ga. App. 903, 363 S.E.2d 159 (1987).

Policy language fairly interpreted as an exclusion. — When a policy states that "the coverage afforded by this policy shall not apply …" unless the aircraft operator holds a "valid and effective pilot and medical certificate," this language would unambiguously indicate to the insured that insurance coverage would be suspended if the plane was operated by a pilot without an effective pilot certificate and medical examination. Thus, the language was fairly interpreted as an exclusion. Monarch Ins. Co. v. Polytech Indus., Inc., 655 F. Supp. 1058 (M.D. Ga.), aff'd, 833 F.2d 1020 (11th Cir. 1987).

Exclusion rating to pilot certification valid. — Exclusion of liability was valid under subsection (b) of O.C.G.A. § 33-24-30 where it applied to instances when the pilot was not licensed and qualified under federal laws and regulations. Brown v. North Am. Specialty Ins. Co., 235 Ga. App. 299, 508 S.E.2d 741 (1998).

Endorsement held binding. — Pilot endorsement which says that, in addition to named persons, a pilot approved under the policy would be … "any commercial pilot with a minimum of 300 total logged flying hours, of which not less than 10 hours shall have been in the same make and model aircraft as the insured," was a valid and binding requirement for the insured and barred coverage of a commercial pilot who had not logged 10 flying hours as first in command of the type of aircraft involved, since the pilot was operating the controls at the time of the crash, even if another person was first in command at the time of the crash. Monarch Ins. Co. v. Polytech Indus., Inc., 655 F. Supp. 1058 (M.D. Ga.), aff'd, 833 F.2d 1019 (11th Cir. 1987).

Cited in F & M Bank v. Ranger Ins. Co., 125 Ga. App. 166, 186 S.E.2d 579 (1971); U.S. Fire Ins. Co. v. Hilde, 172 Ga. App. 161, 322 S.E.2d 285 (1984).

RESEARCH REFERENCES

ALR. — Construction and application of provision of life or accident policy relating to aeronautics, 17 A.L.R.2d 1041.

Property insurance on aircraft; risks and losses covered, 48 A.L.R.3d 1120.

Construction of provision of aviation liability policy which requires pilot of insured aircraft to have appropriate license or certification, 72 A.L.R.3d 525.

Risks and causes of loss covered or excluded by aviation liability policy, 86 A.L.R.3d 118.

What is "aircraft" or the like within meaning of exclusion or exception clause of insurance policy, 39 A.L.R.4th 214.

Aviation insurance: causal link between breach of policy provisions and accident as requisite to avoid insurer's liability, 48 A.L.R.4th 778.

33-24-30.1. Excluding or denying coverage on basis of lawful firearms possession.

No policy of insurance issued or delivered in this state covering any loss, damage, expense, or liability shall exclude or deny coverage because the insured, members of the insured's family, or employees of the insured will keep or carry in a lawful manner firearms on the property or premises of the insured.

History. — Code 1981, § 33-24-30.1, enacted by Ga. L. 1998, p. 261, § 1.

33-24-31. Provision in group disability income policies for offsetting of increased social security benefits.

No group disability income policy which integrates benefits shall provide that the amount of any disability benefit actually being paid to the disabled person shall be reduced by changes in the level of social security benefits resulting either from changes in the federal Social Security Act or due to cost-of-living adjustments provided in the federal Social Security Act, which become effective after the first day for which disability benefits become payable.

History. — Code 1933, § 56-2444, enacted by Ga. L. 1979, p. 1289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2019, p. 386, § 46/SB 133.

The 2019 amendment, effective July 1, 2019, deleted the subsection (a) designation; and deleted former subsection (b), which read: "This Code section shall apply to all group disability income policies delivered or issued for delivery in this state on or after July 1, 1979."

Cross references. — Contents of group or blanket accident and sickness insurance, T. 33, C. 30.

U.S. Code. — The federal Social Security Act, referred to in this Code section, is codified as 42 U.S.C. § 301 et seq.

33-24-32. Underwriters' and combination policies.

(a) Two or more authorized insurers may jointly issue and shall be jointly and severally liable on an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and the policy shall plainly show the true name of the insurer.

(b) Two or more insurers may issue a combination policy which shall contain provisions substantially as follows:

(1) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage according to the terms of the

policy or for specified percentages or amounts of such loss or damage, aggregating the full amount of insurance under the policy; and

(2) That service of process or of any notice or proof of loss required by the policy upon any of the insurers executing the policy shall constitute service upon all insurers.

(c) Reserved.

(d) This Code section shall not apply to cosurety obligations.

History. — Code 1933, § 56-2417, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1999, p. 878, § 13.

JUDICIAL DECISIONS

No authorization for separate policies without separability clause. — Without the application of the separability clause in the insuring agreement, there is no authorization for the creation of separate policies. Leader Nat'l Ins. Co. v. Berry, 157 Ga. App. 627, 278 S.E.2d 170 (1981).

"Stacking" permitted only on multiple automobile policies. — As to single policy coverage of automobiles, there can generally be no pyramiding of the uninsured motorist provisions, but, as to multiple policies, an insured may recover on both policies under the uninsured motorist provisions, thus pyramiding or "stacking" the coverage. Leader Nat'l Ins. Co. v. Berry, 157 Ga. App. 627, 278 S.E.2d 170 (1981).

Effect of consent by insurer to dual agency. — When an insurance company acquiesces in an arrangement with an insurance agent representing it whereby the agent may be expected to act also on behalf of the insured, the company consents to the dual agency so that the agent is no longer insulated from responsibility to the insured to effect the agreed-upon coverage on the ground that the agent's undertaking to do so is against public policy. Speir Ins. Agency, Inc. v. Lee, 158 Ga. App. 512, 281 S.E.2d 279 (1981).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 61.

C.J.S. — 44 C.J.S., Insurance, §§ 3, 7, 20, 21. 46A C.J.S., Insurance, §§ 2229, 2231, 2232.

ALR. — Prior or subsequent policy issued by insurer itself as a defense to or a limitation of recovery under another policy, 125 A.L.R. 846.

33-24-33. Binders and other contracts for temporary insurance.

(a) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given together with any applicable endorsements that are designated in the binder, except as superseded by the clear and express terms of the binder.

(b) No binder shall be valid beyond the issuance of the policy with respect to which it was given or beyond 90 days from its effective date,

whichever period is the shorter, provided that this subsection shall not apply to excess or surplus line insurance.

(c) If the policy has not been issued, a binder may be extended or renewed beyond 90 days with the written approval of the Commissioner or in accordance with such rules and regulations relative thereto as the Commissioner may promulgate.

(d) This Code section shall not apply to life or accident and sickness insurance.

History. — Code 1933, § 56-2420, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Binder is contract for temporary insurance. Ebco Gen. Agency v. Mitchell, 186 Ga. App. 874, 368 S.E.2d 782, cert. denied, 186 Ga. App. 917, 368 S.E.2d 782 (1988).

"Application binder" for automobile insurance was not valid beyond 90 days from the binder's effective date, when the insured failed to make any premium payment. Thus, the insurer was entitled to summary judgment in an action to determine the insurer's duty to defend the insured, who was involved in an accident more than 90 days after issuance of the binder. Southern Gen. Ins. Co. v. Snipes, 196 Ga. App. 727, 396 S.E.2d 808 (1990).

Subsection (b) inapplicable when binder ratified by issuance of policy at later date. — Subsection (b) of this section does not apply when binder is ratified by issuance of a policy at a later date. Allstate Ins. Co. v. Reynolds, 138 Ga. App. 582, 227 S.E.2d 77 (1976).

Binder has much the same effect as policy and may be canceled in accordance with this section. Georgia Farm Bureau Mut. Ins. Co. v. Gordon, 126 Ga. App. 215, 190 S.E.2d 447 (1972).

Binder may be either oral or written. — In general, contracts for insurance must be in writing and may not be partially parol. A binder or other contract for temporary insurance is an exception to this general rule and may be either oral or written. Thomas v. Union Fid. Life Ins. Co., 168 Ga. App. 267, 308 S.E.2d 609 (1983), aff'd, 252 Ga. 259, 312 S.E.2d 333 (1984).

Oral orders by insured for change of coverage are in the nature of a binder and enforceable. Canal Ins. Co. v. Aldrich, 489 F. Supp. 157 (S.D. Ga. 1980).

Binder must be a contract in praesenti and actual payment of premium is not a condition precedent to its validity. Greene v. Commercial Union Ins. Co., 136 Ga. App. 346, 221 S.E.2d 479 (1975).

Premium payment as condition precedent to coverage under binder. — When the insurance application stated that the payment of the premium installment was a condition precedent to the existence of coverage and stated the intent of the insurance company that if premium remittance was dishonored no coverage of any type would exist, when check sent as remittance for the premium payment was dishonored, there was a total failure of consideration for the binder and the contract was null and void. McDuffie v. Criterion Cas. Co., 214 Ga. App. 818, 449 S.E.2d 133 (1994).

Language or conduct necessary to create the contract is simply that which is enough to show that there has been a meeting of the minds. Ray v. Georgia Farm Bureau Mut. Ins. Co., 176 Ga. App. 776, 337 S.E.2d 779 (1985).

Purpose and effect of binder. — Binder issued on an application for insurance is a mere memorandum of the most important terms of a preliminary contract of insurance, intended to give temporary protection pending the investigation of the risk by the insurer, or until the issu-

ance of a formal policy. Cincinnati Ins. Co. v. Stuart, 139 Ga. App. 80, 227 S.E.2d 771 (1976).

Insurance binder analysis. — Under subsection (a) of O.C.G.A. § 33-24-33, the analysis of an insurance binder proceeds as follows: If clear and express terms have been agreed upon, they must be considered as controlling over the usual policy provisions. If there are no clear and express terms agreed upon, the usual policy provisions must be considered as controlling, together with any applicable endorsement that is specified in the binder. If there are no applicable endorsements specified in the binder, the usual policy provisions must be considered to be controlling. International Indem. Co. v. McKeever, 174 Ga. App. 871, 331 S.E.2d 909 (1985).

Expiration of binder results in no coverage. — When construction company did not intend to have insurance with defendant insurer after the expiration of the binder coverage and when the accident occurred afterwards, there was no error in granting summary judgment to defendant insurer on the claim by plaintiff insurer for contribution. Southern Guar. Ins. Co. v. Ragan Ins. Agency, Inc., 212 Ga. App. 690, 442 S.E.2d 871 (1994).

Fixing of effective date of policy by parties. — Time when an insurance policy shall become effective is an essential element of the contract, and parties may fix a future date upon which the contract shall become effective. Rowell v. Georgia Cas. & Sur. Co., 109 Ga. App. 631, 136 S.E.2d 917 (1964).

Effective date of a contract for temporary insurance is the time fixed in the contract for the commencement of the risk as opposed to the date upon which the contract is executed or issued. Rowell v. Georgia Cas. & Sur. Co., 109 Ga. App. 631, 136 S.E.2d 917 (1964).

No apparent authority existed. — Grant of summary judgment to an insurance company and an underwriter was affirmed in a case asserting the bad faith failure to pay an insurance claim because the tree service company owner failed to bring forth evidence that the agent had the apparent authority to bind the insurance company or the underwriter to an insurance policy and the payment was not received by the deadline, therefore, there was no coverage under the binder issued. Popham v. Landmark Am. Ins. Co., 340 Ga. App. 603, 798 S.E.2d 257 (2017).

Terms of policy supersede temporary binder coverage. — Fact that the policy application specified a slightly different expiration time than did the policy was irrelevant in determining whether the policy had expired at the time of an accident since the policy superseded any temporary binder of coverage which may have existed by virtue of the application. Green v. Progressive Ins. Co., 196 Ga. App. 733, 397 S.E.2d 20 (1990).

Temporary policy expired by date of collision. — When no formal written policy was ever issued to the decedent and the collision occurred more than 90 days after the date that the decedent's temporary policy of insurance became effective, the temporary policy had expired by the policy's own terms by the time the collision occurred. Jourdan v. First Nat'l Ins. Co. of Am., 203 Ga. App. 155, 416 S.E.2d 162 (1992).

Section nullifies rule prohibiting parol renewal of policy. — This section, in effect and as a practical matter, overrides or nullifies the principle of law which prohibits the parol renewal of a policy of insurance. Rowell v. Georgia Cas. & Sur. Co., 109 Ga. App. 631, 136 S.E.2d 917 (1964).

Conduct of agent. — Insurance agent's conduct, including the agent's acceptance of a premium check, coupled with the parties' past dealings, was sufficient evidence to foreclose summary judgment as to whether a binder for temporary protection had been created. Parks v. State Farm Gen. Ins. Co., 231 Ga. App. 26, 497 S.E.2d 575 (1998).

Agent not automatically clothed with power to issue valid oral binder. — Even if the acts of a party are such as to bring the party within the statutory definition of an agent, this would not automatically clothe the party with the power to issue a valid oral binder as recognized under subsection (a) of this section. Southeastern Fid. Fire Ins. Co. v. State Farm Mut. Auto. Ins. Co., 118 Ga. App. 861, 165 S.E.2d 887 (1968).

Allegation of issuance of oral binder by insurer's agent sufficient. — Allegation in petition that an agent of the defendant insurer by oral agreement issued an oral binder obligating the principal on a contract of insurance is sufficient against demurrer (now motion to dismiss). Farm Bureau Mut. Ins. Co. v. Bennett, 114 Ga. App. 623, 152 S.E.2d 609 (1966).

Presumption of kind and amount of insurance requested inferred from prior dealings. — It is clear that even such terms as amount of premium and kind and limits of insurance may be inferred from the course of dealing between the parties, and when a broker is accustomed to "insuring" the owner's automobiles, it may be presumed that a request for insurance means insurance of the kind and amount habitually purchased. Greene v. Commercial Union Ins. Co., 136 Ga. App. 346, 221 S.E.2d 479 (1975).

Negligent failure to secure written policy may give rise to liability. — Even if a binder expires before the injury of the type which would have been covered occurs, the insurer may still be liable in negligence for the damages if the insurer's agent fails to secure the written policy after having promised to do so, and the insured, reasonably relying on such promise and refraining from obtaining insurance elsewhere, sustains injury of the type against which the insured would have been insured if the policy had been properly issued. Ray v. Georgia Farm Bureau Mut. Ins. Co., 176 Ga. App. 776, 337 S.E.2d 779 (1985).

Binder contained no ambiguity. — Carrier properly applied a coinsurance penalty clause and refused to pay plaintiff insured's claim for damaged tanks and buildings in full because neither the insurance binder, pursuant to O.C.G.A § 33-24-33(a), nor the signed insurance application contained any qualifying language specifying how many tanks, or which tanks, were insured; the meaning of the term "tanks" was plain and obvious. Asphalt Ref. & Tech. Co., LLC v. Underwriters at Lloyd's London, 416 Fed. Appx. 815 (11th Cir. 2011) (Unpublished).

Question regarding terms of binder. — Trial court erred in granting partial summary judgment to the insured on the insured's breach of contract claim because a question of fact remained regarding whether the insurance coverage on the insured's other properties provided coverage for property losses due to theft and, thus, whether such coverage was available for the subject property, for which only a binder had been issued at the time of the theft. Ga. Farm Bureau Mut. Ins. Co. v. T & G Enters., 324 Ga. App. 445, 751 S.E.2d 99 (2013).

Cited in Bryant v. Motors Ins. Corp., 109 Ga. App. 47, 134 S.E.2d 905 (1964); Nationwide Ins. Co. v. Westbrook, 112 Ga. App. 137, 144 S.E.2d 199 (1965); Sasser v. Coastal States Life Ins. Co., 113 Ga. App. 17, 147 S.E.2d 5 (1966); Posey v. Gulf Life Ins. Co., 115 Ga. App. 531, 154 S.E.2d 745 (1967); Parris & Son v. Campbell, 128 Ga. App. 165, 196 S.E.2d 334 (1973); Speir Ins. Agency, Inc. v. Lee, 158 Ga. App. 512, 281 S.E.2d 279 (1981); Guthrie v. GMAC, 172 Ga. App. 260, 322 S.E.2d 752 (1984); Bedgood v. Woodmen of the World Life Ins. Soc'y, 191 Ga. App. 644, 382 S.E.2d 421 (1989); Moore v. Nebb, 200 Ga. App. 242, 407 S.E.2d 411 (1991); Parks v. State Farm Gen. Ins. Co., 238 Ga. App. 814, 520 S.E.2d 494 (1999).

RESEARCH REFERENCES

Am. Jur. 2d. — 7 Am. Jur. 2d, Insurance, § 10 et seq. 43 Am. Jur. 2d, Insurance, § 239.

ALR. — Binding effect of application not signed by insured, 91 A.L.R. 1127.

Periodical payment for which insurer is bound during life of insured or other specified period as apportionable in respect to time, 135 A.L.R. 876.

Temporary automobile insurance pending issuance of policy, 12 A.L.R.3d 1304.

Temporary fire, wind, or hail insurance pending issuance of policy, 14 A.L.R.3d 568.

33-24-34. Authorization of group insurance for government employees; deduction of premiums from wages or salaries.

Each and every county, county board of education, city, town, governmental unit, department, board, or bureau of this state or of the cities and towns of this state is authorized to make deductions periodically from the wages or salaries of its employees with which to pay the premium for life, accident and sickness, hospitalization, or annuity insurance, or any other kind of insurance, for the benefit of such employees upon a group insurance plan and to that end to enter into agreements with insurance companies whereby the kind of group insurance desired by the employees may be furnished to them and the premiums for the group insurance remitted periodically by the counties, boards, cities, towns, units, departments, or bureaus.

History. — Code 1933, § 56-2431, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 47/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "county board of education" for "county board of public instruction" near the beginning, and substituted "towns, units, departments, or bureaus" for "towns, bureaus, or departments" at the end.

Law reviews. — For article discussing the development of group marketing of insurance, with emphasis on recent attempts in the area of property and liability insurance, see 20 J. of Pub. L. 479 (1971).

OPINIONS OF THE ATTORNEY GENERAL

No state agency, including State Merit System, may enter into any optional group insurance plan for life insurance and disability coverage for employees of other departments. 1974 Op. Att'y Gen. No. 74-81.

RESEARCH REFERENCES

ALR. — Insurance: illustrations concerning accumulations, dividends, surplus, etc., 22 A.L.R. 1284; 127 A.L.R. 1464.

Group insurance, 55 A.L.R. 1245; 63 A.L.R. 1034; 85 A.L.R. 1461.

Rights and remedies of insurance company in respect of amounts which employer has deducted, assumed to deduct, or agreed to deduct, as premiums, from salary or wages of employees, 137 A.L.R. 493.

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.

Construction and application of provisions of group insurance policy for extension of its coverage in some instance beyond termination of employment, 147 A.L.R. 287.

Group insurance: employer as agent of insurer or of employee as regards change of beneficiary, 151 A.L.R. 274.

Time of disability or death with regard to termination of coverage under group policy, 68 A.L.R.2d 150.

Cancellation or modification of master policy as termination of coverage under group policy, 68 A.L.R.2d 249.

Persons eligible to receive proceeds of federal employees' group life insurance, where insured does not designate beneficiary, 10 A.L.R.3d 803.

Group insurance: waiver or estoppel on basis of statements in promotional or ex-

planatory literature issued to insureds, 36 A.L.R.3d 541; 63 A.L.R.5th 427.

Validity and effect of choice-of-law provision in group insurance policy, 53 A.L.R.3d 1095.

Group insurance: construction of provision limiting coverage to active employees or to persons working actively in conduct of business, 58 A.L.R.3d 993.

Effective date of group life insurance as to individual policies of employees, 66 A.L.R.3d 1175.

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.

Group insurance: construction, application, and effect of policy provision extending conversion privilege to employee after termination of employment, 32 A.L.R.4th 1037.

33-24-35. Withdrawal or retirement from group insurance plan.

Participation in group insurance by employees shall be entirely voluntary on the part of each employee at all times. Any employee, upon any payday, may withdraw or retire from such group plan upon giving his employer written notice of his intention to do so and directing the discontinuance of deductions from his wages or salary in payment of the plan.

History. — Code 1933, § 56-2432, enacted by Ga. L. 1960, p. 289, § 1.

OPINIONS OF THE ATTORNEY GENERAL

Various state agencies do have legal authority to enter into contracts for optional employee insurance; the only limitation upon the power granted is that the participation by the employees must be voluntary. 1974 Op. Att'y Gen. No. 74-81.

33-24-36. Effect of government employee group insurance upon rights under Workers' Compensation Act.

The insurance permitted under Code Sections 33-24-34 and 33-24-35 shall be in addition to and in no manner in lieu of Chapter 9 of Title 34.

History. — Code 1933, § 56-2433, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 344 et seq., 357 et seq., 393. 44 Am. Jur. 2d, Insurance, § 876. 44A Am. Jur. 2d, Insurance, § 1831 et seq.

ALR. — Insurance under Workmen's Compensation Act as coextensive with insured's liability under act, 108 A.L.R. 812.

Right to compensation under Workmen's Compensation Act as affected by pension, insurance, gratuities, or other benefits derived from the act itself, 119 A.L.R. 920.

33-24-37. Effect of government employee group insurance upon local and special laws.

Reserved. Repealed by Ga. L. 2019, p. 386, § 48/SB 133, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1933, § 56-2434, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 333.

33-24-38. Renewal or extension of policies by certificate or endorsement.

Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer and upon a currently authorized policy form and at the premium rate then required for renewal or extension for a specific additional period or periods by certificate or by endorsement of the policy and without requiring the issuance of a new policy.

History. — Code 1933, § 56-2422, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 560.

ALR. — Death of insured or other loss pending application not effectively granted, for reinstatement of life or accident insurance, after lapse, 105 A.L.R. 478; 164 A.L.R. 1057.

Express provisions in life, accident, or health policies that authorize refusal of renewal premium or otherwise make renewal optional with insurer, 119 A.L.R. 530; 161 A.L.R. 193.

Extent of liability on fidelity bond renewed from year to year, 7 A.L.R.2d 946.

Insurance: incontestable clause as affected by reinstatement of policy, 23 A.L.R.3d 743.

Insurance agent's right to commissions on renewal premiums, 36 A.L.R.3d 958.

Person to whom renewal premium may be paid or tendered so as to bind insurer, 42 A.L.R.3d 751.

33-24-39. Insurers to furnish forms for proof of loss; effect of furnishing or failure to furnish forms.

An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by the insurer, forms for proof of loss for completion by the person, but the insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of the proof or the manner of any completion or attempted completion. Failure or refusal to furnish the form upon written request or written notice of a loss shall constitute waiver of the right of the insurer to require proof of loss.

History. — Orig. Code 1863, § 2763; Code 1868, § 2771; Code 1873, § 2813; Code 1882, § 2813; Civil Code 1895, § 2108; Civil Code 1910, § 2490; Code

1933, § 56-831; Code 1933, § 56-2427, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For note, "Wrongful Refusal to Pay Insurance Claims in Georgia," see 13 Ga. L. Rev. 935 (1979).

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Legal consequence of absolute refusal to pay within filing time. — General law as to the legal consequence of an absolute refusal to pay within the time allowed for the filing of proofs of loss still remains in force despite the omission of such provision from this section. South Carolina Ins. Co. v. Hunnicutt, 107 Ga. App. 366, 130 S.E.2d 239 (1963).

Proof of loss waived when liability denied on ground of lapsed policy. — If liability is denied on the ground that the contract of insurance was not in force at the time of the loss, notice and proofs of loss are waived. Life Ins. Co. v. Williams, 48 Ga. App. 101, 172 S.E. 101 (1933).

Refusal to pay or denial of liability by authorized agent. — Absolute refusal to pay or denial of liability under the policy, made by an authorized agent of the insurer, waives the requirement of proof of loss. Life Ins. Co. v. Williams, 48 Ga. App. 101, 172 S.E. 101 (1933).

Cancellation prior to loss. — Defendant having contended that the policy had been canceled prior to the loss and that, therefore, there was no liability thereunder, it was unnecessary for the plaintiff to do a futile act in filing a proof of loss as required by the provisions of the policy. Union Fire Ins. Co. v. Stone, 41 Ga. App. 49, 152 S.E. 146 (1930).

Filing of proof of loss. — Denial of liability on the part of an insurance company and an absolute refusal, on demand, to pay, made within the time required by the policy for the furnishing of proof of death (and not predicated upon a failure to furnish proof of death or some ground other than a denial of all liability), amounts to a waiver of such proof. Schneider v. Metropolitan Life Ins. Co., 62 Ga. App. 148, 7 S.E.2d 772 (1940).

When an insurance company, within the time for presenting proof of loss, denies liability or refuses to pay the loss, it thereby waives the necessity of furnishing such proof. Boston Ins. Co. v. Harmon, 66 Ga. App. 383, 18 S.E.2d 84 (1941).

Denial of coverage of an injury and absolute refusal to pay a claim constitute a waiver of the policy requirements requiring the filing of proof of loss. Whitmire v. Canal Ins. Co., 102 Ga. App. 611, 117 S.E.2d 348 (1960).

Offer of amount inadequate to cover loss constitutes absolute refusal to pay. — Offer to pay some amount, such amount not being paid by way of compromise, is in effect an acknowledgement of the right of the plaintiff to payment of some amount, and if such amount so offered is entirely inadequate to cover the loss, it may amount to an absolute refusal to pay; if there is a refusal to pay, the necessity for the proofs of loss as required by the policy is then waived. Firemen's Ins. Co. v. Oliver, 53 Ga. App. 638, 186 S.E. 706 (1936).

Refusal after expiration of filing time not a waiver of proof. — Absolute refusal by the insurer to pay, made before the expiration of the time within which the insured has to furnish proof of disability, will be a waiver thereof; but such refusal made after such time has expired will not be a waiver of such proof. Patrick v. Travelers' Ins. Co., 51 Ga. App. 253, 180 S.E. 141 (1935).

If the insured is to rely upon an absolute refusal to pay as a waiver of the requirement for filing a proof of loss within 60 days after the loss occurred, it must appear that the refusal to pay (or what amounted to a refusal to pay) occurred within the same period, for nothing short of an express waiver by the insurer can be effective after expiration of the time for performing the condition precedent, i.e., the filing of a proof of loss. Reserve Ins. Co. v. Campbell, 107 Ga. App. 311, 130 S.E.2d 236 (1963).

Even though the policy contains no provision making the policy void upon failure of the insured to furnish proof of loss within the stated time after the loss, if the proof is not timely furnished, a refusal by the insurer to pay after expiration of that

time will not operate as a waiver of the proofs. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Promise to pay constitutes waiver of proof. — There is no sound distinction between a waiver of proof of loss by a refusal to pay and a waiver by a promise to pay; if anything, the waiver would be more strongly implied by the promise to pay than by the refusal. Sentinel Fire Ins. Co. v. McRoberts, 50 Ga. App. 732, 179 S.E. 256 (1934); American Cas. Co. v. Holloway Loan & Fin. Co., 99 Ga. App. 471, 108 S.E.2d 881 (1959).

If the insurer admits or declares the insurer's liability to pay a claim, after loss, it constitutes a waiver of requirements of the policy as to notice and proofs of loss; waiver thus occurs when the company promises to pay the loss or the amount of an appraisement when made. Sentinel Fire Ins. Co. v. McRoberts, 50 Ga. App. 732, 179 S.E. 256 (1934); American Cas. Co. v. Holloway Loan & Fin. Co., 99 Ga. App. 471, 108 S.E.2d 881 (1959).

Refusal to furnish blanks constitutes waiver of proof. — If the insurer refuses to furnish blanks for proof of loss or disability on the ground that no liability exists, the insurer waives the furnishing of such proof on behalf of the insured. Life Ins. Co. v. Williams, 48 Ga. App. 10, 172 S.E. 101 (1933) (decided under former Civil Code 1910, § 2490).

Because a failure to furnish forms amounts to a waiver of the proof of loss requirement, an absolute refusal to pay also amounts to such a waiver. Danielson v. Insurance Co. of N. Am., 309 F. Supp. 26 (N.D. Ga. 1969).

Effect of waiver. — Waiver is tantamount to relinquishing, discarding, and, in effect, erasing a condition from the policy. Danielson v. Insurance Co. of N. Am., 309 F. Supp. 26 (N.D. Ga. 1969).

Purpose of notice requirement. — Requirement of notice is intended merely to give the insurer information upon which the insurer may take prompt action in commencing an investigation, and if the company does not take immediate action, the company does so to the company's detriment. Georgia Mut. Ins. Co. v. Morgan, 115 Ga. App. 520, 154 S.E.2d 720 (1967).

Compliance with policy provisions with respect to notice and proof of loss are conditions precedent to recovery. Cooper v. Glens Falls Indem. Co., 93 Ga. App. 127, 91 S.E.2d 120 (1955) (decided under former Code 1933, § 56-831).

Absent a waiver, furnishing proof of loss as required by the policy is a condition precedent to the accrual of liability on the part of the company and to the bringing of an action by the insured. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Supplying invoices and list of items lost satisfies notice requirement. — Supplying of invoices and list of items claimed to have been lost in the fire is deemed to amount to a written notice as required by this section. Georgia Mut. Ins. Co. v. Morgan, 115 Ga. App. 520, 154 S.E.2d 720 (1967).

Policy requirement of written notice of loss to be given by the insured to the company is not met by a sending to the company of copies of investigation reports on the loss by an adjuster for another company having coverage. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Photographs and repair estimates. — In an action on an automobile policy seeking recovery for collision damage, there was a genuine issue of material fact as to whether the insurer waived the requirement that the insured file a proof of loss within 60 days of the loss when the insured sent photographs and repair estimates to the insurer and there were apparent ongoing settlement negotiations by telephone and letters. Williams v. Southern General Ins. Co., 211 Ga. App. 867, 440 S.E.2d 753 (1994).

Giving of notice does not dispense with necessity of making proof of loss unless company fails to supply forms as required by this section. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Purpose of requiring proofs of loss. — Sole purpose of requiring sworn proofs of loss is to enable the insurer to pass upon and determine the question of the insurer's liability and the extent thereof. Sentinel Fire Ins. Co. v. McRoberts, 50 Ga. App. 732, 179 S.E. 256 (1934).

Purpose of proof of loss is to secure an adjustment between the insured and the insurer. Firemen's Ins. Co. v. Blount, 52 Ga. App. 223, 183 S.E. 111 (1935), rev'd on other grounds, 182 Ga. 459, 185 S.E. 717 (1936).

Proof of loss or notice must be given one authorized to receive notice. — It must appear that the person to whom notice of the loss was given was an agent authorized to receive notice or proof of loss on behalf of the company or one having apparent authority upon which there was reliance. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Fact that insurer has knowledge of loss does not relieve insured of making proof of loss under terms of the policy. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Although insurer may have information indicating that the insured has suffered a loss under the policy, there is no duty on the insurer to notify the insured to give notice of the loss or to call upon the insured to furnish proofs of loss as required by the policy. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Validity of demand under § 33-4-6 dependent on waiver under § 33-24-39. — Whether a demand is good under former Code 1933, § 56-1206 (see O.C.G.A. § 33-24-6(a)) depends on whether the demand 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).

Authorized officer or agent may waive notice, regardless of policy stipulation. — By the weight of authority, an officer or agent otherwise having authority to waive notice or proofs of loss may bind the company by an oral or implied waiver, notwithstanding a stipulation in the policy that no officer or agent shall have power to waive any of the policy's terms or conditions unless the waiver is in writing endorsed on the policy or attached thereto. Life Ins. Co. v. Williams, 48 Ga. App. 10, 172 S.E. 101 (1933) (decided under former Civil Code 1910, § 2490).

Adjuster's original declarations constituted implied but absolute waiver of proof. — Testimony as to original declarations of the adjuster that the investigation showed it had been an honest fire and that settlement would be promptly made, fully authorized a finding that the declaration constituted an implied but absolute waiver of proof of loss, and not merely an estoppel; this is true because the statements of the adjuster, as testified, were voluntary and intentional, and the adjustee's acts and conduct were not involuntary, unintentional, or dependent for their efficacy on what they caused the insured to do. Sentinel Fire Ins. Co. v. McRoberts, 50 Ga. App. 732, 179 S.E. 256 (1934).

Action not barred when proofs furnished at least 60 days before expiration of year's limitation. — Failure by insured to furnish proofs of loss within the time specified for such proofs will not operate as a bar to an action on the policy if the insured furnished the required proofs of loss in time for at least 60 days to elapse between the date upon which they were furnished and the expiration of the 12-months limitation. Sentinel Fire Ins. Co. v. McRoberts, 50 Ga. App. 732, 179 S.E. 256 (1934).

Demand for additional proofs and refusal to comply are matter of defense. — In action on a health and accident policy, which contains provisions that give to insurer the right to demand proofs of the continuance of a total disability once acknowledged by the company and on which it is paying benefits, it is not necessary to allege that such proofs of continued disability have been furnished; the demand for such additional proofs and the refusal to comply with such demand are a matter of defense. New York Life Ins. Co. v. Bradford, 55 Ga. App. 248, 189 S.E. 914 (1937).

Cited in Progressive Mut. Ins. Co. v. Burrell Motors, Inc., 112 Ga. App. 88, 143 S.E.2d 757 (1965); Cotton States Mut. Ins. Co. v. Clark, 114 Ga. App. 439, 151 S.E.2d

780 (1966); Reserve Ins. Co. v. Associates Disct. Corp., 116 Ga. App. 792, 159 S.E.2d 97 (1967); Southern Ins. Co. v. Martin, 118 Ga. App. 608, 164 S.E.2d 887 (1968); Key Life Ins. Co. v. Mitchell, 129 Ga. App. 192, 198 S.E.2d 919 (1973); Canal Ins. Co. v. Savannah Bank & Trust Co., 181 Ga. App. 520, 352 S.E.2d 835 (1987).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 4.

ALR. — Necessity under marine insurance policy of showing specific cause of sinking of vessel, 31 A.L.R. 1378.

Sufficiency of bookkeeping to satisfy conditions of insurance policy, 39 A.L.R. 1443; 62 A.L.R. 630; 125 A.L.R. 350.

Burglary, theft, or robbery within policy of insurance, 44 A.L.R. 471; 54 A.L.R. 467; 37 A.L.R.2d 1081.

Assignment of claim for loss under fire insurance policy as affecting the furnishing of proofs of loss, 101 A.L.R. 1300.

Insanity of insured as excusing lack of, or delay in, notice or proof of accident or disability, 142 A.L.R. 852.

Provisions of burglary or theft policy as to evidence of loss, 169 A.L.R. 224.

Insurer's denial that insured has suffered disability as waiver of requirement that insured furnish periodic proof thereof, 173 A.L.R. 973.

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.

Form and sufficiency of proof of death in case of insured's disappearance, 26 A.L.R.2d 1073.

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.

Insurer's admission of liability, offers of settlement, and negotiations for adjustment or settlement, as waiver of proof of property loss, 49 A.L.R.2d 87.

Denial of liability as waiver of proofs of loss required by insurance policy, 49 A.L.R.2d 161.

Admissibility and conclusiveness, as against insured, of statements in proof of loss, 58 A.L.R.2d 429.

Necessity and sufficiency of insurer's demand, under fire insurance policy, for examination of insured or his books or papers, or for proofs of loss, certificates, or sworn statements, 4 A.L.R.3d 631.

Time within which demand for appraisal of property loss must be made, under insurance policy providing for such appraisal, 14 A.L.R.3d 674.

Provisions of burglary or theft policy requiring losses evidenced by "physical damage to premises," 22 A.L.R.3d 1305.

Notice or proof of loss under one policy as notice or proof of loss under another provision of same policy or another policy issued by same insurer, 29 A.L.R.3d 856.

What constitutes "direct loss" under windstorm insurance coverage, 65 A.L.R.3d 1128.

Nature and extent of insured's duty to seek retrieval of stolen automobile, 9 A.L.R.4th 405.

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.

33-24-40. Acts of claims administration not to be deemed waiver of policies or defenses under policies.

Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer under the policy:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy;

(2) Furnishing forms for reporting a loss or claim, for giving information relative to the loss or claim, or for making proof of loss or receiving or acknowledging receipt of any forms or proofs completed or uncompleted; or

(3) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any loss or claim.

History. — Code 1933, § 56-2428, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Fact that insurer has knowledge of loss does not relieve insured of making proof of loss under terms of the policy. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Negotiating for settlement. — Insurer could not enforce a policy provision requiring a policyholder to submit a formal proof of loss within 60 days of the loss and to file suit within 12 months of the loss, since the insurer's acts in negotiating for settlement led the policyholder to believe that the policyholder would be paid without a suit. Lynn v. Georgia Farm Bureau Mut. Ins. Co., 189 Ga. App. 209, 375 S.E.2d 259 (1988).

Insurer's offer to settle a homeowner's property damage claim did not waive a residency requirement in the policy or estop the insurer from denying coverage; O.C.G.A. § 33-24-40(3) precluded the settlement offer from being deemed a waiver. Mahens v. Allstate Ins. Co., 447 Fed. Appx. 51 (11th Cir. 2011) (Unpublished).

Collection of information and investigation of loss not waiver of policy requirements. — Collection of information or the making of an investigation relative to a loss that may be covered under a policy issued by a company does not work a waiver of the policy requirements and compliance therewith by the insured. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Collection by insurer of information concerning a loss on which it may have coverage, or an investigation of the circumstances, does not work a waiver of policy requirements as to the giving of notice and the furnishing of proofs of loss. Buffalo Ins. Co. v. Star Photo Finishing Co., 120 Ga. App. 697, 172 S.E.2d 159 (1969).

Provision in a homeowner's insurance policy stated that an action under the policy had to be brought within one year after the occurrence causing the loss. The insurer did not waive the insurer's right to enforce this provision by carrying on an investigation of two fires, which totally destroyed the insureds' premises, for some 16 months after the last fire. The insurer, while the insurer never told the insureds that the insurer would not pay the insureds' claim, never indicated that the insurer intended to settle the claim prior to or after the insurer completed the insurer's investigation. American Mut. Fire Ins. Co. v. Coats, 620 F. Supp. 768 (S.D. Ga. 1985).

Trial court did not err in granting summary judgment to the insurance association on the insured's claim for damages relating to the destruction of the insured's property by fire as the fact that the insurance company did not settle and, instead, insisted on conducting an investigation did not waive the requirement the policy placed on the insured to provide a proof of loss statement. Since the insured did not submit a proof of loss statement and was unquestionably required to do so, the summary judgment grant to the insurance association was proper. Evans v.

Ohio Cas. Ins. Co., 264 Ga. App. 485, 591 S.E.2d 378 (2003).

Because an insured was on notice that, pursuant to O.C.G.A. § 33-24-40, the insurer did not waive any provision of a policy merely by investigating the insured's claim, and because there was no evidence that the insured was induced to delay filing a lawsuit until after the expiration of the one-year-period, the insurer was entitled to summary judgment. Thornton v. Ga. Farm Bureau Mut. Ins. Co., 297 Ga. App. 132, 676 S.E.2d 814 (2009).

Waiver of proof based on refusal to pay must be express after filing time expires. — Waiver of the proof-of-loss requirement occurs only when it appears that the refusal to pay (or what amounts to a refusal to pay) occurs within the time period allowed for proof of loss, for nothing short of an express waiver by the insurer can be effective after expiration of the time for performing the condition precedent, i.e., the filing of a proof of loss. McCauley v. Boston Old Colony Ins. Co., 149 Ga. App. 706, 256 S.E.2d 19 (1979).

Insurer does not waive the insurer's right to assert the proof-of-loss requirement by investigating the loss, obtaining an independent appraisal, and entering into negotiations looking toward a possible settlement of the loss or claim after receiving the appellants' written notice five months after the loss. McCauley v. Boston Old Colony Ins. Co., 149 Ga. App. 706, 256 S.E.2d 19 (1979).

Oral notice, and claim's denial, waives written notice. — If an agent of the insurer is orally notified of a claim by the insured within a reasonable time after the accident, and if at that time the agent denies liability under the policy, then the insurer has waived the right to written notice of the claim, but the agent's denial must be an unambiguous statement that coverage is not available under the policy. Lathem v. Sentry Ins., 845 F.2d 914 (11th Cir. 1988).

Waiver not based on insured's unilateral assumption. — Waiver cannot be based upon the insured's own unilateral assumption or expectation that a 38-month delay in notice of a claim would not be enforced against the insured simply because the insurer did not undertake immediately and definitively to deny coverage on that specific basis, but subjected the claim to the normal administrative formal process before doing so. Brazil v. Government Employees Ins. Co., 199 Ga. App. 343, 404 S.E.2d 807, cert. denied, 199 Ga. App. 905, 404 S.E.2d 807 (1991).

Settlement negotiations did not constitute waiver of limitations period. — Insured's claim against an insurer, alleging a breach of the insured's insurance contract for failure to pay on a claim that resulted from a theft on the insured's premises, was properly found barred by the two-year limitations period contained in the insurance policy; the insurer's settlement negotiations did not lull the insured into believing that the insured did not have to file suit under O.C.G.A. § 33-24-40(3). Stone Mt. Collision Ctr. v. General Cas. Co. of Wis., 307 Ga. App. 394, 705 S.E.2d 163 (2010).

No waiver shown in insurance dispute. — Insured failed to demonstrate that the insured was entitled to summary judgment on the basis of waiver or estoppel because the reservation of rights provision was enforceable even as to the insured's uncooperativeness and there was no basis that the insurer waived the reservation of rights provision. 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).

Insurer not estopped from raising defense. — Even without disclaiming liability and giving notice of the insurer's reservation of rights, any insurer who merely proceeds to investigate a claim with knowledge of facts which might otherwise constitute a defense to coverage is not estopped from thereafter setting up the defense. Brazil v. Government Employees Ins. Co., 199 Ga. App. 343, 404 S.E.2d 807, cert. denied, 199 Ga. App. 905, 404 S.E.2d 807 (1991).

Issues of fact as to whether insurer was estopped from voiding policy for misrepresentation. — In a fire insurance case, the insurer's assertion that the insurer's actions were part of a necessary investigation to avoid possible bad faith liability was insufficient to warrant sum-

mary judgment on the issue of estoppel when the insurer denied coverage but failed to give any reason for a period of seven months, renewed the policy, and failed to notify the insured of the insurer's intent to void the policy; issues of fact existed with regard to detrimental reliance and estoppel. 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).

Whether clause was waived is question for jury. — If the insurer never denied liability, but continually discussed the loss with the insured with a view toward negotiation and settlement without the intervention of a suit, whether or not this lulled the insured into a belief that the clause in the contract requiring the insured to file suit within 12 months was waived by the insurer can become a disputed question of fact for a jury under appropriate instructions. Edwards v. Atlantic Ins. Co., 203 Ga. App. 608, 417 S.E.2d 410, cert. denied, 203 Ga. App. 906, 417 S.E.2d 410 (1992).

Summary judgment was improper since a question of fact remained as to whether the insurance company waived a contractual limitation when, after the limitations period expired, the adjuster informed the insured's counsel that the insurer might still consider payment. Ogden v. Auto-Owners Ins. Co., 251 Ga. App. 723, 554 S.E.2d 575 (2001) (Unpublished).

Waiver of limitation on actions was a question of fact. — Whether insurer's conduct reasonably led insured to believe that strict compliance with the insurance policy's one year limitation provision on loss filings would not be insisted upon was a question of fact for a jury to decide and thus precluded summary judgment. Appleby v. Merastar Ins. Co., 223 Ga. App. 463, 477 S.E.2d 887 (1996).

Acceptance and payment of claims. — Fact issues precluded summary judgment with regard to whether an insurer waived a contractual limitations provision by failing to explain coverage fully to the insureds while purporting to do so when the insurer's accepted and paid claims; O.C.G.A. § 33-24-40 creates no waiver exception or exemption for accepting a claim as covered or making payments on the claim. Thompson v. State Farm Fire & Cas. Co., 264 F. Supp. 3d 1302 (M.D. Ga. 2017).

Cited in Progressive Mut. Ins. Co. v. Burrell Motors, Inc., 112 Ga. App. 88, 143 S.E.2d 757 (1965); Modestino v. Allstate Ins. Co., 125 Ga. App. 665, 188 S.E.2d 830 (1972); GEICO v. Gates, 134 Ga. App. 795, 216 S.E.2d 619 (1975); Shield Ins. Co. v. Kitt, 143 Ga. App. 48, 237 S.E.2d 515 (1977); Carpenters Local 1977 v. General Ins. Co. of Am., 167 Ga. App. 299, 306 S.E.2d 383 (1983); Weis v. International Ins. Co., 567 F. Supp. 631 (N.D. Ga. 1983); Commercial Union Ins. Co. v. F.R.P. Co., 172 Ga. App. 244, 322 S.E.2d 915 (1984); Shelter Am. Corp. v. Georgia Farm Bureau Mut. Ins. Co., 209 Ga. App. 258, 433 S.E.2d 140 (1993).

RESEARCH REFERENCES

ALR. — Subsequent denial of liability following promise or negotiations as affecting contractual limitation for action upon insurance policy, 3 A.L.R. 218.

Incontestable clause as affecting failure to comply with provisions as to proofs of loss, 41 A.L.R. 382.

Insurer's denial of or refusal to allow claim as waiver of right under policy to pay in lump sum or in installments, 94 A.L.R. 1176.

Insurer's assertion, before claim is made, that policy is ineffective as waiver of condition as to notice or proof of disability, 172 A.L.R. 636.

Right of contingent beneficiary to proceeds of life policy upon death of direct or primary beneficiary after death of insured, 172 A.L.R. 642.

Insurer's denial that insured has suffered disability as waiver of requirement that insured furnish periodic proof there, 173 A.L.R. 973.

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.

Insurer's admission of liability, offers of settlement, negotiations, and the like, as

waiver of, or estoppel to assert, contractual limitation provision, 29 A.L.R.2d 636.

Insurer's admission of liability, offers of settlement, and negotiations for adjustment or settlement, as waiver of proof of property loss, 49 A.L.R.2d 87.

Denial of liability as waiver of proofs of loss required by insurance policy, 49 A.L.R.2d 161.

Provisions of burglary or theft policy requiring losses evidenced by "physical damage to premises," 22 A.L.R.3d 1305.

Insurance: necessity and sufficiency of notice of and hearing in proceedings before appraisers and arbitrators appointed to determine amount of loss, 25 A.L.R.3d 680.

Notice or proof of loss under one policy as notice or proof of loss under another provision of same policy or another policy issued by same insurer, 29 A.L.R.3d 856.

Nature and extent of insured's duty to seek retrieval of stolen automobile, 9 A.L.R.4th 405.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

33-24-41. Discharge of insurer by payment generally.

Whenever the proceeds of or payments under a life or accident and sickness insurance policy or annuity contract become payable in accordance with the terms of the policy or contract or the exercise of any right or privilege under the policy or contract and the insurer makes payment of the proceeds or payments in accordance with the terms of the policy or contract or in accordance with any written assignment of the policy or contract, the person then designated in the policy or contract or by the assignment as being entitled to the proceeds or payments, if legally competent, shall be entitled to receive the proceeds or payments and to give full acquittance for the proceeds or payments and the payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that the other person claims to be entitled to the payment or some interest in the policy or contract.

History. — Code 1933, § 56-2424, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For annual survey of insurance law, see 57 Mercer L. Rev. 221 (2005). For annual survey of insurance law, see 58 Mercer L. Rev. 181 (2006). For annual survey on insurance law, see 70 Mercer L. Rev. 111 (2018).

JUDICIAL DECISIONS

O.C.G.A. § 33-24-41 does not apply to vehicle insurance policies. JCS Enter., Inc. v. Vanliner Ins., 227 Ga. App. 371, 489 S.E.2d 95 (1997).

This section is not retroactive as to payments made prior to the statute's effective date, to wit, January 1, 1961. Life & Cas. Ins. Co. v. Webb, 112 Ga. App. 344, 145 S.E.2d 63 (1965).

Loan receipt agreement between plaintiff and tortfeasor is covenant not to sue. — Loan receipt agreement between a plaintiff and a joint tortfeasor in exchange for a forbearance to sue is an absolute payment and not a loan; as such, the agreement constitutes a covenant not to sue and not a release. American Chain & Cable Co. v. Brunson, 157 Ga. App. 833, 278 S.E.2d 719 (1981).

Applicability of § 13-4-81 only to parties with whom covenant is made. — While O.C.G.A. § 13-4-81 provides that a covenant never to sue is equivalent to a release, § 13-4-81 applies to the parties

with whom the covenant is made and not to another tortfeasor; a covenant not to sue one tortfeasor will not bar actions against another tortfeasor. American Chain & Cable Co. v. Brunson, 157 Ga. App. 833, 278 S.E.2d 719 (1981).

Notice obligations. — Because O.C.G.A. § 33-24-41 clearly discharged the insurer from liability when an individual did not notify the insurer that the individual sought the proceeds of the insurance on the individual's father's life, the trial court erred in denying the insurer's motion for summary judgment. Colonial Life & Accident Ins. Co. v. Heveder, 274 Ga. App. 377, 618 S.E.2d 39 (2005).

RESEARCH REFERENCES

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, § 1727 et seq.

C.J.S. — 46A C.J.S., Insurance, § 1978.

ALR. — What rights are waived by insurer who pays money into court, 15 A.L.R. 1260.

Necessity and sufficiency of tender to avoid interest on insurance premiums, 35 A.L.R. 1252.

Right of court or insurer to require bond as condition of paying policy where there is not conclusive proof of insured's death, 61 A.L.R. 824.

Settlement with insurance company for less than face of valued policy as bar to recovery of difference where total loss shown, 109 A.L.R. 1485.

Judgment as res judicata as to whether insured is "permanently disabled" within contemplation of insurance policy, 142 A.L.R. 1170.

Right of insurer to restitution of payments made under mistake, 167 A.L.R. 470.

Liability of life insurer which pays proceeds of policy direct to beneficiary, for the portion of estate or succession tax attributable to such proceeds, 10 A.L.R.2d 657.

Rights and remedies of insurer paying loss as against insured who has released or settled with third person responsible for loss, 51 A.L.R.2d 697.

Duty of liability insurer to appeal, 69 A.L.R.2d 690.

Insured's exercise of election afforded under life insurance policy as affected by his death before complete consummation of option, 15 A.L.R.3d 1317.

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.

Allocation of defense costs between primary and excess insurance carriers, 19 A.L.R.4th 107.

Credit life insurer's punitive damage liability for refusing payment, 55 A.L.R.4th 246.

33-24-41.1. Motor vehicle accident claim covered by two or more insurance carriers; limited release.

(a) In any instance where a claim arising out of a motor vehicle accident is covered by two or more insurance carriers, one such carrier may tender, and the claimant may accept, the limits of such policy; and, in the event of multiple claimants, the settling carrier may tender, and the claimants may accept, the limits of the policy pursuant to a written agreement between or among the claimants. Such claimant or claimants may execute a limited release applicable to the settling carrier and its insured based on injuries to such claimants including, without limitation, claims for loss of consortium or loss of services asserted by any person.

(b) The limited release provided for in subsection (a) of this Code section shall:

(1) Release the settling carrier from all liability from any claims of the claimant or claimants based on injuries to such claimant or claimants; and

(2) Release the insured tort-feasor covered by the policy of the settling carrier from all personal liability from any and all claims arising from the occurrence on which the claim is based except to the extent other insurance coverage is available which covers such claim or claims.

(c) No policy of uninsured or underinsured motorist coverage issued in this state shall prohibit any claimant from settling any claim with a liability carrier as provided in subsection (a) of this Code section or require the permission of the uninsured or underinsured motorist carrier to so settle any claim with the liability carrier.

(d) The limited release of the settling carrier provided for in subsection (a) of this Code section shall not:

(1) Bar a claimant's recovery against any other tort-feasor or under any other policy of insurance or release any other insurance carrier providing applicable coverage unless specifically provided for in such release;

(2) Be admissible in evidence before the trier of fact in the trial of a tort action, but the amount paid thereunder shall be admissible as provided by law as evidence of the offset against the liability of an uninsured motorist carrier and as evidence of the offset against any verdict of the trier of fact;

(3) Affect any duty the settling carrier owes to its insured under its policy including, without limitation, the duty to defend a subrogation claim brought against its insured; or

(4) Release the tort-feasor from personal liability to the extent that there is other insurance in effect which covers the said claim or claims, but only to the extent of such other insurance.

(e) The provisions of this Code section shall not be construed so as to interfere with the obligation of the insured to cooperate in his or her defense with the insurance carrier as provided in the policy of insurance.

(f) The provisions of this Code section shall not be construed to interfere with a claimant's right to pursue claims or an insurance company's obligation to pay claims based on a negligent or bad faith refusal to settle a claim or claims; provided, however, that the provisions of this subsection shall not be construed to create any new claim not otherwise provided by law.

History. — Code 1981, § 33-24-41.1, enacted by Ga. L. 1992, p. 2514, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 1994, p. 1156, § 1; Ga. L. 2019, p. 386, § 49/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted "after July 1, 1994" following "issued in this state" near the middle of subsection (c).

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

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1994, "this Code section" was substituted for "this Code Section" and "provided, however," was substituted for "provided however" in subsection (f).

Law reviews. — For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999). 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 on trial practice and procedure, see 64 Mercer L. Rev. 305 (2012). For annual survey on insurance, see 65 Mercer L. Rev. 135 (2013). For annual survey of insurance law, see 67 Mercer L. Rev. 73 (2015).

For note on the 1994 amendment of this Code section, see 11 Georgia St. U.L. Review 200 (1994).

JUDICIAL DECISIONS

Effect of general release. — Insured defeated the ability to collect underinsured motorist benefits from the 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).

Reformation of release. — When an insured signed a general release believing that the release would not affect the insured's claim against the insured's underinsured motorist carrier, reformation of the release would be warranted if mutual mistake of law could be proved. Superior Ins. Co. v. Dawkins, 229 Ga. App. 45, 494 S.E.2d 208 (1997).

Because the insured exercised reasonable diligence in relying on representations made by both the insured's insurer's agent and the tortfeasor's agent, the trial court should have reformed the settlement and release to reflect the parties' intent to only release the tortfeasor and the tortfeasor's insurer from liability rather than granting summary judgment. Clark v. Byrd, 254 Ga. App. 826, 564 S.E.2d 742 (2002).

Evidence did not show limited release. — Plaintiff failed to take those steps which would have indicated, without equivocation, that the plaintiff's release of the automobile accident tortfeasor was intended to allow the plaintiff to retain the right to sue the carriers of uninsured/underinsured motor vehicle coverage. Cook v. State Farm Mut. Auto. Ins. Co., 237 Ga. App. 400, 514 S.E.2d 48 (1999).

Dismissal with prejudice barred recovery. — Insureds' dismissal with prejudice claim against the defendant driver, rather than merely executing a limited liability release against the defendant, defeated the insureds' ability to recover damages from the insureds' underinsured motorist carrier. Kent v. State Farm Mut. Auto. Ins. Co., 233 Ga. App. 564, 504 S.E.2d 710 (1998).

Settlement does not prevent application of underinsured motorist coverage. — Settlement for the limits as stated in the policy satisfies the exhaustion requirement of O.C.G.A. § 33-24-41.1, and the insured may then pursue a claim against the insured's underinsurance carrier, even though under O.C.G.A. §§ 33-24-41.1 and 33-34-3, the "deemer" statute, the tortfeasor's policy is deemed to provide greater coverage. Daniels v. Johnson, 270 Ga. 289, 509 S.E.2d 41 (1998).

Because the insured accepted the limits of liability insurance coverage of the first defendant and executed a limited-liability release, the insured exhausted the liability limits of the first defendant and was entitled to pursue underinsured motorist benefits to the extent the first defendant was underinsured; the insured's settlement with the dismissed defendants pre-

cluded the insured's ability to pursue underinsured motorist benefits against those defendants, but it did not preclude the insured from seeking underinsured motorist benefits based on the possibility that the first defendant was underinsured. Wade v. Allstate Fire & Cas. Co., 324 Ga. App. 491, 751 S.E.2d 153 (2013).

Release did not extinguish uninsured motorist carrier's subrogation rights. — 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).

Settlement for less than policy limit. — To satisfy the exhaustion requirement of O.C.G.A. § 33-24-41.1, a carrier must offer and a claimant must accept an amount equal to the limit stated in the policy, not an amount less than the limit stated in the policy; accordingly, when an insured settled with a second person's carrier for less than the policy limit, the insured did not satisfy the exhaustion requirement and was not entitled to uninsured/underinsured motorist coverage from the insured's own insurer. Holland v. Cotton States Mut. Ins. Co., 285 Ga. App. 365, 646 S.E.2d 477 (2007), cert. denied, No. S07C1403, 2007 Ga. LEXIS 619 (Ga. 2007).

Acceptance of settlement offer. — Trial court erred in granting the insureds' motion to enforce a settlement agreement a parent and an administrator allegedly reached with an insurer because the insurer's tender was not sufficient to constitute acceptance of the settlement offer; assuming that the offer by the parent and the administrator contemplated a legal impossibility or was in "tension" with the governing law, it did not follow that the insurer could accept something other than the offer made. Kitchens v. Ezell, 315 Ga. App. 444, 726 S.E.2d 461 (2012).

Insurance company, on defendant's behalf, accepted plaintiff's offer by providing a limited release that adhered to plaintiff's specifications and by tendering a check for $100,000. Thus, the defendant and the insurance company's compliance with the demands of the plaintiff's offer constituted an acceptance and the settlement agreement was enforceable. Arnold v. Neal, 320 Ga. App. 289, 738 S.E.2d 707 (2013).

Insurer complied with the terms of an injured driver's settlement offer by submitting a $25,000 check within the offer's deadline, and the trial court erred in denying the insurer's motion to enforce the settlement agreement based on the insurer's inclusion of a general release rather than a limited release with its letter because the insurer's language regarding the release was precatory rather than mandatory. Newton v. Ragland, 325 Ga. App. 371, 750 S.E.2d 768 (2013).

No binding settlement agreement formed. — Grant of the defendant's motion to enforce a settlement agreement was error because there was no unequivocal acceptance of the settlement offer that the plaintiff made to the defendant's insurer; thus, no binding settlement agreement was formed as the offer specified a particular release that was necessary for effectuating settlement, and there was no acceptance if the responding party did not accept that release. Yim v. Carr, 349 Ga. App. 892, 827 S.E.2d 685 (2019), cert. denied, No. S19C1220, 2019 Ga. LEXIS 853 (Ga. 2019).

Injury claim and spouse's loss of consortium claim were injury to one person. — An injured wife and her husband satisfied the exhaustion requirement of O.C.G.A. § 33-24-41.1 and could proceed against their UM insurer; the husband's loss of consortium claim arose out of the wife's claim, so by settling both their claims for $25,000, the other driver's per person limit, the couple exhausted the available coverage. Mullinax v. State Farm Mut. Auto. Ins. Co., 303 Ga. App. 76, 692 S.E.2d 734 (2010).

Issues existed as to application of underinsured motorist coverage. — In a suit for underinsured/uninsured motorist coverage involving an accident in Georgia and a Kentucky insurance policy, the grant of summary judgment to the insurer was vacated because the trial

court did not reach the additional issues of opposition raised by the insured, namely that the insurer's summary judgment motion should have been denied on grounds of estoppel, public policy, and ambiguity of terms within the insurance policy, to see if they had merit. Helton v. United Servs. Auto. Ass'n, 354 Ga. App. 208, 840 S.E.2d 692 (2020).

Cited in Integon Indem. Corp. v. Henry Medical Ctr., Inc., 235 Ga. App. 97, 508 S.E.2d 476 (1998); Edmond v. Cont'l Ins. Co., 249 Ga. App. 338, 548 S.E.2d 450 (2001).

33-24-41.2. Written notice by insurer to claimant of payment of claim in third-party settlement.

(a) Upon the payment of $5,000.00 or more in settlement of any third-party liability claim, where the claimant is a natural person, the insurer or its representative shall provide written notice to the claimant at the same time payment is made by draft, check, or otherwise by such insurer or its representative, including the insurer's attorney, to the claimant's attorney or other representative of the claimant.

(b) Nothing in subsection (a) of this Code section shall:

(1) Create, or be construed to create, a cause of action for any person or entity, other than the Commissioner, against the insurer or its representative based upon a failure to serve such notice or the defective service of such notice;

(2) Establish, or be construed to establish, a defense for any party to any cause of action based upon a failure by the insurer or its representative to serve such notice or the defective service of such notice; or

(3) Invalidate or in any way affect the settlement for which the payment was made by the insurer.

History. — Code 1981, § 33-24-41.2, enacted by Ga. L. 1993, p. 1048, § 1; Ga. L. 1994, p. 97, § 33; Ga. L. 2019, p. 386, § 50/SB 133.

The 2019 amendment, effective July 1, 2019, substituted the present provisions of subsection (b) for the former provisions, which read: "Nothing in subsection (a) of this Code section shall create, or be construed to create, a cause of action for any person or entity, other than the Commissioner of Insurance, against the insurer or its representative based upon a failure to serve such notice or the defective service of such notice. Nothing in subsection (a) of this Code section shall establish, or be construed to establish, a defense for any party to any cause of action based upon a failure by the insurer or its representative to serve such notice or the defective service of such notice. Nothing in subsection (a) of this Code section shall invalidate or in any way affect the settlement for which the payment was made by the insurer."

33-24-42. Payment of claims in event of simultaneous deaths.

Where the individual insured or the annuitant and the beneficiary designated in a life insurance policy or policy insuring against accidental death or in an annuity contract have died and there is not sufficient

evidence that they have died otherwise than simultaneously, the proceeds of the policy or contract shall be distributed as if the insured or annuitant had survived the beneficiary unless otherwise specifically provided in the policy or contract. Payment made in accordance with this Code section shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that the person claims to be entitled to the payment or some interest in the policy or contract.

History. — Code 1933, § 56-2426, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

This section makes the actual circumstances of the parties' deaths irrelevant and provides that for purposes of distribution the property will be disposed of as if the insured survived the beneficiary. Estate of Wien v. Commissioner, 441 F.2d 32 (5th Cir. 1971).

Once it is found that the actual order of the parties' respective deaths is not ascertainable, this section applies so as to make the prescribed property disposition mandatory regardless of the factual circumstances which might have existed at the time of the parties' demise. Estate of Wien v. Commissioner, 441 F.2d 32 (5th Cir. 1971).

Sufficient evidence standard. — Use of phrase "sufficient evidence" in O.C.G.A. § 33-24-42 does not require higher standard of appellate review than the normal "any evidence" rule. Hitchcock v. Key, 163 Ga. App. 901, 296 S.E.2d 625 (1982).

RESEARCH REFERENCES

ALR. — Insurance: presumption and burden of proof as to accident in case of death from poison, 7 A.L.R. 1226.

Construction and application of statute respecting proceeds of life insurance in event of death of named beneficiary before insured, 167 A.L.R. 1021.

33-24-43. Medium of payment.

It shall be unlawful for any insurer to provide in a policy or contract of insurance that the face amount thereof or any loss or indemnity which may accrue thereunder shall be payable in anything other than legal tender of the United States to the beneficiary named in the policy or contract of insurance or to the legal representative of the insured; and any provision to the contrary shall be null and void, provided that this Code section shall not prevent property insurance policies from including an option to the insurer authorizing it to repair the damage incurred or paying the debtor the dollar amount thereof.

History. — Code 1933, § 56-9901, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Sollek v. Laseter, 126 Ga. App. 137, 190 S.E.2d 148 (1972).

OPINIONS OF THE ATTORNEY GENERAL

Contract with cemetery company providing for free burial spaces unlawful. — When 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 the 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 this section. 1963-65 Op. Att'y Gen. p. 367.

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.

33-24-44. Cancellation of policies generally.

(a) Except as otherwise provided in this chapter, cancellation of a policy which by its terms and conditions may be canceled by the insurer or its agent duly authorized by the insurer to effect such cancellation shall be accomplished as prescribed in this Code section.

(b) Written notice stating the time when the cancellation will be effective, which shall not be less than 30 days from the date of mailing or delivery in person of such notice of cancellation or such other specific longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of any lienholder, where applicable, 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. For the purposes of this subsection, notice to the lienholder shall be considered delivered or mailed if, with the lienholder's consent, it is delivered by electronic transmittal or facsimile. Any irregularity in the notice to the lienholder shall not invalidate an otherwise valid cancellation as to the insured.

(c)(1) Any unearned premium which has been paid by the insured shall be refunded to the insured on a pro rata basis as provided in this Code section. If the return does not accompany notice of cancellation, then such return shall be made on or before the cancellation date either directly to the named insured or to the insured's agent of

record. In the event the insurer elects to return such unearned premium to the insured via the insured's agent of record, such agent shall return the unearned premium to the insured either in person or by depositing such return in the mail within ten working days of receipt of the unearned premium, or within ten working days of notification from the insurer of the amount of return of unearned premium due, or on the effective date of cancellation, whichever is later. If the insured has an open account with the agent, such return of unearned premium may be applied to any outstanding balance and any remaining unearned premium shall be returned to the insured either in person or by depositing such return in the mail within ten working days of receipt of the unearned premium, or within ten working days of notification from the insurer of the amount of return of unearned premium due, or on the effective date of cancellation, whichever is later.

(2) Paragraph (1) of this subsection shall not apply if an audit or rate investigation is required or if the premiums are financed by a premium finance company. If an audit or rate investigation is required, then the refund of unearned premium shall be made within 30 days after the conclusion of the audit or rate investigation. If the premiums are financed by a premium finance company, any unearned premiums shall be tendered to the premium finance company within ten working days after cancellation.

(3) Any insurer or agent failing to return any unearned premium as prescribed in paragraphs (1) and (2) of this subsection shall pay to the insured a penalty equal to 25 percent of the amount of the return of the unearned premium and interest equal to 18 percent per annum until such time that proper return has been made, which penalty and interest must be paid at the time the return is made; provided, however, that the maximum amount of such penalty and interest shall not exceed 50 percent of the amount of the refund due. Failure to return any unearned premium shall not invalidate a notice of cancellation given in accordance with subsection (b) of this Code section.

(d) When a policy is canceled for failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums for a policy or any installment of premiums due, whether payable directly to the insurer or indirectly to the agent, or when a policy that has been in effect for less than 60 days is canceled for any reason, the notice requirements of this Code section may be satisfied by delivering or mailing written notice to the named insured and any lienholder, where applicable, at least ten days prior to the effective date of cancellation in lieu of the number of days' notice otherwise required by this Code section. For the purposes of this

subsection, notice to the lienholder shall be considered delivered or mailed if, with the lienholder's consent, it is delivered by electronic transmittal or facsimile. Any irregularity in the notice to the lienholder shall not invalidate an otherwise valid cancellation as to the insured.

(d.1) The notice requirements of this Code section shall not apply in any case where a binder or contract of insurance is void ab initio for failure of consideration.

(d.2) If the terms of a policy permit an audit and the insured fails to submit to or allow an audit for the current or most recently expired term, the insurer may, after two documented efforts to notify the policyholder and the policyholder's agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to the named insured at least ten days prior to the effective date of cancellation in lieu of the number of days' notice otherwise required by law; provided, however, that no cancellation notice shall be mailed within 20 days of the first documented effort to notify the policyholder of potential cancellation.

(e) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement which has been filed with the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party 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.

(f) Cancellation by the insured shall be accomplished in accordance with Code Section 33-24-44.1.

(g) Any unearned premium which has been paid by the insured may be refunded to the insured on other than a pro rata basis if:

(1) The cancellation results from failure of the insured to pay, when due, any premium to the insurer or any amount, when due, under a premium finance agreement;

(2) The policy contains language which specifies that a penalty may be charged on unearned premium; and

(3) The method of computing such penalty is filed with the Commissioner in accordance with Chapter 9 of this title.

History. — Code 1933, § 56-2430, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1967, p. 653, § 1; Ga. L. 1968, p. 1126, § 1; Ga. L. 1973, p. 499, § 6; Ga. L. 1975, p. 1242, § 1; Ga. L. 1984, p. 1345, § 4; Ga. L. 1987, p. 1466, § 1; Ga. L. 1995, p. 1011, § 4; Ga. L. 1999, p. 834, § 1; Ga. L. 2005, p. 562, § 1/HB 418; Ga. L. 2014, p. 823, § 1/HB 375; Ga. L. 2014, p. 829, § 5/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2016, p. 864, § 33/HB 737.

Editor's notes. — Ga. L. 2014, p. 823, § 2/HB 375, not codified by the General Assembly, provides: "This Act shall be applicable to policies issued or renewed on or after July 1, 2014."

Law reviews. — For article surveying Georgia cases in the area of insurance from June 1979 through May 1980, see 32 Mercer L. Rev. 79 (1980). For annual survey of insurance law, see 35 Mercer L. Rev. 177 (1983). For article, "Insurance," see 53 Mercer L. Rev. 281 (2001). For annual survey of insurance law, see 58 Mercer L. Rev. 181 (2006). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010).

For comment on Life Ins. Co. v. Bartlett, 37 Ga. App. 22, 138 S.E. 589 (1927), see 1 Ga. L. Rev. No. 2 P. 49 (1927).

JUDICIAL DECISIONS

Analysis

General Consideration
Exceptions
Form, Sufficiency, and Proof of Notice

General Consideration

This section was intended to provide the minimum standards for cancellation. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

Requirements of this section were designed to place upon the insurer the responsibility of taking adequate steps to do all within the insurer's power to make certain the insurer's insured was placed on notice that insurance coverage had been cancelled. Favati v. National Property Owners Ins., 153 Ga. App. 723, 266 S.E.2d 359 (1980).

Two methods set forth in this section to constitute an effective cancellation are mandatory, and when utilized by the insurance company, the language of this section must be strictly construed; however, the methods adopted by the General Assembly are intended to assure actual notice of cancellation to an insured and when it is admitted such notice was received, the purpose of this section has been accomplished. Travelers Indem. Co. v. Guess, 243 Ga. 559, 255 S.E.2d 55 (1979).

Statutory requirements under this section are: (1) the policy must by the policy's terms and conditions provide for cancellation; (2) a post office receipt must be obtained; (3) it must be "dispatched by at least first class mail to the last address of record of the insured"; and (4) the evidence adduced must show the mailed envelope contained the statutory cancellation notice. Bituminous Cas. Co. v. Renfroe, 130 Ga. App. 621, 204 S.E.2d 317 (1974).

ERISA preemption of subsection (d)'s notice requirement. — O.C.G.A. § 33-24-44 relates strictly to the administration of insured benefit plans; to permit the "saving clause" (29 U.S.C. § 1144 (b)(2)(A)) of the Employee Retirement and Income Security Act to foreclose preemption would undermine a core purpose of ERISA providing uniform standards for administration of benefit plans. Accordingly, the saving clause does not apply to subsection (d), and welfare benefit plan case was required to proceed under federal law. Smith v. Jefferson Pilot Life Ins. Co., 14 F.3d 562 (11th Cir.), cert. denied, 513 U.S. 808, 115 S. Ct. 57, 130 L. Ed. 2d 15 (1994).

Supreme Court review of notice provisions authorized. — Question was certified to the state supreme court pursuant to O.C.G.A. § 15-2-9 as to whether a notice of cancellation, properly given by

General Consideration (Cont'd)

an insurer after the premium was past due, was ineffective under O.C.G.A. § 33-24-44 because the notice provided the insured an opportunity to keep the policy in force by paying the past due premium within the 10-day statutory period. Infinity Gen. Ins. Co. v. Reynolds, 570 F.3d 1228 (11th Cir. 2009).

Right to cancel and right to limit liability distinguished. — Policy providing for limitation of insurer's liability upon insured's suicide did not give the insurer the right to cancel the policy following the insured's suicide as cancellation involves discharge from future liability rather than from liability already incurred. Sunbelt Life Ins. Co. v. Bank of Alapaha, 176 Ga. App. 628, 337 S.E.2d 410 (1985).

Effect of claim that cancellation not effective. — Cancellation of a worker's compensation insurance policy in compliance with subsection (b) of O.C.G.A. § 33-24-44 and a state board of worker's compensation rule, regardless of other circumstances surrounding the cancellation, does not automatically entitle a workers' compensation insurer to complete relief against a claim that the cancellation was not effective or applicable. Travelers Ins. Co. v. Adkins, 200 Ga. App. 278, 407 S.E.2d 775 (1991).

Time provisions of O.C.G.A. § 33-24-44 were intended to also apply to unearned premiums returned through premium finance companies. Balboa Ins. Co. v. Hunter, 165 Ga. App. 273, 299 S.E.2d 91 (1983).

Expiration or lapse due to nonpayment of premium. — This section has no application when policy in issue was not canceled, but simply expired or lapsed because of nonpayment of premium. Robertson v. Southland Life Ins. Co., 130 Ga. App. 807, 204 S.E.2d 505 (1974).

Insurer is not required to comply with the notice requirements of O.C.G.A. § 33-24-44 when a policy expires or lapses according to the policy's terms upon a policyholder's failure to pay the premiums. King v. Guardian Life Ins. Co. of Am., 686 F.2d 894 (11th Cir. 1982); Goodley v. Fireman's Fund Am. Life Ins. Co., 173 Ga. App. 277, 326 S.E.2d 7 (1985); Southern Gen. Ins. Co. v. Tippins Bank & Trust Co., 213 Ga. App. 176, 444 S.E.2d 331 (1994), aff'd, 266 Ga. 97, 464 S.E.2d 381 (1995); Ponderosa Collections, Inc. v. Frady, 216 Ga. App. 619, 455 S.E.2d 346 (1995).

O.C.G.A. § 33-24-44 applies only to the cancellation of an insurance policy. It does not apply when an insurer declines to accept coverage, nor does the statute apply to the expiration of a binder. Marchel v. Georgia Mut. Ins. Co., 188 Ga. App. 604, 373 S.E.2d 787, cert. denied, 188 Ga. App. 912, 373 S.E.2d 787 (1988).

In an action to avoid coverage on an automobile policy, because a jury's determination was required as to whether the insured failed to pay premiums when due and whether the insurer sent notice of cancellation after premiums were due, the trial court properly denied the insurer's motion for summary judgment and erred in granting the insured's motions for summary judgment. Atlanta Cas. Co. v. Boatwright, 244 Ga. App. 36, 534 S.E.2d 516 (2000).

Reinstatement retroactive to cancellation date for nonpayment not required. — In an insured's action against an automobile insurer that denied coverage, there was no issue of material fact as to whether the policy had been effectively cancelled for nonpayment. The insurer had mailed a notice of cancellation to the insured in accordance with O.C.G.A. § 33-24-44(d), and the insured, who did not recall seeing the notice, did not maintain that the mailing address was incorrect; moreover, although the policy was reinstated when the premium was received after the cancellation date, nothing in the policy required that the reinstatement be retroactive to the date of cancellation. Zilka v. State Farm Mut. Auto. Ins. Co., 291 Ga. App. 665, 662 S.E.2d 777 (2008).

Effect of custom and practice of renewing policy "without interruption." — When an insurer's practice had been to reinstate coverage "without interruption" upon receipt of premium following cancellation, an issue arose as to whether the policy in question had been effectively cancelled so as to permit the

insurer to deny coverage, or whether, by the past conduct of the parties, the policy was reinstated following such cancellation. Holland v. Allstate Ins. Co., 200 Ga. App. 668, 409 S.E.2d 79 (1991).

This section contemplates written notice. Employers' Fire Ins. Co. v. Pennsylvania Millers Mut. Ins. Co., 116 Ga. App. 433, 157 S.E.2d 807 (1967).

Insurer's history of accepting late payments precludes "automatic termination" defense. — Insurer's history of accepting late payment premiums, coupled with the insurer's failure to give notice of the insurer's intent to insist upon timely payment under the original contractual provisions of a health insurance policy, precludes the establishment, as a matter of law, of an "automatic termination" defense to an action on the policy. If there is no "automatic termination" of the policy as the result of this history of late payment, the jury is authorized to consider whether or not the insurer validly cancelled the policy at any time by notice to the insured. General Am. Life Ins. Co. v. Samples, 167 Ga. App. 622, 307 S.E.2d 51 (1983).

Premium return after notice of cancellation. — Belated return of premium (or a failure itself) following a 10-day notice of cancellation pursuant to subsection (d) of O.C.G.A. § 33-24-44 has no greater detrimental impact upon the notice of cancellation than such a delinquent or failed return following a 30-day notice of a cancellation pursuant to subsection (b), which, under subsection (c)(1), does not invalidate a properly executed notice of cancellation. Southern Ins. Co. v. Walker, 184 Ga. App. 369, 361 S.E.2d 502, cert. denied, 184 Ga. App. 910, 361 S.E.2d 502 (1987).

Prior cancellation notice ineffective. — Insurer's acceptance of a late monthly premium payment rendered a prior notice of cancellation ineffective; thus, a cancellation in the next month required additional notice. Allstate Ins. Co. v. Ackley, 227 Ga. App. 104, 488 S.E.2d 85 (1997).

New policy does not automatically cancel old. — Procurement of new insurance as an intended substitution for an existing policy does not constitute an effective cancellation of the policy unless the terms of the policy specifically provide for cancellation in this manner or the parties have otherwise mutually agreed upon this method of cancellation. Davidson v. State Farm Mut. Auto. Ins. Co., 161 Ga. App. 21, 288 S.E.2d 832 (1982).

Computation of period of time anterior to commencement of action. — Ten-day notice period required by subsection (e) for cancellation of an insurance policy is not a statute of limitations, but it does involve the computation, under O.C.G.A. § 1-3-1 and not under O.C.G.A. § 9-11-6, of a period of time anterior to the commencement of an action. Southern Trust Ins. Co. v. First Fed. Sav. & Loan Ass'n, 168 Ga. App. 899, 310 S.E.2d 712 (1983).

Until the notice requirements of this section are met the policy remains in effect. Nationwide Mut. Fire Ins. Co. v. Bridges, 140 Ga. App. 242, 230 S.E.2d 491 (1976).

Lessor of automobile was entitled to prior notice of policy cancellation as a "lienholder" under subsection (d) of O.C.G.A. § 33-24-44. Metropolitan Prop. & Cas. Ins. Co. v. Zeller, 246 Ga. App. 637, 541 S.E.2d 433 (2000).

Regardless of terms of policy, minimum requirement for cancellation includes return of unearned premium within 15 days unless a rate investigation is necessary. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

Subsection (c) is mandatory, and failure to refund the unearned premium within 15 days renders the attempted cancellation ineffective. Chicago Ins. Co. v. Camors, 296 F. Supp. 1335 (N.D. Ga. 1969), aff'd, 420 F.2d 376 (5th Cir. 1970).

Definite requirement for cancellation is that tender of unearned premiums be made within prescribed time limits. Georgia Mut. Ins. Co. v. Fraser, 152 Ga. App. 866, 264 S.E.2d 315 (1980).

Under Georgia law, O.C.G.A. § 33-24-44, any unearned premium which has been paid by the insured must be refunded when a policy is cancelled; however, the legislature has not provided such relief when premiums are "unearned" in the sense that a policyholder has accepted

General Consideration (Cont'd)

the terms of a policy under which the policyholder may be paying a premium for a period when the policyholder is not insured. Bogard v. Inter-State Assur. Co., 263 Ga. App. 767, 589 S.E.2d 317 (2003).

Tender of unearned premiums is not a necessary condition preceding cancellation. International Serv. Ins. Co. v. Consolidated Underwriters, 125 Ga. App. 786, 189 S.E.2d 123 (1972).

Policy in effect at time of loss since written notice ineffective prior to loss. — When written notice of cancellation of a policy would not have been effective prior to the occurrence of the property loss, any actual notice could not have accomplished a prior cancellation and the policy was still in effect at the time of the loss. Pennsylvania Millers Mut. Ins. Co. v. Employers' Fire Ins. Co., 118 Ga. App. 655, 165 S.E.2d 309 (1968).

Mortgagee entitled to sue when no notice of nonrenewal given. — When the loss payee, first mortgagee of the destroyed premises, never received notice that the insurance policy had not been renewed and did not know that the premises were therefore uninsured, the payee was not precluded from recovering for the damages to the premises under the policy since the insurance company failed to follow the applicable notice provisions. Waco Fire & Cas. Ins. Co. v. Jones, 180 Ga. App. 26, 348 S.E.2d 547 (1986).

Applicability to termination of insurance agent. — O.C.G.A. § 33-24-44 governed the cancellation of insurance policies but did not govern the termination of insurance agents which may have had the ancillary effect of terminating an insurance policy and, thus, the court could not reasonably conclude that the retroactive termination of the financial planner was the harm § 33-24-44 was intended to guard against. Therefore, the financial planner did not allege a viable negligence per se claim and the negligence claims against the insurance company were required to be dismissed. Rosen v. Protective Life Ins. Co., No. 1:09-cv-03620-WSD, 2010 U.S. Dist. LEXIS 50392 (N.D. Ga. May 20, 2010).

Trial court's jury instruction, based on entirety of O.C.G.A. § 33-24-44, was not an error since subsection (c) was applicable to the situation, found in the case at hand, in which a policy financed through a premium finance company was cancelled. Thico Plan, Inc. v. Ashkouti, 171 Ga. App. 536, 320 S.E.2d 604 (1984).

Cited in Nationwide Mut. Ins. Co. v. Barnes, 108 Ga. App. 643, 134 S.E.2d 552 (1963); Brown v. Quality Fin. Co., 112 Ga. App. 369, 145 S.E.2d 99 (1965); Georgia Mut. Ins. Co. v. Ragan, 122 Ga. App. 56, 176 S.E.2d 230 (1970); Brewer v. General Accident, Fire & Life Assurance Corp., 122 Ga. App. 270, 176 S.E.2d 556 (1970); Canal Ins. Co. v. Lawson, 123 Ga. App. 376, 181 S.E.2d 91 (1971); Georgia Farm Bureau Mut. Ins. Co. v. Gordon, 126 Ga. App. 215, 190 S.E.2d 447 (1972); Reserve Ins. Co. v. Ford Motor Credit Corp., 127 Ga. App. 193, 192 S.E.2d 925 (1972); Thames v. Piedmont Life Ins. Co., 128 Ga. App. 630, 197 S.E.2d 412 (1973); Republic Ins. Co. v. Cook, 129 Ga. App. 833, 201 S.E.2d 668 (1973); American Indem. Ins. Co. v. Brown, 134 Ga. App. 34, 213 S.E.2d 135 (1975); Motors Ins. Corp. v. Roper, 136 Ga. App. 224, 221 S.E.2d 55 (1975); Ector v. American Liberty Ins. Co., 138 Ga. App. 519, 226 S.E.2d 788 (1976); Liberty Nat'l Life Ins. Co. v. Davis, 146 Ga. App. 38, 245 S.E.2d 316 (1978); American Int'l Life Ins. Co. v. Hartsfield, 147 Ga. App. 213, 248 S.E.2d 518 (1978); Transamerica Ins. Co. v. Smith, 147 Ga. App. 574, 249 S.E.2d 663 (1978); Pearce v. Southern Guar. Ins. Co., 246 Ga. 33, 268 S.E.2d 623 (1980); Speir Ins. Agency, Inc. v. Lee, 158 Ga. App. 512, 281 S.E.2d 279 (1981); Lumbermen's Inv. Corp. v. American Modern Home Ins. Co., 158 Ga. App. 705, 282 S.E.2d 178 (1981); Daniels v. Allstate Ins. Co., 162 Ga. App. 758, 293 S.E.2d 39 (1982); Maddox v. Allstate Ins. Co., 164 Ga. App. 21, 296 S.E.2d 84 (1982); Smith v. Allstate Ins. Co., 573 F. Supp. 707 (N.D. Ga. 1983); Bush v. Vanguard Ins. Co., 172 Ga. App. 704, 324 S.E.2d 554 (1984); Doxie v. Ford Motor Credit Co., 603 F. Supp. 624 (S.D. Ga. 1984); Perry & Co. v. New S. Ins. Brokers of Ga., Inc., 182 Ga. App. 84, 354 S.E.2d 852 (1987); Pennsylvania Nat'l Mut. Cas. Ins. Co. v. O'Berry, 184 Ga. App. 606, 362 S.E.2d 157 (1987); Leader Nat'l Ins. Co. v. Gaydon, 185 Ga. App. 322, 363 S.E.2d 859 (1987); Dupree v. Georgia Mut.

Ins. Co., 188 Ga. App. 857, 374 S.E.2d 546 (1988); Georgia Ins. Co. v. White, 190 Ga. App. 208, 378 S.E.2d 523 (1989); Massachusetts Bay Ins. Co. v. Photographic Assistance Corp., 732 F. Supp. 1572 (N.D. Ga. 1990); Timely Entertainment Int'l, Inc. v. State Farm Fire & Cas. Co., 208 Ga. App. 467, 430 S.E.2d 844 (1993).

Exceptions

Thirty-day notice for cancellation not required. — Thirty-day notice of cancellation was not required when, even if a child's actions in requesting that a vehicle be added to the parent's existing policy were contractually and legally unauthorized so that the policy should not have been modified to provide coverage for the vehicle and require a premium increase, coverage on all of the vehicles was cancelled because of nonpayment of premiums which included an amount due on a truck added by the parent. Buffington v. State Auto. Mut. Ins. Co., 192 Ga. App. 389, 384 S.E.2d 873, cert. denied, 192 Ga. App. 901, 384 S.E.2d 873 (1989).

Trial court erred in finding that the insurance company had to give notice of cancellation for nonpayment of premiums under O.C.G.A. § 33-24-44 as that statute did not apply because the insurance contract stated that cancellation was automatic upon failure to pay premiums; thus, the trial court erred in granting summary judgment to a wife in an action to recover benefits under a life insurance policy. Guideone Life Ins. Co. v. Ward, 275 Ga. App. 1, 619 S.E.2d 723 (2005).

Notice provisions of O.C.G.A. § 33-24-44 are inapplicable to a policy which expires due to an insured's affirmative rejection of renewal. Lumbermens Mut. Cas. Co. v. Haynes, 163 Ga. App. 288, 293 S.E.2d 744 (1982).

Form, Sufficiency, and Proof of Notice

Failure to follow statutory requirements. — Insurer's notice which failed to provide 30 days' notice of cancellation and failed to state a valid reason for cancellation resulted in noncancellation of a policy and, because no notice of nonrenewal was given, the policy was extended under the policy's terms for another six months. Bank of Toccoa v. Cotton States Mut. Ins. Co., 211 Ga. App. 389, 439 S.E.2d 60 (1993).

Notice of insurance policy cancellation was not effective under O.C.G.A. § 33-24-44(b) because the insurer did not provide the statutorily-acceptable proof that the mailing of the notice to the insured took place not less than 30 days before the date of cancellation contained in the notice. Cresent Hill Apts. v. Admiral Ins. Co., 277 Ga. 396, 589 S.E.2d 96 (2003).

Insurer's notice of intent to cancel failed to satisfy insurance cancellation notice requirements because the notice never stated unequivocally that the car insurance policy would have been cancelled for non-payment of premiums, the notice did not unequivocally state that premiums were past due, and the notice also suggested that it was a "billing" notice. Southern Pilot Ins. Co. v. CECS, Inc., 15 F. Supp. 3d 1329 (N.D. Ga. 2013).

Noncompliance with statutory requirements not excused. — Insurer's failure to strictly comply with the notice of cancellation requirements of subsection (b) was not excused, when there was undisputed evidence that the insured did not receive notice at least 30 days in advance of the stated cancellation date. Trammell Crowe Constr. Co. v. Rumph, 198 Ga. App. 754, 403 S.E.2d 72 (1991).

Regardless of when it was generated, under O.C.G.A. § 33-24-45(d), an auto insurer's cancellation notice could not take effect until the date of mailing, at which point the insurer had received payment satisfying the insured's past-due balance. Therefore, cancellation for non-payment was improper under O.C.G.A. § 33-24-44. Auto-Owners Ins. Co. v. Alexander, 293 Ga. App. 459, 667 S.E.2d 628 (2008).

Notice that policy will be cancelled upon nonpayment of future premiums. — Notice of cancellation which states that a policy will be cancelled on a specified date unless premiums due are paid prior to that date is merely a demand for payment and ineffective as a notice of cancellation. Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Person, 164 Ga. App. 488, 297 S.E.2d 80 (1982).

Form, Sufficiency, and Proof of Notice (Cont'd)

When notice of cancellation was not given to the insured upon the insured's failure to pay the premium when due, but rather, was given before the premium was due, there was a failure to adhere to statutory requirements resulting in noncancellation of the policy. Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Person, 164 Ga. App. 755, 297 S.E.2d 337 (1982).

Upon the insured's failure to pay the insured's premiums on June 27, 2003, the insurer followed the proper procedure under Georgia law for cancellation of an insurance policy when the insurer sent a certified letter to the insured informing the insured of the payment problems and noticing the insured that the policy would be cancelled if the premium was not paid by July 20, 2003; the insurer had no duty, under the original written policy, to defend the insured in any civil action arising from the July 31, 2003, crash since this was subsequent to the date coverage was cancelled due to nonpayment of premium. Rutland v. State Farm Mut. Auto. Ins. Co., 392 Fed. Appx. 721 (11th Cir. 2010) (Unpublished).

This section authorizes mailing as minimum requirement and makes this method sufficient only when policy so provides. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

Policy cannot be cancelled unless notice is at least mailed to insured. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

Cancellation accomplished only by strict compliance with cancellation. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

When the parties have provided stricter notice provisions, cancellation of an insurance policy may be accomplished only by complying with the strict terms of the policy. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

Mailing notice of cancellation without proof of receipt is sufficient to accomplish cancellation of an insurance policy only when that method is specifically provided in the policy. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

When by the terms of an insurance policy more than mere mailing was required, if the notice was not received by the insured, the policy was not cancelled. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

Insurer failed to comply with O.C.G.A. § 33-24-44(b) when the insurer attempted to cancel a commercial property insurance policy issued to an insured by taping an envelope containing the cancellation notice to the outside of a mailbox with an attached note asking the letter carrier to date and sign or postmark the certified mail receipt with the date it was picked up for delivery and deliver the envelope via certified mail to the insured; therefore, the insurer was not entitled to summary judgment in the insurer's action for a declaration that the insurer was not obligated to pay the insured's claim because the insurer had cancelled the policy. Admiral Ins. Co. v. Cresent Hills Apts., 354 F.3d 1301 (11th Cir. 2003).

Following procedures of company in giving notice of cancellation. — Insurer's evidence establishing that on the same date of the mailing receipt, the insureds were sent a cancellation notice, and that it was the insurer's practice to have cancellation notices inserted into envelopes manually or by machine before being matched to the appropriate mailing receipt, was sufficient to establish that the mailing contained a notice of cancellation sent to the insureds. Burnside v. GEICO Gen. Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Certified or registered mailings. — There is no requirement under this section that mailing should be either certified or registered, and there is nothing in the statute with reference to "return receipt requested." Bituminous Cas. Co. v. Renfroe, 130 Ga. App. 621, 204 S.E.2d 317 (1974).

Receipt of notice by insured. — Stamped notice of cancellation, plus meeting the other requisites of this section, satisfies the notice requirements of this section whether notice has in fact been received by the insured. Favati v. National Property Owners Ins., 153 Ga. App. 723, 266 S.E.2d 359 (1980).

Mandatory that notice be properly addressed and mailed. — While it is not

essential that the notice of cancellation be received by the insured to effectuate a cancellation, it is mandatory that the notice be properly addressed and mailed to bring about a cancellation. Harris v. United States Fid. & Guar. Co., 134 Ga. App. 739, 216 S.E.2d 127 (1975).

Actual receipt of notice not required under insurance contract. — When there is uncontradicted direct proof of a proper mailing, and uncontradicted and direct proof that the post office receipt introduced in evidence was taken for such mailing, which mailing, according to this section and to the insurance contract, constitutes delivery to the insured, the failure of the insured's agent (the Post Office Department) to deliver insured mail to insured is not evidence which contradicts the prior proof of mailing (by evidence not circumstantial in nature); actual receipt of the mail by the insured is not required before a cancellation of the policy occurs. Harris v. United States Fid. & Guar. Co., 134 Ga. App. 739, 216 S.E.2d 127 (1975).

That carrier does not make delivery is insufficient to raise issue that delivery was not made to the carrier, which has been proved by a receipt of the carrier showing delivery, when delivery to the carrier is not otherwise assailed. Harris v. United States Fid. & Guar. Co., 134 Ga. App. 739, 216 S.E.2d 127 (1975).

Delivery legally effected by act of mailing and securing post office receipt. — When notice of cancellation has been mailed, proof of the subsequent failure of the Post Office Department to deliver the mails is not proof of nondelivery of the notice as delivery was legally effected by the act of mailing and securing the post office receipt. Harris v. United States Fid. & Guar. Co., 134 Ga. App. 739, 216 S.E.2d 127 (1975).

Insurer was entitled to a declaration that the insurer cancelled a policy before a collision because when the premium payments were overdue, the insurer sent a timely and sufficient cancellation notice, as the insurer had done twice before, and the insureds failed to make a premium payment by the effective cancellation date, and there was record evidence that the insurer mailed the cancellation notice, which, combined with a Post Office receipt, gave the notice of cancellation its legal effect. S. Pilot Ins. Co. v. CECS, Inc., 52 F. Supp. 3d 1240 (N.D. Ga. 2014).

When insured admits receipt of notice of cancellation of policy, it is error to deny a motion for summary judgment by the insurer as to the issue of notice under the policy and to grant summary judgment to the insured because the insurer failed to obtain a Post Office Department receipt at the time of mailing the cancellation notice as required. Travelers Indem. Co. v. Guess, 243 Ga. 559, 255 S.E.2d 55 (1979).

Issue of receipt of notice by insured irrelevant when section satisfied. — When evidence showed without contradiction that this section had been satisfied, whether notice of cancellation had in fact been received by the insured was legally irrelevant and was not an issue which would preclude summary judgment. Hill v. Allstate Ins. Co., 151 Ga. App. 542, 260 S.E.2d 370 (1979).

Even assuming that the insured was entitled to assert that notice had not in fact been received, the insured's affidavits to the effect that the insured did not remember receiving any cancellation notice did not demand summary judgment in the insured's favor. Hill v. Allstate Ins. Co., 151 Ga. App. 542, 260 S.E.2d 370 (1979).

Whether the notice actually had been received by the insured is legally irrelevant when all the requisites of the delivery to the postal authorities had met sufficient compliance and the fact of nondelivery is not an issue which would preclude summary judgment. Favati v. National Property Owners Ins., 153 Ga. App. 723, 266 S.E.2d 359 (1980).

Because the mailing receipt and other uncontradicted evidence showed that the requisites of O.C.G.A. §§ 33-24-44 and 33-24-45(c) were satisfied, whether the insureds actually received notice of cancellation of the insureds' auto insurance policy was irrelevant and did not preclude the insurer from cancelling the insureds' policy due to non-payment. Burnside v. GEICO Gen. Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Form, Sufficiency, and Proof of Notice (Cont'd)

Computer mailing list of insurer stamped by post office constituted proper receipt. — "PORS" list (a computer compilation prepared in insurer's ordinary course of business containing the names, addresses, and policy numbers of all those policyholder's whose policies were to be cancelled by mail) stamped by postal authorities to indicate receipt of the letters addressed to those persons appearing on the list, constituted the post office receipt for the mailing within the contemplation of this section. Hill v. Allstate Ins. Co., 151 Ga. App. 542, 260 S.E.2d 370 (1979); Continental Ins. Co. v. State Farm Mut. Ins., 212 Ga. App. 839, 443 S.E.2d 509 (1994).

Stamped post-office list of names and addresses, showing mailing of notice of cancellation, constituted an appropriate receipt that the mail was in the hands of the postal authorities. State Farm Mut. Auto. Ins. Co. v. Harris, 177 Ga. App. 826, 341 S.E.2d 472 (1986).

This section requires written notice to effect cancellation of policy which protects interest of lienholder. Pennsylvania Millers Mut. Ins. Co. v. Employers' Fire Ins. Co., 118 Ga. App. 655, 165 S.E.2d 309 (1968).

Effect of notice on bank as lienholder. — Notice of cancellation sent to insured is ineffective as to bank as lienholder, and the insurance company remains liable to the bank. South Carolina Ins. Co. v. Glennville Bank, 111 Ga. App. 174, 141 S.E.2d 168 (1965).

Issue raised of whether notice was mailed. — Evidence to the effect that insured and lienholder on the insured property never received the notice required by this section is sufficient to raise an issue of fact as to whether the notice was or was not mailed. Powell v. Lititz Mut. Ins. Co., 419 F.2d 62 (5th Cir. 1969).

No cancellation when evidence failed to show mail contained notice. — When the evidence adduced failed to show that the mail addressed to the insured and receipted for by the United States Post Office contained the notice of cancellation of the policy as required under former Code 1933 §§ 56-2430 and 56-2430.1 (see O.C.G.A. §§ 33-24-44 and 33-24-45), no cancellation was effected, in the absence of a showing of actual receipt of the cancellation notice by the insured. Allstate Ins. Co. v. Cody, 123 Ga. App. 265, 180 S.E.2d 596 (1971).

Issue of fact as to whether notice mailed. — Introduction of evidence that cancellation notice was never received raises an issue of fact as to whether the notice was mailed. Bituminous Cas. Co. v. Renfroe, 130 Ga. App. 621, 204 S.E.2d 317 (1974).

Determination of the conflict between the contentions of the sender and the addressee as to whether cancellation notice was sent is for the fact-finding body, whether it be a jury in law cases or an administrative agency in administrative matters. Bituminous Cas. Co. v. Renfroe, 130 Ga. App. 621, 204 S.E.2d 317 (1974).

Presumption of receipt of notice rebuttable. — Evidence showing that a letter was written, properly addressed, stamped with sufficient postage, and deposited in the United States mail gives rise to the presumption of receipt of the letter by the addressee, but the presumption arising that it was received by the addressee is merely prima facie, and may be successfully rebutted by uncontradicted evidence of the addressee that the addressee did not in fact receive the letter. Bituminous Cas. Co. v. Renfroe, 130 Ga. App. 621, 204 S.E.2d 317 (1974).

Evidence of sufficient postage. — Manager's testimony that a cancellation notice was mailed to the insureds pursuant to the insurer's policies regarding the handling of mail was sufficient to establish that the notice was given the proper amount of postage. Burnside v. GEICO Gen. Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Notice sufficient. — In response to a certified question, the Georgia Supreme Court held that a cancellation notice, given after an insurance premium was past due, which clearly stated that cancellation was occurring, was not ineffective simply because the notice also provided the insured with an opportunity to reinstate coverage. Reynolds v. Infinity Gen. Ins. Co., 287 Ga. 86, 694 S.E.2d 337 (2010).

When an insured was in a car crash after an insurer canceled the policy for failing to pay the premium, the insurer had no duty to defend the insured because, inter alia, the insurer followed the proper procedure under Georgia law for cancellation of an insurance policy, and the insurer did not waive cancellation of the insured's policy by accepting a late premium payment. Rutland v. State Farm Mut. Auto. Ins. Co., 426 Fed. Appx. 771 (11th Cir. 2011) (Unpublished).

Fact that the insurer's Notice of Intent to Cancel contained an option to avoid imminent cancellation by promptly paying the amount due did not render the Notice of Cancellation purportedly sent with the Notice of Intent ineffective. Southern Pilot Ins. Co. v. CECS, Inc., 15 F. Supp. 3d 1284 (N.D. Ga. 2013).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 397 et seq.

C.J.S. — 45 C.J.S., Insurance, § 817 et seq.

ALR. — Insurance: incorrect statement of age, 1 A.L.R. 459; 160 A.L.R. 295.

Provision suspending insurance during default in payment of premiums or assessments as affected by failure of insurer to declare a suspension before loss, 8 A.L.R. 395.

Automobile liability insurance, 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: guaranty fund as preventing forfeiture for nonpayment of premiums or assessments, 29 A.L.R. 517.

Contract providing that obligation thereof shall be canceled in case of death or other extrinsic event as contract of insurance, 35 A.L.R. 1039; 63 A.L.R. 711; 100 A.L.R. 1449; 119 A.L.R. 1241.

Liability in respect of premium where policy is rejected by applicant or prospect, 41 A.L.R. 644.

Validity and enforceability of contractual stipulation for payment of additional amount in case of delay in payment of insurance dues, premiums, or assessments, 41 A.L.R. 979.

Necessity of giving beneficiary notice before cancellation or forfeiture of insurance for nonpayment of premiums or assessments, 44 A.L.R. 1372.

Practice of taking notes for premiums as waiver of requirement of payment as to premium for which note not given, 53 A.L.R. 915.

Avoidance of renewed fire policy for breach of warranty or representation first made in original application or policy, 62 A.L.R. 823.

Outstanding interest in one to whom loss is payable as ground of forfeiture under condition on insurance policy respecting title or encumbrances, 65 A.L.R. 913.

Contractual provision for lapse of policy or certificate in event of disappearance of insured or his failure to report to insurer, 65 A.L.R. 1038.

Exercise of reserved right to cancel policy of insurance as affected by motive or reason for cancellation, 68 A.L.R. 1171.

Rescission of policy of life or accident insurance after death of insured by agreement, express or implied, with beneficiaries, 80 A.L.R. 185.

Action of insurer in regard to unpaid premium note after maturity as waiver of, or estoppel to claim, forfeiture for nonpayment, 83 A.L.R. 846.

Disability feature of insurance contract as subject of rescission apart from life insurance feature, 91 A.L.R. 1470.

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.

Burden of proof as regards payment or nonpayment of renewal premiums or assessments on policy of life or accident insurance, 95 A.L.R. 745.

Impaired eyesight as within representation, warranty, or condition of insurance policy as regards health or physical condition, 96 A.L.R. 429.

Construction, application, and effect of provisions of war risk insurance precluding or terminating, because of misconduct, the right of one otherwise entitled to benefits, 99 A.L.R. 1284.

Continued acceptance of insurance premiums or dues as basis of waiver of, or

estoppel to assert, misrepresentation or breach affected by alternative obligation which survived misrepresentation or breach, 101 A.L.R. 1138.

Conclusiveness of insurer's statement to insured or beneficiary after lapse as to period of extended insurance or amount of paid-up insurance, 103 A.L.R. 1364.

Death of insured or other loss pending application not effectively granted, for reinstatement of life or accident insurance, after lapse, 105 A.L.R. 478; 164 A.L.R. 1057.

Scope and application of limitation provision of statute or policy against actions under forfeited policy, 105 A.L.R. 1093.

Equity jurisdiction for cancelation of insurance policy upon ground within incontestable clause prior to termination of period, 111 A.L.R. 1275.

Computation of cash surrender value or extended or paid-up insurance as affected by loan on policy, 113 A.L.R. 606.

Payment or tender, after lapse of policy for nonpayment of premium, of amount of loan on policy as affecting computation of paid-up or extended insurance, 114 A.L.R. 901.

Admissibility and weight on question of materiality of misrepresentation, of testimony of officers or employees of insurer to effect that application would not have been accepted but for misrepresentation, or that there was a rule or policy to reject risks of the kind that would have been shown but for the misrepresentation, 115 A.L.R. 100.

Rights and obligations of conditional purchaser of automobile, or one in same right, and insurer, as affected by notice of cancelation of policy given by insurer to conditional seller or finance company, 115 A.L.R. 482.

False answer in application for life insurance to question regarding previous rejection, 120 A.L.R. 1425.

Wrongful termination of policy by insurer, or false information to insured in that regard, as excusing further tend and payment of premiums or assessments, 122 A.L.R. 385; 160 A.L.R. 629.

Cancellation of life insurance policy for nonpayment of loan, 126 A.L.R. 102.

Repayment or tender of unearned premium as condition precedent to exercise by insurer of right to cancel policy, 127 A.L.R. 1341; 16 A.L.R.2d 1200.

Right to return of premiums paid upon insurance policy which is void ab initio, 129 A.L.R. 57.

Grounds for cancellation or rescission of annuity agreement, or for recovery back of property conveyed, or money paid, thereunder, 131 A.L.R. 424.

Materiality of false representation, in application for policy of insurance, as to whether applicant has consulted physicians, 131 A.L.R. 617.

Duty of life insurer, or its agents, to inform or explain to insured his rights under policy before accepting his surrender the same, 131 A.L.R. 1299.

Notice to insured of insufficiency to meet premiums of cash or loan value, reserve, or dividends, 140 A.L.R. 683.

Falsity of representation or warranty as defense to action upon policy of insurance on life of infant, 143 A.L.R. 331.

Mutual rescission, waiver, ratification, or estoppel, as regards insurer's attempt to rescind policy of insurance or particular provisions thereof, 152 A.L.R. 95.

Defense predicated upon falsity of answer to question in original application for insurance, or in application for reinstatement, as to whether applicant has had any serious illness or disease, 153 A.L.R. 709.

Suspension of contestable period of incontestable clause of life insurance policy pending appointment of personal representative of insured or of beneficiary, 157 A.L.R. 1204.

Wrongful termination of policy by insurer, or false information to insured in that regard, as excusing further tend and payment of premiums or assessments, 160 A.L.R. 629.

Express provisions in life, accident, or health policies that authorize refusal of renewal premiums or otherwise make renewal optional with insurer, 161 A.L.R. 193.

Sale of land with reservation of insured building as violation of provisions of insurance policy, 173 A.L.R. 1207.

Construction and application of provision of statute designed to prevent avoidance of automobile liability policy by reason of violation of its exclusions or conditions, or other terms, 1 A.L.R.2d 822.

Clause in life, accident, or health policy excluding or limiting liability in case of insured's use of intoxicants or narcotics, 13 A.L.R.2d 987.

Judgment avoiding indemnity or liability policy for fraud as barring recovery from insurer by or on behalf of third person, 18 A.L.R.2d 891.

Limitations governing action to recover unearned premium retained by insurer upon cancelation of policy, 29 A.L.R.2d 938.

Insured's discontinued breach of warranty relating to use or keeping of prohibited articles as barring recovery on fire policy, 44 A.L.R.2d 1048.

Receipt of check for insurance premium as preventing forfeiture for nonpayment, 50 A.L.R.2d 630.

Insurer's previous custom in giving notice of due date of premiums as affecting its right to declare liability policy forfeited or canceled for failure to pay premium, 52 A.L.R.2d 1157.

Provision of policy for mailing of notice to insured's address as stated therein, as affected by change of address, 63 A.L.R.2d 570.

Cancellation or modification of master policy as termination of coverage under group policy, 68 A.L.R.2d 249.

False statements favorable to defense, made and persisted in by insured, as breach of cooperation clause, 79 A.L.R.2d 1040.

Insurer's denial of renewal of policy: waiver and estoppel, 85 A.L.R.2d 1410.

Right of insurance agent to sue in his own name for unpaid premium, 90 A.L.R.2d 1291.

Physician giving medical examination to insurance applicant as agent of insured or of insurer, 94 A.L.R.2d 1389.

Effect of attempt to terminate insurance or fidelity contract upon notice allowing a shorter period than that stipulated in contract, 96 A.L.R.2d 286.

Insurance agent's statement or conduct indicating that insurer's cancellation of policy shall not take effect as binding on insurer, 3 A.L.R.3d 1135.

Dividends as preventing lapse of policy for nonpayment of premiums, 8 A.L.R.3d 862.

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

Insured's failure to inform insurer of pending condemnation proceedings as concealment of fraud within provision of fire policy, 9 A.L.R.3d 1411.

Overvaluation in proof of loss of property insured as fraud avoiding fire insurance policy, 16 A.L.R.3d 774.

Construction of express insurance policy provision restricting insurer's right to cancel or otherwise terminate coverage, 19 A.L.R.3d 1429.

Insured's misrepresentation or misstatement as to his name or marital status as ground for avoiding liability insurance, 27 A.L.R.3d 849.

What constitutes "serious illness," "serious disease," or equivalent language used in insurance application, 28 A.L.R.3d 1255.

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.

Liability insurer's unconditional right to cancel policy as affected by considerations of public policy, 40 A.L.R.3d 1439.

Construction and effect of arrangement under which insurance premiums are paid automatically via insurer's draft on insured's bank account, 45 A.L.R.3d 1349.

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.

Libel and slander: privileged nature of communications between insurer and insured, 85 A.L.R.3d 1161.

Wrongful cancellation of medical malpractice insurance, 99 A.L.R.3d 469.

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.

Obtaining new property insurance as cancellation of existing insurance, 11 A.L.R.4th 774.

Termination of employee's individual coverage under group policy for nonpayment of premiums, 22 A.L.R.4th 321.

Actual receipt of cancellation notice mailed by insurer as prerequisite to cancellation of insurance, 40 A.L.R.4th 867.

Cancellation of compulsory or "financial responsibility" automobile insurance, 44 A.L.R.4th 13.

33-24-44.1. Procedure for cancellation by insured and notice.

(a) An insured may request cancellation of an existing insurance policy by returning the original policy to the insurer or by making a request for cancellation of an insurance policy to the insurer or its duly authorized agent orally, electronically, or in writing stating a future date on which the policy is to be canceled. In the event of oral cancellation the insurer shall within ten days provide such insured electronically or in writing, confirmation of such requested cancellation. The insurer or its duly authorized agent may require that the insured provide written, electronic, or other recorded verification of the request for cancellation prior to such cancellation taking effect. Such cancellation shall be accomplished in the following manner:

(1) If only the interest of the insured is affected, the policy shall be canceled on the later of the date the returned policy or request is received by the insurer or its duly authorized agent or the date specified in the request; provided, however, that upon receipt of a request for cancellation from an insured, an insurer may waive the future date requirement by confirming the date and time of cancellation to the insured and the insurer shall document in its policy file the request for cancellation along with the date of the requested cancellation;

(2) If by statute, regulation, or contract the insurance policy may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party, the insurer shall mail or deliver such notice stating the date cancellation shall become effective, but such date shall not be less than ten days from the date of mailing or delivery of the notice.

(b) Notices required by this Code section shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the named insured, governmental agency, mortgagee, or other third party, where applicable, 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.

(c) Where any notice is mailed or delivered in accordance with this Code section, the effective date of cancellation of the policy shall be the last effective date of any such notice.

(d) Notwithstanding the failure of the insurer to comply with the provisions of this Code section, cancellation shall be effective on the effective date of any replacement policy providing the same or similar coverage, which date shall not be prior to the date provided in subsection (a) of this Code section.

(e) Except as provided in Chapter 22 of this title, an insurance policy which by its terms may be canceled by the insured shall be canceled in accordance with this Code section.

History. — Code 1981, § 33-24-44.1, enacted by Ga. L. 1987, p. 1466, § 2; Ga. L. 1994, p. 344, § 1; Ga. L. 2014, p. 829, § 6/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2018, p. 675, § 1/HB 878; Ga. L. 2019, p. 386, § 51/SB 133; Ga. L. 2019, p. 1056, § 33/SB 52.

The 2018 amendment, effective July 1, 2018, deleted "written" preceding "request" throughout subsection (a); in subsection (a), inserted "orally, electronically, or in writing" in the middle of the first sentence, and added the second and third sentences; in paragraph (a)(1), in the proviso, deleted "in writing" following "cancellation", and added "and the insurer shall document in its policy file the request for cancellation along with the date of the requested cancellation" at the end.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "the insurer, shall within ten days provide such insured electronically or in writing" for "the insurer, shall, within 10 days provide such insured, electronically or in writing" in the second sentence of subsection (a). The second 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, substituted "the insurer shall within ten days" for "the insurer, shall, within 10 days" in the second sentence of subsection (a).

JUDICIAL DECISIONS

Insured's oral request that the policy be changed so as to delete coverage on one vehicle and extend coverage to another vehicle was in the nature of a binder and was enforceable according to the policy's terms, there being no evidence of the insured's intent or attempt to abandon or cancel the existing policy. Progressive Preferred Ins. Co. v. Davis, 199 Ga. App. 598, 405 S.E.2d 529, cert. denied, 199 Ga. App. 907, 405 S.E.2d 529 (1991).

Cancellation after injured employee had vested interest. — Insured contractor, attempting to retroactively cancel the contractor's general commercial liability policy once a less expensive policy became effective, could not unilaterally effectuate the same when the contractor's employee and injured party had acquired a vested interest; the first insurer thus remained liable under O.C.G.A. § 33-24-44.1(a)(1). Harleysville-Atlantic Ins. Co. v. Queen, 250 Ga. App. 382, 552 S.E.2d 436 (2001).

Modification was not cancellation. — Trial court's grant of summary judgment to insurers in the insurers' declaratory judgment action, wherein it was determined that the insurers owed no coverage obligations under a motorist's mother's policy to a driver who was involved in a collision with the motorist, was proper as the motorist's mother had not cancelled the policy when she sought deletion of the motorist's vehicle therefrom and a new policy solely in the motorist's name; rather, the motorist had modified the existing policy and, accordingly, the requirements for cancellation under O.C.G.A. § 33-24-44.1(a) were inapplicable. Danforth v. Gov't Emples. Ins. Co., 282 Ga. App. 421, 638 S.E.2d 852 (2006), cert. denied, No. S07C0473, 2007 Ga. LEXIS 143 (Ga. 2007).

RESEARCH REFERENCES

ALR. — What constitutes waiver by insured or insured's agent of required notice of cancellation of insurance policy, 86 A.L.R.4th 886.

33-24-45. Cancellation or nonrenewal of automobile or motorcycle policies; procedure for review by Commissioner.

(a) This Code section shall apply only to those portions of an automobile policy or a motorcycle policy which relate to bodily injury and property damage liability, personal injury protection, medical payments, physical damage, and uninsured motorists' coverage.

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

(1) "Policy" means a policy, or policies issued by the same insurer, insuring a natural person as named insured or one or more related individuals resident of the same household and which provides bodily injury coverage and property damage liability coverage, personal injury protection, physical damage coverage, medical payments coverage, or uninsured motorists' protection coverage or any combination of coverages and under which the insured vehicles designated in the policy are of the following types only:

(A) Any motor vehicle of the private passenger, station wagon, or jeep type or a motorcycle that is not used as a public or livery conveyance for passengers nor rented to others; or

(B) Any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less which is not used in the occupation or professional business of the insured; provided, however, that this Code section shall not apply to policies of automobile liability insurance issued under the Georgia Automobile Insurance Plan nor to any policy insuring an automobile which is one of more than four insured under a single policy nor to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(2) "Reduction in coverage" shall mean a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

(3) "Renewal" means issuance and delivery by an insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer or issuance and delivery of

a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium; provided, however, that any policy with a policy period or term of less than six months shall, for the purpose of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim termination by its terms or by refusal to accept premium shall be a cancellation subject to this Code section, except in case of termination under any of the circumstances specified in subsection (f) of this Code section; provided, further, that, for purposes of this Code section, any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of the policy shall be deemed a refusal to renew.

(c) No notice of cancellation of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such cancellation, except for one or more of the following reasons:

(1) The named insured failed to discharge when due any of his obligations in connection with the payment of premiums on such policy or any installment of premiums or the renewal of premiums, whether payable directly to the insurer or indirectly to the agent. Notwithstanding the provisions of subsection (d) of Code Section 33-24-44, such notice of cancellation issued to an insured, who is paying on a monthly basis, may be included with the bill issued to the insured, provided that the bill is mailed to the insured at least ten days prior to the due date;

(2) The issuance was obtained through a material misrepresentation;

(3) Any insured violated any of the terms and conditions of the policy;

(4) The named insured failed to disclose fully, if called for in the application, his record for the preceding 36 months of motor vehicle accidents and moving traffic violations;

(5) The named insured failed to disclose in his written application or in response to inquiry by his broker or by the insurer or its agent information necessary for the acceptance or proper rating of the risk;

(6) The named insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim;

(7) The named insured or any other operator either resident in the same household or who customarily operates an automobile insured under such policy:

(A) Has, within the 36 months prior to the notice of cancellation, had his driver's license under suspension or revocation;

(B) Is or becomes subject to epilepsy or heart attacks and the individual does not produce a certificate from a physician testifying to his unqualified ability to operate a motor vehicle;

(C) Has an accident record; a conviction record, criminal or traffic; or a physical, mental, or other condition which is such that his operation of an automobile might endanger the public safety;

(D) Has within a three-year period prior to the notice of cancellation been addicted to the use of narcotics or other drugs;

(E) Has been convicted or forfeited bail during the 36 months immediately preceding the notice of cancellation for:

(i) Any felony;

(ii) Criminal negligence resulting in death, homicide, or assault arising out of the operation of a motor vehicle;

(iii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs;

(iv) Being intoxicated while in or about an automobile or while having custody of an automobile;

(v) Leaving the scene of an accident without stopping to report;

(vi) Theft or unlawful taking of a motor vehicle; or

(vii) Making false statements in an application for a driver's license; or

(F) Has been convicted of or forfeited bail for three or more violations, within the 36 months immediately preceding the notice of cancellation, of any law, ordinance, or regulation limiting the speed of motor vehicles or any of the provisions of the motor vehicle laws of any state, violation of which constitutes a misdemeanor, whether or not the violations were repetitions of the same offense or different offenses;

(8) The insured automobile:

(A) Is so mechanically defective that its operation might endanger public safety;

(B) Is used in carrying passengers for hire or compensation; provided, however, that the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation;

(C) Is used in the transportation of flammables or explosives;

(D) Is an authorized emergency vehicle; or

(E) Has changed in shape or condition during the policy period so as to increase substantially the risk.

(d) No notice of cancellation of a policy to which this Code section applies shall be effective unless mailed or delivered as prescribed in Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(e)(1) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 30 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of the lienholder, where applicable, 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 insurer shall specify in writing the reason or reasons for such nonrenewal as required by Chapter 39 of this title.

(3) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(A) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(B) A change in the insurer's eligibility rules or underwriting rules, provided that this subparagraph shall not apply to a change in such rules if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subparagraph (B) of paragraph (4) of this subsection;

(C) With respect to any driver or with respect to any automobile or its replacement, except when the replacement is such that together with other relevant underwriting or eligibility rules it would not have been insured as an original policy risk of the

insurer, for two or fewer of the following within the preceding 36 month period:

(i) Accidents involving two or more motor vehicles in which the driver of the insured automobile under this subparagraph was not at fault;

(ii) Uninsured or underinsured motorist coverage claims;

(iii) Comprehensive coverage claims; and

(iv) Towing or road service coverage claims;

(D) Age, sex, location of residence address within the state, race, creed, national origin, ancestry, or marital status;

(E) Lawful occupation, provided that the insured automobile is not used in such occupation and provided, further, that such automobile would have been insured as an original policy risk of the insurer when such occupation is considered together with other relevant underwriting or eligibility rules of the insurer;

(F) Military service, provided that the named insured has no change of legal residence from this state;

(G) Number of years of driving experience of a named insured or of any other operator who is either a resident in the same household or customarily an operator of an automobile insured under such policy;

(H) Accidents or violations which occurred more than 36 months prior to the expiration date or anniversary date of the policy or solely for claims paid or payable pursuant to the policy during the preceding 36 month period which did not aggregate in an amount in excess of $750.00;

(I) One claim against the policy based on fault if such coverage has been in effect continuously for at least 36 preceding months;

(J) Notwithstanding subparagraph (I) of this paragraph, two claims against the policy based on fault if such coverage has been in effect continuously for at least 72 preceding months; and

(K) Factors not relating to the claims record, driving record, or driving ability of the named insured or of any other operator who is either a resident in the same household or customarily an operator of an automobile insured under such policy.

(4)(A) Notwithstanding paragraph (3) of this subsection, any reason set forth in subsection (c) of this Code section, relating to cancellation, shall also constitute a reason for nonrenewal.

(B) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or

would be hazardous to its policyholders or the public, subparagraph (B) or (K) of paragraph (3) shall not apply.

(5)(A) If the insurer complies with paragraph (1) of this subsection, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of this subsection, no violation of this subsection may be alleged other than the specific allegations contained in the notice filed by the named insured.

(B) In addition to other requirements, a notice of nonrenewal shall contain the provisions of subparagraph (A) of this paragraph, in substantially the form which follows:

"NOTICE

Code Section 33-24-45 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal."

(6)(A) Notwithstanding paragraph (3) of this subsection, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in this subparagraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(B) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of subparagraph (A) of this paragraph, in substantially the form which follows:

"NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-45 of the Official Code of Georgia Annotated provides that if you will locate another agent of this insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy."

(f) Subsection (e) of this Code section shall not apply in case of:

(1) Nonpayment of premium for the expiring policy;

(2) Failure of the insured to pay the premium as required by the insurer for renewal;

(3) The insurer having manifested its willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his or her representative or by offering to issue a renewal policy, certificate, or other evidence of renewal or having manifested such intention by any other means; or

(4) A reduction in coverage where an insurer provides a written notice of a reduction in coverage to the named insured or his or her representative no less than 30 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be in a separate document with the words "NOTICE OF REDUCTION IN COVERAGE" written in all capital letters in at least 12 point type. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured 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.

(g) Notwithstanding the failure of an insurer to comply with this Code section, termination of any coverage under the policy either by cancellation or nonrenewal shall be effective on the effective date of any other policy providing similar coverage on the same motor vehicle or any replacement of coverage.

(h) Renewal or continuation of a policy shall not constitute a waiver or estoppel with respect to ground for cancellation which existed before the effective date of the renewal or continuance.

(i) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer

shall notify the named insured of his possible eligibility for insurance through the Georgia Automobile Insurance Plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice of availability of the Georgia Automobile Insurance Plan is given pursuant to this Code section.

(j) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them in any written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining to the reasons for cancellation or nonrenewal or for statements made or evidence submitted at any formal or informal hearing conducted in connection with the reasons for cancellation or nonrenewal of the insured's policy.

(k) This Code section shall not apply to any policy which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal of a policy. Such policies shall be canceled in accordance with Code Section 33-24-44.

(l) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(m) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party 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.

(n) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(o) An insured may request a review by the Commissioner if the insured believes that his or her policy has been canceled or nonrenewed

in violation of this Code section. Such request must be filed with the Commissioner within 15 days of receipt of a notice of cancellation or nonrenewal. A review of the cancellation or nonrenewal shall be conducted within 30 days of said request. The Commissioner shall notify the insured and the insurer of his or her decision within the 30 day period. During the pendency of such review, the policy shall continue in full force and effect and the Commissioner shall specify by rule or regulation the method of payment of premium due and the disposition of premium refunds, if any. The Commissioner shall either require that the policy be reinstated or renewed or may uphold the nonrenewal or cancellation. In the event the Commissioner determines that an insurer's cancellation or nonrenewal action constitutes an unfair act or practice, the Commissioner may take action as authorized by this title. Following the completion of any review provided by this subsection, an insured may request a hearing pursuant to Code Section 33-2-17, and nothing in this subsection shall be deemed to waive an insured's right to request such a hearing.

History. — Code 1933, § 56-2430.1, enacted by Ga. L. 1968, p. 1126, § 1; Ga. L. 1971, p. 658, §§ 1-5; Ga. L. 1975, p. 1242, §§ 2, 3; Ga. L. 1982, p. 3, § 33; Ga. L. 1984, p. 1345, § 5; Ga. L. 1987, p. 1466, § 3; Ga. L. 1988, p. 677, §§ 1, 2; Ga. L. 1991, p. 1608, §§ 1.8, 1.9, 1.10, 1.11; Ga. L. 1996, p. 705, § 15; Ga. L. 1996, p. 767, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2012, p. 1117, § 6/SB 385; Ga. L. 2014, p. 829, §§ 7, 8/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2017, p. 692, § 1/HB 92; Ga. L. 2018, p. 210, § 1/HB 760; Ga. L. 2019, p. 474, § 5/SB 156; Ga. L. 2019, p. 1056, § 33/SB 52.

The 2018 amendment, effective July 1, 2018, deleted "and providing no less than the coverage contained in the superseded policy" following "same insurer" near the middle of paragraph (b)(2); added paragraph (b)(3); deleted "or" at the end of paragraph (f)(2); in paragraph (f)(3), inserted "or her" in the middle and substituted "; or" for a period at the end; and added paragraph (f)(4).

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "shall be in a separate document with the words 'NOTICE OF REDUCTION IN COVERAGE' written in all capital letters in at least 12 point type" for "shall be printed in all capital letters in a separate document entitled 'NOTICE OF REDUCTION IN COVERAGE.'" in the proviso of the first sentence of paragraph (f)(4). The second 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, redesignated former paragraphs (b)(2) and (b)(3) as present paragraphs (b)(3) and (b)(2), respectively.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1985, in subsection (b), paragraph (1) was redesignated as paragraph (2) and paragraph (2) was redesignated as paragraph (1) in order to arrange the defined terms in alphabetical order.

Editor's notes. — Ga. L. 1991, p. 1608, § 3.1, not codified by the General Assembly, provides that this Code section shall apply to policies of motor vehicle insurance issued, issued for delivery, delivered, or renewed on and after October 1, 1991. Except for an otherwise permissible cancellation of policy of motor vehicle insurance, coverages payable without regard to fault in motor vehicle insurance policies in existence on October 1, 1991, shall remain in effect until changed by specific request of the policyholder and reflected by endorsement to the policy or until the renewal date of the policy; provided, however, the insurer shall be required to send written notice to the policyholder of any changes in coverage to be effective upon renewal of the policy as a result of this Act not less than 60 days prior to the renewal

date of the policy. Written notice to the policyholder shall be accomplished in such form and manner as prescribed by the Commissioner of Insurance.

Law reviews. — For article surveying Georgia cases in the area of insurance from June 1979 through May 1980, see 32 Mercer L. Rev. 79 (1980). For annual survey of insurance law, see 35 Mercer L. Rev. 177 (1983). For annual survey of insurance law, see 42 Mercer L. Rev. 259 (1990). For annual survey on insurance law, see 69 Mercer L. Rev. 117 (2017).

For review of 1996 department and commissioner of insurance legislation, see 13 Ga. St. U.L. Rev. 183.

For comment on Life Ins. Co. v. Bartlett, 37 Ga. App. 22, 138 S.E. 589 (1927), see 1 Ga. L. Rev. No. 2 P. 49 (1927).

JUDICIAL DECISIONS

Analysis

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General Consideration

Purpose of this section is to provide an insured with notice as to the status of the insured's policy, and when the record affirmatively shows compliance with this section by the insurer, knowledge of the policy's status, and admitted inactivity and nonresponse by the insured to effect a renewal thereof, the law should not create a contractual relationship due to after-the-fact circumstances. National Indem. Co. v. Berry, 136 Ga. App. 545, 221 S.E.2d 624 (1975).

Terms of this section as to cancellation must be exactly followed. Garber v. American Mut. Fire Ins. Co., 131 Ga. App. 366, 206 S.E.2d 86 (1974).

Applicant's misrepresentation. — Regardless of whether the applicant made material misrepresentations on the applicant's application, the applicant's policy with the insurer remained enforceable; the insurer cited no case, and the appellate court found none, that would allow an insurer to void an automobile insurance policy affording third-party liability protection without utilizing the statutory procedures mandated by O.C.G.A. § 33-24-45. Liberty Ins. Corp. v. Ferguson, 263 Ga. App. 714, 589 S.E.2d 290 (2003).

Strict adherence to this section, in regard to automobile insurance policies, is required to accomplish cancellation. American Int'l Life Ins. Co. v. Hartsfield, 147 Ga. App. 213, 248 S.E.2d 518 (1978).

This section provides for automatic renewal of automobile liability coverage unless the company meets notice requirements therein set forth. Unigard Mut. Ins. Co. v. Fox, 142 Ga. App. 706, 236 S.E.2d 851 (1977).

1988 amendment not applied retroactively. — The 1988 amendment, which added division (e)(3)(C)(i) so as to prevent nonrenewal except under stated conditions, is not applied retroactively. Banks v. Aetna Cas. & Sur. Co., 189 Ga. App. 758, 377 S.E.2d 685 (1989).

Written notice required to effect cancellation of policy which protects interest of lienholder. Pennsylvania Millers Mut. Ins. Co. v. Employers' Fire Ins. Co., 118 Ga. App. 655, 165 S.E.2d 309 (1968).

O.C.G.A. § 33-24-7 does not apply to insurance policies covered by O.C.G.A. § 33-24-45. Sentry Indem. Co. v. Sharif, 248 Ga. 395, 282 S.E.2d 907 (1981); Georgia Farm Bureau Mut. Ins. Co. v. Phillips, 251 Ga. 244, 304 S.E.2d 725 (1983).

"Renewal" means renewal of the terms of the original policy; when the original policy is for six months, the renewal period must be the same. Wisener v. American S. Ins. Co., 150 Ga. App. 795, 258 S.E.2d 908 (1979).

Mandatory minimum and optional amounts of coverage. — Paragraph (b)(1) (formerly paragraph (b)(2)) of O.C.G.A. § 33-24-45 does not distinguish

General Consideration (Cont'd)

between mandatory minimum and optional amounts of coverage. Georgia Farm Bureau Mut. Ins. Co. v. Phillips, 251 Ga. 244, 304 S.E.2d 725 (1983).

Applicability of subsection (g). — Under the terms of the insured's homeowners' policy and consistent with subsection (g) of O.C.G.A. § 33-24-45, an insured effected a termination of the auto insurance endorsement to the insured's homeowners' policy when the insured procured an auto insurance policy from another company. Cincinnati Ins. Co. v. St. Paul Fire & Marine Ins. Co., 222 Ga. App. 190, 474 S.E.2d 78 (1996).

Applicability of subsection (i). — While it would appear that subsection (i) (formerly subsection (j)) of this section was intended to apply when the policy was either canceled or not renewed because the insurance company felt that the insured was a poor risk, this section does not so provide but in fact makes subsection (i) (formerly subsection (j)) apply in all cases when the policy is canceled or not renewed. Concord Group Ins. Co. v. Terry, 130 Ga. App. 13, 202 S.E.2d 471 (1973).

Subsection (i) (formerly subsection (j)) of O.C.G.A. § 33-24-45, which provides for the notification of the insured of the insured's possible eligibility for insurance in the Georgia Automobile Assigned Risk Plan (now Georgia Automobile Insurance plan), only comes into play when a notice of intention not to renew under subsection (e) must be given. Notice need not be given when "the insurer … manifested its willingness to renew …" under paragraph (f)(3). Wheeler v. Standard Guar. Ins. Co., 168 Ga. App. 565, 309 S.E.2d 805 (1983).

Failure to follow statutory requirements resulting in noncancellation and renewal of policy. — Insurer's notice which failed to provide 30 days' notice of cancellation and failed to state a valid reason for cancellation resulted in noncancellation of a policy and, because no notice of nonrenewal was given, the policy was extended under the policy's terms for another six months. Bank of Toccoa v. Cotton States Mut. Ins. Co., 211 Ga. App. 389, 439 S.E.2d 60 (1993).

Notice of willingness to renew may be given simultaneously with issuance of policy. Wheeler v. Standard Guar. Ins. Co., 168 Ga. App. 565, 309 S.E.2d 805 (1983).

Notice required for cancellation of policy for nonpayment of premiums. — Automobile insurance policy as to bodily injury and property damage liability, medical payments, physical damage, and uninsured motorists coverage is controlled by this section, specifically as to cancellations, and notice is required to cancel for nonpayment of premiums, or any installment thereof. American Int'l Life Ins. Co. v. Hartsfield, 147 Ga. App. 213, 248 S.E.2d 518 (1978).

Policy automatically renewed absent compliance with section. — Policy is automatically renewed in the event of failure on the part of the insurer to mail the required notice of intention not to renew, or to comply with subsections (e) through (h) of this section. Garner v. GEICO, 129 Ga. App. 235, 199 S.E.2d 350 (1973).

Mailing alone of notice of willingness or intent to renew, if unreceived, does not constitute an offer to the insured to renew so as to prevent the automatic renewal of the policy. Garner v. GEICO, 129 Ga. App. 235, 199 S.E.2d 350 (1973).

If the insurer does not properly comply with the notice requirements of O.C.G.A. § 33-24-45, then the insured's policy is automatically renewed. Georgia Mut. Ins. Co. v. Mims, 187 Ga. App. 783, 371 S.E.2d 426, cert. denied, 187 Ga. App. 907, 371 S.E.2d 426 (1988).

Insured's automobile liability policy automatically renewed under O.C.G.A. § 33-24-45(e) when the insurer did not send the insurer's renewal declaration statement until three days after the date on which the policy expired and, thus, the insured had coverage on the insured's automobile at the time of the accident one month after the expiration and automatic renewal occurred. Stedman v. Cotton States Ins. Co., 254 Ga. App. 325, 562 S.E.2d 256 (2002).

Renewal versus new policy. — 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 the policy bore a slightly different number and that there were changes in the premium amounts and the vehicles insured did not mean that the policy 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).

Effect of lapse between expiration of existing policy and issuance of new policy. — Lapse of two days between the expiration of the existing policy and the issuance of another policy does not preclude the second policy from being a renewal contract. A renewal policy can begin on another date by agreement of the parties to the contract. Progressive Preferred Ins. Co. v. Brown, 261 Ga. 837, 413 S.E.2d 430 (1992).

Effect of insurer's practice of renewing policy "without interruption." — When the custom and practice between an insurer and an insured was that the insurer would renew the policy "without interruption" upon receipt of late premiums, an issue arose as to whether, as a result of a quasi-new agreement created by the past conduct of the parties, the policy was reinstated following such cancellation. Holland v. Allstate Ins. Co., 200 Ga. App. 668, 409 S.E.2d 79 (1991).

Effect of redepositing dishonored check. — Insurance company does not accept a premium check as absolute payment when the company promptly presents a dishonored check a second time for collection. Accordingly, the insurer did not waive the insurer's right to treat the insured's check as a conditional payment by redepositing the check after the check's initial dishonor. Progressive Preferred Ins. Co. v. Brown, 261 Ga. 837, 413 S.E.2d 430 (1992).

Mailed cancellation proper for DUI violation. — Information that the driver's license of a driver recently added to the policy had recently been suspended because of a DUI violation was clearly necessary for a proper risk evaluation, according to subsection (c) of O.C.G.A. § 33-24-45, sufficient to cancel via mailed notice. Ramsdell v. State Auto Mut. Ins. Co., 206 Ga. App. 357, 425 S.E.2d 661 (1992).

Caveat providing for no grace period not against public policy. — Caveat in month to month insurance plan stating "No grace period! If premium is not received by due date your coverage expires" is governed by the exceptions enumerated in subsections (e) through (g) of O.C.G.A § 33-24-45 and is not offensive to the general welfare of the public. Whitlock v. Dairyland Ins. Co., 160 Ga. App. 113, 286 S.E.2d 343 (1981).

Payment of renewal premium must be to insurer's agent. — When there was a payment by the plaintiff, as evidenced by a receipt to the plaintiff from an insurance broker, for the minimum payment requested in the notice after the expiration date, the policy had expired and there was no coverage unless one of the insurance brokers was acting as agent for the insurer so that the payment to one of the agents would constitute payment to insurer. National Property Owners Ins. Co. v. Wells, 166 Ga. App. 281, 304 S.E.2d 458 (1983).

Effect of payment made after cancellation. — While insureds made a payment after sustaining auto damage and after allegedly learning for the first time that the insureds' coverage had been cancelled for non-payment, the insurer's receipt of this payment resulted in the reinstatement of the policy the following day. Thus, the insureds' intent in making payment after the fact was irrelevant to whether the insureds' policy was cancelled at the time of the accident. Burnside v. GEICO Gen. Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Cited in Employers' Fire Ins. Co. v. Pennsylvania Millers Mut. Ins. Co., 116 Ga. App. 433, 157 S.E.2d 807 (1967); International Serv. Ins. Co. v. Consolidated Underwriters, 125 Ga. App. 786, 189 S.E.2d 123 (1972); Atlanta Cas. Co. v. Williams, 135 Ga. App. 562, 218 S.E.2d 282 (1975); Roberts v. American S. Ins. Co., 142 Ga. App. 232, 235 S.E.2d 660 (1977); Peek v. Southern Guar. Ins. Co., 240 Ga. 498, 241 S.E.2d 210 (1978); Howard v. American S. Ins. Co., 148 Ga. App.

General Consideration (Cont'd)

25, 251 S.E.2d 7 (1978); Pearce v. Southern Guar. Ins. Co., 246 Ga. 33, 268 S.E.2d 623 (1980); Smith v. Allstate Ins. Co., 573 F. Supp. 707 (N.D. Ga. 1983); Lyles v. Fire & Cas. Ins. Co., 179 Ga. App. 425, 346 S.E.2d 585 (1986); Stegall v. Leader Nat'l Ins. Co., 256 Ga. 765, 353 S.E.2d 484 (1987); Leader Nat'l Ins. Co. v. Gaydon, 185 Ga. App. 322, 363 S.E.2d 859 (1987); Borders v. Global Ins. Co., 208 Ga. App. 480, 430 S.E.2d 854 (1993); Infinity Gen. Ins. Co. v. Litton, 308 Ga. App. 497, 707 S.E.2d 885 (2011); McGraw v. IDS Prop. & Cas. Ins. Co., 323 Ga. App. 408, 744 S.E.2d 891 (2013).

Exceptions

Cancellation provisions apply only to natural persons and did not apply to a policy covering corporate insureds. Capital City Ins. Co. v. Rick Taylor Timber Co., 918 F. Supp. 1558 (S.D. Ga. 1995), aff'd, 106 F.3d 417 (11th Cir. 1997).

Subsection (k) (formerly subsection (i)) eliminates the requirement of notice to the insured if the policy has been in effect for less than 60 days. Sentry Indem. Co. v. Sharif, 248 Ga. 395, 282 S.E.2d 907 (1981).

Notice of intention not to renew requirement when corporate insured. — Justification for imposing the additional burden of a written notice of intention not to renew upon the insurer under subsection (e) of O.C.G.A. § 33-24-45 may not be present when the insured is a corporation rather than an individual. Disparate treatment of an individual and corporate insureds is not a violation of equal protection in that it bears a real relation to the object of the legislation, which is to protect unsophisticated and more likely unwary insureds by assuring that insurance remains in effect. Home Materials, Inc. v. Auto Owners Ins. Co., 250 Ga. 599, 300 S.E.2d 139 (1983).

No notice required when premium not paid. — When an insured failed to pay a premium for renewal coverage following the insurer's manifestation of the insurer's willingness to renew, no written notice of nonrenewal was required to terminate coverage. Smith v. Southeastern Fid. Ins. Co., 171 Ga. App. 26, 318 S.E.2d 708 (1984).

Cancellation for nonpayment of premiums is within the purview of subsection (f) of O.C.G.A. § 33-24-45 and without the purview of subsection (e) of O.C.G.A. § 33-24-45. Southern Gen. Ins. Co. v. Gailey, 168 Ga. App. 102, 308 S.E.2d 219 (1983).

Cancellation is allowed for any reason of policy "which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal of a policy." Georgia Mut. Ins. Co. v. Ragan, 122 Ga. App. 56, 176 S.E.2d 230 (1970).

Effectiveness of Notice

Insurer's intent not to renew cannot act to bar automatic renewal of the policy unless that intent to renew is communicated to and received by the insured prior to the expiration date of the policy. Prudential Property & Cas. Ins. Co. v. Pritchett, 169 Ga. App. 564, 313 S.E.2d 706 (1983).

Notice ineffective as notice of cancellation. — Notice of cancellation which states that a policy will be cancelled on a specified date unless premiums due are paid prior to that date is merely a demand for payment and ineffective as a notice of cancellation. Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Person, 164 Ga. App. 488, 297 S.E.2d 80 (1982).

When notice of cancellation was not given to the insured upon the insured's failure to pay the premium when due, but rather, was given before the premium was due, there was a failure to adhere to statutory requirements resulting in noncancellation of the policy. Pennsylvania Nat'l Mut. Cas. Ins. Co. v. Person, 164 Ga. App. 755, 297 S.E.2d 337 (1982).

Regardless of when it was generated, under O.C.G.A. § 33-24-45(d), an auto insurer's cancellation notice could not take effect until the date of mailing, at which point the insurer had received payment satisfying the insured's past-due balance. Therefore, cancellation for non-payment was improper under O.C.G.A. § 33-24-44. Auto-Owners Ins. Co. v. Alexander, 293 Ga. App. 459, 667 S.E.2d 628 (2008).

Written notice ineffective prior to loss. — When written notice of cancellation of a policy would not have been effective prior to the occurrence of the property loss, any actual notice could not have accomplished a prior cancellation and the policy was still in effect at the time of the loss. Pennsylvania Millers Mut. Ins. Co. v. Employers' Fire Ins. Co., 118 Ga. App. 655, 165 S.E.2d 309 (1968).

No cancellation when evidence failed to show mail contained notice to insured. — When the evidence adduced failed to show that the mail addressed to the insured and receipted for by the United States Post Office contained the notice of cancellation of the policy as required under O.C.G.A. §§ 33-24-44 and 33-24-45, no cancellation was effected in the absence of a showing of actual receipt of the cancellation notice by the insured. Allstate Ins. Co. v. Cody, 123 Ga. App. 265, 180 S.E.2d 596 (1971).

Notice effective. — In response to a certified question, the Georgia Supreme Court held that a cancellation notice, given after an insurance premium was past due, which clearly stated that cancellation was occurring, was not ineffective under O.C.G.A. § 33-24-45(c)(1) simply because it also provided the insured with an opportunity to reinstate coverage. Reynolds v. Infinity Gen. Ins. Co., 287 Ga. 86, 694 S.E.2d 337 (2010).

Insurer's evidence establishing that on the same date of the mailing receipt, the insureds were sent a cancellation notice, and that it was the insurer's practice to have cancellation notices inserted into envelopes manually or by machine before being matched to the appropriate mailing receipt, was sufficient to establish that the mailing contained a notice of cancellation sent to the insureds. Burnside v. GEICO Gen. Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Because the mailing receipt and other uncontradicted evidence showed that the requisites of O.C.G.A. §§ 33-24-44 and 33-24-45(c) were satisfied, whether the insureds actually received notice of cancellation of the insureds auto insurance policy was irrelevant and did not preclude the insurer from cancelling the insureds' policy due to non-payment. Burnside v. GEICO Gen. Ins. Co., 309 Ga. App. 897, 714 S.E.2d 606 (2011).

Insurance Agents

Standing lies in policyholders. — Insurance agent had no claim for negligence against an insurer based on the insurer's cancellation of policies since such a claim could be asserted only by the policyholders. Keith v. Alexander Underwriters Gen. Agency, Inc., 226 Ga. App. 838, 487 S.E.2d 673 (1997).

Insurance brokers not normally insurer's agents. — While insurance agents or brokers may be considered as "dual" agents, or agents for both the insurer and the insured, normally such insurance representatives are independent insurance brokers and are the insured's agents, not those of the insurer. National Property Owners Ins. Co. v. Wells, 166 Ga. App. 281, 304 S.E.2d 458 (1983).

Denial of agency sufficient to support insurer's motion for judgment. — Since an assertion or denial of the existence of an agency relationship is a statement of fact when made by one of the purported parties, such a statement may not be disregarded by the trial court and is sufficient to support a motion for summary judgment; and an affidavit of insurer's officer categorically denying that insurance brokers were its agents effectively pierces the insured's pleadings and places on the insured the burden of showing the fact of agency. National Property Owners Ins. Co. v. Wells, 166 Ga. App. 281, 304 S.E.2d 458 (1983).

Insurance agent has right to bring action in agent's own name for unpaid premium when, on behalf of the insured, the agent has paid the premium to the insurer or, although the agent has not paid the premium, the agent has become personally liable for the premium's payment. Spalding Ins. & Realty Co. v. Morris, 154 Ga. App. 869, 270 S.E.2d 78 (1980).

RESEARCH REFERENCES

Am. Jur. 2d. — 7 Am. Jur. 2d, Automobile Insurance, § 50 et seq. 43 Am. Jur. 2d, Insurance, § 378 et seq.

C.J.S. — 44 C.J.S., Insurance, § 403 et seq.

ALR. — Delay of remittance in mail as affecting forfeiture or loss of rights through nonpayment, 1 A.L.R. 677.

Provision suspending insurance during default in payment of premiums or assessments as affected by failure of insurer to declare a suspension before loss, 8 A.L.R. 395.

Insurance against theft of automobile, 19 A.L.R. 171.

Insurance: guaranty fund as preventing forfeiture for nonpayment of premiums or assessments, 29 A.L.R. 517.

Contract providing that obligation thereof shall be canceled in case of death or other extrinsic event as contract of insurance, 35 A.L.R. 1039; 63 A.L.R. 711; 100 A.L.R. 1449; 119 A.L.R. 1241.

Practice of taking notes for premiums as waiver of requirement of payment as to premium for which note not given, 53 A.L.R. 915.

Validity of provision avoiding insurance if insured has been treated for any serious disease or complaint, 60 A.L.R. 198.

Exercise of reserved right to cancel policy of insurance as affected by motive or reason for cancellation, 68 A.L.R. 1171.

Action of insurer in regard to unpaid premium note after maturity as waiver of, or estoppel to claim, forfeiture for nonpayment, 83 A.L.R. 846.

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.

Antedating policy of insurance as affecting liability for loss that had already occurred, 132 A.L.R. 1325.

Notice to insured of insufficiency to meet premiums of cash or loan value, reserve, or dividends, 140 A.L.R. 683.

Insurance: incorrect statement of age, 160 A.L.R. 295.

Wrongful termination of policy by insurer, or false information to insured in that regard, as excusing further tend and payment of premiums or assessments, 160 A.L.R. 629.

Independent investigation by insurer as affecting its right to avoid policy because of misrepresentations in application, 169 A.L.R. 361.

Construction and application of provision of statute designed to prevent avoidance of automobile liability policy by reason of violation of its exclusions or conditions, or other terms, 1 A.L.R.2d 822.

Limitations governing action to recover unearned premium retained by insurer upon cancellation of policy, 29 A.L.R.2d 938.

Misrepresentation by applicant for automobile liability insurance as to ownership of vehicle as material to risk, 33 A.L.R.2d 948.

Delivery to insured of receipt showing premium payment as bar to, or waiver or estoppel of, insurer's right to terminate automobile insurance for nonpayment of premium, 48 A.L.R.2d 1094.

Time for payment of insurance premium where last day falls on Sunday or holiday, 53 A.L.R.2d 877.

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.

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.

Rescission or avoidance, for fraud or misrepresentation, of compulsory, financial responsibility, or assigned risk automobile insurance, 83 A.L.R.2d 1104.

Insurer's denial of renewal of policy: waiver and estoppel, 85 A.L.R.2d 1410.

Materiality of false statements by applicant for automobile insurance as to license revocations or suspensions or traffic violations, 89 A.L.R.2d 1027.

Insurance company as bound by greater coverage in earlier policy where renewal policy is issued without calling to insured's attention a reduction in the policy coverage, 91 A.L.R.2d 535.

Effect of attempt to terminate insurance or fidelity contract upon notice allow-

ing a shorter period than that stipulated in contract, 96 A.L.R.2d 286.

Insurer's acceptance of defaulted premium payment or defaulted payment on premium note, as affecting liability for loss which occurred during period of default, 7 A.L.R.3d 414.

Dividends as preventing lapse of policy for nonpayment of premiums, 8 A.L.R.3d 862.

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

Construction of express insurance policy provision restricting insurer's right to cancel or otherwise terminate coverage, 19 A.L.R.3d 1429.

Insured's misrepresentation or misstatement as to his name or marital status as ground for avoiding liability insurance, 27 A.L.R.3d 849.

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.

Automobile insurance: concealment or nondisclosure of physical defects or conditions as avoiding coverage, 72 A.L.R.3d 804.

Insured's right of action for arbitrary nonrenewal of policy, where insurer has option not to renew, 37 A.L.R.4th 862.

Actual receipt of cancellation notice mailed by insurer as prerequisite to cancellation of insurance, 40 A.L.R.4th 867.

Cancellation of compulsory or "financial responsibility" automobile insurance, 44 A.L.R.4th 13.

33-24-46. Cancellation or nonrenewal of certain property insurance policies.

(a) This Code section shall apply only to policies of insurance against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies insuring natural persons as the named insured.

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

(1) "Claim against a policy" means a contact with an insurer by the insured under the policy or an affected third party for the express purpose of seeking payment of proceeds under the terms of the policy in question. A report of loss or a question relating to coverage shall not independently establish a claim against a policy nor be considered as a claim under Article 2 of Chapter 6 of this title.

(2) "Nonrenewal" or "nonrenewed" means a refusal by an insurer or an affiliate of an insurer to renew. Failure of an insured to pay the premium as required of the insured for renewal, a change in policy terms, or a reduction in coverage after the insurer has manifested a willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his or her representative or has offered to issue a renewal policy, certificate, or other evidence of renewal or has manifested such intention by any other means shall not be construed to be a nonrenewal.

(3) "Policies" means a policy insuring a natural person as named insured against direct loss to residential real property and the

contents thereof, as defined and limited in standard fire policies as approved by the Commissioner.

(4) "Reduction in coverage" means a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

(5) "Renewal" means issuance and delivery by an insurer or an affiliate of such insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer or issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium. Any policy with a policy period or term of less than six months shall, for the purposes of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim termination by its terms or by refusal to accept premiums shall be a cancellation subject to this Code section. Any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of such policy shall be deemed a refusal to renew.

(c)(1) No notice of cancellation of a policy as to which this Code section applies shall be effective unless mailed or delivered as prescribed in Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(2) After coverage under a policy to which this Code section applies has been in effect more than 60 days or after the effective date of a renewal policy to which this Code section applies, a notice of cancellation may be issued only for one or more of the following reasons:

(A) Nonpayment of premium;

(B) Discovery of fraud, concealment of material fact, or material misrepresentation made by or with the knowledge of the insured in obtaining the policy, continuing the policy, or presenting a claim under the policy;

(C) The occurrence of a change in the risk which substantially increases any hazard the policy insures against; or

(D) The insured violates any of the material terms or conditions of the policy.

(d)(1) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 30 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of the lienholder, where applicable, 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. The insurer shall provide the reason or reasons for nonrenewal as required by Chapter 39 of this title.

(2) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 30 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be in a separate document with the words "NOTICE OF REDUCTION IN COVERAGE" written in all capital letters in at least 12 point type. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured 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.

(e) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer shall notify the named insured of his possible eligibility for insurance through the Georgia Fair Access to Insurance Requirements Plan. The notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice availability of the Georgia Fair Access to Insurance Requirements Plan is given pursuant to this Code section. Included in the notice shall be the address by which the Georgia Fair Access to Insurance Requirements Plan might be contacted in order to determine eligibility.

(f) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer

information as to reasons for cancellation or nonrenewal for any statement made by any of them and in written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining thereto or for statements made or evidence submitted at any formal or informal hearing conducted in connection therewith.

(g) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(h) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party 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.

(i) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(j) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(1) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(2) A change in the insurer's eligibility rules or underwriting rules, provided that this paragraph shall not apply to a change in such rules if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subsection (k) of this Code section; and

(3) Two or fewer claims against the policy within the preceding 36 month period if such claims are not attributable to the negligent or intentional acts of the insured or of persons residing at the insured premises.

(k) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or would be

hazardous to its policyholders or the public, paragraph (2) of subsection (j) shall not apply.

(l)(1) If the insurer complies with subsection (d) of this Code section, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of subsection (c), (j), or (k) of this Code section, no violation may be alleged other than the specific allegations contained in the notice filed by the named insured.

(2) In addition to other requirements, a notice of nonrenewal shall contain the provisions of paragraph (1) of this subsection in substantially the form which follows:

"NOTICE

Code Section 33-24-46 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal."

(m)(1) Notwithstanding subsection (j) of this Code section, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in this paragraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(2) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of paragraph (1) of this subsection, in substantially the form which follows:

"NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring

coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-46 of the Official Code of Georgia Annotated provides that if you will locate another agent of the insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy."

History. — Code 1933, § 56-2430.3, enacted by Ga. L. 1978, p. 2017, § 1; Ga. L. 1984, p. 1345, § 6; Ga. L. 1987, p. 1466, § 4; Ga. L. 1988, p. 677, §§ 3, 4; Ga. L. 1993, p. 483, § 6; Ga. L. 1995, p. 1011, § 5; Ga. L. 1996, p. 767, § 2; Ga. L. 2004, p. 754, § 2; Ga. L. 2014, p. 829, §§ 9, 10/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2018, p. 210, § 2/HB 760; Ga. L. 2019, p. 474, § 6/SB 156; Ga. L. 2019, p. 1056, § 33/SB 52.

The 2018 amendment, effective July 1, 2018, inserted ", a change in policy terms, or a reduction in coverage" in the middle of the second sentence of paragraph (b)(2); deleted "and providing no less than the coverage contained in the superseded policy" following "same insurer" in the middle of the first sentence of paragraph (b)(4); added paragraph (b)(5); designated the existing provisions of subsection (d) as paragraph (d)(1); and added paragraph (d)(2).

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "shall be in a separate document with the words 'NOTICE OF REDUCTION IN COVERAGE' written in all capital letters in at least 12 point type" for "shall be printed in all capital letters in a separate document entitled 'NOTICE OF REDUCTION IN COVERAGE.'" in the proviso of the first sentence of paragraph (d)(2). The second 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, redesignated former paragraphs (b)(4) and (b)(5) as present paragraphs (b)(5) and (b)(4), respectively.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1985, in subsection (b), paragraph (1) was redesignated paragraph (3) and paragraph (3) was redesignated paragraph (1) to arrange the defined terms in alphabetical order.

Pursuant to Code Section 28-9-5, in 1988, "insured" was substituted for "insurer" in the first sentence of paragraph (l)(1).

Pursuant to Code Section 28-9-5, in 1995, "an insurer" was substituted for "a insurer" in paragraph (b)(1).

Law reviews. — For annual survey on insurance law, see 70 Mercer L. Rev. 111 (2018).

JUDICIAL DECISIONS

Notice to mortgagee. — Fire insurer was not required to give written notice to the mortgagee of the insurer's nonrenewal of a policy at the end of the term based on the failure of the insured mortgagor to pay the premium. Southern Gen. Ins. Co. v. Tippins Bank & Trust Co., 213 Ga. App. 176, 444 S.E.2d 331 (1994), aff'd, 266 Ga. 97, 464 S.E.2d 381 (1995).

Endorsement reducing coverage. — Standard form homeowners insurance policies covered diminished value when loss was not otherwise defined and an endorsement providing that loss did not include diminution in value was ineffective as to renewal policies absent a notice informing policyholders that coverage for diminished value was not renewed. Thompson v. State Farm Fire & Cas. Co., 264 F. Supp. 3d 1302 (M.D. Ga. 2017).

Reason for cancellation sufficient. — Cancellation was authorized because premises that were used as a residence and for ordinary farm activities only were subsequently used to conduct horse shows and rodeos with public attendance. Manley v. Willis, 241 Ga. App. 158, 526 S.E.2d 370 (1999).

Cited in Protective Nat'l Ins. Co. v. Ashley, 182 Ga. App. 526, 356 S.E.2d 230

(1987); Strickland Gen. Agency v. Puritan Ins. Co., 184 Ga. App. 286, 361 S.E.2d 186 (1987).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 378 et seq.

C.J.S. — 44 C.J.S., Insurance, § 551 et seq. 45 C.J.S., Insurance, § 781 et seq.

ALR. — Insurance: guaranty fund as preventing forfeiture for nonpayment of premiums or assessments, 29 A.L.R. 517.

Repayment or tender of unearned premium as condition precedent to exercise by insurer of right to cancel policy, 16 A.L.R.2d 1200.

Limitations governing action to recover unearned premium retained by insurer upon cancellation of policy, 29 A.L.R.2d 938.

Effect of attempt to terminate insurance or fidelity contract upon notice allowing a shorter period than that stipulated in contract, 96 A.L.R.2d 286.

Construction of express insurance policy provision restricting insurer's right to cancel or otherwise terminate coverage, 19 A.L.R.3d 1429.

Remedies and measure of damages for wrongful cancellation of liability and property insurance, 34 A.L.R.3d 385.

Right of mortgagee to notice by insurer of expiration of fire insurance policy, 60 A.L.R.3d 164.

Obtaining new property insurance as cancellation of existing insurance, 14 A.L.R.4th 781.

Insured's right of action for arbitrary nonrenewal of policy, where insurer has option not to renew, 37 A.L.R.4th 862.

33-24-47. Notice required of termination or nonrenewal, increase in premium rates, or change restricting or reducing coverage; failure of insurer to comply.

(a) Each insurer licensed to transact business in this state which issues or issues for delivery in this state policies or contracts of insurance insuring risks or residents in this state and insuring against liability for loss of, damage to, or injury to persons or property shall comply with the provisions of this Code section. This Code section shall not apply to personal automobile or personal property and casualty insurance policies. Cancellation of a policy for failure of the named insured to discharge when due any obligations in connection with the payment of premiums or cancellation for any reason of a policy that has been in effect for less than 60 days shall be governed by the provisions of Code Section 33-24-44.

(b) A notice of termination, including a notice of cancellation or nonrenewal, by the insurer or a notice of an increase in premiums, other than an increase in premiums due to a change in risk or exposure, including a change in experience modification or resulting from an audit of auditable coverages, which exceeds 15 percent of the current policy's premium, shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured, at least 45 days prior to the termination date of such policy; provided, however, that a notice

of cancellation or nonrenewal of a policy of workers' compensation insurance shall be controlled by the provisions of subsection (f) of this Code section. In those instances where an increase in premium exceeds 15 percent, the notice to the insured shall indicate the dollar amount of the increase. The insurer may obtain a receipt provided by the United States Postal Service as evidence of mailing such notice or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(c) The failure of an insurer to comply with the requirements of subsection (b) of this Code section shall entitle the policyholder to purchase, under the same premiums and policy terms and conditions, an additional 30 day period of insurance coverage beyond the termination date of such policy; provided, however, that the policyholder shall tender the premium amount, computed on a pro rata basis, to the insurer on or before the termination date. No provision of this Code section shall be construed as requiring the insurance coverage under a policy to be extended for more than 30 days from the termination date stated in such policy. An insurer shall not be subject to any other penalty for the failure to comply with the requirements of subsection (b) of this Code section unless the Commissioner finds, after a hearing, that such noncompliance by the insurer has occurred with such frequency as to indicate a general business practice by the insurer of noncompliance with subsection (b) of this Code section. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or the Commissioner's employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them and in written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining thereto or for statements made or evidence submitted at any formal or informal hearing conducted in connection therewith.

(d) This Code section shall not apply to policies canceled in accordance with the provisions of Chapter 22 of this title.

(e) Cancellation by the insured shall be accomplished in accordance with Code Section 33-24-44.1.

(f) A notice of cancellation or nonrenewal of a policy of workers' compensation insurance shall be dispatched to the insured as provided in subsection (d) of Code Section 33-24-14 or by certified mail or statutory overnight delivery, return receipt requested, to the last address of record of the insured at least 75 days prior to the termination date of such policy. The workers' compensation insurer shall retain the receipt of mailing provided by the United States Postal Service as

evidence of mailing unless such mailing was accomplished as provided in subsection (d) of Code Section 33-24-14.

(g) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 45 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be in a separate document with the words "NOTICE OF REDUCTION IN COVERAGE" written in all capital letters in at least 12 point type. Such notice shall be delivered to the insured as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail, to be dispatched by at least first-class mail to the last address of record of the insured. A reduction in coverage shall mean a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

History. — Code 1981, § 33-24-47, enacted by Ga. L. 1986, p. 695, § 1; Ga. L. 1987, p. 1466, §§ 5, 6; Ga. L. 1993, p. 1507, § 2; Ga. L. 1996, p. 705, § 16; Ga. L. 2000, p. 1589, § 3; Ga. L. 2014, p. 829, §§ 11, 12/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2018, p. 210, § 3/HB 760; Ga. L. 2019, p. 474, § 7/SB 156.

The 2018 amendment, effective July 1, 2018, in subsection (b), in the first sentence, substituted "insurer or a notice" for "insurer, a notice" near the beginning and deleted "or a notice of change in any policy provision which limits or restricts coverage" following "policy's premium," in the middle; and added subsection (g).

The 2019 amendment, effective July 1, 2019, substituted "shall be in a separate document with the words 'NOTICE OF REDUCTION IN COVERAGE' written in all capital letters in at least 12 point type" for "shall be printed in all capital letters in a separate document entitled 'NOTICE OF REDUCTION IN COVERAGE.'" in the proviso of the first sentence of subsection (g).

Editor's notes. — The former Code Section 33-24-47 was based on Code 1933, § 56-2430.1, enacted by Ga. L. 1964, p. 335, § 1; Code 1933, § 56-2430.2, as redesignated by Ga. L. 1968, p. 1126, § 1; and Ga. L. 1977, p. 877, § 1, relating to cancellation or nonrenewal of policies in which interests of lienholders were protected by loss payable clauses, and was repealed by Ga. L. 1984, p. 1345, § 7, effective July 1, 1984.

Ga. L. 1993, p. 1507, § 1, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Small Business Protection Act of 1993.'"

Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (f) is applicable with respect to notices delivered on or after July 1, 2000.

Law reviews. — For note on 1993 amendment of this Code section, see 10 Ga. St. U.L. Rev. 152 (1993). For review of 1996 department and commissioner of insurance legislation, see 13 Ga. St. U.L. Rev. 183 (1996).

JUDICIAL DECISIONS

Mortgagee entitled to sue on policy when no notice of nonrenewal given. — When the loss payee, first mortgagee of the destroyed premises, never received notice that the insurance policy had not been renewed and did not know that the

premises were therefore uninsured, the loss payee was not precluded from recovering for the damages to the premises under the policy since the insurance company had failed to follow the applicable notice provisions. Waco Fire & Cas. Ins. Co. v. Jones, 180 Ga. App. 26, 348 S.E.2d 547 (1986).

Notice following nonpayment of renewal premium. — Workers' compensation insurer was not required to give notice to the insured when the insurer had offered to renew a policy and coverage was terminated because of nonpayment of the renewal premium. Riley v. Taylor Orchards, 226 Ga. App. 394, 486 S.E.2d 617 (1997).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 378 et seq.

ALR. — Rights as between mortgagor and insurance company where policy avoided as to mortgagor, but not as to mortgagee, 52 A.L.R. 278.

Right to proceeds of insurance where loss occurs after mortgage foreclosure sale, but during redemption period, 52 A.L.R. 898.

Insured's ratification, after loss, of policy procured without his authority, knowledge, or consent, 52 A.L.R.3d 235.

What constitutes waiver by insured or insured's agent of required notice of cancellation of insurance policy, 86 A.L.R.4th 886.

33-24-47.1. Notice prior to cancellation or nonrenewal of individual or group accident and sickness policy.

(a) This Code section shall apply only to policies, contracts, or certificates of insurance insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future governed by the provisions of Chapters 15, 20, 21, 30, and 42 of this title.

(b) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the group policyholder. Such notice stating the time when nonrenewal will be effective, which shall not be less than 60 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14 in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the group policyholder 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.

(c) Notice to the group policyholder shall not be required by this Code section when a group or blanket accident and sickness policy is canceled by an insurer for nonpayment of any premium at the expiration of the grace period as required by Code Section 33-30-4 or when the group

policyholder has given any required written notice of termination to the insurer.

(d) Notice by the insurer to the group members shall be required by this Code section when a group or blanket accident and sickness policy is canceled or not renewed, within 14 days of the expiration of the grace period, by an insurer for nonpayment of any premium as required by Code Section 33-30-4. Such notice of cancellation shall be delivered to each group member affected either in person or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the group member 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. Such notice shall be accompanied by a statement of the enrollee's continuation or conversion rights under Code Section 33-24-21.1 or 33-24-21.2 or any other applicable Code section. If such group or blanket accident or sickness policy is canceled or not renewed due to intentional nonpayment of premium by the group policyholder, the group policyholder shall have the duty to notify the enrollees of termination of coverage no later than 14 days after the expiration of the grace period provided in Code Section 33-30-4.

(e) A notice of termination of a policy to which subsection (b) of this Code section applies shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the policy not less than 60 days prior to the effective date of the termination of the policy. A notice of termination shall be mailed or delivered in the same manner provided in subsection (b) of this Code section for a notice of nonrenewal.

History. — Code 1981, § 33-24-47.1, enacted by Ga. L. 1989, p. 891, § 1; Ga. L. 1991, p. 1358, § 1; Ga. L. 2002, p. 441, § 7; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2019, p. 386, § 52/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "18, 19," following "Chapters 15," near the end of subsection (a); and inserted "as provided in subsection (d) of Code Section 33-24-14" in the middle of the second sentence of subsection (b).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2002, "canceled" was substituted for "cancelled" in the last sentence of subsection (d).

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).

RESEARCH REFERENCES

ALR. — What constitutes waiver by insured or insured's agent of required notice of cancellation of insurance policy, 86 A.L.R.4th 886.

33-24-48. Acceptance of surety insurance companies as sureties upon bonds of persons or corporations; rights and liabilities of corporate sureties.

Any surety insurance company or any other corporation or company that may do a surety insurance business, incorporated and organized under the laws of this state or of any other state or a foreign country for the purpose of transacting the business of surety insurance, which has complied with all requirements of law for license to transact business in this state, upon proper proof of compliance and upon production of evidence of solvency and credit satisfactory to the judge, head of the department, or other officer or officers authorized to approve and accept bonds, may be accepted as surety upon the bond of any person, company, or corporation required by law to execute bonds in lieu of any surety or sureties otherwise required by law. Any surety insurance company or other company doing a surety insurance business may be released from its liability on the bond on the same terms and conditions as are prescribed by law for the release of individuals, it being the purpose of this Code section to enable the companies and corporations doing a surety insurance business to become sureties on all bonds required by law to be taken with all the rights and subject to all the liabilities of individual sureties.

History. — Ga. L. 1887, p. 108, § 2; Civil Code 1895, § 2142; Civil Code 1910, § 2551; Code 1933, § 56-1102; Code 1933, § 56-2435, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For article analyzing problems and obligation of parties in personal suretyship, see 5 Mercer L. Rev. 289 (1954).

OPINIONS OF THE ATTORNEY GENERAL

At least one corporate surety required for full amount of bond. — Requirement of two sureties under former Code 1933, § 24-2607 (see O.C.G.A. § 15-16-5) was to ensure that any recovery against the sheriff could be satisfied by either of two sureties who were each jointly and severally liable for the full amount of the statutorily fixed bond penalty; it was thus more than clear that under former Code 1933, §§ 56-2435 and 89-415 and Ga. L. 1951, p. 741, § 1 (see O.C.G.A. §§ 33-24-48, 45-4-6, and 45-4-7), there must be one bond in the penal sum

fixed by statute and at least one corporate surety for the full amount of the bond. 1976 Op. Att'y Gen. No. 76-31

RESEARCH REFERENCES

ALR. — Authority of officer or agent to bind corporation as guarantor or surety, 34 A.L.R.2d 290.

33-24-49. Deposit of funds covered by bonds.

It shall be lawful for any party of whom a bond, undertaking, or other obligation is required to agree with his surety or sureties for the deposit of any or all moneys and assets for which he and his surety or sureties are or may be held responsible with a bank, savings bank, safe-deposit, or trust company authorized by law to do business as such or with such other depository as approved by the court or a judge of the court, if the deposit is otherwise proper, for the safekeeping of the moneys or assets. The agreement shall prevent the withdrawal of the moneys or assets or any part of the moneys or assets without the written consent of the surety or sureties or an order of the court or a judge of the court made on notice to the surety or sureties as the court or judge may direct; provided, however, that the agreement shall not in any manner release from or change the liability of the principal or sureties as established by the terms of the said bond.

History. — Code 1933, § 56-2436, enacted by Ga. L. 1960, p. 289, § 1.

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Joint control over funds. — Agreement giving joint control of a checking account to a guardian and to the surety on the guardianship bond was not in violation of public policy. Travelers Indemnity Co. v. Trust Co. Bank, 228 Ga. App. 893, 495 S.E.2d 296 (1998), overruling First Nat'l Bank v. Rapides Bank & Trust Co., 145 Ga. App. 514, 244 S.E.2d 51 (1978).

33-24-50. Action as sureties upon guaranteed arrest bond certificates; acceptance of certificates.

(a) Any domestic or foreign insurance company, fidelity insurance company, or surety company which has qualified to transact business within this state may contract to become surety, in an amount not to exceed $1,000.00 each, for any guaranteed arrest bond certificates issued by an automobile club or association or by a trucking club or association by filing with the Commissioner a certificate thus to become surety.

(b) The certificate shall be in a form which shall be prescribed by the Commissioner and shall state:

(1) The name and address of the automobile club or clubs or automobile association or associations or of the trucking club or clubs or trucking association or associations issuing the guaranteed arrest bond certificates of which the company undertakes to be surety; and

(2) The unqualified obligations of the company undertaking to become surety to pay the fine or forfeiture, in an amount not to exceed $1,000.00, of any person who fails to make an appearance to answer to the charges for which said guaranteed arrest bond certificate is posted.

(c) Any guaranteed arrest bond certificate to which an insurance, fidelity insurance, or surety company has become surety, as provided for in this Code section, shall, when posted by the person whose signature appears thereon, be accepted, in lieu of cash bail or other bond in an amount not to exceed $1,000.00, as a bail bond to guarantee the appearance of the person in any court in this state, including all municipal courts in this state, at such time as may be required by the court when the person is arrested for violation of any motor vehicle law of this state, including, but not limited to, violations regarding the size, weight, or height of vehicles, improperly licensed vehicles, improper identification devices, safety infractions, and faulty equipment or pollution control devices, or any motor vehicle ordinance of any municipality in this state except for the offense of driving under the influence of intoxicating liquors or drugs or for any felony. Any guaranteed arrest bond certificates so posted as bail bond in any court in this state shall be subject to the forfeiture and enforcement provisions with respect to bail bonds in criminal cases as provided by law. Any guaranteed arrest bond certificate posted as a bail bond in any municipal court of this state shall be subject to the forfeiture and enforcement provisions of the charter or ordinance of the particular municipality pertaining to bail bonds.

History. — Code 1933, § 56-2438, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1983, p. 695, § 1; Ga. L. 1991, p. 794, § 1.

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Law enforcement officials must accept guaranteed arrest bond certificate when offered in compliance with this section. 1960-61 Op. Att'y Gen. p. 102.

Bonds guaranteed by noncomplying companies. — Court is not com-

pelled to accept bonds guaranteed by companies which have not complied with this section. 1965-66 Op. Att'y Gen. No. 65-67.

33-24-51. Purchase of insurance covering injuries resulting from governmental ownership and use of motor vehicles; waiver of governmental immunity; limitation of liabilities.

(a) A municipal corporation, a county, or any other political subdivision of this state is authorized in its discretion to secure and provide insurance to cover liability for damages on account of bodily injury or death resulting from bodily injury to any person or for damage to property of any person, or for both arising by reason of ownership, maintenance, operation, or use of any motor vehicle by the municipal corporation, county, or any other political subdivision of this state under its management, control, or supervision, whether in a governmental undertaking or not, and to pay premiums for the insurance coverage.

(b) The sovereign immunity of local government entities for a loss arising out of claims for the negligent use of a covered motor vehicle is waived as provided in Code Section 36-92-2. Whenever a municipal corporation, a county, or any other political subdivision of this state shall purchase the insurance authorized by subsection (a) of this Code section to provide liability coverage for the negligence of any duly authorized officer, agent, servant, attorney, or employee in the performance of his or her official duties in an amount greater than the amount of immunity waived as in Code Section 36-92-2, its governmental immunity shall be waived to the extent of the amount of insurance so purchased. Neither the municipal corporation, county, or political subdivision of this state nor the insuring company shall plead governmental immunity as a defense; and the municipal corporation, county, or political subdivision of this state or the insuring company may make only those defenses which could be made if the insured were a private person.

(c) The municipal corporation, county, or any other political subdivision of this state shall be liable for damages in excess of the amount of immunity waived as provided in Code Section 36-92-2 which are sustained only while the insurance is in force and only to the extent of the limits or the coverage of the insurance policy.

(d) If a verdict rendered by the jury exceeds the limits of the applicable insurance, the court shall reduce the amount of said judgment or award to a sum equal to the applicable limits stated in the insurance policy but not less than the amount of immunity waived as provided in Code Section 36-92-2.

(e) Premiums on the insurance authorized by subsection (a) of this Code section shall be paid from the general funds of the municipal corporation, county, or political subdivision.

History. — Code 1933, § 56-2437, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1985, p. 1054, § 1; Ga. L. 2002, p. 579, § 1.

Cross references. — Effect of purchasing liability insurance on sovereign immunity of municipality, § 36-33-1.

Law reviews. — For article surveying developments in Georgia local government law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 187 (1981). For article surveying developments in Georgia torts law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 247 (1981). For survey article on insurance, see 34 Mercer L. Rev. 177 (1982). For survey article on local government law, see 34 Mercer L. Rev. 225 (1982). For article surveying local government law in 1984-1985, see 37 Mercer L. Rev. 313 (1985). For article, "Defending the Lawsuit: A First-Round Checklist," see 22 Ga. St. B.J. 24 (1985). For annual survey of local government law, see 38 Mercer L. Rev. 289 (1986). For article, "Georgia Local Government Tort Liability: the 'Crisis' Conundrum", see 2 Ga. St. U.L. Rev. 19 (1986). For article, "The Fall and Rise of Official Immunity," see 25 Ga. St. B.J. 93 (1988). For annual survey of local government law, see 43 Mercer L. Rev. 317 (1991). For annual survey article discussing developments in education law, see 52 Mercer L. Rev. 221 (2000). For annual survey article on local government law, see 52 Mercer L. Rev. 341 (2000). For article, "Education Law," see 53 Mercer L. Rev. 281 (2001). For article, "Local Government Law," see 53 Mercer L. Rev. 389 (2001). For survey article on local government law for the period from June 1, 2002 to May 31, 2003, see 55 Mercer L. Rev. 353 (2003). For annual survey of administrative law, see 56 Mercer L. Rev. 31 (2004). For annual survey of construction law, see 56 Mercer L. Rev. 109 (2004). For annual survey of local government law, see 56 Mercer L. Rev. 351 (2004). For annual survey of local government law, see 58 Mercer L. Rev. 267 (2006). For survey article on insurance law, see 60 Mercer L. Rev. 191 (2008). For survey article on local government law, see 60 Mercer L. Rev. 263 (2008). For annual survey of law on insurance, see 62 Mercer L. Rev. 139 (2010). For annual survey on local government law, see 64 Mercer L. Rev. 213 (2012). For annual survey on local government law, see 65 Mercer L. Rev. 205 (2013). For survey article on local government law, see 67 Mercer L. Rev. 147 (2015). For annual survey on trial practice and procedure, see 67 Mercer L. Rev. 257 (2015). For article, "What's the 'Use': Vehicle Maintenance Liability Barred by Sovereign Immunity Amendment Intended to Promote Waiver," see 69 Mercer L. Rev. 651 (2018). For annual survey on local government law, see 71 Mercer L. Rev. 189 (2019).

For note discussing some limitations on governmental tort immunity, see 5 Ga. St. B.J. 494 (1969). For note analyzing sovereign immunity in this state and proposing implementation of a waiver scheme and creation of a court of claims pursuant to Ga. Const., Art. VI, Sec. V, Para. I, see 27 Emory L.J. 717 (1978). For note on the 2002 amendment of this Code section, see 19 Ga. St. U.L. Rev. 243 (2002).

JUDICIAL DECISIONS

Analysis

General Consideration
Waiver of Immunity
Applicability

General Consideration

Constitutionality of statutory scheme for waiver of immunity by state and counties. — Statutory scheme under which plaintiffs having tort claims against the state have the benefit of the broad waiver of sovereign immunity afforded by the Georgia Tort Claims Act, O.C.G.A. § 50-21-20 et seq., which does not extend to counties, whereas a county's waiver of immunity is allowed only to the extent of insurance purchased for negligence arising from the use of a motor vehicle, results in unequal treatment; however, the statute does not violate due process or equal protection. Woodard v. Laurens County, 265 Ga. 404, 456 S.E.2d 581 (1995).

Legislative intent. — Construed together, the legislative intent of O.C.G.A § 33-24-51 and former O.C.G.A. § 45-9-40 was to require that the state procure liability insurance for the operation of state-owned motor vehicles, but to permit procurement of similar insurance by counties and municipalities at their discretion. Logue v. Wright, 260 Ga. 206, 392 S.E.2d 235 (1990).

Definition of "motor vehicle." — In determining if a county waived the county's sovereign immunity through the voluntary purchase of liability insurance under the second sentence of O.C.G.A. § 33-24-51(b), a trial court erred in considering the definition of "motor vehicle" provided in O.C.G.A. § 36-92-1; rather, "any motor vehicle" was defined as a vehicle that was capable of being driven on the public roads that was covered by a liability insurance policy purchased by the county. Glass v. Gates, 311 Ga. App. 563, 716 S.E.2d 611 (2011), aff'd, 291 Ga. 350, 729 S.E.2d 361 (2012).

Waiver does not apply to intentional conduct. — It is clear from the text of O.C.G.A. § 33-24-51(b) that the waiver is meant to encompass negligent acts, not intentional ones. Williams v. DeKalb County, 327 Fed. Appx. 156 (11th Cir. 2009) (Unpublished).

Discretion to provide insurance. — Decision whether to provide insurance is made discretionary by O.C.G.A. § 33-24-51. Brantley v. Edwards, 197 Ga. App. 713, 399 S.E.2d 215 (1990).

City has the discretion to decide whether to purchase liability insurance for its police cars. Williams v. Solomon, 242 Ga. App. 807, 531 S.E.2d 734 (2000).

Section prohibits inquiry during voir dire as to jurors' possessing interest in city's insurer. — Legislature must be presumed to have been familiar with Ga. L. 1951, p. 214, § 2 (see O.C.G.A. § 15-12-133), which provides for a searching examination during voir dire to achieve the goal of an impartial and unbiased jury, when there was included in this section, the prohibition of suggesting the existence of insurance; the intention of the lawmakers was obviously to forbid any inquiry during voir dire as to jurors' possessing any financial interest in the insurance company carrying the public liability insurance on the city's vehicles. Mitchell v. City of Newnan, 125 Ga. App. 761, 188 S.E.2d 917 (1972) (decided prior to 1985 amendment, deleting language in subsection (d) forbidding suggesting existence of insurance).

Subsection (d) of this section clearly shows that the parties in the trial of a case may not quiz the jurors either individually or as a panel concerning financial interest in the insurance company carrying public liability coverage on the city's vehicle involved in the collision. Mitchell v. City of Newnan, 125 Ga. App. 761, 188 S.E.2d 917 (1972) (decided prior to 1985 amendment, deleting language in subsection (d) forbidding suggesting existence of insurance).

Cited in City of Macon v. Smith, 117 Ga. App. 363, 160 S.E.2d 622 (1968); Foster v. Crowder, 117 Ga. App. 568, 161 S.E.2d 364 (1968); Schaefer v. Mayor of Athens, 120 Ga. App. 301, 170 S.E.2d 339 (1969); Winston v. City of Austell, 123 Ga. App. 183, 179 S.E.2d 665 (1971); Tennyson v. Columbus, 127 Ga. App. 3, 192 S.E.2d 396 (1972); Strickland v. City of Winterville, 130 Ga. App. 425, 203 S.E.2d 706 (1973); Sheley v. Board of Pub. Educ., 132 Ga. App. 314, 208 S.E.2d 126 (1974); Lee v. Petty, 133 Ga. App. 201, 210 S.E.2d 383 (1974); Foster v. Cobb County Bd. of Educ., 133 Ga. App. 768, 213 S.E.2d 38 (1975); Central of Ga. R.R. v. Schnadig Corp., 139 Ga. App. 193, 228 S.E.2d 165 (1976); Meriwether County v. Creamer,

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146 Ga. App. 651, 247 S.E.2d 178 (1978); Cason v. Columbus, 148 Ga. App. 208, 250 S.E.2d 836 (1978); City of Atlanta v. Whatley, 161 Ga. App. 705, 289 S.E.2d 541 (1982); City of Rossville v. Britton, 170 Ga. App. 1, 316 S.E.2d 16 (1984); Hicks v. Walker County Sch. Dist., 172 Ga. App. 428, 323 S.E.2d 231 (1984); Western Stone & Metal Corp. v. Jones, 180 Ga. App. 79, 348 S.E.2d 478 (1986); Peeples v. City of Atlanta, 189 Ga. App. 888, 377 S.E.2d 889 (1989); Swan v. Johnson, 219 Ga. App. 450, 465 S.E.2d 684 (1995); Crisp County Sch. Sys. v. Brown, 226 Ga. App. 800, 487 S.E.2d 512 (1997); Cameron v. Lang, 274 Ga. 122, 549 S.E.2d 341 (2001); CSX Transp., Inc. v. City of Garden City, 196 F. Supp. 2d 1288 (S.D. Ga. 2002); City of Atlanta v. Mitcham, 296 Ga. 576, 769 S.E.2d 320 (2015); Primas v. City of Milledgeville, 296 Ga. 584, 769 S.E.2d 326 (2015); Franklin v. Pitts, 349 Ga. App. 544, 826 S.E.2d 427 (2019).

Waiver of Immunity

Section limits the right of municipalities to waive governmental immunity in cases arising out of the operation of motor vehicles. Koehler v. Massell, 229 Ga. 359, 191 S.E.2d 830 (1972).

This section clearly contemplates that all valid claims against a municipality up to the limits of the insurance policies provided pursuant thereto shall be paid when liability would exist except for governmental immunity. Koehler v. Massell, 229 Ga. 359, 191 S.E.2d 830 (1972).

Construction of duplicative constitutional grants of sovereign immunity. — The 1991 amendment of Ga. Const. 1983, Art. I, Sec. II, Para. IX, extending sovereign immunity to all state departments and agencies regardless of any insurance, did not divest the General Assembly of authority under Ga. Const. 1983, Art. IX, Sec. II, Para. IX, to waive the immunity of counties based on motor vehicle liability insurance; therefore, the amendment did not abrogate the provisions of O.C.G.A. § 33-24-51 and a county's governmental immunity was waived to the extent of liability insurance purchased. Daniels v. Decatur County, 212 Ga. App. 378, 441 S.E.2d 790 (1994).

Term "governmental immunity," as used in O.C.G.A § 33-24-51, is synonymous with "sovereign immunity" and does not encompass both "sovereign" and "official" immunity. Thus, the waiver of immunity provided by O.C.G.A § 33-24-51 is not in conflict with Ga. Const. 1983, Art. I, Sec. II, Para. IX, since the statute provides both a waiver of sovereign immunity and the extent of such waiver, i.e., the extent of liability insurance coverage. Gilbert v. Richardson, 264 Ga. 744, 452 S.E.2d 476 (1994).

Construction of subsection (b). — Subsection (b) of O.C.G.A. § 33-24-51 provides for waiver of sovereign immunity to the extent of the amount of liability insurance purchased for the negligence of duly authorized officers, agents, servants, attorneys, or employees in the performance of their official duties that arises out of either ownership, maintenance, operation, or use of a motor vehicle. Chamlee v. Henry County Bd. of Educ., 239 Ga. App. 183, 521 S.E.2d 78 (1999).

Trial court erred in dismissing the farmers' tort claims based on sovereign immunity because the date that an action was filed did not determine whether the 1991 amendment to Ga. Const. 1983, Art. I, Sec. II, Para. IX controlled; as a truck was used for spreading sewage sludge on the farmers' property, damages resulting from the spreading of the sludge from the truck were injuries arising by reason of use of the truck for purposes of O.C.G.A. § 33-24-51(b). McElmurray v. Augusta-Richmond County, 274 Ga. App. 605, 618 S.E.2d 59 (2005).

O.C.G.A. § 33-24-51 subject to waiver of immunity provision. — O.C.G.A. § 33-24-51 provides immunity only to governmental entities; consequently, it is a governmental immunity statute and is subject to the waiver of immunity provision of subsection (b). Ekarika v. City of East Point, 204 Ga. App. 731, 420 S.E.2d 391 (1992).

In an arrestee's 42 U.S.C. § 1983 suit against a lead pursuit deputy and the supervisor for using excessive force to stop the arrestee's car during a high-speed chase, the county was not entitled to sov-

ereign immunity under Ga. Const. 1983, Art. I, Sec. II, Para. IX(d) from liability for negligence because the county waived the county's immunity pursuant to O.C.G.A. § 33-24-51(b) by purchasing liability insurance coverage to cover the negligence of county employees arising from the use of a motor vehicle. Harris v. Coweta County, No. 3:01-CV-148-WBH, 2003 U.S. Dist. LEXIS 27348 (N.D. Ga. Sept. 25, 2003).

County's participation in an interlocal risk management plan. — Even though the 1991 amendment of Ga. Const. 1983, Art. I, Sec. II, Para. IX, eliminated the language under which O.C.G.A. § 36-85-20 was found unconstitutionally void, the revision did not resurrect the statute and, accordingly, the statute provided no basis for finding a county's participation in an interlocal risk management plan was not a waiver of sovereign immunity; the county's purchase of such insurance agreement constituted the purchase of insurance under subsection (b) of O.C.G.A. § 33-24-51 and the county waived the county's sovereign immunity to the extent of such coverage. Gilbert v. Richardson, 264 Ga. 744, 452 S.E.2d 476 (1994).

Purchase of insurance did not waive sovereign immunity. — Because there was no evidence that the county waived the county's immunity by the purchase of insurance, an action against the county based on the negligence of paramedics in failing to diagnose plaintiff's pregnancy complications and in failing to transfer the plaintiff to the hospital in a timely manner was barred by sovereign immunity. Schulze v. DeKalb County, 230 Ga. App. 305, 496 S.E.2d 273 (1998).

O.C.G.A. § 33-24-51 did not apply in an action against a county for injuries arising from an auto accident because there was no allegations that the car was owned by the county nor that the car was operated by an authorized officer, agent, servant, attorney, or employee in the performance of his or her official duties. Butler v. Dawson County, 238 Ga. App. 808, 518 S.E.2d 430 (1999).

Waiver of sovereign immunity limited by terms of policy. — When insurance coverage is obtained by a government entity, the government entity waives the government's sovereign immunity to the extent of such insurance coverage, however, when the plain terms of the policy provide that there is no coverage for the particular claim, the policy does not create a waiver of sovereign immunity as to that claim. Dugger v. Sprouse, 257 Ga. 778, 364 S.E.2d 275 (1988).

In a negligence action against a city by plaintiffs injured in a collision with an on-duty police officer, the city's purchase of a general liability insurance policy covering claims in excess of $250,000 waived the city's sovereign immunity to the limits of the policy; since the city did not have a self-insurance plan, participate in any sort of insurance fund or pool, or set aside funds for the payment of liability claims, the plaintiffs could recover only damages exceeding the $250,000 threshold. McLemore v. City Council, 212 Ga. 862, 443 S.E.2d 505 (1994).

Motor vehicle. — When a local entity purchases automobile liability insurance in an amount greater than the prescribed limits set forth for a waiver of sovereign immunity under O.C.G.A. § 36-92-1 et seq., the entity waives sovereign immunity to the extent of the entity's insurance coverage as required by O.C.G.A. § 33-24-51(b), and the broad definition of "any motor vehicle" set forth in § 33-24-51 applies. Therefore, in a wrongful death and survivor case, a county waived sovereign immunity to the extent of the county's insurance coverage as required by § 33-24-51(b), and the Georgia legislature did not intend to apply a narrow definition of motor vehicle under § 36-92-1 in a case involving an injury caused by a bush hog and a tractor. Gates v. Glass, 291 Ga. 350, 729 S.E.2d 361 (2012).

Injured driver could establish extent of damages caused by collission with county vehicle. — Driver's employer's uninsured motorist (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

Waiver of Immunity (Cont'd)

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).

Immunity waived to extent of liability insurance. — In a personal injury action arising from an accident involving a school bus, the school district waived sovereign immunity to the extent the district was covered by liability insurance. Coffee County Sch. Dist. v. King, 229 Ga. App. 143, 493 S.E.2d 563 (1997).

In a tort action for personal injuries and property damage arising from an auto collision filed against a city and the city's police officer, the trial court erred in granting a city summary judgment as: (1) O.C.G.A. § 40-6-6(d)(2) did not apply; and (2) the city waived the city's sovereign immunity to the extent that the city purchased liability coverage to cover the officer's actions in operating that officer's police car. But, the trial court properly granted summary judgment to the officer, given that the officer was engaged in a discretionary function of responding to an emergency situation at the time the accident at issue occurred. Weaver v. City of Statesboro, 288 Ga. App. 32, 653 S.E.2d 765 (2007), cert. denied, No. S08C0421, 2008 Ga. LEXIS 221 (Ga. 2008).

Immunity waived by purchase of insurance. — County was not entitled to sovereign immunity in an estate's claim arising from the death of an inmate because the county bought the type of insurance defined in O.C.G.A. § 33-24-51; the estate claimed that the inmate's death resulted from an officer's negligent supervision of the inmate's actions in maintaining a tractor by trying to replace a tire. The policy covered negligence for autos, the tractor was an auto under the statute and the policy, and the policy covered maintenance of a covered auto, which included changing a tire. McDuffie v. Coweta County, 299 Ga. App. 500, 682 S.E.2d 609 (2009).

School district waived immunity to extent of insurance covering school bus accident. — In a parent's action against a school district for the death of the parent's child as the child tried to board a school bus, although the district had sovereign immunity, the district waived sovereign immunity to the extent of the district's purchase of liability insurance pursuant to O.C.G.A. § 33-24-51(b); the exclusion from the waiver of sovereign immunity for school districts in O.C.G.A. § 36-92-2(a) did not extend to the second sentence of § 33-24-51(b). Tift County Sch. Dist. v. Martinez, 331 Ga. App. 423, 771 S.E.2d 117 (2015), cert. denied, No. S15C1084, 2015 Ga. LEXIS 458 (Ga. 2015).

Limited waiver. — County's sovereign immunity is waived only when the county's insurer satisfies a claim under the coverage provided. Saylor v. Troup County, 225 Ga. App. 489, 484 S.E.2d 298 (1997).

O.C.G.A. § 33-24-51(b) provides that the government waives immunity to the extent the government purchases liability insurance for the government's employees' negligent use of a motor vehicle. Smith v. Chatham County, 264 Ga. App. 566, 591 S.E.2d 388 (2003).

Limited waiver of sovereign immunity set forth in O.C.G.A. § 33-24-51(b) does not implicate the 12-month presentation requirement under O.C.G.A. § 36-11-1. Warnell v. Unified Gov't of Athens-Clarke County, 328 Ga. App. 903, 763 S.E.2d 284 (2014).

Immunity in the absence of insurance. — When a sheriff's deputy caused a collision with another vehicle when the deputy failed to use blue lights or a siren when responding to an emergency call, the deputy was entitled to immunity in the absence of insurance purchased by the county which would protect the deputy. Logue v. Wright, 260 Ga. 206, 392 S.E.2d 235 (1990).

Payment of claims arising out of negligent performance of governmental function illegal unless pursuant to statute. — Payment by municipality of claims arising by reason of the negligent performance of a governmental function, except pursuant to this section or pursuant to one of the Acts permitting a municipality to become a self-insurer, is an illegal and ultra vires act barred under the doctrine of governmental immunity. Koehler v. Massell, 229 Ga. 359, 191 S.E.2d 830 (1972).

County school district's governmental immunity was waived only to extent of insurance coverage, which applied only to amounts in excess of $100,000; thus, the district was liable only for damages greater than $100,000 but less than the policy's upper limit. DeKalb County Sch. Dist. v. Bowden, 177 Ga. App. 296, 339 S.E.2d 356 (1985).

County's purchase of a general liability insurance policy for purposes of the waiver of sovereign immunity was authorized by O.C.G.A. § 33-24-51 and an accident involving the operation of a back hoe owned by the county was covered by the policy. Crider v. Zurich Ins. Co., 222 Ga. App. 177, 474 S.E.2d 89 (1996).

Georgia Mental Health Institute did not waive immunity to extent of insurance coverage. — When decedent was riding as a passenger in an automobile owned by Georgia Mental Health Institute (GMHI) and driven by the GMHI's employee, and GMHI had insurance on the automobile, GMHI did not thereby waive governmental immunity to the extent of that insurance. Hicks v. Shea, 149 Ga. App. 396, 254 S.E.2d 511 (1979).

Plaintiff must allege waiver of governmental immunity. — To show the plaintiff's right to relief against the county, it was necessary that the plaintiff allege waiver of governmental immunity in accordance with this section. Dowling v. Camden County, 113 Ga. App. 34, 146 S.E.2d 925, cert. dismissed, 222 Ga. 122, 149 S.E.2d 103 (1966).

Effect of plaintiff's allegation of waiver of governmental immunity. — Complaint stating that sovereign immunity was waived to the extent of the defendant's purchase of liability insurance for injuries arising out of the use of a school bus was sufficient to put the onus on the defendant to submit an affidavit denying the existence of a motor vehicle liability policy. Maxwell v. Cronan, 241 Ga. App. 491, 527 S.E.2d 1 (1999).

Petition alleging purchase of liability insurance and injury from operation of vehicle sufficient. — When plaintiff's petition alleges the purchase of liability insurance as contemplated and described in this section, and further alleges bodily injury as the result of the negligence of the defendant county's servants in the operation and use of the defendant's motor vehicles, a cause of action is set out. Strickland v. Wayne County, 113 Ga. App. 499, 148 S.E.2d 467 (1966).

Trial court can require evidence of insurance purchased by county in order to mold the court's judgment to conform to this section. Dowling v. Camden County, 113 Ga. App. 34, 146 S.E.2d 925, cert. dismissed, 222 Ga. 122, 149 S.E.2d 103 (1966).

Resolution of existence of legal liability for courts only. — When parties disagree as to whether legal liability exists in a given situation, the place for the resolution of that question is in courts of justice; the determination of such a question is not the function of a legislative body. Koehler v. Massell, 229 Ga. 359, 191 S.E.2d 830 (1972).

No conflict between statute of limitations and provisions concerning waiver of immunity. — There is no conflict between the statute of limitations applicable to insurance actions against municipalities and the constitutional and statutory provisions relating to waiver of immunity. Cobb v. Board of Comm'rs of Rds. & Revenue, 151 Ga. App. 472, 260 S.E.2d 496 (1979).

Post-trial hearing required to determine amount of insurance carried by city. — Since at a hearing conducted immediately after trial the city did not produce evidence of insurance and of policy limits, a rehearing, held specifically for the purpose of determining the amount of insurance carried by the city, must be conducted, unless an employee of defendant-city chooses not to contest the policy limits asserted by the city, in order to determine if the defendant-city maintained liability insurance authorized by this section in any greater or lesser amount than the judgment rendered, and to remold the judgment in accordance with this section. City of Waycross v. Beaty, 157 Ga. App. 765, 278 S.E.2d 697 (1981).

Waiver does not depend upon whether the county is named as a defendant. — Waiver of sovereign immunity, pursuant to O.C.G.A. § 33-24-51,

Waiver of Immunity (Cont'd)

does not depend upon whether a county is named as a defendant. Rather, suits against public employees in the employees' official capacities are in reality suits against the state and involve sovereign immunity. Standard v. Hobbs, 263 Ga. App. 873, 589 S.E.2d 634 (2003).

Summary judgment based on sovereign immunity improper. — Trial court erred in granting a police officer and a city summary judgment on the ground that the officer was performing a discretionary duty and the city was protected by sovereign immunity, in an arrestee's action to recover damages for injuries sustained when the officer ran over the arrestee's foot with a patrol car during the arrest. A jury would be authorized to find that the officer did not act intentionally, but rather, negligently came too close to the arrestee with the car for the purposes that the officer was trying to achieve and used poor judgment under the circumstances; there was an issue of fact on whether the arrestee assumed the risk of injury because it was not beyond dispute that the arrestee was aware of the actual risk of being hit by the officer or that the arrestee had subjective knowledge that the arrestee was at risk of being hit from behind by a police car being driven by a trained officer when the arrestee had not threatened the officer with deadly force. Davis v. Batchelor, 300 Ga. App. 662, 686 S.E.2d 314 (2009).

Applicability

Former Code 1933, § 56-2437 (see O.C.G.A. § 33-24-51) did not affect the operation of former Code 1933, § 69-308 (see O.C.G.A. § 36-33-5). Perdue v. City Council, 137 Ga. App. 702, 225 S.E.2d 62 (1976).

Negligence must arise from "use" of vehicle. — Non-use of a motor vehicle is not encompassed within the meaning of subsection (a) of O.C.G.A. § 33-24-51; thus, a county road superintendent's failure to drive to the scene of a fallen tree to place warnings was not a negligent use of a vehicle. Lincoln County v. Edmond, 231 Ga. App. 871, 501 S.E.2d 38 (1998).

Immunity from liability for a claim of negligence against a paramedic and a county as the paramedic's employer was not waived by the county's purchase of insurance since the action was based on the paramedic's misdiagnosis or choice of treatment and did not "arise from the use of a motor vehicle." Harry v. Glynn County, 269 Ga. 503, 501 S.E.2d 196 (1998).

It was error for the trial court to grant summary judgment to the defendant school board on grounds that sovereign immunity was not waived because a government official was not personally operating the vehicle at the time of the accident, when there was an issue of fact with regard to a teacher's use of the car in connection with the teaching of an automotive shop class. Chamlee v. Henry County Bd. of Educ., 239 Ga. App. 183, 521 S.E.2d 78 (1999).

Use of school bus not shown. — When a child was killed when the child ran into the road at a school bus stop before the bus arrived and was struck by a truck, the bus was too remote from the site of the accident as a matter of law for the accident to be considered as arising out of the use of the bus. Brock v. Sumter County Sch. Bd., 246 Ga. App. 815, 542 S.E.2d 547 (2000).

Use of a motor vehicle for rape. — In an action against a city's mayor and police chief alleging that a city police officer raped the plaintiff because the cause of action did not arise out of the use of a motor vehicle, the city's purchase of liability insurance did not waive the immunity of the officials. Carter v. Glenn, 249 Ga. App. 414, 548 S.E.2d 110 (2001).

Sovereign immunity barred the inmate's claims against the government because the injuries the inmate sustained while welding a garbage truck belonging to the government did not arise from the negligent use of a motor vehicle and the waiver of sovereign immunity was limited to those claims arising out of the negligent use of a covered motor vehicle as a vehicle. Columbus Consol. Gov't v. Woody, 342 Ga. App. 233, 802 S.E.2d 717 (2017).

After the plaintiffs were injured when a speeding car driven by a suspect who was fleeing law enforcement crashed into the plaintiffs' car, the trial court properly

granted summary judgment to the Lamar Sheriff as the plaintiffs' claims against the Lamar Sheriff were barred as a matter of law by sovereign immunity because, by the time the plaintiffs were injured by the fleeing driver, the Lamar deputy's patrol car was immobile and inoperative on the side of the road approximately 20 miles away as the result of a blown tire; thus, the plaintiffs' injuries did not arise out of the "use" of the patrol car, and the sovereign immunity of the Lamar Sheriff was not waived. Wingler v. White, 344 Ga. App. 94, 808 S.E.2d 901 (2017), cert. denied, No. S18C0651, 2018 Ga. LEXIS 467, cert. denied, No. S18C0649, 2018 Ga. LEXIS 522 (Ga. 2018).

Negligence must arise from "ownership, maintenance, operation, or use" of vehicle. — County did not waive the county's sovereign immunity under O.C.G.A. § 33-24-51(a) after the decedent's vehicle was struck by a county emergency rescue driver who was allegedly in violation of the county safe driving policy because if the county's safe driving policy was violated, it did not arise by reason of ownership, maintenance, operation, or use of any vehicle, but rather by the county's failure to enforce the county's safe driving policy. Anderson v. Barrow County, 256 Ga. App. 160, 568 S.E.2d 68 (2002).

Trial court properly granted summary judgment to the county as the evidence did not show that the county waived the sovereign immunity the county had pursuant to the Georgia Constitution; the decedent's spouse's argument that the fire vehicle which arrived at a lake where a canoe had capsized should have been equipped with a rope long enough to rescue the decedent, who swam into the lake to see if the decedent could rescue a fisherman who had been in the canoe, had to be rejected since the county waived sovereign immunity for inadequate maintenance of a motor vehicle under O.C.G.A. § 33-24-51(a), but the failure to have a rope long enough or other sufficient rescue equipment had nothing to do with the maintenance of the vehicle, and, hence, the death of the decedent did not arise by reason of the inadequate maintenance of a vehicle. Robinson v. DeKalb County, 261 Ga. App. 163, 582 S.E.2d 156 (2003).

County sued by a motorcyclist who was injured on a closed road did not waive sovereign immunity under O.C.G.A. § 33-24-51. The claim did not arise from the use of an excavator that was parked on the road as the excavator was not involved in the accident, was not under the control of the county, but by the contractor that owned and insured the excavator, and was not being operated by any agent or employee of the county. Williams v. Whitfield County, 289 Ga. App. 301, 656 S.E.2d 584 (2008).

Use of vehicle too remote in time. — County's use of a pot-patcher vehicle the day before an accident was too remote in time to constitute "use" of the vehicle sufficient to waive sovereign immunity pursuant to O.C.G.A. § 33-24-51. Bd. of Comm'rs v. Barefoot, 313 Ga. App. 406, 721 S.E.2d 612 (2011).

Landfill compactor is not a "motor vehicle" as that term is defined in O.C.G.A. § 33-34-2. Pate v. Turner County, 162 Ga. App. 463, 291 S.E.2d 400 (1982).

Department of Transportation, as state agency, does not come within ambit of subsection (b) of O.C.G.A § 33-24-51, which provides for waiver of governmental immunity to the extent of the amount of motor vehicle liability insurance purchased by "a municipal corporation, a county or any other political subdivision of this state …." Huggins v. Georgia Dept. of Transp., 165 Ga. App. 178, 300 S.E.2d 195 (1983).

Portable tar kettle machine. — In a worker's suit alleging negligence on the part of a county with regard to the county allegedly failing to properly instruct and supervise the worker in the use of a portable tar kettle machine, the trial court erred by granting the county's motion for a judgment on the pleadings based on sovereign immunity as the worker sufficiently alleged that the machine was a vehicle as contemplated by O.C.G.A. § 33-24-51, which established a waiver of sovereign immunity if the county had purchased liability insurance to cover damages and injuries arising from the use of motor vehicles under the county's management. Hewell v. Walton County, 292 Ga. App. 510, 664 S.E.2d 875 (2008).

Applicability (Cont'd)

Policy inapplicable to ministerial acts of deputy sheriffs. — Liability insurance policy purchased by county did not provide protection to deputy sheriffs from a suit based on the deputies' alleged negligent acts while in the commission of the deputies' ministerial duties. Keener v. Kimble, 170 Ga. App. 674, 317 S.E.2d 900 (1984).

Claim against sheriff's deputy barred. — Trial court erred in denying the defendants' motion to dismiss the deputy on the ground that the plaintiff's tort claim was barred by O.C.G.A. § 36-92-3(a) because the deputy was not a governmental entity; rather, the deputy was an employee of the county sheriff's department, was on duty, and was driving a county-owned patrol vehicle when the accident that injured the plaintiff occurred; thus, the deputy was not subject to liability for the accident and the claims against the deputy were barred. Moats v. Mendez, 349 Ga. App. 811, 824 S.E.2d 808 (2019).

Injury excluded from policy beyond waiver of governmental immunity. — When the plaintiff was injured on a prisoner work detail at a county work camp to load a quantity of pipe onto a flatbed truck, when, as the plaintiff was reaching to attach a chain connected to one of the pipes to the bucket of a front-end loader, the front-end loader struck the pipe, which in turn struck and injured the plaintiff, but the county's policy on the truck, as limited by an exclusion, extended liability coverage to injuries sustained during loading or unloading of the truck, but only when the loading or unloading was not being accomplished by means of a mechanical device, the plaintiff was either injured while the covered truck was being loaded by means of a mechanical device or before loading had begun, and the plaintiff's injury was excluded from coverage under the policy and thus was beyond the defendant's waiver of governmental immunity. Cobb County v. Hunt, 166 Ga. App. 409, 304 S.E.2d 403 (1983).

Even if insurance has been purchased by a municipality, should the occurrence giving rise to the suit against the municipality be within an exclusion from the coverage afforded by the policy, governmental immunity remains a viable defense. Mitchell v. Hartford Accident & Indem. Co., 168 Ga. App. 126, 308 S.E.2d 374 (1983).

No waiver of immunity regarding negligence unconnected with motor vehicles. — Procurement of insurance does not constitute a waiver of sovereign immunity in regard to damages caused by the county's negligence not connected with motor vehicles. Revels v. Tift County, 235 Ga. 333, 219 S.E.2d 445 (1975).

Truck stolen by escaped prisoner not waiver. — Waiver provision of subsection (b) of O.C.G.A. § 33-24-51 did not apply to an action against county officials arising from injuries to plaintiffs in a collision with a truck stolen by an escaped prison inmate. Long v. Hall County Bd. of Comm'rs, 219 Ga. App. 853, 467 S.E.2d 186 (1996).

In an action arising out of an arrest, despite the way the arrestee was treated, the trial court properly dismissed a complaint against a county, and granted summary judgment on the same complaint against a city, on sovereign immunity grounds because the arrestee failed to show that the immunity had been waived. Scott v. City of Valdosta, 280 Ga. App. 481, 634 S.E.2d 472 (2006).

Trial court erred in denying a city and the city's police officers summary judgment as to an arrestee's claims against the city and the officers in the officers official capacities because the claim against one of the officers in the officer's official capacity was, in reality, a suit against a governmental entity and subject to a claim of sovereign immunity, and no genuine issue of fact remained as to whether the city waived the city's sovereign immunity pursuant to O.C.G.A. § 33-24-51; the alleged negligence was unrelated to the use of a motor vehicle. Campbell v. Goode, 304 Ga. App. 47, 695 S.E.2d 44 (2010).

Trial court erred in denying a motion for summary judgment filed by a county and a paramedic with the county emergency medical services in a patient's spouse's action alleging that the paramedic acted negligently in the paramedic's assessment

of the patient because the county and paramedic were shielded from liability by sovereign and official immunity, and there was no waiver of sovereign immunity under the motor vehicle exception found in O.C.G.A. § 33-24-51 since the liability of the county and paramedic was not predicated on their alleged negligent use of an ambulance as a motor vehicle; there was no evidence that the ambulance and the ambulance's use played any part in the paramedic's diagnosis of or choice of treatment for the patient, and thus, the county ambulance was, at best, tangentially related to the paramedic's failure to use a cardiac monitor on the patient. Polk County v. Ellington, 306 Ga. App. 193, 702 S.E.2d 17 (2010).

Sovereign immunity barred the claimants' personal injury and nuisance claims against the members of a county board of commissioners in the commissioners' official capacities because the claimants did not show that the county waived the county's sovereign immunity with regard to the county's operation of a mosquito control helicopter which sprayed one of the claimants with chemicals. Further, the county did not waive the county's sovereign immunity under O.C.G.A. § 33-24-51 by purchasing a liability insurance policy covering the helicopter because the helicopter was not a "motor vehicle" as that term was understood in the statute. Bd. of Comm'rs v. Johnson, 311 Ga. App. 867, 717 S.E.2d 272 (2011).

County's participation in an interlocal risk management plan did not constitute liability insurance for the purpose of waiving the county's sovereign immunity to the extent of the plan's coverage. Gilbert v. Richardson, 264 Ga. 744, 452 S.E.2d 476 (1994).

County's "risk management fund" for the investigation and defense of tort claims was a self-insurance plan constituting liability insurance which waived sovereign immunity within the ambit of O.C.G.A. § 33-24-51 and the former provisions of Ga. Const. 1983, Art. I, Sec. II, Par. IX. Mims v. Clanton, 222 Ga. App. 657, 475 S.E.2d 662 (1996).

"Such insurance" defined. — While this section is a conditional limitation on the doctrine of sovereign immunity, the meaning of "such insurance " as used therein is governed by the preceding language referring to "insurance to cover liability … arising by reason of ownership, maintenance, operation, or use of any motor vehicle by the municipal corporation " and cannot be construed to mean liability insurance generally so that procurement of general liability insurance would create a waiver of sovereign immunity with respect to activities beyond the scope of the activities specifically mentioned in this section. Winston v. City of Austell, 123 Ga. App. 183, 179 S.E.2d 665 (1971).

Self insurance plans. — Trial court properly entered summary judgment for a county as to two injured parties' tort claims as the county's self-insurance plan for certain claims did not constitute a waiver of the county's sovereign immunity because the county did not purchase a motor vehicle liability insurance policy—a requirement under O.C.G.A. § 33-24-51(b); there is no statute which provides that by establishing a self-insurance plan, a county waives sovereign immunity. Smith v. Chatham County, 264 Ga. App. 566, 591 S.E.2d 388 (2003).

Action may be brought only against political subdivision. — Nothing in this section authorizes bringing an action on account of the negligence of an employee of any political subdivision against anyone other than the political subdivision itself. Ray v. Cobb County Bd. of Educ., 110 Ga. App. 258, 138 S.E.2d 392 (1964).

School district of each county is one of the "other political subdivision(s)" referred to in this section which may be sued in any case coming within the terms of this section. Ray v. Cobb County Bd. of Educ., 110 Ga. App. 258, 138 S.E.2d 392 (1964).

County board of education is not a political subdivision and not a body corporate liable to action in the ordinary sense (except in cases made so by an Act of the Legislature), and the board of education of a particular county through the board's members merely has the control and management of that county's school district. Ray v. Cobb County Bd. of Educ., 110 Ga. App. 258, 138 S.E.2d 392 (1964).

County sheriff and deputy. — In a wrongful death suit brought after a patrol

Applicability (Cont'd)

car driven by a deputy sheriff struck and killed the decedent, the sheriff and the deputy were not entitled to summary judgment on the claims against them in their official capacity; under O.C.G.A. § 33-24-51, the sheriff and deputy could be held liable to the extent that the county waived the county's sovereign immunity by the purchase of automobile liability insurance. Nichols v. Prather, 286 Ga. App. 889, 650 S.E.2d 380 (2007), cert. denied, S07C1873, 2007 Ga. LEXIS 766 (Ga. 2007).

In a parent's wrongful death action, the trial court did not err by granting summary judgment to a county sheriff and a county deputy sheriff on the basis of sovereign immunity because, at the time of the son's suicide, the deputy's vehicle was essentially being used as a holding cell and did not relate to the use of the patrol car as a vehicle pursuant to O.C.G.A. § 33-24-51. Gish v. Thomas, 302 Ga. App. 854, 691 S.E.2d 900 (2010).

Extent of coverage of liability insurance for school bus. — The insurer which provided liability insurance for a school bus was legally obligated to provide coverage for a child who was struck by another motor vehicle while crossing a road after disembarking from the school bus; thus, the interpretation given to "use" of a school bus as included in the insurance policy included responsibility to children until they have safely crossed a road after disembarking from the bus. Georgia Farm Bureau Mut. Ins. Co. v. Greene, 174 Ga. App. 120, 329 S.E.2d 204 (1985).

Whether a child was acting pursuant to prior crossing instructions from a school bus driver or was not acting reasonably within the purview of those orders, in determining whether the child's actions were a part of the process of loading the bus so as to come within the coverage of a liability policy, was a question of fact precluding summary judgment. Cawthon v. Waco Fire & Cas. Ins. Co., 183 Ga. App. 238, 358 S.E.2d 615, cert. denied, 183 Ga. 905, 358 S.E.2d 615 (1987).

When the county purchased liability insurance to provide coverage for bodily injury or death caused by an accident resulting from the ownership, maintenance, or use of a covered automobile, and the incident arose from the "use" of a school bus, the county was not immune from liability in the death of a child. DeKalb County Sch. Dist. v. Allen, 254 Ga. App. 66, 561 S.E.2d 202 (2002).

County may be liable for negligence of convict while maintaining county roads. — When governmental immunity is not present, no reason exists why a county may not be liable for the negligence of a convict who is engaged in the performance of a duty of a county, the maintenance of the roads of the county, and at the direction, with the knowledge and consent, and under the express authorization of the county. Hall County v. Loggins, 110 Ga. App. 432, 138 S.E.2d 699 (1964).

Worker's suit against a county brought after the worker stepped into an open manhole was barred by sovereign immunity. O.C.G.A. § 33-24-51(a) did not apply as no evidence supported the worker's allegation that a county employee mowing in the area with a tractor had knocked the manhole cover off or had a duty to inspect and report a missing cover. Dunn v. Telfair County, 288 Ga. App. 200, 653 S.E.2d 537 (2007).

Intentional conduct of officer in beating arrestee. — Arrestee's state law claims against a county for false imprisonment, kidnapping, and aggravated assault in connection with a police officer's transporting of the arrestee to a wooded area and subsequent beating and stabbing of the arrestee were barred under the doctrine of sovereign immunity, and the waiver of immunity in O.C.G.A. § 33-24-51(b) did not apply because although the officer used an insured patrol car to transport the arrestee, the officer's acts were intentional, not negligent. Williams v. DeKalb County, 327 Fed. Appx. 156 (11th Cir. 2009) (Unpublished).

Known hazard in road. — Trial court erred in denying a county's motion for summary judgment in a driver's action alleging that the county was negligent for failing to maintain and repair a roadway and/or failing to warn of a known hazard because there was no evidence that the

county waived the county's sovereign immunity under O.C.G.A. § 36-92-2, and there was no evidence that a county vehicle caused the hole in the roadway; the plaintiff, not the defendants, has the burden of establishing that a county waived sovereign immunity by purchasing liability insurance protection covering the plaintiff's claim. Effingham County v. Rhodes, 307 Ga. App. 504, 705 S.E.2d 856 (2010).

OPINIONS OF THE ATTORNEY GENERAL

County board of education may legally expend school funds for insurance coverage. — If a county board of education, as a political subdivision of the state, operates a public library, the board could legally expend public school funds for the purchase of a tag for the board's book-mobile; the same would be true as to the expense of insurance coverage. 1958-59 Op. Att'y Gen. p. 131. But see Ray v. Cobb County Bd. of Educ., 110 Ga. App. 258, 138 S.E.2d 392 (1964).

Waiver of sovereign immunity by Board of Regents. — Judiciary of this state would find that the powers delegated to the Board of Regents do not include by clear implication the power to waive sovereign immunity by the contractual assumption of tort liability. 1965-66 Op. Att'y Gen. No. 66-261.

Hold harmless clause executed by the Board of Regents would be invalid and ultra vires. 1965-66 Op. Att'y Gen. No. 66-261.

Board of Regents may legally execute a hold harmless agreement, although the better practice would be to specifically exclude it where possible; if and when the clause is not excluded, the lessor should be notified that the Board of Regents does not consider such a clause binding upon the Board under Georgia law. 1965-66 Op. Att'y Gen. No. 66-261.

County is not liable for the negligent acts of the county's servants. 1969 Op. Att'y Gen. No. 69-131.

If county has purchased liability insurance, then the county is liable as provided to extent of this insurance coverage. 1969 Op. Att'y Gen. No. 69-131.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Negligent Vehicular Police Chase, 41 POF2d 79.

ALR. — Liability of municipality for tort in construction or operation of municipally owned railroad or street railway, 31 A.L.R. 1306.

Power of municipal corporation to take out liability insurance, 33 A.L.R. 717.

Liability of street railway company for injury to person in "safety zone," 41 A.L.R. 376.

Liability of county for torts in connection with activities which pertain, or are claimed to pertain, to private or proprietary functions, 101 A.L.R. 1166; 16 A.L.R.2d 1079.

Construction and application of statute making municipal corporation liable for damages due to negligence of official or employee while operating vehicle, 136 A.L.R. 582.

Operation of garage for maintenance and repair of municipal vehicles as governmental function, 26 A.L.R.2d 944.

Application of financial responsibility or compulsory insurance laws to governmental vehicles or their operators, 87 A.L.R.2d 1224.

Validity and construction of statute authorizing or requiring governmental unit to procure liability insurance covering public officers or employees for liability arising out of performance of public duties, 71 A.L.R.3d 6.

Who is "named insured" within meaning of automobile insurance coverage, 91 A.L.R.3d 1280.

Liability of governmental unit or its officers for injury to innocent pedestrian or occupant of parked vehicle, or for damage to such vehicle, as result of police chase, 100 A.L.R.3d 815.

Tort liability of public schools and institutions of higher learning for accident

involving motor vehicle operated by student, 85 A.L.R.5th 301.

33-24-52. Direct response insurance business.

(a) For the purposes of this Code section, "direct response insurance business" means the solicitation, delivery, and servicing of group or individual life or accident and sickness insurance policies in this state, other than franchise insurance policies or other policies sold through a third party, travel life or accident insurance policies, or life or accident and sickness insurance policies sold or issued in connection with an extension of credit, under a general mode of business in which there is no face-to-face contact between the insured and an agent or other representative of the insurer.

(b) Any foreign or alien insurer who conducts a direct response insurance business in this state shall:

(1) Maintain a registered agent for service of process who is a resident of this state; and

(2) Maintain an office within this state, accept collect telephone calls from its direct response insurance policyholders, or provide toll free telephone service to such policyholders in order to provide information and assistance to such policyholders and their beneficiaries.

(c) Any insurer providing collect or toll free telephone service pursuant to this Code section shall notify its direct response insurance policyholders in writing of the applicable telephone number or numbers and of any subsequent changes in the telephone number or numbers within 90 days of such change.

History. — Code 1981, § 33-24-52, enacted by Ga. L. 1987, p. 1054, § 1.

33-24-53. Solicitation, release, or sale of automobile accident information prohibited; definitions; exceptions; penalties.

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

(1) "Capper," "runner," or "steerer" means a person who receives a pecuniary benefit from a practitioner or health care service provider, whether directly or indirectly, to solicit, procure, or attempt to procure a client, patient, or customer at the direction or request of, or in cooperation with, a practitioner or health care service provider whose purpose is to obtain benefits under a contract of insurance or to assert a claim against an insured or an insurer for providing

services to the client, patient, or customer. Capper, runner, or steerer shall not include:

(A) Any insurance company or agent or employee thereof who provides referrals or recommendations to its insureds; or

(B) A practitioner or health care service provider who procures clients, patients, or customers through the use of public media or by referrals or recommendations from other practitioners or health care service providers.

(2) "Practitioner" means an attorney, health care professional, owner or partial owner of a health care practice or facility, or any person employed or acting on behalf of any of the individuals in this paragraph.

(3) "Public media" means telephone directories, professional directories, newspapers and other periodicals, radio and television, billboards, and mailed or electronically transmitted written communications that do not involve in-person contact with a specific prospective client, patient, or customer.

(b) Except as provided for in paragraph (5) of subsection (a) of Code Section 50-18-72, it is unlawful for any person in an individual capacity or in a capacity as a law enforcement officer, law enforcement records staff member, wrecker services staff member, emergency staff member, physician, hospital employee, or attorney to solicit, release, or sell any information relating to the parties of a motor vehicle collision for personal financial gain. This subsection shall not apply to mass public media advertisement and solicitation.

(c) It is unlawful for:

(1) Any person in an individual capacity or in a capacity as a public or private employee or any firm, corporation, partnership, or association to act as a capper, runner, or steerer for any practitioner or health care service provider. This paragraph shall not prohibit an attorney or health care provider from making a referral and receiving compensation as is permitted under applicable professional rules of conduct; and

(2) Any practitioner or health care service provider to compensate or give anything of value to a person acting as a capper, runner, or steerer. It is also unlawful for any capper, runner, or steerer to recommend or secure a practitioner's or health care service provider's employment by a client, patient, or customer if such practitioner or health care service provider obtains or intends to obtain benefits under a contract of insurance or asserts a claim against an insured or an insurer for providing services to the client, patient, or customer.

(d) Any natural person convicted of a violation of this Code section shall, on the first offense, be guilty of a misdemeanor and, upon conviction thereof, shall be punished by imprisonment of not less than 30 days and a fine not to exceed $1,000.00. Any natural person convicted of a second or subsequent violation of this Code section shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment of not more than ten years and by a fine of not more than $100,000.00 per violation.

History. — Code 1981, § 33-24-53, enacted by Ga. L. 2014, p. 418, § 1/HB 828.

Editor's notes. — This Code section formerly pertained to prohibition and penalties for compensation for referrals or recommendations to attorneys and was repealed by Ga. L. 2014, p. 418, § 1/HB 828, effective July 1, 2014. The former Code section was based on Code 1981, § 33-24-53, enacted by Ga. L. 1991, p. 1864, § 2; Ga. L. 2011, p. 583, § 9/HB 137; Ga. L. 2012, p. 775, § 33/HB 942.

OPINIONS OF THE ATTORNEY GENERAL

Fingerprinting required. — Any misdemeanor offense under O.C.G.A. § 33-24-53 would be designated as one which requires fingerprinting. 2014 Op. Att'y Gen. No. 2014-2.

33-24-54. Payments to nonparticipating or nonpreferred providers of health care services.

(a) Notwithstanding any provisions of Code Sections 33-1-3, 33-1-5, and 33-24-17 and Chapter 20 of this title or any other provisions of this title which might be construed to the contrary, whenever an accident and sickness insurance policy, subscriber contract, or self-insured health benefit plan, by whatever name called, which is issued or administered by a person licensed under this title provides that any of its benefits are payable to a participating or preferred provider of health care services licensed under the provisions of Chapter 4 of Title 26 or of Chapter 9, 11, 30, 34, 35, or 39 of Title 43 or of Chapter 11 of Title 31 for services rendered, the person licensed under this title shall be required to pay such benefits either directly to any similarly licensed nonparticipating or nonpreferred provider who has rendered such services, has a written assignment of benefits, and has caused written notice of such assignment to be given to the person licensed under this title or jointly to such nonparticipating or nonpreferred provider and to the insured, subscriber, or other covered person; provided, however, that in either case the person licensed under this title shall be required to send such benefit payments directly to the provider who has the written assignment. When payment is made directly to a provider of health care services as authorized by this Code section, the person licensed under this title shall give written notice of such payment to the insured, subscriber, or other covered person.

(b) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by participating or preferred providers and nonparticipating or nonpreferred providers as otherwise authorized under the provisions of Code Sections 33-30-20 through 33-30-27.

(c) Payments made by a person licensed under this title under subsection (a) of this Code section to a nonparticipating or nonpreferred provider or jointly to the provider and the insured, subscriber, or other covered person shall discharge such person's obligation with respect to the amount so paid.

(d) The provisions of this Code section shall not apply to credit insurance, disability income insurance, or limited accident and sickness policies such as hospital indemnity policies, specified disease policies, limited accident policies, or similar limited policies.

History. — Code 1981, § 33-24-54, enacted by Ga. L. 1992, p. 1184, § 2; Ga. L. 2006, p. 652, § 4/HB 1257.

JUDICIAL DECISIONS

Anti-assignment clauses. — Physician could not bring suit against a health care plan because a patient's assignment to the physician of the right to payment of benefits was voided by the plan's unambiguous anti-assignment provision; Georgia law neither required assignment of benefits to health care providers nor barred anti-assignment provisions. Griffin v. Habitat for Humanity Int'l, Inc., 641 Fed. Appx. 927 (11th Cir. 2016) (Unpublished).

District court properly dismissed the healthcare provider's action against an employer seeking payment of benefits and penalties under the Employment Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq., because the provider lacked standing to file an ERISA claim based upon an unambiguous anti-assignment provision in the plan and the lack of a written assignment from the member; further, nothing in O.C.G.A. § 33-24-54 explicitly prohibited health benefits plan from barring assignment so the statute did not render anti-assignment provisions unenforceable, and the provider pled no facts setting forth a clear case of implied waiver of the anti-assignment clause by the employer or showing that the employer expressly waived the anti-assignment clause such that estoppel applied. Griffin v. Coca-Cola Enters., 686 Fed. Appx. 820 (11th Cir. 2017) (Unpublished).

Anti-assignment provision not void. — After a doctor appealed a district court's dismissal of the doctor's case, because an anti-assignment provision in the plan under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., barred assignments, the insureds' assignments to the doctor were void and the anti-assignment provision was not void under O.C.G.A. § 33-24-54. Griffin v. Verizon Communs., Inc., 641 Fed. Appx. 869 (11th Cir. 2016) (Unpublished).

Anti-assignment provisions impact on benefits' recovery. — Healthcare provider who had been assigned patients' rights under a medical benefits plan that contained an anti-assignment provision could not state a claim to recover benefits; the anti-assignment provision was not unenforceable under O.C.G.A. § 33-24-54, which neither explicitly nor implicitly prohibits a health benefits plan from barring

assignment. Griffin v. S. Co. Servs., 635 Fed. Appx. 789 (11th Cir. 2015) (Unpublished).

Anit-assignment provision enforceable. — Healthcare provider could not bring suit against a plan sponsor to recover benefits because the insured's assignment of the right to payment to the provider was void under the plan's anti-assignment provision; the anti-assignment provision was not unenforceable under O.C.G.A. § 33-24-54, which does not explicitly or implicitly prohibit a health benefits plan from barring assignment. Griffin v. FOCUS Brands, Inc., 635 Fed. Appx. 796 (11th Cir. 2015) (Unpublished).

Anti-assignment provision not enforceable. — Dermatologist who had been assigned ERISA benefits by the dermatologist's patients lacked standing to bring a 29 U.S.C. § 1132(a)(1)(B) claim against an employer when the wrap document governing the healthcare plan at issue contained an unambiguous anti-assignment clause, and even if O.C.G.A. § 33-24-54 mandated the recognition of assignments of benefits in an insurance contract, it was preempted by ERISA. Griffin v. Southern Co. Servs., 157 F. Supp. 3d 1277 (N.D. Ga. 2015).

Payments. — O.C.G.A. § 33-24-54 guarantees that if benefits are payable to preferred or participating providers under a plan, the plan must also pay benefits to non-participating or non-preferred healthcare providers to whom patients have assigned their rights. But nothing in § 33-24-54 requires an insured to assign the insured's benefits to a medical provider or renders a plan's anti-assignment provision unenforceable. Griffin v. Health Sys. Mgmt., 635 Fed. Appx. 768 (11th Cir. 2015) (Unpublished).

Payment of benefits. — O.C.G.A. § 33-24-54 guarantees that if benefits are payable to preferred or participating providers under a plan, the plan must also pay benefits to non-participating or non-preferred healthcare providers to whom patients have assigned their rights. But nothing in § 33-24-54 requires an insured to assign the insured's benefits to a medical provider or renders a plan's anti-assignment provision unenforceable. Griffin v. Gen. Mills, Inc., 634 Fed. Appx. 281 (11th Cir. 2015) (Unpublished).

33-24-55. Health insurance; recovery rights of state for payments made under Medicaid; rights of children to coverage; requirements for insurers under orders to provide coverage.

(a) Any health insurer under this title, including a group health plan, as defined in Section 607(1) of the federal Employee Retirement Income Security Act of 1974, is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. 1396(a), Section 1902 of the Social Security Act, herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.

(b) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(c) An insurer shall not deny enrollment of a child under the health plan of the child's parent on the ground that the child was born out of

wedlock, is not claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the insurer's service area.

(d) Where a child has health coverage under this title through an insurer of a noncustodial parent, the insurer shall:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(3) Make payments on claims submitted in accordance with paragraph (2) of this subsection directly to the custodial parent, the provider, or the state Medicaid agency.

(e) Where a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, the insurer shall be required:

(1) To permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under the family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sections 651 through 669, the child support enforcement program; and

(3) Not to disenroll or eliminate coverage of any child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(f) An insurer may not impose requirements on a state agency which has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(g) In any case in which a group health insurance plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions

as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.

(h) A group health plan may not restrict coverage under the plan for any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

History. — Code 1981, § 33-24-55, enacted by Ga. L. 1994, p. 1728, § 5.

Law reviews. — For note on the 1994 enactment of this Code section, see 11 Ga. St. U.L. Rev. 171 (1994).

33-24-56. Prohibition against requiring referral from primary care physician to dermatologist.

(a) It is the intent of the General Assembly to encourage health care cost containment while preserving the quality of care offered to citizens of this state. The General Assembly finds that there is an increasing number of health insurance benefit providers which require a referral from a primary care physician to a dermatologist as a condition of the payment of benefits to an insured patient. The General Assembly finds that such a requirement as it relates to dermatological services may block unfairly a patient's choice of direct access to providers of health care services and may not be in the public interest.

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

(1) "Dermatological services" means services ordinarily and customarily rendered by a physician specializing in the practice of dermatology.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state by a health care corporation, health maintenance organization, accident and sickness insurer, fraternal benefit society, or similar entity.

(c) No health benefit policy which is issued, delivered, issued for delivery, or renewed in this state shall require as a condition to the coverage of dermatological services that an enrollee, subscriber, or insured first obtain a referral from a primary care physician, as such term is defined by the group plan, policy, or contract for health care services.

History. — Code 1981, § 33-24-56, enacted by Ga. L. 1995, p. 235, § 1; Ga. L. 2017, p. 164, § 28/HB 127; Ga. L. 2019, p. 386, § 53/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1995," following "renewed in this state" near the middle of subsection (c).

Law reviews. — For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999).

33-24-56.1. Reimbursement of medical expense or disability benefit providers in personal injury cases; subrogation prohibited; notice.

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

(1) "Benefit provider" means any insurer, health maintenance organization, health benefit plan, preferred provider organization, employee benefit plan, or other entity which provides for payment or reimbursement of health care expenses, health care services, disability payments, lost wage payments, or any other benefits under a policy of insurance or contract with an individual or group.

(2) "Injured party" means a person who alleges that he or she has been injured by the acts or omissions of a third party and who has received benefits from a benefit provider. This term also includes the personal representative of the estate of such person.

(b) In the event of recovery for personal injury from a third party by or on behalf of a person for whom any benefit provider has paid medical expenses or disability benefits, the benefit provider for the person injured may require reimbursement from the injured party of benefits it has paid on account of the injury, up to the amount allocated to those categories of damages in the settlement documents or judgment, if:

(1) The amount of the recovery exceeds the sum of all economic and noneconomic losses incurred as a result of the injury, exclusive of losses for which reimbursement may be sought under this Code section; and

(2) The amount of the reimbursement claim is reduced by the pro rata amount of the attorney's fees and expenses of litigation incurred by the injured party in bringing the claim.

(c) In the settlement of any claim for personal injury, under circumstances where it is claimed that the amount of the recovery does not exceed the sum of all economic and noneconomic losses incurred as a result of the injury, a benefit provider which has paid benefits to or on behalf of the injured person may seek a declaratory judgment pursuant to Code Section 9-4-2 as to what extent it may equitably share in said settlement. If the court determines said settlement does not fully and completely compensate the injured party, the benefit provider has no right of reimbursement.

(d) In the trial of any case for personal injury submitted to a court or jury, the trier of fact may allocate the amounts paid among the

categories of damages actually sought by the plaintiff at trial, and it shall be conclusively presumed that such allocation by the trier of fact is reasonable.

(e) Subrogation for medical expenses and disability payments by a benefit provider against a person at fault for injury is prohibited and no defendant or liability insurance carrier shall include any insurer seeking reimbursement under subsection (b) of this Code section as a copayee on any check or draft in payment of a settlement or judgment.

(f) No benefit provider shall be entitled to reduce the amount for which it is liable under an insured party's coverage for liability, uninsured motorist, disability, medical payments, or other benefits as a setoff against any claim for reimbursement under subsection (b) of this Code section, nor shall any benefit provider be entitled to withhold or set off insurance benefits as a means of enforcing a claim for reimbursement. Nothing in this subsection shall be deemed to prohibit the coordination of benefits between or among benefit providers.

(g) When a recovery for personal injury is sought from a third party by or on behalf of a person for whom any benefit provider has paid medical expenses or disability benefits, the person asserting the claim for recovery against the third party shall provide notice of the existence of the claim, by certified mail or statutory overnight delivery unless some other form of notice is agreed to by the designated recipient of the notice, to any benefit provider which the person asserting the claim has reason to believe has paid benefits relating to the injury for which the injured party seeks a recovery. This notice shall be provided no later than ten days prior to the consummation of any settlement or commencement of any trial unless a shorter notice period is agreed to by the designated recipient of the notice and shall include a request for information regarding the existence of any claim by a benefit provider and an itemization of payments for which the benefit provider seeks reimbursement including the names of payees, the dates of service or payment or both, and the amounts thereof.

(h) If the notice required in subsection (g) of this Code section is provided, a claim for reimbursement under subsection (b) of this Code section is enforceable against an injured party only to the extent that such person has actual notice prior to the consummation of a settlement or commencement of trial, by certified mail or statutory overnight delivery or other form of notice if agreed to by the designated recipient of the notice, of the claim of the benefit provider for reimbursement including a specific itemization of payments for which the benefit provider seeks reimbursement, including the names of payees, the dates of service or payment or both, and the amounts thereof. Nothing contained in this subsection shall prohibit the supplementation of a claim prior to the consummation of a settlement or judgment, except

that any supplemental claims shall be subject to the notice requirements contained in this subsection.

(i) If the notice required in subsection (g) of this Code section is not provided, then subsection (h) of this Code section shall not apply, and a claim for reimbursement under subsection (b) of this Code section is enforceable subject to the other provisions of this Code section.

(j) No benefit provider contracts or policies containing or incorporating provisions in conflict with this Code section may be issued in this state, and no policy or contract provisions for subrogation or reimbursement in conflict with this Code section may be enforced by a benefit provider with regard to claims or injuries.

(k) Any settlement which is subject to this Code section that contains a confidentiality provision as to any terms of the settlement which are necessary to a proceeding under this Code section shall be unenforceable as to the disclosure of such required information.

(l) This Code section shall not apply to the rights of the Department of Community Health to recover under Article 7 of Chapter 4 of Title 49, nor shall it affect the subrogation rights and obligations provided in Code Section 34-9-11.1.

History. — Code 1981, § 33-24-56.1, enacted by Ga. L. 1997, p. 668, § 1; Ga. L. 1999, p. 296, § 24; Ga. L. 2000, p. 1589, § 3.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1997, "consummation" was substituted for "consumation" in the second sentence in subsection (g) and in the first sentence in subsection (h).

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendments to subsections (g) and (h) are applicable with respect to notices delivered on or after July 1, 2000.

Law reviews. — For discussion of insurance reimbursement law in annual survey article on trial practice and procedure, see 49 Mercer L. Rev. 313 (1997). For article commenting on the enactment of this Code section, see 14 Ga. St. U.L. Rev. 172 (1997). For annual survey article discussing trial practice and procedure, see 51 Mercer L. Rev. 487 (1999). For article, "Insurance," see 53 Mercer L. Rev. 281 (2001). For survey article on trial practice and procedure, see 59 Mercer L. Rev. 423 (2007). For annual survey on trial practice and procedure, see 64 Mercer L. Rev. 305 (2012). For article, "Uninsured Motorist Benefits in Light of Thurman v. State Farm," see 23 Ga. Bar. J. 19 (Oct. 2017).

For note, "ERISA Subrogation and the Controversy Over Sereboff: Silencing the Critics, the Divided Bench is a Legitimate Standard," see 45 Ga. L. Rev. 579 (2011).

JUDICIAL DECISIONS

Construction. — Legislature intended, when the legislature enacted O.C.G.A. § 33-24-56.1, to state the preexisting law, that the rule of complete compensation is the public policy of this state. Davis v. Kaiser Found. Health Plan of Ga., Inc., 271 Ga. 508, 521 S.E.2d 815 (1999).

Applicability. — O.C.G.A. § 33-24-56.1 did not apply when an insurer did not seek reimbursement or subrogation, but instead relied on a coverage exclusion. State Farm Auto. Ins. Co. v. Walker, 234 Ga. App. 101, 505 S.E.2d 828 (1998).

Full compensation rule codified in O.C.G.A. § 33-24-56.1 did not apply when an insurer settled with an alleged tortfeasor and the insureds claimed the insureds were owed monies in excess of the insureds' policy limits as the insurer did not seek reimbursement from the insured, or seek to recover medical or disability payments, and the alleged tortfeasor did not have limited assets such that either the insurer or the insureds had to some extent go unpaid; the fact that the insurer had taken the lead in the litigation with the alleged tortfeasor did not bring the case within the purview of Georgia's public policy concerns related to subrogation. Ga. Cas. & Sur. Co. v. Woodcraft by MacDonald, Inc., 315 Ga. App. 331, 726 S.E.2d 793 (2012).

Federal preemption. — Trial court erroneously granted summary judgment to an UM insurer, when 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 the liens 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).

Georgia's anti-subrogation statute, O.C.G.A. § 33-24-56.1, did not apply to prevent a welfare benefit plan from enforcing its reimbursement claim against an employee because the plan was exempt from the statute by virtue of the deemer clause in 29 U.S.C. § 1144(b)(2)(B). Summerlin v. Georgia-Pacific Corp. Life, Health and Accident Plan, 366 F. Supp. 2d 1203 (M.D. Ga. 2005).

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., did not preempt O.C.G.A. § 33-24-56.1 because the state statute was directed toward the insurance industry, and affects the risk pooling arrangement between the insurer and the insured. Smith v. Life Ins. Co. of N. Am., 466 F. Supp. 2d 1275 (N.D. Ga. 2006).

ERISA plan administrator off-set. — Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq., plan administrator was prevented from off-setting a participant's monthly disability under Georgia's anti-subrogation statute, O.C.G.A. § 33-24-56.1. Smith v. Life Ins. Co. of N. Am., 466 F. Supp. 2d 1275 (N.D. Ga. 2006).

Complete compensation rule inapplicable due to federal statute. — Since there was no conflict between state law and federal interests, an action by a state service benefit plan for reimbursement from a plan beneficiary after a settlement with a third party under the Federal Employees Health Benefits Act of 1959 (FEHBA) lacked subject matter jurisdiction under 28 U.S.C. § 1331 and had to be dismissed. There was no conflict because Georgia courts determined that when the FEHBA applied, the complete compensation rule under O.C.G.A. § 33-24-56.1(b) did not apply. Blue Cross Blue Shield Health Care Plan of Ga., Inc. v. Gunter, 541 F.3d 1320 (11th Cir. 2008).

Insurer not entitled to setoff following Medicare payment. — 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).

Policy provision subject to public policy. — Insurance policy provision that required reimbursement without regard to whether the insured was completely compensated was unenforceable as violative of public policy of this state regarding complete compensation. Davis v. Kaiser Found. Health Plan of Ga., Inc., 271 Ga. 508, 521 S.E.2d 815 (1999), reversing Davis v. Kaiser Found. Health Plan of Ga., Inc., 235 Ga. App. 13, 508 S.E.2d 431 (1998).

Vested subrogation rights not abrogated. — Subrogation rights, if any, that a medical insurer had against an insured were vested at the time O.C.G.A. § 33-24-56.1 became effective and could

not be abrogated by the statute. Jefferson-Pilot Life Ins. Co. v. Fraker, 234 Ga. App. 430, 507 S.E.2d 188 (1998).

Subrogation rights of underinsured motorist inusurer. — Because the insured's release of an underinsured tortfeasor reserved the rights of an insurer against the tortfeasor, the insurer was entitled to judgment on the insurer's cross-claim against the tortfeasor for the amount the insurer paid to the insured and the "full compensation" rule of paragraph (b)(1) of O.C.G.A. § 33-24-56.1 did not prohibit the insurer's subrogation claim. Landrum v. State Farm Mut. Auto. Ins. Co., 241 Ga. App. 787, 527 S.E.2d 637 (2000).

Insurer entitled to set-off. — In a personal injury action to recover damages incurred in an automobile collision, an insurer that was served as the plaintiffs' uninsured motorist carrier was entitled to set-off the amount the insurer had already paid the plaintiffs from the amount of the judgment. Yates v. Dean, 244 Ga. App. 333, 535 S.E.2d 335 (2000).

Cited in Davis v. Kaiser Found. Health Plan of Ga., Inc., 235 Ga. App. 13, 508 S.E.2d 431 (1998); Lamb v. Salvation Army, 301 Ga. App. 325, 687 S.E.2d 615 (2009); Woodcraft by MacDonald, Inc. v. Ga. Cas. & Sur. Co., 293 Ga. 9, 743 S.E.2d 373 (2013).

RESEARCH REFERENCES

Am. Jur. Trials. — Litigation of Recovery from Insurers for Medical Provider Liens, 152 Am. Jur. Trials 265.

33-24-56.2. Surveillance tests for ovarian cancer.

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

(1) "At risk for ovarian cancer" means:

(A) Having a family history:

(i) With one or more first or second-degree relatives with ovarian cancer;

(ii) Of clusters of women relatives with breast cancer;

(iii) Of nonpolyposis colorectal cancer; or

(B) Testing positive for BRCA1 or BRCA2 mutations.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(4) "Surveillance tests" means annual screening using:

(A) CA-125 serum tumor marker testing;

(B) Transvaginal ultrasound; and

(C) Pelvic examination.

(b) Every health benefit policy that is delivered, issued, issued for delivery, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner shall provide coverage for surveillance tests for women age 35 and over at risk for ovarian cancer.

(c) The benefits provided in this Code section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given health benefit policy.

(d) A physician who assesses a patient for ovarian cancer and such patient is at risk for ovarian cancer is encouraged to advise such patient of the availability of surveillance tests in accordance with the practices of the profession generally under similar conditions and like surrounding circumstances.

History. — Code 1981, § 33-24-56.2, enacted by Ga. L. 2001, p. 91, § 1; Ga. L. 2019, p. 386, § 54/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "including, but not limited to, those contracts executed by the state" for "including but not limited to those contracts executed by the State of Georgia" in paragraph (a)(2); deleted "hospital service corporation, medical service corporation," following "fraternal benefit society" near the middle of paragraph (a)(3); and deleted "on or after July 1, 2001," following "Commissioner" in the middle of subsection (b).

33-24-56.3. Colorectal cancer screening and testing.

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

(1) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state, including, but not limited to, those contracts executed by the Department of Community Health pursuant to paragraph (1) of subsection (d) of Code Section 31-2-4. The term "health benefit policy" does not include the following limited benefit insurance policies: accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and nonrenewable individual policies written for a period of less than six months.

(2) "Insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(b) Every health benefit policy shall provide coverage for colorectal cancer screening, examinations, and laboratory tests in accordance with guidelines and recommendations established by the American

Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations and deemed appropriate by the attending physician after conferring with the patient.

(c) The benefits provided in this Code section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given health benefit policy.

History. — Code 1981, § 33-24-56.3, enacted by Ga. L. 2002, p. 1089, § 1; Ga. L. 2009, p. 453, § 1-41/HB 228; Ga. L. 2019, p. 386, § 55/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 2002," following "insurer in this state" in the middle of the first sentence of paragraph (a)(1); and deleted "the most recently published" preceding "guidelines and recommendations" near the middle of subsection (b).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in the first sentence of paragraph (a)(1).

Law reviews. — For note on the 2002 enactment of this Code section, see 19 Ga. St. U.L. Rev. 220 (2002).

33-24-56.4. Short title; definitions; payment for telehealth services.

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

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

(1) "Distant site" means a site at which a health care provider legally allowed to practice in this state is located while providing health care services by means of telemedicine or telehealth.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, any health insurance plan established under Article 1 of Chapter 18 of Title 45 or under Article 7 of Chapter 4 of Title 49.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(4) "Originating site" means a site in this state at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided,

however, that notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(5) "Store and forward transfer" means the transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(6) "Telehealth" means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health, and health administration.

(7) "Telemedicine" means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site.

(c) It is the intent of the General Assembly to mitigate geographic discrimination in the delivery of health care by recognizing the application of and payment for covered medical care provided by means of telehealth, provided that such services are provided by a physician or by another health care practitioner or professional acting within the scope of practice of such health care practitioner or professional and in accordance with the provisions of Code Section 43-34-31.

(d) Each insurer proposing to issue a health benefit policy shall provide coverage for the cost of health care services provided through telehealth or telemedicine as directed through regulations promulgated by the department.

(e) An insurer shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(f) An insurer shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least

at the rate that the insurer is responsible for coverage for the provision of the same service through in-person consultation or contact; provided, however, that nothing in this subsection shall require a health care provider or telemedicine company to accept more reimbursement than they are willing to charge. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services.

(g) No insurer shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this Code section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health benefit policy.

(h) No insurer shall require its insureds to use telemedicine services in lieu of in-person consultation or contact.

(i) On and after January 1, 2020, every health benefit policy that is issued, amended, or renewed shall include payment for services that are covered under such health benefit policy and are appropriately provided through telehealth in accordance with Code Section 43-34-31, this Code section, and generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided.

History. — Code 1981, § 33-24-56.4, enacted by Ga. L. 2005, p. 481, § 3/HB 291; Ga. L. 2009, p. 859, § 11/HB 509; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2019, p. 386, § 56/SB 133; Ga. L. 2019, p. 512, § 1/SB 118.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, in paragraph (b)(1), substituted "the state" for "the State of Georgia"; and, in paragraph (b)(2), deleted "hospital service corporation, medical service corporation," following "fraternal benefits society,". The second 2019 amendment, effective January 1, 2020, substituted "telemedicine" for "telehealth" in the middle of subsections (c) and (i); substituted "Telehealth" for "Telemedicine" in subsection (a); rewrote subsection (b), which read: "(b) As used in this Code section, the term:

"(1) 'Health benefit policy' means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the State of Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

"(2) 'Insurer' means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

"(3) 'Telemedicine' means the practice, by a duly licensed physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation,

treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured e-mail, or a combination thereof do not constitute telemedicine services."; added subsections (d) through (h); redesignated former subsection (d) as subsection (i); and, in subsection (i), substituted "January 1, 2020" for "July 1, 2005", inserted "this Code section,", and deleted the last sentence, which read: "The coverage required in this Code section may be subject to all terms and conditions of the applicable health benefit plan." See the Code Commission notes regarding the effect of these amendments.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, the amendment of subsection (b) of this Code section by Ga. L. 2019, p. 386, § 56/SB 133, was treated as impliedly repealed and superseded by Ga. L. 2019, p. 512, § 1/SB 118, due to irreconcilable conflict.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Authorized or Prohibited Practice of Telemedicine, 183 Am. Jur. POF 3d 353.

33-24-56.5. Health benefit policy to provide coverage for orally administered chemotherapy for the treatment of cancer; definitions.

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

(1) "Cost sharing requirements" includes co-payments, coinsurance, deductibles, and any other amounts paid by the covered person for a prescription dispensed by a licensed retail pharmacy.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state. The term "health benefit policy" does not include the following limited benefit insurance policies: accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, Medicaid, medicare supplement, specified disease, vision, self-insured plans, and nonrenewable individual policies written for a period of less than six months.

(3) "Insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(b) A health benefit policy that provides coverage for intravenously administered or injected chemotherapy for the treatment of cancer shall provide coverage for orally administered chemotherapy for the treatment of cancer on a basis no less favorable than the intravenously administered or injected chemotherapy regardless of the formulation or benefit category determination by the insurer.

(c) An insurer providing a health benefit policy and any participating entity through which the insurer offers health services shall not:

(1) Vary the terms of any health benefit policy, to avoid compliance with this Code section;

(2) Provide any incentive, including, but not limited to, a monetary incentive, or impose treatment limitations to encourage a covered person to accept less than the minimum protections available under this Code section;

(3) Penalize a health care practitioner or reduce or limit the compensation of a health care practitioner for recommending or providing services or care to a covered person as required under this Code section;

(4) Provide any incentive, including, but not limited to, a monetary incentive, to induce a health care practitioner to provide care or services that do not comply with this Code section; or

(5) Change the classification of any intravenously administered or injected chemotherapy treatment or increase the amount of cost sharing applicable to any intravenously administered or injected chemotherapy, in order to achieve compliance with this Code section.

(d) An insurer that limits the total amount paid by a covered person through all cost sharing requirements to no more than $200.00 per filled prescription for any orally administered chemotherapy shall be deemed to be in compliance with this Code section.

History. — Code 1981, § 33-24-56.5, enacted by Ga. L. 2014, p. 243, § 2-2/HB 943; Ga. L. 2019, p. 386, § 57/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after January 1, 2015" following "state" at the end of the first sentence of paragraph (a)(2); deleted "in effect on December 30, 2014" following "health benefit policy" in paragraph (c)(1); and deleted "in effect on January 1, 2015," following "chemotherapy" in paragraph (c)(5).

Editor's notes. — Ga. L. 2014, p. 243, § 2-2/HB 943, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Cancer Treatment Fairness Act.'"

Law reviews. — For article on the 2014 enactment of this Code section, see 31 Ga. St. U. L. Rev. 113 (2014).

33-24-57. Health insurance; provision that coverage cannot be terminated due to individual claims experience required.

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

(1) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, or any similar entity and any self-insured health care plan not subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.

(2) "Policy" means any health care plan, subscriber contract, or accident and sickness plan, contract, or policy by whatever name

called other than a disability income policy, a long-term care insurance policy, a medicare supplement policy, a health insurance policy written as a part of workers' compensation equivalent coverage, a specified disease policy, a credit insurance policy, a hospital indemnity policy, a limited accident policy, or other type of limited accident and sickness policy.

(b) Notwithstanding any provisions of this title which might be construed to the contrary, all individual basic hospital or medical expense, major medical, or comprehensive medical expense insurance policies issued, delivered, issued for delivery, or renewed in this state shall provide that once an individual has been accepted for coverage, his or her coverage cannot be terminated by the insurer due solely to his or her individual claims experience.

(c) The Commissioner shall promulgate appropriate procedures and guidelines by rules and regulations to implement the provisions of this Code section after notification and review of such regulation by the appropriate standing committees of the House of Representatives and Senate in accordance with the requirements of applicable law. Nothing in this Code section shall be construed to prohibit the Commissioner and any insurers with a desire to do so from mutually agreeing on procedures, rules, regulations, and guidelines and from implementing the provisions of this Code section on a voluntary basis before April 1, 1996.

History. — Code 1981, § 33-24-57, enacted by Ga. L. 1995, p. 1242, § 2; Ga. L. 2017, p. 164, § 29/HB 127; Ga. L. 2019, p. 386, § 58/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted "on and after April 1, 1996," following "to the contrary," near the middle of subsection (b); deleted "on or before November 1, 1995," following "Code section" in the middle of the first sentence of subsection (c); and deleted former subsection (d), which read: "Beginning April 1, 1999, the Commissioner shall conduct a review of the costs associated with the coverage required by this Code section and shall provide the members of the General Assembly with such information no later than December 31, 1999."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, substituted "Section" for "Sec." in paragraph (a)(1).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, this Code section, originally designated as Code Section 33-24-56, was redesignated as Code Section 33-24-57.

33-24-57.1. Health insurance identification card; issue required; contents; updating; social security numbers not to be displayed.

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

(1) "Dental insurer" means any person, firm, corporation, joint venture, or other similar business entity that offers dental health benefit plans in consideration of periodic payments.

(2) "Fully insured" means any health policy in which all benefits payable are guaranteed under a contract or policy on insurance issued by an insurer authorized to transact business in this state.

(3) "Health policy" means any health care plan, dental plan, subscriber contract, or other policy plan or contract by whatever name called, including without limitation any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45; other than a disability income policy, a long-term care insurance policy, a medicare supplement policy, a health insurance policy written as a part of workers' compensation equivalent coverage, a specified disease policy, a credit insurance policy, a hospital indemnity policy, a limited accident policy, or other type of limited accident and sickness policy.

(4) "Insurer" means a health care corporation, health maintenance organization, preferred provider organization, dental insurer, accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance corporation, provider sponsored health care corporation, any similar entity authorized to issue contracts under this title, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(b) Each insurer writing a health policy in this state shall provide subscribers of such policies with an insurance identification card, which shall, at a minimum, contain the following preprinted, not handwritten, information:

(1) The subscriber's name and:

(A) The names of all other persons included under the subscriber's coverage; or

(B) If a separate card is issued for each person included under the subscriber's coverage, the name of the covered person for whom such card is issued may be listed in lieu of the information required by subparagraph (A) of this paragraph;

(2) The subscriber's identification number;

(3) The group number, if applicable;

(4) The effective date of coverage;

(5) The name of the subscriber's primary care physician, if applicable;

(6) The name of the subscriber's insurer, the name of the health plan, and the plan type or product name, if applicable;

(7) The address of the office where claims are to be filed;

(8) The insurer's contact phone numbers and the phone number for coverage confirmation and preauthorization, if applicable;

(9) The policy's requirements as to copayments, coinsurance payments, or deductibles, as applicable;

(10) Either the name of the primary hospital and of the laboratory and radiology services to be used or a toll-free or local telephone number for contacting the health plan and obtaining such information. Such a toll-free or local telephone number shall be available to health care providers and consumers to obtain eligibility and coverage information from at least 7:00 A.M. until 9:00 P.M. daily on Monday through Friday, whether staffed by a live person or via an automated phone-line basis; and

(11) If the subscriber's health policy is fully insured, a statement indicating that the subscriber's health policy is regulated by the Commissioner, except that this requirement shall not apply to any licensed group model health maintenance organization with the exclusive medical group contract.

(c) Any insurance identification card which contains the information required by subsection (b) of this Code section in preprinted form may, at the option of the insurer, additionally contain at least such information encoded on a magnetic strip or other electronic memory card.

(d) In addition to the information required by subsection (b) of this Code section, each insurance identification card provided under this Code section shall contain prescription drug coverage information, if applicable. Information provided pursuant to this subsection shall include:

(1) BIN number;

(2) Processor control number, if applicable; and

(3) Pharmacy help desk telephone number and names.

(e) So as to ensure that insurance identification cards issued under this Code section contain accurate and updated information, each insurer shall provide each subscriber with a new insurance identification card whenever any information required to be on the card is changed not later than 60 days after such change becomes effective. If the insurer issues annual renewal cards, it may issue a temporary sticker containing the new information in lieu of issuing a new card prior to the annual renewal date. Such sticker shall be so designed that it can be attached to the existing card.

(f) Insurance identification cards issued by any insurer under this Code section shall not use or display the insured's social security number for any purpose or in any manner on such card.

History. — Code 1981, § 33-24-57.1, enacted by Ga. L. 2000, p. 1220, § 1; Ga. L. 2003, p. 444, § 1; Ga. L. 2019, p. 386, § 59/SB 133; Ga. L. 2019, p. 905, § 1/SB 142.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in the middle of paragraph (a)(2) (now paragraph (a)(4)); and deleted "on an after July 1, 2004," following "Code section" in subsection (f). The second 2019 amendment, effective July 1, 2019, added paragraphs (a)(1) and (a)(2); redesignated former paragraphs (a)(1) and (a)(2) as present paragraphs (a)(3) and (a)(4), respectively; inserted "dental insurer," near the middle of paragraph (a)(4); deleted "and" at the end of paragraph (b)(9); substituted "; and" for the period at the end of paragraph (b)(10); and added paragraph (b)(11). See Editor's notes for applicability.

Editor's notes. — Ga. L. 2000, p. 1220, § 2, not codified by the General Assembly, provides that this Code section is applicable to all policies issued, delivered, issued for delivery, or renewed on or after July 1, 2000.

Ga. L. 2019, p. 905, § 2/SB 142, not codified by the General Assembly, provides: "This Act shall apply to all insurance identification cards issued by an insurer on and after January 1, 2020."

33-24-58. Newborn Baby and Mother Protection Act; short title.

This Code section and Code Sections 33-24-58.1 and 33-24-58.2 shall be known and may be cited as the "Newborn Baby and Mother Protection Act."

History. — Code 1981, § 33-24-58, enacted by Ga. L. 1996, p. 409, § 1.

Cross references. — Breast-feeding of baby, § 31-1-9. Employer obligation to provide time for women to express breast milk for infant child, § 34-1-6.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "This Code section and Code Sections 33-24-58.1 and 33-24-58.2" was substituted for "This Act".

Editor's notes. — Ga. L. 1996, p. 409, § 2, not codified by the General Assembly, provides: "All contracts relating to the provision of health care services in effect on the effective date of this Act shall be appropriately adjusted to reflect any change in services provided as required by this Act."

Ga. L. 1996, p. 409, § 3, not codified by the General Assembly, provides: "The provisions of this Act shall not be construed to apply to or in any way affect the provisions of the federal Employee's Retirement Income Security Act."

Law reviews. — For review of 1996 insurance legislation, see 13 Ga. St. U.L. Rev. 201 (1996).

33-24-58.1. Newborn Baby and Mother Protection Act; legislative findings and declaration.

The General Assembly finds and declares that:

(1) Whereas, until recently health care insurers covered costs of hospital stays of a mother and a newborn until they were discharged by a physician after a consultation with the mother. Now many insurers are refusing payment for a hospital stay that extends beyond 24 hours after an uncomplicated vaginal delivery and 48 hours after a cesarean delivery;

(2) There is sufficient scientific data to question the safety and appropriateness of such early releases from the hospital following delivery, particularly as it relates to the detection of many problems which if undiagnosed may pose life-threatening and costly complications and may require a longer period of observation by skilled personnel;

(3) Guidelines developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend as a minimum that mothers and infants meet certain medical criteria and conditions prior to discharge, and it is unlikely that these criteria and conditions can be met in less than 48 hours following a normal vaginal delivery and 96 hours following a cesarean delivery;

(4) The length of postdelivery inpatient stay should be a clinical decision made by a physician based on the unique characteristics of each mother and her infant, taking into consideration the health of the mother, the health and stability of the baby, the ability and confidence of the mother to care for her baby, the adequacy of support systems at home, and access to appropriate follow-up care; and

(5) Requiring insurers to cover minimum postdelivery inpatient stays will allow identification of early problems with the newborn, prevent disability through appropriate use of metabolic screening, and help ensure that the family is able and prepared to care for the baby at home.

History. — Code 1981, § 33-24-58.1, enacted by Ga. L. 1996, p. 409, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, this Code section, originally designated as Code Section 33-24-59, was redesignated as Code Section 33-24-58.1.

Editor's notes. — Ga. L. 1996, p. 409, § 2, not codified by the General Assembly, provides: "All contracts relating to the provision of health care services in effect on the effective date of this Act shall be appropriately adjusted to reflect any change in services provided as required by this Act."

Ga. L. 1996, p. 409, § 3, not codified by the General Assembly, provides: "The provisions of this Act shall not be construed to apply to or in any way affect the provisions of the federal Employee's Retirement Income Security Act."

33-24-58.2. Newborn Baby and Mother Protection Act; minimum health benefit policy coverage; prohibited actions by insurance providers; required notice to mother.

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

(1) "Attending provider" means:

(A) Pediatricians and other physicians attending the newborn; and

(B) Obstetricians, other physicians, and certified nurse midwives attending the mother.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including those contracts executed by the state on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, or other insurer or similar entity.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under this title and also means any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396, et seq., and any other publicly funded state health care program.

(b) Every health benefit policy that provides maternity benefits that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner shall provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newly born child in a licensed health care facility.

(c) Any decision to shorten the length of stay to less than that provided under subsection (b) of this Code section shall be made by the attending physician, the obstetrician, pediatrician, or certified nurse midwife after conferring with the mother.

(d) If a mother and newborn are discharged pursuant to subsection (c) of this Code section prior to the postpartum inpatient length of stay provided under subsection (b) of this Code section, coverage shall be provided for up to two follow-up visits, provided that the first such visit shall occur within 48 hours of discharge. Such visits shall be conducted by a physician, a physician assistant, or a registered professional nurse with experience and training in maternal and child health nursing. After conferring with the mother, the health care provider shall determine whether the initial visit will be conducted at home or at the office. Thereafter, he or she shall confer with the mother and determine whether a second visit is appropriate and where it shall be conducted. Services provided shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, and the performance of any medically necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services.

(e) The Commissioner shall adopt rules and regulations necessary to implement the provisions of this Code section.

(f) Every insurer shall provide notice to policyholders regarding the coverage required by this Code section. The notice shall be in writing and prominently positioned in any of the following literature:

(1) The next mailing to the policyholder;

(2) The yearly informational packets sent to the policyholder; or

(3) Other literature.

In addition to such notice, the insurer shall also provide a notice to the expectant mother within 30 days following the date the insurer first learns that the expectant mother covered by maternity benefits of the health benefit policy is pregnant in substantially the following form:

"NOTICE

The Newborn Baby and Mother Protection Act (Code Section 33-24-58.2 of the O.C.G.A.) requires that health benefit policies which provide maternity benefits must provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newborn child. The care must be provided in a licensed health care facility. A decision to shorten the length of stay may be made only by the attending health care provider after conferring with the mother. If the stay is shortened, coverage must be provided for up to two follow-up visits with specified health care providers with the first visit being within 48 hours after discharge. After conferring with the mother, the health care provider must determine whether the initial visit will be conducted at home or at the office and whether a second visit is appropriate. Specified services are required to be provided at such visits."

(g) No insurer covered under this Code section shall deselect, terminate the services of, require additional utilization review, reduce capitation payment, or otherwise penalize an attending physician or other health care provider who orders care consistent with the provisions of this Code section. For purposes of this subsection, health care provider shall be defined to include the attending physician, certified nurse midwife, and hospital.

History. — Code 1981, § 33-24-58.2, enacted by Ga. L. 1996, p. 409, § 1; Ga. L. 2002, p. 613, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2009, p. 859, § 3/HB 509; Ga. L. 2019, p. 386, § 60/SB 133.

Cross references. — Medicaid coverage for lactation and postpartum care, § 49-4-159.

The 2019 amendment, effective July 1, 2019, deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in paragraphs (a)(2) and (a)(3); substituted "the state" for "the State of Georgia" in the middle of paragraph (a)(2); deleted "on or after July 1, 1996," following "Commissioner" in the middle of subsection (b); and deleted "mailed before January 1, 1997" following "literature" at the end of paragraph (f)(3).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, this Code section, originally designated as Code Section 33-24-60, was redesignated as Code Section 33-24-58.2.

Pursuant to Code Section 28-9-5, in 2005, quotation marks were added at the beginning and end of the insurer's form.

Editor's notes. — Ga. L. 1996, p. 409, § 2, not codified by the General Assembly, provides: "All contracts relating to the provision of health care services in effect on the effective date of this Act shall be appropriately adjusted to reflect any change in services provided as required by this Act."

Ga. L. 1996, p. 409, § 3, not codified by the General Assembly, provides: "The provisions of this Act shall not be construed to apply to or in any way affect the provisions of the federal Employee's Retirement Income Security Act."

33-24-59. Women's access to health care; health insurance; provision disclosing insured's right to direct access to obstetricians and gynecologists required.

(a) The General Assembly finds and declares that the specialty of obstetrics and gynecology is devoted to health care of women throughout their lifetimes.

(b)(1) As used in this Code section, the term "health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state by a health care corporation, health maintenance organization, accident and sickness insurer, fraternal benefit society, or similar entity.

(2) Any accident and sickness policies, plans, or contracts which contain no provisions which require referrals from another physician for coverage of the services of an obstetrician or gynecologist shall not be required to give the notice required in subsection (d) of this Code section.

(c) No health benefit policy which is issued, delivered, issued for delivery, or renewed in this state shall require as a condition to the coverage of services of an obstetrician or gynecologist who is within the health benefit policy network of health care providers that an enrollee, subscriber, or insured first obtain a referral from another physician; provided, however, that the services covered by this subsection shall be limited to those services defined by the published recommendations of the Accreditation Council for Graduate Medical Education for training as an obstetrician or gynecologist, including, but not limited to, diagnosis, treatment, and referral.

(d) Each health benefit policy which is issued, delivered, issued for delivery, or renewed in this state shall disclose to enrollees, subscribers, or insureds, in clear, accurate language, such person's right to direct access to obstetricians and gynecologists as provided in this Code section. Such information shall be disclosed to each such person at the time of enrollment or otherwise first becoming an enrollee, subscriber, or insured, and at least annually thereafter.

History. — Code 1981, § 33-24-59, enacted by Ga. L. 1996, p. 703, § 2; Ga. L. 1998, p. 1064, § 6; Ga. L. 2017, p. 164, § 30/HB 127; Ga. L. 2019, p. 386, § 61/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1996," following "in this state" in subsections (c) and (d); and, in subsection (c), in the proviso, substituted "Council for Graduate" for "Council For Graduate", and inserted a comma following "including" and following "but not limited to" near the end.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, this Code section, originally designated as Code Section 33-24-58, was redesignated as Code Section 33-24-59.

Editor's notes. — Ga. L. 1996, p. 703, § 1, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Women's Access to Health Care Act.'"

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

33-24-59.1. Coverage for treatment of dependent children with cancer.

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

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) An individual accident and sickness insurance policy or contract, as defined in Chapter 29 of this title;

(B) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(C) An individual or group contract of the type issued by a health care plan established under Chapter 20 of this title;

(D) An individual or group contract of the type issued by a health maintenance organization established under Chapter 21 of this title;

(E) An individual or group contract of the type issued by a fraternal benefit society; or

(F) Any similar individual or group accident and sickness benefit plan, policy, or contract.

(2) "Approved clinical trial program for treatment of children's cancer" means a Phase II and III prescription drug clinical trial program in this state, as approved by the federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in children under the age of 19 and that:

(A)(i) Tests new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children;

(ii) Introduces a new therapy or regimen to treat recurrent cancer in children; or

(iii) Seeks to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens; and

(B) Has been certified by and utilizes the standards for acceptable protocols established by the:

(i) Pediatric Oncology Group;

(ii) Children's Cancer Group; or

(iii) Commissioner as he or she may otherwise define such term by rule and regulation after due notice, any required hearing, and compliance with any other requirements of applicable law, but only providing for such definition in a manner at least as restrictive as that established in this Code section.

(3) "Routine patient care costs" means those medically necessary costs of blood tests, X-rays, bone scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally incurred by the insured party in connection with the provision of goods, services, or benefits to dependent children under an approved clinical trial program for treatment of children's cancer which otherwise would be covered under the major medical accident and sickness insurance benefit plan, policy, or contract if such medically necessary costs were not incurred in connection with an approved clinical trial program for treatment of children's cancer. Routine patient care costs specifically shall not include the costs of any clinical trial therapies, regimens, or combinations thereof, any drugs or pharmaceuticals, any costs associated with the provision of any goods, services, or benefits to dependent children which generally are furnished without charge in connection with such an approved clinical trial program for treatment of children's cancer, any additional costs associated with the provision of any goods, services, or benefits which previously have been provided to the dependent child, paid for, or reimbursed, or any other similar costs. It is specifically the intent of this Code section not to relieve the sponsor of a clinical trial program of financial responsibility for accepted costs of such program.

(4) "State health plan" means any health insurance plan established for employees of the state under Article 1 of Chapter 18 of Title 45 or Chapter 4 of Title 49 to provide health care services to state employees and indigents.

(b) Any state health plan or any accident and sickness insurance benefit plan, policy, or contract, by whatever name called, that provides major medical coverage for dependent children and which is issued, delivered, issued for delivery, or renewed in this state shall provide coverage for routine patient care costs incurred in connection with the

provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:

(1) Are covered dependents under a state health plan or under the major medical coverage of an accident and sickness insurance plan, policy, or contract;

(2) Have been diagnosed with cancer prior to their nineteenth birthday;

(3) Are enrolled in an approved clinical trial program for treatment of children's cancer; and

(4) Are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.

(c) For purposes of this Code section, any exclusions, reductions, or limitations as to coverages or any cost-sharing arrangements provided for in a state health plan or in an accident and sickness insurance benefit plan, policy, or contract which provides major medical coverage for dependent children and which applies to any benefits, payments, or reimbursements for routine patient care provided to dependent children in connection with generally recognized therapies or regimens for the treatment of children's cancer shall also apply to such benefits, payments, or reimbursements for any dependent child who is enrolled in an approved clinical trial program for treatment of children's cancer.

(d) Except as provided in subsections (b) and (c) of this Code section, nothing in this Code section shall be construed to:

(1) Prohibit a state health plan or an insurer, health care plan, health maintenance organization, fraternal benefit society, or other person from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which has benefits that are greater than the minimum benefits required by this Code section or from issuing or continuing to issue any accident and sickness insurance plan, policy, or contract which provides benefits which are generally more favorable to the insured than those required by this Code section; or

(2) Change the contractual relations between any insurer, nonprofit corporation, health care plan, health maintenance organization, fraternal benefit society, or other similar person and their insureds or covered dependents by whatever name called.

History. — Code 1981, § 33-24-59.1, enacted by Ga. L. 1998, p. 649, § 1; Ga. L. 2017, p. 164, § 31/HB 127; Ga. L. 2019, p. 386, § 62/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (b), substituted "Any" for "On and after July 1, 1998, any" at the beginning, and deleted "on or after July 1, 1998," following "renewed in this state" in the middle; and deleted "non-

profit corporation," following "or an insurer," near the beginning of paragraph (d)(1).

Code Commission notes. — Ga. L. 1998, p. 649; Ga. L. 1998, p. 660; and Ga. L. 1998, p. 1382 each enacted a Code section designated as Code Section 33-24-59.1. Pursuant to Code Section 28-9-5, in 1998, the version enacted by Ga. L. 1998, p. 649 retained the designation as Code Section 33-24-59.1, the version enacted by Ga. L. 1998, p. 660 was redesignated as Code Section 33-24-59.2, and the version enacted by Ga. L. 1998, p. 1382 was redesignated as Code Section 33-24-59.3.

33-24-59.2. Coverage for equipment and self-management training for individuals with diabetes; enforcement.

(a) Every individual major medical and group health insurance policy, group health insurance plan or policy, and any other form of managed or capitated care plans or policies shall provide coverage for medically necessary equipment, supplies, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy, for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a physician licensed to practice medicine pursuant to Title 43.

(b)(1) Diabetes outpatient self-management training and education as provided for in subsection (a) of this Code section shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

(2) The Commissioner shall promulgate rules and regulations after consultation with the Department of Public Health which conform to the standards for diabetes outpatient self-management training and educational services established by the American Diabetes Association for purposes of this Code section.

(3) The Commissioner shall promulgate rules and regulations, relating to standards of diabetes care, after consultation with the Department of Public Health, the American Diabetes Association, and the National Institutes of Health. Such rules and regulations shall be adopted in accordance with the provisions of Code Section 33-2-9.

(c) The benefits provided in this Code section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy.

(d) Private third-party payors may not reduce or eliminate coverage due to the requirements of this Code section.

(e) Enforcement of the provisions of this Code section shall be performed by the Commissioner of Insurance.

History. — Code 1981, § 33-24-59.2, enacted by Ga. L. 1998, p. 660, § 1; Ga. L. 2002, p. 646, § 1; Ga. L. 2009, p. 453, § 1-42/HB 228; Ga. L. 2011, p. 705, § 6-3/HB 214; Ga. L. 2019, p. 386, § 63/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "Every" for "On or after July 1, 2002, every" at the beginning of subsection (a); in paragraph (b)(2), substituted "The Commissioner" for "The office of the Commissioner of Insurance" at the beginning, deleted "current" following "conform to the" in the middle; and rewrote paragraph (b)(3), which read: "The office of the Commissioner of Insurance shall promulgate rules and regulations, relating to standards of diabetes care, to become effective July 1, 2002, after consultation with the Department of Human Resources (now known as the Department of Public Health for these purposes), the American Diabetes Association, and the National Institutes of Health. Such rules and regulations shall be adopted in accordance with the provisions of Code Section 33-2-9."

Code Commission notes. — Ga. L. 1998, p. 649; Ga. L. 1998, p. 660; and Ga. L. 1998, p. 1382 each enacted a Code section designated as Code Section 33-24-59.1. Pursuant to Code Section 28-9-5, in 1998, the version enacted by Ga. L. 1998, p. 649 retained the designation as Code Section 33-24-59.1, the version enacted by Ga. L. 1998, p. 660 was redesignated as Code Section 33-24-59.2, and the version enacted by Ga. L. 1998, p. 1382 was redesignated as Code Section 33-24-59.3.

Law reviews. — For article on the 2011 amendment of this Code section, see 28 Ga. St. U.L. Rev. 147 (2011).

For note on the 2002 amendment of this Code section, see 19 Ga. St. U.L. Rev. 232 (2002).

33-24-59.3. Payments sent directly to health care provider by insurer.

(a) As used in this Code section, the term "health care insurer" means any insurer which issues, delivers, issues for delivery, or renews an individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, or other insurer or similar entity. It shall not, however, include a policy of insurance designed, advertised, and marketed to supplement basic health care coverage for hospital, medical-surgical, or major medical expenses so long as said supplemental insurance contract provides for payment directly to the insured.

(b) Any other provision of law to the contrary notwithstanding, if a covered person provides in writing to a health care provider, whether the health care provider is a preferred provider or not, that payment for health care services shall be made solely to the health care provider and be sent directly to the health care provider by the health care insurer, and the health care provider certifies to same upon filing a claim for the delivery of health care services, the health care insurer shall make payment solely to the health care provider and shall send said payment directly to the health care provider. This subsection shall not be construed to extend coverages or to require payment for services not otherwise covered.

History. — Code 1981, § 33-24-59.3, enacted by Ga. L. 1998, p. 1382, § 1; Ga. L. 2019, p. 386, § 65/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," near the end of the first sentence of subsection (a).

Cross references. — Preferred provider arrangements, § 33-30-23.

Code Commission notes. — Ga. L. 1998, p. 649; Ga. L. 1998, p. 660; and Ga. L. 1998, p. 1382 each enacted a Code section designated as Code Section 33-24-59.1. Pursuant to Code Section 28-9-5, in 1998, the version enacted by Ga. L. 1998, p. 649 retained the designation as Code Section 33-24-59.1, the version enacted by Ga. L. 1998, p. 660 was redesignated as Code Section 33-24-59.2, and the version enacted by Ga. L. 1998, p. 1382 was redesignated as Code Section 33-24-59.3.

Pursuant to Code Section 28-9-5, in 1998, a comma was added following "advertised" and following "medical-surgical" in the last sentence of subsection (a).

33-24-59.4. Confidentiality of medical information obtained from pharmacies; restrictions on release of information; penalty for violation.

(a) As used in this Code section, the term "insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, provider sponsored health care corporation, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45 and includes any entity which administers or processes claims on behalf of any of the foregoing.

(b) Any medical information concerning a patient that was obtained by or released to an insurer from a pharmacy or pharmacist shall be confidential and privileged and may be released by such insurer to a third party for consideration only if such release is specifically authorized by such patient or a person otherwise authorized to act therefor. Any insurer possessing patient medical information which was obtained from a pharmacy or pharmacist shall not release such information to any third party for consideration without the explicit written consent of the patient or a person otherwise authorized to act therefor, which consent was obtained after written notice by the insurer to such patient or person otherwise authorized to act therefor of the purpose of such release, the party or parties to whom the information will be released, and any consideration paid or to be paid to the insurer for such information.

(c) The provisions of subsection (b) of this Code section shall not prohibit the release of medical information by an insurer to a third party for purposes of appropriate medical research without notice to or the written consent of a patient or person authorized to act therefor, provided that such release does not provide any information that identifies a patient, prescriber, pharmacy, or pharmacist, including without limitation any name, address, or telephone number of a patient, prescriber, pharmacy, or pharmacist. Information released in

accordance with the provisions of this subsection may be used for appropriate medical research.

(d) Violation of this Code section by any insurer to which any license or certificate of authority has been issued under this title shall constitute an unfair trade practice punishable under Article 1 of Chapter 6 of this title.

History. — Code 1981, § 33-24-59.4, enacted by Ga. L. 1999, p. 289, § 1; Ga. L. 2017, p. 164, § 32/HB 127; Ga. L. 2019, p. 386, § 66/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "Title 45 and includes any entity which administers" for "Title 45; and such term includes any entity which administrates" near the end of subsection (a).

Law reviews. — For article, "Is Too Much Privacy Bad for Your Health? An Introduction to the Law, Ethics, and HIPAA Rule on Medical Privacy," see 17 Ga. St. U.L. Rev. 481 (2000).

33-24-59.5. Definitions; timely payment of health benefits; notification of failure to pay; penalties; applicability.

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

(1) "Benefits" means the coverages provided by a health benefit plan for financing or delivery of health care goods or services; but such term does not include capitated payment arrangements under managed care plans.

(2) "Health benefit plan" means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, health maintenance organization subscriber contract, any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45, or any dental or vision care plan or policy, or managed care plan or self-insured plan; but health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; or Chapter 9 of Title 34, relating to workers' compensation.

(3) "Insurer" 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, which entity provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45 or any other administrator as defined in paragraph (1) of subsection (a) of Code Section 33-23-100.

(b)(1) All benefits under a health benefit plan will be payable by the insurer which is obligated to finance or deliver health care services under that plan upon such insurer's receipt of written or electronic

proof of loss or claim for payment for health care goods or services provided. The insurer shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the insured or other person claiming payments under the plan payment for such benefits or a letter or electronic notice which states the reasons the insurer may have for failing to pay the claim, either in whole or in part, and which also gives the person so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer in accordance with this chapter. When all of the listed documents or other information needed to process the claim has been received by the insurer, the insurer shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the insured or other person claiming payments under the plan the insurer's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer shall pay to the insured or other person claiming payments under the health benefit plan interest equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.

History. — Code 1981, § 33-24-59.5, enacted by Ga. L. 1999, p. 289, § 2; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2011, p. 595, § 5/HB 167; Ga. L. 2017, p. 164, § 33/HB 127; Ga. L. 2019, p. 386, § 67/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "administers" for "administrates" in the middle of paragraph (b)(2).

Cross references. — Required accident and sickness insurance policy provisions, §§ 33-29-3, 33-30-6.

Editor's notes. — Ga. L. 1999, p. 289, § 6, not codified by the General Assembly, provides that this Act shall apply to plans, policies, or contracts issued, delivered, issued for delivery, or renewed on or after July 1, 1999.

Ga. L. 2011, p. 595, § 1/HB 167, not

codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Insurance Delivery Enhancement Act of 2011.'"

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

33-24-59.6. Prescribed female contraceptive drugs or devices; insurance coverage.

(a) The General Assembly finds and declares that:

(1) Maternal and infant health are greatly improved when women have access to contraceptive supplies to prevent unintended pregnancies;

(2) Because many Americans hope to complete their families with two or three children, many women spend the majority of their reproductive lives trying to prevent pregnancy;

(3) Research has shown that 49 percent of all large group insurance plans do not routinely provide coverage for contraceptive drugs and devices. While virtually all health care plans cover prescription drugs generally, the absence of prescription contraceptive coverage is largely responsible for the fact that women spend 68 percent more in out-of-pocket expenses for health care than men; and

(4) Requiring insurance coverage for prescription drugs and devices for contraception is in the public interest in improving the health of mothers, children, and families and in providing for health insurance coverage which is fairer and more equitable.

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

(1) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including those contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, provider sponsored health care corporation, or other insurer or similar entity.

(2) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under this title.

(c) Every health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner which provides coverage for prescription drugs on an outpatient basis shall provide coverage for any prescribed drug or device approved by the United States Food and Drug Administration for

use as a contraceptive. This Code section shall not apply to limited benefit policies described in paragraph (4) of subsection (e) of Code Section 33-30-12. Likewise, nothing contained in this Code section shall be construed to require any insurance company to provide coverage for abortion.

(d) No insurer shall impose upon any person receiving prescription contraceptive benefits pursuant to this Code section any:

(1) Copayment, coinsurance payment, or fee that is not equally imposed upon all individuals in the same benefit category, class, coinsurance level or copayment level, receiving benefits for prescription drugs; or

(2) Reduction in allowable reimbursement for prescription drug benefits.

(e) This Code section shall not be construed to:

(1) Require coverage for prescription coverage benefits in any contract, policy, or plan that does not otherwise provide coverage for prescription drugs; or

(2) Preclude the use of closed formularies; provided, however, that such formularies shall include oral, implant, and injectable contraceptive drugs, intrauterine devices, and prescription barrier methods.

History. — Code 1981, § 33-24-59.6, enacted by Ga. L. 1999, p. 317, § 1; Ga. L. 2019, p. 386, § 68/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "the state" for "the State of Georgia" in the middle of paragraph (b)(1); deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in paragraphs (b)(1) and (b)(2); and deleted "on or after July 1, 1999," following "by the Commissioner" near the middle of the first sentence of subsection (c).

Cross references. — Family planning services, T. 49, C. 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, this Code section, originally designated as Code Section 33-24-59.1, was redesignated as Code Section 33-24-59.6, "of the Official Code of Georgia Annotated" was deleted from paragraph (b)(1), "Code section" was substituted for "Act" in subsection (c), and in subsection (e), "or" was inserted at the end of paragraph (e)(1) and "; provided," was substituted for ", provided," in paragraph (e)(2).

Law reviews. — For note on 1999 enactment of this Code section, see 16 Ga. St. U.L. Rev. 146 (1999). For note, "Let Your Conscience Be Your Guide: Comparing and Contrasting Washington's Death with Dignity Act and Pharmacy Regulations After the Ninth Circuit's Decision in Stormans, Inc. v. Wiesman," see 52 Ga. L. Rev. 613 (2018).

33-24-59.7. Coverage for the treatment of morbidly obese patients; short title; legislative findings; adoption of rules and regulations by Commissioner.

(a) This Code section shall be known and may be cited as the "Morbid Obesity Anti-discrimination Act."

(b) The General Assembly finds and declares that:

(1) Whereas many health care insurers cover the costs of treatment for patients diagnosed as morbidly obese by their physicians, many other insurers refuse to cover such costs;

(2) There is sufficient scientific data that implicate morbid obesity as the cause of many other medical problems and costly health complications, such as diabetes, hypertension, heart disease, and stroke. These data indirectly question the safety and appropriateness of the continued refusal of some insurers to cover the medically indicated treatment of the morbidly obese patient. The association of morbid obesity with the aforementioned devastating diseases refutes any claim of a purely cosmetic indication for the treatment of morbid obesity and clearly designates morbid obesity as a life-threatening disease;

(3) The cost of managing the complications of morbid obesity, largely due to inadequate treatment, far outweighs the cost of expeditious, effective medical treatment. Therefore, insurers who continue to refuse to pay for the primary treatment of morbid obesity are contributing to the high cost of management of secondary complications;

(4) Guidelines developed by the National Institute of Health, the American Society for Bariatric Surgery, the American Obesity Association, and Shape Up America and embraced by the American Medical Association and the American College of Surgeons recommend that patients who are morbidly obese receive responsible, affordable medical treatment for their obesity; and

(5) The diagnosis of morbid obesity should be a clinical decision made by a physician based on the guidelines set by the appropriate health and medical associations and organizations. The treatment modality should also be a clinical decision made by the physician based on set guidelines.

(c)(1) As used in this Code section, the term:

(A) "'Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state which provides major medical benefits, including those contracts executed by the state on behalf

of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, or other insurer or similar entity.

(B) "Health care providers" means those physicians and medical institutions that are specifically qualified to treat in a comprehensive manner the entire complex of illness and disease associated with morbid obesity.

(C) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, or any similar entity authorized to issue contracts under this title and also means any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396, et seq., and any other publicly funded state health care program.

(D) "Morbid obesity" means a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables. Morbid obesity also means a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

(2) Every health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner which provides major medical benefits may offer coverage for the treatment of morbid obesity.

(d) The Commissioner of Insurance shall adopt rules and regulations necessary to implement the provisions of this Code section in collaboration with the Department of Public Health and in compliance with current guidelines established by professional medical organizations relating to the treatment of morbid obesity.

History. — Code 1981, § 33-24-59.7, enacted by Ga. L. 1999, p. 368, § 1; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2011, p. 705, § 6-1/HB 214; Ga. L. 2019, p. 386, § 69/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "the state" for "the State of Georgia" in the middle of subparagraph (c)(1)(A); deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in subparagraphs (c)(1)(A) and (c)(1)(C); and deleted "on or after July 1, 1999," following "Commissioner" in paragraph (c)(2).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in subparagraph (c)(1)(C).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, this Code section, originally designated as Code Section 33-24-59.4, was redesignated as Code Section 33-24-59.7.

Editor's notes. — Ga. L. 1999, p. 368, § 2, not codified by the General Assembly, provides that: "All contracts relating to the provision of health care services in effect on July 1, 1999, shall be appropriately adjusted to reflect any change in services provided as required by Section 1 of this Act."

Law reviews. — For article on the 2011 amendment of this Code section, see 28 Ga. St. U.L. Rev. 147 (2011).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Discrimination Against the Obese, 36 POF2d 249.

33-24-59.8. Coverage for prescription inhalers; no restriction on the number of days before obtaining a refill as prescribed.

No individual major medical or group health insurance policy, group health insurance plan or policy, or any other form of managed or capitated health care plans or policies issued, delivered, issued for delivery, or renewed containing coverage for prescription drugs and pharmaceuticals shall deny or limit coverage for prescription inhalants required to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments based upon any restriction on the number of days before an inhaler refill may be obtained if, contrary to such restrictions, such inhalants have been ordered or prescribed by the treating physician.

History. — Code 1981, § 33-24-59.8, enacted by Ga. L. 1999, p. 559, § 1; Ga. L. 2019, p. 386, § 70/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1999," following "or renewed" in the middle of this Code section.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, this Code section, originally designated as Code Section 33-24-59.4, was redesignated as Code Section 33-24-59.8.

33-24-59.9. Registered nurse first assistants.

(a) This Code section shall be known and may be cited as the "Registered Nurse First Assistant Consumer Act."

(b) It is the intent of the General Assembly to:

(1) Encourage the continued use of registered nurse first assistants who meet the qualifications of this Code section as "assistants at surgery" by physicians and surgical facilities to provide quality, cost-effective surgical intervention to health care recipients in the state; and

(2) Establish policies within managed health care agencies, workers' compensation carriers, and all private insurance companies to

provide for adequate and justifiable reimbursement for the registered nurse first assistant for services rendered.

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

(1) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including, but not limited to, those policies, plans, or contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, workers' compensation insurance carrier in accordance with Chapter 9 of Title 34, or other insurer or similar entity.

(2) "Insurer" means an accident and sickness insurer, fraternal benefit society, workers' compensation insurance carrier, health care corporation, health maintenance organization, managed care plan other than a dental plan, or any similar entity authorized to issue contracts under this title, but shall exclude any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396, et seq., and any other publicly funded state health care program.

(3) "Perioperative nursing" means a practice of registered professional nursing in which the registered nurse provides preoperative, intraoperative, and postoperative nursing care to surgical patients.

(4) "Recognized educational curriculum program" means a program that:

(A) Addresses all content of the Association of periOperative Registered Nurses, Inc., Core Curriculum for the Registered Nurse First Assistant and the Certification Board of Perioperative Nurses; and

(B) Includes indicated didactic and clinical internship as required by the curriculum.

(5) "Registered nurse first assistant" means a person who:

(A)(i) Is licensed as a registered professional nurse in this state;

(ii) Is certified in perioperative nursing; and

(iii) Has successfully completed a registered nurse first assistant education program that meets the Association of periOperative Registered Nurses, Inc.'s education standard for the registered nurse first assistant; or

(B) Was holding the title of and practicing as a registered nurse first assistant as of January 1, 1993.

(d) Notwithstanding any provisions in policies or contracts which might be construed to the contrary, whenever any health benefit policy which is issued, executed, or renewed in this state provides that any of its benefits are payable to a surgical first assistant for services rendered, the insurer shall be required to directly reimburse any registered nurse first assistant who has rendered such services at the request of a physician and within the scope of a registered nurse first assistant's professional license. This Code section shall not apply to a registered nurse first assistant who is employed by the requesting physician or renders such services in the capacity as an employee of the hospital where services are rendered.

History. — Code 1981, § 33-24-59.9, enacted by Ga. L. 2001, p. 28, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2019, p. 386, § 71/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, in paragraph (c)(1), substituted "the state" for "the State of Georgia" in the middle, and deleted "hospital service corporation, medical service corporation," following "fraternal benefit society" near the end; in paragraph (c)(2), deleted "hospital service corporation," following "fraternal benefit society," and deleted "medical service corporation," following "insurance carrier" near the middle; substituted "this state" for "the State of Georgia" in division (5)(A)(i); and deleted "on or after July 1, 2001," following "renewed in this state" in the middle of the first sentence of subsection (d).

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

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, Code Section 33-24-59.9, as enacted by Ga. L. 2001, p. 852, § 1, was redesignated as Code Section 33-24-59.10.

Law reviews. — For note on the 2001 enactment of this Code section, see 18 Ga. St. U.L. Rev. 172 (2001).

33-24-59.10. Coverage for autism.

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

(1) "Accident and sickness contract, policy, or benefit plan" shall have the same meaning as found in Code Section 33-24-59.1. Accident and sickness contract, policy, or benefit plan shall also include without limitation any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45. Accident and sickness contract, policy, or benefit plan 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.

(2) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improve-

ment in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(3) "Autism spectrum disorder" means autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(4) "Treatment of autism spectrum disorder" includes the following types of care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder:

(A) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis shall be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(B) Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker; and

(C) Therapy services provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.

(b) Accident and sickness contracts, policies, or benefit plans shall provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is 20 years of age or under in accordance with the following:

(1) The policy or contract shall provide coverage for any assessments, evaluations, or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder;

(2) The policy or contract shall provide coverage for applied behavior analysis for the treatment of autism spectrum disorders when it is determined by the covering entity that the treatment is medically necessary health care according to established criteria. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage provided under this Code section at least annually;

(3) The policy or contract shall not include any limits on the number of visits;

(4) The policy or contract may limit coverage for applied behavior analysis to $35,000.00 per year. An insurer shall not apply payments

for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph; and

(5) This subsection shall not be construed to require coverage for prescription drugs if prescription drug coverage is not provided by the policy or contract.

(c) Except as otherwise provided in this Code section, any policy or contract that provides coverage for services under this Code section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements of this Code section.

(d) This Code section shall not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized family service plan, an individualized education plan as required by the federal Individuals with Disabilities Education Act, or an individualized service plan. This Code section also shall not be construed to limit benefits that are otherwise available to an individual under an accident and sickness contract, policy, or benefit plan.

(e)(1) An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to this Code section, is exempt from providing coverage for behavioral health treatment required under this Code section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to this Code section as of December 31, 2016, if:

(A) An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a member of the American Academy of Actuaries and meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making, certifies in writing to the Commissioner that:

(i) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this Code section, and not covered as of December 31, 2016, exceeded 1 percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(ii) Those costs solely would lead to an increase in average premiums charged of more than 1 percent for all insurance

policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, or health maintenance organization, or such governmental entity, employs; and

(B) The Commissioner approves the certification of the actuary.

(2) An exemption allowed under paragraph (1) of this subsection shall apply for a one-year coverage period following inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization, or such governmental entity, shall again provide coverage for behavioral health treatment required under this subsection.

(3) An insurer, corporation, or health maintenance organization, or such governmental entity, may claim an exemption for a subsequent year, but only if the conditions specified in this subsection again are met.

(4) Notwithstanding the exemption allowed under paragraph (1) of this subsection, an insurer, corporation, or health maintenance organization, or such governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this subsection.

(f) Beginning January 1, 2016, to the extent that this Code section requires benefits that exceed the essential health benefits required under Section 1302(b) of the federal Patient Protection and Affordable Care Act, P.L. 111-148, the specific benefits that exceed the required essential health benefits shall not be required of a "qualified health plan" as defined in such Act when the qualified health plan is offered in this state through the exchange. Nothing in this subsection shall nullify the application of this Code section to plans offered outside the state's exchange.

(g) This Code section shall not apply to any accident and sickness contract, policy, or benefit plan offered by any employer with ten or fewer employees.

(h) Nothing in this Code section shall be construed to limit any coverage under any accident and sickness contract policy or benefit plan, including, but not limited to, speech therapy, occupational therapy, or physical therapy otherwise available under such plan.

(i) By June 15, 2019, and every June 15 thereafter, the department shall submit a report to the General Assembly regarding the implemen-

tation of the coverage required under this Code section. The report shall include, but shall not be limited to, the following:

(1) The total number of insureds diagnosed with autism spectrum disorder;

(2) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this Code section;

(3) The cost of such coverage per insured per month; and

(4) The average cost per insured for coverage of applied behavior analysis.

All health carriers and health benefit plans subject to the provisions of this Code section shall provide the department with all data requested by the department for inclusion in the annual report.

History. — Code 1981, § 33-24-59.10, enacted by Ga. L. 2001, p. 852, § 1; Ga. L. 2015, p. 111, §§ 2A, 2B/HB 429; Ga. L. 2018, p. 950, § 1/SB 118; Ga. L. 2019, p. 386, § 72/SB 133; Ga. L. 2019, p. 1029, § 1/HB 310.

The 2018 amendment, effective January 1, 2019, substituted "20 years of age" for "six years of age" in the introductory paragraph of subsection (b); in paragraph (b)(2), in the first sentence, inserted "for applied behavior analysis" near the beginning, substituted "the covering entity" for "a licensed physician or licensed psychologist" in the middle, and added "according to established criteria" at the end; substituted "$35,000.00" for "$30,000.00" in the first sentence of paragraph (b)(4); and deleted the former second sentence in paragraph (b)(5), which read: "Coverage for prescription drugs for the treatment of autism spectrum disorders shall be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition is determined under the policy or contract."

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, in subsection (f), substituted "P.L. 111-148" for "P. L. 111-148" and "such Act" for "such act" in the first sentence. The second 2019 amendment, effective May 9, 2019, substituted "June 15, 2019, and every June 15" for "January 15, 2017, and every January 15" near the beginning of subsection (i).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2001, Code Section 33-24-59.9, as enacted by Ga. L. 2001, p. 852, § 1, was redesignated as Code Section 33-24-59.10.

Editor's notes. — Ga. L. 2015, p. 111, § 3/HB 429, not codified by the General Assembly, provided that the amendment of this Code section is effective upon ratification at the November, 2016, general election of an amendment allowing the General Assembly to appropriate funds derived from an additional .2 percent increase in the general state sales and use tax for the treatment of autism spectrum disorder. No such constitutional amendment was included on the ballot in the general election held on November 8, 2016.

Law reviews. — For article on the 2015 amendment of this Code section, see 32 Ga. St. U. L. Rev. 193 (2015).

33-24-59.11. Insurance coverage for prescription drugs used in manner different than use authorized by FDA.

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

(1) "Chronic and seriously debilitating" means diseases or conditions that cause significant long-term morbidity and that require ongoing treatment to maintain remission or prevent deterioration.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer; provided, however, that "health benefit policy" shall not include the limited benefit policies as defined in paragraph (4) of subsection (e) of Code Section 33-30-12.

(3) "Insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(4) "Life-threatening" means:

(A) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;

(B) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival; or

(C) The natural process of aging shall not be construed as a disease or condition for the purposes of this definition or this Code section.

(b) No health benefit policy issued, delivered, or renewed in this state that, as a provision of hospital, medical, or surgical services, directly or indirectly covers prescription drugs shall limit or exclude coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration, provided that all of the following conditions have been met and subject to the prior authorization process or other restrictions of the insurer:

(1) The drug has been approved by the federal Food and Drug Administration;

(2)(A) The drug is prescribed by a contracting licensed health care professional for the treatment of a life-threatening disease or condition;

(B) The drug is prescribed by a contracting licensed health care professional for the treatment of a chronic and seriously debilitating disease or condition, the drug is medically necessary to treat that disease or condition, and the drug is on the insurer's formulary or preferred drug list, if any; or

(C) The drug is prescribed by a contracting licensed health care professional to treat a disease or condition in a child where the

drug has been approved by the federal Food and Drug Administration for similar conditions or diseases in adults and the drug is medically necessary to treat that disease or condition; and

(3) The drug has been recognized for treatment of that disease or condition or pediatric application by one of the following:

(A) The American Medical Association Drug Evaluations;

(B) The American Hospital Formulary Service Drug Information; or

(C) The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"; or

(D) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

(c) It shall be the responsibility of the contracting prescriber to submit to the insurer documentation supporting compliance with the requirements of subsection (b) of this Code section, if requested by the insurer.

(d) Any coverage required by this Code section shall also include medically necessary services associated with the administration of a drug subject to the conditions of the contract.

(e) The provisions of this Code section shall not be deemed to require coverage for any of the following:

(1) The treatment of a condition or disease that is excluded under the terms of the health benefit policy;

(2) An experimental drug not approved for indication by the federal Food and Drug Administration; or

(3) Drug treatment by a drug not listed on the health benefit plan formulary or preferred drug list.

(f) The benefits provided in this Code section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given health benefit policy.

History. — Code 1981, § 33-24-59.11, enacted by Ga. L. 2003, p. 872, § 2; Ga. L. 2019, p. 386, § 73/SB 133.

The 2019 amendment, effective July 1, 2019, in paragraph (a)(2), in the middle, deleted "on or after July 1, 2003" following "renewed in this state", and substituted "the state" for "the State of Georgia".

Cross references. — Standards, labeling, and adulteration of drugs and cosmetics, § 26-3-21 et seq.

Law reviews. — For article, "Free

Speech and Off-Label Rights," see 54 Ga. L. Rev. 463 (2020).

33-24-59.12. Patient access to eye care.

(a) This Code section shall be known and may be cited as the "Patient Access to Eye Care Act."

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

(1) "Covered person" means an individual enrolled in a health benefit plan or an eligible dependent thereof.

(2) "Covered services" means those health care services which a health care insurer is obligated to pay for or provide to a covered person under a health benefit plan.

(3) "Eye care" means those health care services and materials related to the care of the eye and related structures and vision care services which a health care insurer is obligated to pay for or provide to covered persons under the health benefit plan.

(4) "Health benefit plan" means any public or private health plan, program, policy, or agreement implemented in this state which provides health benefits to covered persons, including but not limited to payment and reimbursement for health care services.

(5) "Health care insurer" means an entity, including but not limited to insurance companies, health care corporations, health maintenance organizations, and preferred provider organizations, authorized by the state to offer or provide health benefit plans, programs, policies, subscriber contracts, or any other agreements of a similar nature which compensate or indemnify health care providers for furnishing health care services.

(c) A health care insurer providing a health benefit plan which includes eye care benefits shall:

(1) Not set professional fees or reimbursement for the same eye care services as defined by established current procedural terminology codes in a manner that discriminates against an individual eye care provider or a class of eye care providers;

(2) Not preclude a covered person who seeks eye care from obtaining such service directly from a provider on the health benefit plan provider panel who is licensed to provide eye care;

(3) Not promote or recommend any class of providers to the detriment of any other class of providers for the same eye care service;

(4) Ensure that all eye care providers on a health benefit plan provider panel are included on any publicly accessible list of participating providers for the plan;

(5) Allow each eye care provider on a health benefit plan provider panel, without discrimination between classes of eye care providers, to furnish covered eye care services to covered persons to the extent permitted by such provider's licensure;

(6) Not require any eye care provider to hold hospital privileges or impose any other condition or restriction for initial admittance to a provider panel not necessary for the delivery of eye care upon such providers which would have the effect of excluding an individual eye care provider or class of eye care providers from participation on the health benefit plan; and

(7) Include optometrists and ophthalmologists on the health benefit plan provider panel in a manner that ensures plan enrollees timely access and geographic access.

(d) Nothing in this Code section shall preclude a covered person from receiving eye care or other covered services from the covered person's personal physician in accordance with the terms of the health benefit plan.

(e) A person adversely affected by a violation of this Code section by a health care insurer may bring an action in a court of competent jurisdiction for injunctive relief against such insurer and, upon prevailing, in addition to any injunctive relief that may be granted, shall recover from such insurer damages of not more than $100.00 and attorney's fees and costs.

(f) Nothing in this Code section requires a health benefit plan to include eye care benefits.

(g) The Commissioner is authorized to enforce this Code section and, in doing so, to exercise the powers granted to the Commissioner by Code Section 33-2-24 and any other provisions of this title.

History. — Code 1981, § 33-24-59.12, enacted by Ga. L. 2005, p. 692, § 2/SB 81; Ga. L. 2017, p. 164, § 34/HB 127.

Law reviews. — For annual survey on insurance law, see 66 Mercer L. Rev. 93 (2014).

JUDICIAL DECISIONS

Independent participating provider agreement violated section. — Georgia Court of Appeals correctly interpreted the Patient Access to Eye Care Act, O.C.G.A. § 33-24-59.12(c)(2), and determined that an insurer's independent participating provider (IPP) agreements violated that section as the IPP prohibited providers from providing certain eye care, in particular the preparation of eyeglasses, directly to the insureds, therefore, the IPP agreement violated paragraph

(c)(2). Spectera, Inc. v. Wilson, 294 Ga. 23, 749 S.E.2d 704 (2013).

Georgia Court of Appeals was incorrect in finding that an insurer's independent participating provider (IPP) agreement violated the Patient Access to Eye Care Act, O.C.G.A. § 33-24-59.12(c)(5), because the IPP agreement did not in any way create the type of impermissible discrimination between classes of licensed eye care providers contemplated by paragraph (c)(5). Spectera, Inc. v. Wilson, 294 Ga. 23, 749 S.E.2d 704 (2013).

33-24-59.13. Exemptions from certain unfair trade practices for certain wellness and health improvement programs; incentives.

(a) An insurer issuing life, comprehensive, major medical group, or individual health insurance benefit plans may, in keeping with federal requirements, offer wellness or health improvement programs, including voluntary wellness or health improvement programs that provide for rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts, credits or rebates, contributions towards a member's health savings account, modifications to copayment, deductible, or coinsurance amounts, cash value, or any combination of these incentives, to encourage participation in such wellness or health improvement programs and to reward insureds for participation in such programs.

(b) The offering of such rewards or incentives to insureds under such wellness or health improvement programs shall not be considered an unfair trade practice under Code Section 33-6-4 if such programs are filed with the Commissioner and made a part of the life or health insurance master policy and certificates or the individual life or health insurance evidence of coverage as a policy amendment, endorsement, rider, or other form of policy material as agreed upon by the Commissioner. The Commissioner shall be authorized to develop an automatic or expedited approval process for review of such wellness or health improvement programs, including those programs already approved under the laws and regulations of other states.

History. — Code 1981, § 33-24-59.13, enacted by Ga. L. 2010, p. 755, § 2/SB 411; Ga. L. 2012, p. 1080, § 1/SB 337.

33-24-59.14. Definitions; prompt pay requirements; penalties.

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

(1) "Administrator" shall have the same meaning as provided in Code Section 33-23-100.

(2) "Benefits" shall have the same meaning as provided in Code Section 33-24-59.5.

(3) "Facility" shall have the same meaning as provided in Code Section 33-20A-3.

(4) "Health benefit plan" shall have the same meaning as provided in Code Section 33-24-59.5.

(5) "Health care provider" shall have the same meaning as provided in Code Section 33-20A-3.

(6) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, provider sponsored health care corporation, or any similar entity, which provides for the financing or delivery of health care services through a health benefit plan, the plan administrator of any health plan, or the plan administrator of any health benefit plan established pursuant to Article 1 of Chapter 18 of Title 45.

(b)(1) All benefits under a health benefit plan will be payable by the insurer or administrator which is obligated to finance or deliver health care services or process claims under that plan upon such insurer's or administrator's receipt of written or electronic proof of loss or claim for payment for health care goods or services provided. The insurer or administrator shall within 15 working days for electronic claims or 30 calendar days for paper claims after such receipt mail or send electronically to the facility or health care provider claiming payments under the plan payment for such benefits or a letter or notice which states the reasons the insurer or administrator may have for failing to pay the claim, either in whole or in part, and which also gives the facility or health care provider so notified a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. Where the insurer or administrator disputes a portion of the claim, any undisputed portion of the claim shall be paid by the insurer or administrator in accordance with this chapter. When all of the listed documents or other information needed to process the claim have been received by the insurer or administrator, the insurer or administrator shall then have 15 working days for electronic claims or 30 calendar days for paper claims within which to process and either mail payment for the claim or a letter or notice denying it, in whole or in part, giving the facility or health care provider claiming payments under the plan the insurer's or administrator's reasons for such denial.

(2) Receipt of any proof, claim, or documentation by an entity which administers or processes claims on behalf of an insurer shall be deemed receipt of the same by the insurer for purposes of this Code section.

(c) Each insurer or administrator shall pay to the facility or health care provider claiming payments under the health benefit plan interest

equal to 12 percent per annum on the proceeds or benefits due under the terms of such plan for failure to comply with subsection (b) of this Code section.

(d) An insurer or administrator may only be subject to an administrative penalty by the Commissioner as authorized by the insurance laws of this state when such insurer or administrator processes less than 95 percent of all claims in a standard financial quarter in compliance with paragraph (1) of subsection (b) of this Code section. Such penalty shall be assessed on data collected by the Commissioner.

(e) This Code section shall be applicable when an insurer is adjudicating claims for its fully insured business or its business as a third-party administrator.

(f) This Code section shall not apply to limited benefit insurance policies. For the purpose of this subsection, the term "limited benefit insurance" means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance and specifically shall include accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease insurance.

History. — Code 1981, § 33-24-59.14, enacted by Ga. L. 2011, p. 595, § 6/HB 167; Ga. L. 2017, p. 164, § 35/HB 127; Ga. L. 2019, p. 386, § 74/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "entity" preceding "provides for the financing" in the middle of paragraph (a)(6).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-24-59.14 as enacted by Ga. L. 2011, p. 609, § 2, was redesignated as Code Section 33-24-59.15.

Editor's notes. — Ga. L. 2011, p. 595, § 1/HB 167, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Insurance Delivery Enhancement Act of 2011.'"

JUDICIAL DECISIONS

Preemption. — Because self-funded plans would have different timeliness obligations in different states if amended state prompt-pay legislation went into effect, ERISA preempted the challenged provisions as relating to benefit plans, regardless of whether risk pooling was affected for saving clause purposes; ERISA's deemer clause applied. America's Health Ins. Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014).

33-24-59.15. Definitions; dental insurance.

(a) As used in this Code section:

(1) "Covered dental services" means dental care services for which a reimbursement is available under a covered person's dental benefit plan, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maxi-

mums, frequency limitations, alternative benefit payments, or any other limitation.

(2) "Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when that covered person receives dental care services rendered or authorized by a dentist licensed under Chapter 11 of Title 43.

(3) "Dental benefit plan" means any individual or group plan, policy, contract, or subscription agreement which includes or is for dental care services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes dental care services to patients, insureds, beneficiaries, or covered dependents in this state.

(4) "Dental insurer" means any person, firm, corporation, joint venture, or other similar business entity that offers dental benefit plans in consideration of periodic payments.

(b) No contract between a dental insurer and a dentist shall require a dentist to accept an amount set by the dental insurer as payment for dental care services that are not covered dental services under the covered person's dental benefit plan.

(c) A dental insurer or other person or entity providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

(d) A dental insurer shall not draft, publish, disseminate, or circulate explanation of benefit forms that include language which directly or indirectly implies that a dentist may or should extend discounts to patients for noncovered dental services. Statements by a dental insurer which are prohibited by this Code section include but are not limited to, "Our members value the services you provide and we encourage you to continue extending the discount on noncovered services."

History. — Code 1981, § 33-24-59.15, enacted by Ga. L. 2011, p. 609, § 2/HB 189; Ga. L. 2017, p. 164, § 36/HB 127.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2011, Code Section 33-24-59.14 as enacted by Ga. L. 2011, p. 609, § 2, was redesignated as Code Section 33-24-59.15.

Editor's notes. — Ga. L. 2011, p. 609, § 1/HB 189, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Noncovered Dental Services Act.'"

33-24-59.16. Equal access to child's health insurance information; exceptions.

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

(1) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the State of Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

(2) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(b) An insurer shall provide a parent of a child the right to inspect, review, or attain copies of health insurance records relating to his or her own child; provided, however, that if the parent making such request is not the named insured or owner of such policy, he or she shall provide the insurer a certified copy of his or her divorce decree, a parenting plan pursuant to Code Section 19-9-1, or other court document establishing that the parent may have access to such records.

(c) Health insurance records and information pertaining to the child shall not be withheld from the custodial parent or from the noncustodial parent unless a court order has specifically removed the right of the noncustodial parent to such information or unless parental rights have been terminated.

(d) In the absence of fraud or bad faith, the insurer shall not be subject to liability for furnishing information and records requested pursuant to subsection (b) of this Code section.

History. — Code 1981, § 33-24-59.16, enacted by Ga. L. 2013, p. 553, § 1/SB 1; Ga. L. 2019, p. 386, § 75/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in paragraph (a)(2).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2013, a misspelling of "health" was corrected near the beginning of subsection (b).

33-24-59.17. Coverage of certain abortions through certain qualified health plans prohibited; definitions.

(a) No abortion coverage shall be provided by a qualified health plan offered within the State of Georgia through a state law, a federal law, or regulation or exchange created by the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal

Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and regulations or guidance issued under those acts, except in the case of medical emergency.

(b) For the purposes of this Code section, the term "abortion" has the same meaning as provided in Code Section 31-9A-2.

(c) For the purposes of this Code section, the term "medical emergency" has the same meaning as provided in Code Section 31-9A-2.

(d) Nothing in this Code section shall be construed as creating or recognizing a right to an abortion.

(e) It is not the intention of this Code section to make lawful an abortion that is unlawful.

History. — Code 1981, § 33-24-59.17, enacted by Ga. L. 2014, p. 349, § 1/SB 98; Ga. L. 2019, p. 386, § 76/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "currently" preceding "unlawful" near the end of subsection (e).

Editor's notes. — Ga. L. 2014, p. 349, § 3/SB 98, not codified by the General Assembly, provides: "The General Assembly, by joint resolution, may appoint one or more of its members who sponsored or cosponsored this Act in his or her official capacity to intervene as a matter of right in any case in which the constitutionality of this Act or any portion thereof is challenged."

Law reviews. — For article on the 2014 enactment of this Code section, see 31 Ga. St. U. L. Rev. 177 (2014).

33-24-59.18. Coverage for treatment of a terminal condition.

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

(1) "Health benefit plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization, subscriber contract or agreement, preferred provider organization, accident and sickness insurance benefit plan, or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45 and under Chapter 4 of Title 49, the "Georgia Medical Assistance Act of 1977."

(2) "Terminal condition" means any disease, illness, or health condition that a physician has diagnosed as expected to result in death in 24 months or less.

(3) "Treatment" does not include any medication or medical procedure, regardless of where actually prescribed, dispensed, or administered, which if prescribed, dispensed, or administered in this state would constitute assisted suicide in violation of Code Section 16-5-5.

(b) No health benefit plan shall restrict coverage for treatment of a terminal condition when such treatment has been prescribed by a

physician as medically appropriate and such treatment has been agreed to by an insured patient or by a person to whom the insured patient has legally delegated such authority or to whom otherwise has the legal authority to consent on behalf of the insured patient. The health benefit plan shall not refuse to pay or otherwise reimburse for the treatment diagnosed under this subsection, including any drug or device, so long as such end of life care is consistent with best practices for the treatment of the terminal condition and such treatment is supported by peer reviewed medical literature.

(c) A denial or a refusal to pay for treatment prescribed under subsection (b) of this Code section shall be a violation of this Code section.

(d) A violation of this Code section shall be a per se violation of Chapter 6 of this title, and the penalties, procedures, and remedies applicable to violations of Chapter 6 of this title shall be applicable to a violation of this Code section.

History. — Code 1981, § 33-24-59.18, enacted by Ga. L. 2015, p. 111, § 1/HB 429.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2015, Code Section 33-24-59.18, as enacted by Ga. L. 2015, p. 1317, § 1/HB 409, was redesignated as Code Section 33-24-59.19.

Law reviews. — For article on the 2015 enactment of this Code section, see 32 Ga. St. U. L. Rev. 193 (2015).

33-24-59.19. Coverage for treatment of burns with skin substitutes utilizing cryopreserved cadaver derived skin tissue.

No health benefit policy issued, delivered, or renewed in this state that, as a provision of hospital, medical, or surgical services, directly or indirectly covers the treatment and management of burns shall limit or exclude coverage for such treatment on the basis that the use of cryopreserved cadaver derived skin tissue is an experimental or investigational medical treatment.

History. — Code 1981, § 33-24-59.19, enacted by Ga. L. 2015, p. 1317, § 1/HB 409.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2015, Code Section 33-24-59.18, as enacted by Ga. L. 2015, p. 1317, § 1/HB 409, was redesignated as Code Section 33-24-59.19.

Law reviews. — For article, "Reforming Regenerative Medicine Regulation," see 34 Ga. St. U. L. Rev. 631 (2018).

33-24-59.20. Access to stage four advanced, metastatic cancer treatments in health benefit plans.

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

(1) "Health benefit plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization, subscriber contract or agreement, preferred provider organization, accident and sickness insurance benefit plan, or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45 and under Article 7 of Chapter 4 of Title 49, the "Georgia Medical Assistance Act of 1977."

(2) "Stage four advanced, metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

(b) No health benefit plan issued, delivered, or renewed in this state that, as a provision of hospital, medical, or surgical services, directly or indirectly covers the treatment of stage four advanced, metastatic cancer shall limit or exclude coverage for a drug approved by the United States Food and Drug Administration by mandating that the insured shall first be required to fail to successfully respond to a different drug or drugs or prove a history of failure of such drug or drugs; provided, however, that the use of such drug or drugs is consistent with best practices for the treatment of stage four advanced, metastatic cancer and is supported by peer reviewed medical literature.

History. — Code 1981, § 33-24-59.20, enacted by Ga. L. 2016, p. 580, § 3/HB 965.

Editor's notes. — Ga. L. 2016, p. 580, § 1/HB 965, not codified by the General Assembly, provides: "This Act shall be known and may be cited as 'The Honorable Jimmy Carter Cancer Treatment Access Act.'"

Ga. L. 2016, p. 580, § 2/HB 965, not codified by the General Assembly, provides: "WHEREAS, the Honorable Jimmy Carter of Plains, Georgia, announced in August that he had an aggressive form of melanoma skin cancer; and

"WHEREAS, in that announcement, President Carter detailed that tumors had spread from his skin into his liver and brain. President Carter received surgery, radiation, and multiple doses of another drug; and

"WHEREAS, on December 6, President Carter revealed that his physicians said that all signs of cancer were gone; and

"WHEREAS, it is the intent of the General Assembly that every Georgian with health insurance that covers cancer should have the same access to cancer drugs as President Carter."

RESEARCH REFERENCES

Am. Jur. 2d. — 61 Am. Jur. 2d, Physicians, Surgeons, and Other Healers, § 244.

33-24-59.21. Health plans to provide coverage for hearing aids for certain individuals; frequency of replacement; coverage of services and supplies; options for higher priced devices.

(a) This Code section shall be known and may be cited as the "Hearing Aid Coverage for Children Act."

(b) The General Assembly finds and declares that:

(1) The language development of children with partial or total hearing loss may be impaired due to the hearing loss. Children learn the concept of spoken language through auditory stimuli, and the language skills of children who have hearing loss improve when they are provided with hearing aids and access to visual language upon the discovery of hearing loss; and

(2) Providing hearing aids to children with hearing loss will reduce the costs borne by this state, including special education, alternative treatments that would otherwise be necessary if a hearing aid were not provided, and other costs associated with such hearing loss.

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

(1) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state which provides major medical benefits, including those contracts executed by the State of Georgia on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, or any similar entity and any self-insured health care plan not subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.

(2) "Hearing aid" means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. The term "hearing aid" includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, nonimplanted bone anchored hearing aids, nonimplanted bone conduction hearing aids, and frequency modulation systems. Personal sound amplification products shall not qualify as hearing aids.

(d) Every health benefit policy that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner on or after January 1, 2018, shall provide

coverage for the billed charges of one hearing aid per hearing impaired ear not to exceed $3,000.00 per hearing aid for covered individuals 18 years of age or under. Such coverage shall provide the replacement for one hearing aid per hearing impaired ear every 48 months for covered individuals. The parent or guardian of such individual is responsible for billed charges in excess of such benefits. This subsection shall not prohibit an entity subject to this Code section from providing coverage that is greater or more favorable to an insured or enrolled individual than the coverage required under this Code section.

(e) In the event that a hearing aid or aids cannot adequately meet the needs of the covered individual and the hearing aid or aids cannot be adequately repaired or adjusted, the hearing aid or aids shall be replaced. Coverage for the replacement shall be offered within two months from the date it is determined that the hearing aid or aids cannot be repaired or adjusted.

(f) The coverage provided by this Code section shall include the following:

(1) Medically necessary services and supplies, including the initial hearing aid evaluation, fitting, dispensing, programming, servicing, repairs, follow-up maintenance, adjustments, ear molds, ear mold impressions, auditory training, and probe microphone measurements to ensure appropriate gain and output, as well as verifying benefit from the system selected according to accepted professional standards. Such services shall be covered on a continuous basis, as needed, during each 48 month coverage period not to exceed $3,000.00 per hearing impaired ear or for the duration of the hearing aid warranty, whichever time period is longer;

(2) An option for the covered individual to choose a higher priced hearing aid or aids and to pay the difference between the price of the hearing aid or aids and the benefit amount as referenced in subsection (d) of this Code section, without financial or contractual penalty to the insured or to the provider of the hearing aid; and

(3) An option for the covered individual to purchase his or her hearing aid or aids through any licensed audiologist or licensed hearing aid dealer or dispenser in this state.

(g) A health benefit policy shall not deny or refuse coverage of, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage of a covered individual solely because he or she is or has been previously diagnosed with hearing loss.

(h) The benefits covered under this Code section shall be subject to the same annual deductible, coinsurance or copayment, or utilization review applicable to other similar covered benefits under the health benefit policy.

(i) An insurer, corporation, health maintenance organization, or governmental entity providing coverage for a hearing aid or aids pursuant to this Code section is exempt from providing coverage for children's hearing aids required under this Code section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to this Code section as of January 1, 2019, if:

(1) An actuary affiliated with the insurer, corporation, health maintenance organization, or governmental entity who is a member of the American Academy of Actuaries and who meets the American Academy of Actuaries' professional qualification standards for rendering an actuarial opinion related to health insurance rate making certifies in writing to the Commissioner that:

(A) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, health maintenance organization, or governmental entity for the most recent experience period of at least one year's duration, the costs associated with coverage of children's hearing aids required under this Code section, and not covered as of January 1, 2019, exceeded 1 percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

(B) Such costs solely would lead to an insurance in average premiums charged of more than 1 percent for all insurance policies, subscription contracts, or health care plans commencing on inception or the next renewal date, based on the premium rating methodology and practices the insurer, corporation, health maintenance organization, or governmental entity employs; and

(2) The Commissioner approves the certification of the actuary.

(j) Beginning January 1, 2018, to the extent that this Code section requires benefits that exceed the essential health benefits required under Section 1302(b) of the federal Patient Protection and Affordable Care Act, P. L. 111-148, the specific benefits that exceed the required essential health benefits shall not be required of a qualified health plan as defined in such act when the qualified health plan is offered in this state through the exchange. Nothing in this subsection shall nullify the application of this Code section to plans offered outside the state's exchange.

(k) This Code section shall not apply to any accident and sickness contract, policy, or benefit plan offered by any employer with ten or fewer employees.

History. — Code 1981, § 33-24-59.21, enacted by Ga. L. 2017, p. 361, § 1/SB 206.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2017, Code Section 33-24-59.21, as enacted by Ga. L. 2017, p. 769, § 1/SB 200, was redesignated as Code Section 33-24-59.22.

RESEARCH REFERENCES

Am. Jur. 2d. — 70C Am. Jur. 2d, Social Security and Medicare, § 2392.

33-24-59.22. Prescription drug program defined; cost sharing; denial of coverage; dispensing fees.

(a) As used in this Code section, the term "prescription drug program" means any individual or group plan, policy, or contract for prescription drug services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state on or after July 1, 2017.

(b) A prescription drug program providing prescription drug coverage in this state shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a pharmacy for less than a 30 day supply if the prescriber or pharmacist indicates the fill or refill could be in the best interest of the insured patient or is for the purpose of synchronizing the insured patient's medications.

(c) No prescription drug program providing prescription drug coverage shall deny coverage for the dispensing of any drug prescribed for the treatment of an illness that is made in accordance with a plan among the insured, a practitioner, and a pharmacist to synchronize the refilling of multiple prescriptions for the insured.

(d) No prescription drug program providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees determined by calculation of the days' supply of medication dispensed. Dispensing fees shall be determined exclusively on the total number of prescriptions dispensed.

History. — Code 1981, § 33-24-59.22, enacted by Ga. L. 2017, p. 769, § 1/SB 200; 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 "30 day supply" for "30 days' supply" in the middle of subsection (b).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2017, Code Section 33-24-59.21, as enacted by Ga. L. 2017, p. 769, § 1/SB 200, was redesignated as Code Section 33-24-59.22.

33-24-59.23. (For effective date, see note.) Carrier issuing health benefit plans to pay insurance agent's commissions; regulation.

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

(1) "Agent" shall have the same meaning as in Code Section 33-23-1.

(2) "Carrier" means any entity licensed to provide health insurance in this state and which is subject to state insurance regulation.

(3) "Health benefit plan" means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, or health maintenance organization subscriber contract. Health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; policies issued in accordance with Code Section 34-9-14 or 34-9-122.1; limited accident and sickness insurance policies such as credit, dental, vision, medicare supplement, long-term care, hospital indemnity, or specified disease insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

(4) "Premium" means the consideration paid in exchange for coverage under a health benefit plan.

(b) (For effective date, see note.) Any carrier that issues a health benefit plan in this state through an agent shall pay a commission to such agent. Such carrier shall file with the department its proposed commission rates relevant to all such agents. The commission paid to such agents shall be consistent with the amount proposed in the rates filed with the department, as required by the Commissioner. Such commission shall be structured to compensate the agent for the first term and for each renewal term thereafter, so long as such agent reviews coverage and provides ongoing customer service for such plan; provided, however, that no such first term compensation to such agent shall be required for any individual health benefit plan sold during a special enrollment period. Notwithstanding the above, any carrier that does not provide such first term commission during a special enrollment period shall, upon policy renewal, provide the agent with the renewal commission and any first term commission that was not paid because such policy was sold during a special enrollment period. Nothing in this Code section is intended or shall be construed to require a carrier to pay a commission to an agent who is employed by such carrier.

(c) The Commissioner shall adopt such rules and regulations he or she deems necessary for the administration of this Code section.

History. — Code 1981, § 33-24-59.23, enacted by Ga. L. 2018, p. 1074, § 2/HB 64; Ga. L. 2019, p. 386, § 77/SB 133; Ga. L. 2020, p. 660, § 1/HB 716.

Delayed effective date. — Subsection (b), as set out above, becomes effective January 1, 2021. For version of subsection (b) in effect until January 1, 2021, see the 2020 amendment note.

Effective date. — This Code section became effective July 1, 2018. See Editor's notes for applicability.

The 2019 amendment, effective July 1, 2019, substituted the present provi-

sions of paragraph (a)(3) for the former provisions, which read: "'Health benefit plan' shall have the same meaning as in Code Section 33-30A-1."

The 2020 amendment, effective January 1, 2021, in subsection (b), substituted ". Such carrier shall file with the department its proposed commission rates relevant to all such agents. The commission paid to such agents shall be" for the first comma, substituted "first term compensation to such agent" for "compensation" in the present fourth sentence, and added the next-to-last sentence.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2018, Code Section 33-24-59.23, as enacted by Ga. L. 2018, p. 1078, § 1/HB 818, was redesignated as Code Section 33-24-59.24.

Editor's notes. — Ga. L. 2018, p. 1074, § 1/HB 64, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Protection and Guarantee of Service for Health Insurance Consumers Act.'"

Ga. L. 2018, p. 1074, § 3/HB 64, not codified by the General Assembly, makes this Code section applicable to policies issued or renewed on or after January 1, 2019.

33-24-59.24. Restrictions on payment methods prohibited; waiver of provisions prohibited; enforcement.

(a) 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 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) "Credit card payment" means a type of electronic funds transfer in which a health insurance plan or health insurer or its contracted vendor issues a single-use series of numbers associated with the payment of health care services performed by a health care provider and chargeable to a predetermined dollar amount, whereby the health care provider is responsible for processing the payment by a credit card terminal or Internet portal. Such term shall include virtual or online credit card payments, whereby no physical credit card is presented to the health care provider and the single-use credit card expires upon payment processing.

(3) "Electronic funds transfer" means an electronic funds transfer through the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, standard automated clearing-house network.

(4) "Health care provider" means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, registered optician, licensed professional counselor, physical therapist, chiropractor, hospital, or other entity or person that is licensed or otherwise authorized in this state to furnish health care services.

(5) "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 services and care, 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; 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.

(6) "Health insurance plan" means any hospital or medical insurance policy or certificate; health plan contract or certificate; qualified higher deductible health plan; health maintenance organization subscriber contract; any contract providing benefits for dental care whether such contract is pursuant to a medical insurance policy or certificate; stand-alone dental plan, health maintenance provider contract, managed health care plan, self-insured plan, or otherwise; or any health insurance plan established pursuant to Article 1 of Chapter 18 of Title 45.

(7) "Health insurer" means any entity or person engaged as an indemnitor, surety, or contractor that issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Health care plans under Chapter 20A of this title and health maintenance organizations are health insurers within the meaning of this chapter.

(b) Any health insurance plan issued, amended, or renewed on or after January 1, 2019, between a health insurer or its contracted vendor or a care management organization and a health care provider for the provision of health care services to a plan enrollee shall not contain restrictions on methods of payment from the health insurer or its vendor or the care management organization to the health care provider in which the only acceptable payment method is a credit card payment.

(c) If initiating or changing payments to a health care provider using electronic funds transfer payments, including virtual credit card payments, a health insurance plan, health insurer or its contracted vendor, or care management organization shall:

(1) Notify the health care provider if any fees are associated with a particular payment method; and

(2) Advise the provider of the available methods of payment and provide clear instructions to the health care provider as to how to select an alternative payment method.

(d) The provisions of this Code section shall not be waived by contract, and any contractual clause in conflict with the provisions of this Code section or that purport to waive any requirements of this Code section are void.

(e) Violations of this Code section shall be subject to enforcement by the Commissioner.

History. — Code 1981, § 33-24-59.24, enacted by Ga. L. 2018, p. 1078, § 1/HB 818.

Effective date. — This Code section became effective January 1, 2019.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2018, Code Section 33-24-59.23, as enacted by Ga. L. 2018, p. 1078, § 1/HB 818, was redesignated as Code Section 33-24-59.24.

33-24-59.25. Establishment by health benefit plans of step therapy protocols; exception process; time requirements; appeals; construction; application.

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

(1) "Health benefit plan" means any hospital, health, or medical expense insurance policy; hospital or medical service contract; employee welfare benefit plan; contract or agreement with a health maintenance organization; subscriber contract or agreement; contract or agreement with a preferred provider organization; accident and sickness insurance benefit plan; or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45, the "State Employees' Health Insurance Plan and Post-employment Health Benefit Fund."

(2) "Practitioner" means a physician, dentist, podiatrist, or optometrist and shall include any other person licensed under the laws of this state to use, mix, prepare, dispense, prescribe, and administer drugs in connection with medical treatment for individuals to the extent provided by the laws of this state.

(3) "Step therapy exception" means that a step therapy protocol should be overridden in favor of immediate coverage of the practitio-

ner's selected prescription drug, provided that the drug is covered under the health benefit plan.

(4) "Step therapy protocol" means an evidence based and updated protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient, including self-administered and physician-administered drugs, and are covered by an insurer or health benefit plan.

(b) A step therapy exception shall be granted by a health benefit plan if the prescribing provider's submitted justification and supporting clinical documentation, if needed, is completed and determined to support such provider's statement that:

(1) The required prescription drug is contraindicated or will cause an adverse reaction or physical or mental harm to the patient;

(2) The required prescription drug is expected to be ineffective based on the known clinical condition of the patient and the known characteristics of the prescription drug regimen;

(3) The patient has tried the required prescription drug or another prescription drug in the same pharmacological class or with the same mechanism of action as the required drug while on their current or immediately preceding health plan and such drug was discontinued due to lack of efficacy, diminished effect, or an adverse event; or

(4) The patient is currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current or immediately preceding health plan, the patient received coverage for the prescription drug and the practitioner gives documentation in accordance with this subsection that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to the patient based on the known characteristics of the patient and the known characteristics of the required prescription drug.

(c) Drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy required prescription drug.

(d) A health benefit plan shall grant or deny a step therapy exception or appeal of a step therapy exception within:

(1) Twenty-four hours in an urgent health care situation; and

(2) Two business days from the date such request or appeal is submitted in a nonurgent health care situation.

If the health benefit plan fails to respond in accordance with the established time frame, such step therapy exception or an appeal shall be deemed approved.

(e) Upon the granting of a step therapy exception, the health benefit plan shall immediately authorize coverage for the prescription drug prescribed by the patient's practitioner, provided that the drug is covered under the health benefit plan. Any step therapy exception denial shall be eligible for a physician's or a patient's appeal in accordance with the health benefit plan's existing appeal procedures.

(f) This Code section shall not be construed to prevent:

(1) A health benefit plan from requiring a patient to try an AB-rated generic equivalent prior to providing coverage for the equivalent-branded prescription drug;

(2) A health benefit plan from requiring a patient to try an interchangeable biological product prior to providing coverage for the biological product; or

(3) A practitioner from prescribing a prescription drug that is determined by such practitioner to be medically necessary.

(g) This Code section shall not be construed to impact a health benefit plan's ability to substitute a generic drug for a brand name drug.

(h) This Code section 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.

(i) This Code section shall apply only to health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2020.

History. — Code 1981, § 33-24-59.25, enacted by Ga. L. 2019, p. 192, § 1/HB 63.

Effective date. — This Code section became effective July 1, 2019.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, Code Section 33-24-59.25, as enacted by Ga. L. 2019, p. 386, § 64/SB 133, was redesignated as Code Section 33-24-59.26.

33-24-59.26. Limitation on definition of "preexisting condition".

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

(1) "Preventive services" means screening tests, counseling, and preventive medicines, or treatments provided or conducted to prevent medical illness or condition prior to symptoms or physical manifestations of such medical illness or condition.

(2) "Short-term health benefit policy or certificate" means any individual or group plan, policy, or contract for health care services for a coverage period of less than one year issued, delivered, issued for delivery, or renewed in this state which provides major medical benefits by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer,

fraternal benefit society, or any similar entity and any self-insured plan not subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1101, et seq.

(b) No short-term health benefit policy or certificate shall contain a provision defining "preexisting condition" which is more restrictive than the following:

(1) Preexisting condition means the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care, or treatment; or

(2) A condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person. The condition at issue must be the ultimate condition for which medical advice or treatment was recommended by or received from a provider of health care services and excludes any preventive services.

History. — Code 1981, § 33-24-59.26, enacted by Ga. L. 2019, p. 386, § 64/SB 133.

Effective date. — This Code section became effective July 1, 2019.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, Code Section 33-24-59.25, as enacted by Ga. L. 2019, p. 386, § 64/SB 133, was redesignated as Code Section 33-24-59.26.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 551 et seq.

33-24-59.27. (Effective July 1, 2021) Right to shop for insurance coverage; disclosure of pricing information; notice.

(a) This Code section shall be known and may be cited as the "Georgia Right to Shop Act."

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

(1) "Covered person" means an individual who is covered under a health benefit policy.

(2) "Emergency services" 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.

(3) "Health benefit policy" or "policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, those contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

(4) "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.

(5) "Health care service" means:

(A) Physical and occupational therapy services;

(B) Obstetrical and gynecological services;

(C) Radiology and imaging services;

(D) Laboratory services;

(E) Infusion therapy;

(F) Inpatient or outpatient surgical procedures;

(G) Outpatient nonsurgical diagnostic tests or procedures; and

(H) Any services designated by the Commissioner as shoppable by health care consumers.

(6) "Hierarchical Condition Category Methodology" means a coding system designed by the Centers for Medicare and Medicaid Services to estimate future health care costs for patients.

(7) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored heath care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(c) Each insurer shall make available on its publicly accessible website an interactive mechanism whereby any member of the public may:

(1) For each health benefit policy offered, compare the payment amounts accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(2) For each health benefit policy offered, obtain an estimate of the average amount accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(3) For each health benefit policy offered, obtain an estimate of the out-of-pocket costs that such covered person would owe his or her provider following the provision of a particular health care service;

(4) Compare quality metrics applicable to in-network providers for major diagnostic categories with adjustments by risk and severity based upon the Hierarchical Condition Category Methodology or a nationally recognized health care quality reporting standard designated by the Commissioner. Metrics shall be based on reasonably universal and uniform data bases with sufficient claim volume. If applicable to the provider, quality metrics shall include, but not be limited to:

(A) Risk adjusted and absolute hospital readmission rates;

(B) Risk adjusted and absolute hospitalization rates;

(C) Admission volume;

(D) Utilization volume;

(E) Risk adjusted rates of adverse events; and

(F) Risk adjusted and absolute relative total cost of care.

The Commissioner shall promulgate rules and regulations which define the following terms: risk adjusted hospital readmission rates, absolute hospital readmission rates, risk adjusted hospitalization rates, absolute hospitalization rates, admission volume, utilization volume, risk adjusted rates of adverse events, risk adjusted total cost of care, and absolute relative total cost of care. Such terms shall be defined in accordance with federal law or regulation or as otherwise determined necessary by the Commissioner; and

(5) Access any all-payer health claims data base which may be maintained by the department.

(d) An insurer shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforseen costs that arise during the provision of such service.

(e) Each estimate of out-of-pocket costs provided pursuant to paragraph (3) of subsection (c) of this Code section shall provide the following:

(1) The out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible; and

(2) The out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible.

(f) An insurer may contract with a third party to satisfy part or all of the requirements of this Code section.

(g) Nothing in this Code section shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided pursuant to paragraph (3) of subsection (c) of this Code section if such additional cost sharing resulted from the unforseen provision of additional health care services and the cost-sharing requirements of such unforseen health care services were disclosed in such covered person's policy or certificate of insurance.

(h) The requirements of this Code section, with the exception of paragraph (4) of subsection (c) of this Code section, shall not apply to any health maintenance organization health benefits plan as defined in paragraph (4) of Code Section 33-21-1.

History. — Code 1981, § 33-24-59.27, enacted by Ga. L. 2020, p. 666, § 1/SB 303.

Effective date. — This Code section becomes effective July 1, 2021.

33-24-59.28. Insurer obligations for early prescription refills during emergencies.

(a) As used in this Code section, the term "health care insurer" means an insurer, a fraternal benefit society, a health care plan, or a health maintenance organization authorized under this title to sell accident and sickness insurance policies, subscriber certificates, or other contracts of insurance by whatever name called.

(b) Every health care insurer licensed in this state that provides prescription medication coverage as part of a policy or contract shall waive time restrictions on prescription medication refills, which includes the suspension of electronic "refill too soon" limitations, to enable insureds or subscribers to refill prescriptions in advance and shall authorize payment to pharmacies for a 30 day supply of any prescription medication, regardless of the date upon which the prescription had most recently been filled by a pharmacist, when the following conditions occur:

(1) The person seeking the prescription medication refill resides in a county or other area of this state that:

(A) Is declared to be under a state of emergency by executive order of the Governor; or

(B) Is under a hurricane warning issued by the National Weather Service; and

(2) The prescription medication has refills remaining and a refill is requested within 30 days after the origination date of the conditions described in paragraph (1) of this subsection or until such conditions are terminated by the issuing authority or no longer exist.

(c) The Commissioner may by directive as authorized in Code Section 33-2-10 extend the time restriction waiver on prescription medication refills described in subsection (b) of this Code section for 15 or 30 day increments and until such time as he or she determines such extensions are no longer necessary.

(d) Nothing in this Code section shall exempt any insured or subscriber from compliance with all other terms of the policy or contract providing prescription medication coverage.

History. — Code 1981, § 33-24-59.28, enacted by Ga. L. 2020, p. 802, § 3/SB 391; Ga. L. 2020, p. 805, § 3/HB 791.

Effective date. — This Code section became effective August 5, 2020.

Cross references. — Dispensing of prescription drugs, § 26-4-80.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2020, Code Section 33-24-59.27 as enacted by Ga. L. 2020, p. 802, § 3/SB 391 and Ga. L. 2020, p. 805, § 3/HB 791 was redesignated as Code Section 33-24-59.28.

Editor's notes. — Ga. L. 2020, p. 802, § 1/SB 391 and Ga. L. 2020, p. 805, § 1/HB 791, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Early Prescription Refills During Emergencies Act.'"

Ga. L. 2020, p. 802, § 2/SB 391 and Ga. L. 2020, p. 805, § 2/HB 791, not codified by the General Assembly, provides that: The General Assembly finds that:

"(1) Prescription drug medications may be essential to the maintenance of life or the continuation of therapy for a Georgian with a chronic health condition;

"(2) During times of natural disaster, many Georgians experience significant delays obtaining necessary prescription medication refills; and

"(3) Delays in obtaining such medication may result in serious, undesirable health consequences."

33-24-59.29. (Effective January 1, 2021.) Copayments.

(a) As used in this Code section, the term "health benefit plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization, subscriber contract or agreement, preferred provider organization, accident and sickness insurance benefit plan, or other insurance contract under any other name. The term shall include any health insurance plan established under Article 1 of Chapter 18 of Title 45.

(b) In all health benefit plans issued, delivered, or renewed in this state, copayments shall be reasonable in relation to the covered benefits to which they apply, shall serve as an incentive rather than a barrier to access appropriate care, and shall not work so as to unfairly deny necessary healthcare services.

History. — Code 1981, § 33-24-59.29, enacted by Ga. L. 2020, p. 223, § 1/SB 28.

Effective date. — This Code section becomes effective January 1, 2021.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2020, Code Section 33-24-59.25 as enacted by Ga. L. 2020, p. 223, § 1/SB 28 was redesignated as Code Section 33-24-59.29.

ARTICLE 2

ASSESSMENT OF PROPOSED ACCIDENT AND SICKNESS INSURANCE COVERAGE

33-24-60. Short title.

This article shall be known and may be cited as the "Assessment of Proposed Accident and Sickness Insurance Coverage Act."

History. — Code 1981, § 33-24-60, enacted by Ga. L. 1989, p. 492, § 1.

33-24-61. Legislative findings and intent.

It is the intent of the General Assembly to encourage health care cost containment while preserving the quality of care offered to citizens of this state. The General Assembly finds that there is an increasing number of proposals which mandate that certain health insurance benefits be provided by insurers as components of individual and group accident and sickness insurance policies. The General Assembly further finds that many of these health insurance benefits provide beneficial social and health consequences which may be in the public interest. However, the General Assembly also recognizes that most mandated health insurance benefits contribute to the increasing cost of accident and sickness insurance premiums. Therefore, it is the intent of the General Assembly to conduct a systematic review of proposed mandated or mandatorily offered health insurance benefits and to establish guidelines for such a review. This review will assist the General Assembly in determining whether mandating a certain health insurance benefit is in the public interest.

History. — Code 1981, § 33-24-61, enacted by Ga. L. 1989, p. 492, § 1.

33-24-62. "Health insurance benefit bill" defined.

As used in this article, the term "health insurance benefit bill" means any legislative proposal which either mandates the inclusion of certain benefits, coverages, or reimbursements for covered health care services in accident and sickness insurance policies or provides for the manda-

tory offering of such benefits, coverages, or reimbursements in accident and sickness insurance policies.

History. — Code 1981, § 33-24-62, enacted by Ga. L. 1989, p. 492, § 1.

33-24-63. Review of health insurance benefit bill by General Assembly; Commissioner to issue report on bill.

(a) Every health insurance benefit bill, to be determined by the presiding officer of the House of Representatives or the Senate, shall be subject to review by the General Assembly prior to enactment as provided in this article. The Clerk of the House or the Secretary of the Senate shall deliver such bill or bills to the Commissioner of Insurance within five days after such legislation has been read for the first time.

(b) The Commissioner of Insurance shall issue a report on each health insurance benefit bill which assesses, if possible, the financial effects of the health insurance benefit proposed in such bill. The Commissioner, upon completion of said report, shall deliver a copy thereof to the Governor and to the presiding officer of both houses of the General Assembly.

History. — Code 1981, § 33-24-63, enacted by Ga. L. 1989, p. 492, § 1.

33-24-64. Contents of report by Commissioner on health insurance benefit bills.

The report required under Code Section 33-24-63 for assessing the impact of a health insurance benefit bill shall address the financial impact of such legislation by obtaining, at the minimum and to the extent that the information is available, the following:

(1) To what extent will the benefit increase or decrease the cost of the treatment or service;

(2) To what extent will the benefit increase the appropriate uses of the treatment or service;

(3) To what extent will the benefit be a substitute for a more expensive treatment or service;

(4) To what extent will the benefit increase or decrease the administrative expense of insurers or premium of the policyholders; and

(5) The impact of this coverage on the total cost of insurance premiums or health care to health insurance policyholders, including the impact of all indirect costs, which are costs other than premiums

and administrative costs, on the question of benefit costs and benefits of coverage.

History. — Code 1981, § 33-24-64, enacted by Ga. L. 1989, p. 492, § 1.

33-24-65. Public hearing.

The Commissioner of Insurance, upon receiving a certified copy from the Clerk of the House or the Secretary of the Senate of the bill or bills as provided in Code Section 33-24-63, may in his discretion convene a public hearing within ten calendar days after receipt in order to obtain any information necessary to allow the Commissioner a basis upon which to prepare the report required by this article. If the Commissioner convenes a public hearing, he shall give such notice as is reasonable under the circumstances and, in all other respects, shall conduct such hearing in accordance with Chapter 2 of this title.

History. — Code 1981, § 33-24-65, enacted by Ga. L. 1989, p. 492, § 1.

33-24-66. Evidence, testimony, and information necessary to prepare report under Code Section 33-24-63; time period for issuing of reports on bill.

(a) The Commissioner shall compile all evidence, testimony, and information necessary to prepare the report required by Code Section 33-24-63. The Commissioner may include in this report studies, reviews, or evaluations of similar legislation completed by other states or any department of the government of the United States of America and any evaluations performed by the staff of the Department of Insurance.

(b) Within 20 days of the date of receipt of the health insurance benefit bill, the Commissioner shall issue the report required in Code Section 33-24-63. If a public hearing was conducted, the report shall contain a concise statement of the information revealed at the public hearing and may include copies of any document or documents presented at the public hearing and any other information deemed necessary by the Commissioner.

History. — Code 1981, § 33-24-66, enacted by Ga. L. 1989, p. 492, § 1; Ga. L. 2019, p. 337, § 1-93/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" at the end of subsection (a).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "Insurance Department" was substituted for "Department of Insurance" at the end of subsection (a).

33-24-67. Rules and regulations.

The Commissioner shall promulgate all rules and regulations necessary or appropriate to the administration and enforcement of this article.

History. — Code 1981, § 33-24-67, enacted by Ga. L. 1989, p. 492, § 1.

ARTICLE 3

BREAST CANCER PATIENT CARE

Law reviews. — For note on 1999 enactment of this article, see 16 Ga. St. U.L. Rev. 141 (1999).

33-24-70. Short title.

This article shall be known and may be cited as the "Breast Cancer Patient Care Act."

History. — Code 1981, § 33-24-70, enacted by Ga. L. 1999, p. 319, § 1.

Cross references. — Use of marijuana for treatment of cancer and glaucoma, T. 43, C. 34, A. 5.

33-24-71. Legislative findings.

The General Assembly finds and declares that:

(1) Whereas, until recently health care insurers covered costs of hospital stays of a patient who had undergone a mastectomy or lymph node dissection until that patient was discharged by a physician. Now some insurers are making mastectomies and lymph node dissections an outpatient procedure and refusing to pay for any hospital inpatient care following the procedure;

(2) There is sufficient scientific data to question the safety and appropriateness of such treatment of breast cancer patients; and

(3) The length of postmastectomy or postlymph node dissection inpatient stay should be a clinical decision made by a physician in agreement with the patient based on the unique characteristics of the patient and the surgery involved.

History. — Code 1981, § 33-24-71, enacted by Ga. L. 1999, p. 319, § 1.

33-24-72. Mastectomy; lymph node dissection; coverage for inpatient care and follow-up visits required by health insurers; notice to policyholders.

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

(1) "Attending physician" means any surgeon or other physician attending the breast cancer patient.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, or renewed in this state, including, but not limited to, those contracts executed by the state on behalf of indigents and on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, or other insurer or similar entity; except that such term does not include any policy of limited benefit insurance as defined in paragraph (4) of subsection (e) of Code Section 33-30-12.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, managed care plan other than a dental plan, or any similar entity authorized to issue contracts under this title and also means any state program funded under Title XIX of the federal Social Security Act, 42 U.S.C.A. Section 1396, et seq., and any other publicly funded state health care program.

(4) "Lymph node dissection" means the removal of a part of the lymph node system under the arm using general anesthesia as part of a diagnostic process that is used to evaluate the spread of cancer and to determine the need for further treatment.

(5) "Mastectomy" means surgical removal of one or both breasts.

(b) Every health benefit policy that provides surgical benefits for mastectomies that is delivered, issued, executed, or renewed in this state or approved for issuance or renewal in this state by the Commissioner shall provide coverage in a licensed health care facility for inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending physician in consultation with the patient. Coverage shall also be provided for such number of follow-up visits as determined to be appropriate by the attending physician after consultation with the patient. Such follow-up visits shall be conducted by a physician, a physician assistant, or a registered professional nurse with experience and training in postsurgical care. In consultation with the patient, such attending physician, physician assistant, or registered

professional nurse shall determine whether any follow-up visit or visits will be conducted at home or at the office.

(c) Every insurer shall provide notice to policyholders regarding the coverage required by this Code section. The notice shall be in writing and prominently positioned in any of the following literature:

(1) A mailing to the policyholder;

(2) The yearly informational packets sent to the policyholder; or

(3) Other mailed literature.

(d) No insurer covered under this Code section shall deselect, terminate the services of, require additional utilization review, reduce capitation payment, or otherwise penalize an attending physician or other health care provider who orders care consistent with the provisions of this Code section. For purposes of this subsection, health care provider shall include the attending physician and hospital.

History. — Code 1981, § 33-24-72, enacted by Ga. L. 1999, p. 319, § 1; Ga. L. 2009, p. 859, § 3/HB 509; Ga. L. 2019, p. 386, § 78/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "the state" for "the State of Georgia" near the middle of paragraph (a)(2); deleted "hospital service corporation, medical service corporation," following "fraternal benefit society," in paragraphs (a)(2) and (a)(3); in subsection (b), deleted "on or after July 1, 1999," following "Commissioner" in the middle of the first sentence, and substituted "shall also be provided" for "shall be provided also" near the beginning of the second sentence; substituted "A mailing" for "The next mailing" at the beginning of paragraph (c)(1); and substituted "mailed literature" for "literature mailed before January 1, 2000" in paragraph (c)(3).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in paragraph (a)(3).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, "removal of" was substituted for "removal or" in paragraph (a)(4).

ARTICLE 4

UNDERWRITING AND RATE RISKING

Editor's notes. — Ga. L. 2003, p. 386, § 2, not codified by the General Assembly, makes this article applicable to all personal insurance policies issued or renewed on or after July 1, 2003.

RESEARCH REFERENCES

Am. Jur. 2d. — 15A Am. Jur. 2d, Collection and Credit Agencies, § 80. 43 Am. Jur. 2d, Insurance, § 58 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 150, 151, 222.

33-24-90. Definitions.

As used in this article, the term:

(1) "Adverse action" shall mean a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of personal insurance.

(2) "Affiliate" shall mean any company that controls, is controlled by, or is under common control with another company.

(3) "Applicant" shall mean an individual who has applied to be covered by a personal insurance policy with an insurer.

(4) "Consumer" shall mean an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

(5) "Consumer reporting agency" shall mean any person that, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(6) "Credit information" shall mean any credit related information derived from a credit report or found on a credit report utilized by an insurer or used by an insurer to calculate an insurance score for personal insurance. Information that is not credit related shall not be considered credit information, regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

(7) "Credit report" shall mean any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(8) "Insurance score" shall mean a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(9) "Personal insurance" shall mean private passenger automobile, homeowners, motorcycle, mobile homeowners, and noncommercial dwelling fire insurance policies and boat, personal watercraft, snowmobile, and recreational vehicle policies. Such policies must be individually underwritten for personal, family, or household use. No other type of insurance shall be included as personal insurance for the purpose of this article.

History. — Code 1981, § 33-24-90, enacted by Ga. L. 2003, p. 343, § 1.

33-24-91. Use of credit information to underwrite or rate risks.

An insurer authorized to do business in this state that uses credit information to underwrite or rate risks, shall not:

(1) Use an insurance score that is calculated using income, gender, race, address, ZIP Code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

(2) Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by paragraph (1) of this Code section;

(3) Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information;

(4) Take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information;

(5) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(A) Treat the consumer as otherwise approved by the Commissioner of Insurance, if the insurer presents information that such an absence or inability relates to the risk for the insurer;

(B) Treat the consumer as if the applicant or insured had neutral credit information, as defined by the insurer; or

(C) Exclude the use of credit information as a factor and use only other underwriting criteria;

(6) Take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or an insurance score calculated within 180 days from the date the policy is first written or renewal is issued;

(7) Use credit information unless not later than every 36 months following the last time that the insurer obtained credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this paragraph:

(A) At annual renewal, upon the request of a consumer, the insurer shall reunderwrite and rerate the policy based upon a

credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a 12 month period. Prior to a consumer exercising his or her option for the insurer to reunderwrite or rerate the policy, the insurer shall notify the consumer orally or in writing that the reunderwriting or rerating of the policy may result in a higher rate, a lower rate, or other possible consequences, including nonrenewal or termination of the policy, or could produce no change for the consumer;

(B) The insurer shall have the discretion to obtain credit information upon any renewal before the 36 months, if consistent with its underwriting guidelines; and

(C) No insurer need obtain credit information for an insured, despite the requirements of subparagraph (A) of this paragraph, if one of the following applies:

(i) The insurer is treating the consumer as otherwise approved by the Commissioner;

(ii) The insured is in the most favorably priced tier of the insurer, within a group of affiliated insurers; however, the insurer shall have the discretion to order such report, if consistent with its underwriting guidelines;

(iii) Credit information was not used for underwriting or rating such insured when the policy was initially written; however, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with its underwriting guidelines; or

(iv) The insurer reevaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information; or

(8) Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

(A) Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information;

(B) Inquiries relating to insurance coverage, if so identified on a consumer's credit report;

(C) Collection accounts with a medical industry code, if so identified on the consumer's credit report;

(D) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home

mortgage industry and made within 30 days of one another, unless only one inquiry is considered; or

(E) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered.

History. — Code 1981, § 33-24-91, enacted by Ga. L. 2003, p. 343, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2019, p. 386, § 79/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "current" preceding "credit information" in the first sentence of paragraph (7), subparagraph (7)(B), and in subparagraph (7)(C), and preceding "credit report" in the first sentence of subparagraph (7)(A).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "this paragraph" was substituted for "paragraph (7) of this Code section" in subparagraph (7)(C).

33-24-92. Disputed items in credit report.

If an item or items contained in the credit information for an applicant or insured are in dispute pursuant to the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i, the insurer, during the 45 day period following the date on which the item was placed in dispute pursuant to such dispute resolution process, shall either not use such disputed item or items in making its underwriting or rating determination for such applicant or insured or shall treat the credit information as neutral with respect to the item or items in dispute.

History. — Code 1981, § 33-24-92, enacted by Ga. L. 2003, p. 343, § 1.

33-24-93. Disclosure by insurer of use of credit information.

(a) If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this Code section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

(b) The disclosure required by this Code section shall be in substantially the following form: "In connection with this application for insurance, we may review your credit report or obtain or use a credit based insurance score based on the information contained in that credit

report. We may use a third party in connection with the development of your insurance score."

History. — Code 1981, § 33-24-93, enacted by Ga. L. 2003, p. 343, § 1.

33-24-94. Adverse action based on credit information; notice to consumer.

If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of this Code section. Such insurer shall provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 USC 1681m(a), and shall provide notification to the consumer explaining the reason or reasons for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score" does not meet the explanation requirements of this Code section. Standardized credit explanations provided by consumer reporting agencies or other third party vendors are deemed to comply with this Code section.

History. — Code 1981, § 33-24-94, enacted by Ga. L. 2003, p. 343, § 1.

33-24-95. Filing scoring models with Commissioner; confidential nature of filing.

(a) Insurers that use insurance scores to underwrite and rate risks must file their scoring models or other scoring processes with the Commissioner of Insurance. A third party may file scoring models on behalf of insurers licensed to do business in this state, provided that such third parties are on an approved list maintained by the Commissioner. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

(b) Any filing relating to credit information is considered to be a trade secret and proprietary information of the entity filing the information. Such information shall not be subject to public disclosure and shall be exempt from disclosure under the provisions of Article 4 of Chapter 18 of Title 50.

History. — Code 1981, § 33-24-95, enacted by Ga. L. 2003, p. 343, § 1; Ga. L. 2005, p. 60, § 33/HB 95.

33-24-96. Insurer obligation to indemnify and defend agents.

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an agent or a producer who obtains or uses credit information or insurance scores for an insurer, provided the agent or producer follows the instructions and procedures established by the insurer and complies with any applicable law or regulation. Nothing in this Code section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this Code section.

History. — Code 1981, § 33-24-96, enacted by Ga. L. 2003, p. 343, § 1.
Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "Code" was inserted preceding "section" in two places in the last sentence.

33-24-97. Consumer reporting agency disclosure of insurance information; applicability to motor vehicle reports.

(a) No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

(b) The restrictions provided in subsection (a) of this Code section do not apply to data or lists the consumer reporting agency supplies to the insurance agent or producer from whom information was received, the insurer on whose behalf such agent or producer acted, or such insurer's affiliates or holding companies.

(c) Nothing in this Code section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

History. — Code 1981, § 33-24-97, enacted by Ga. L. 2003, p. 343, § 1.

33-24-98. Use of insurance scores permitted.

Notwithstanding any provision of law to the contrary, insurers shall be allowed to use insurance scores in rating and underwriting subject to the provisions of this article.

History. — Code 1981, § 33-24-98, enacted by Ga. L. 2003, p. 343, § 1.

CHAPTER 25

LIFE INSURANCE

Sec.

33-25-1. "Contract of life insurance" defined.
33-25-2. Inclusion of application for insurance or constitution, bylaws, or other rules of insurer in policies; receipt in evidence.
33-25-3. Required policy provisions generally.
33-25-3.1. Policy loan interest rates on life insurance policies; definitions; construction and applicability.
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33-25-6. When issuance of participating and nonparticipating policies permissible.
33-25-7. Effect of incontestable clause.
33-25-8. Right of person to whom policy or contract issued to return policy or contract and receive premium refund; effect of return; proof of return.
33-25-9. Issuance or delivery of life insurance policies as part of or in combination with other contracts, agreements, or plans.
33-25-10. Payment of interest on proceeds or payments under policies.
33-25-11. Cash surrender value and proceeds of life insurance policies and annuity contracts not liable to attachment, garnishment, or legal process in favor of creditors; proceeds becoming part of insured's estate.
33-25-12. Contesting of policy after reinstatement.
33-25-13. Receipt of benefits from insurance policy of deceased by person found guilty of committing murder or voluntary manslaughter.
33-25-14. Unclaimed life insurance benefits; purpose; definitions; insurer conduct.
33-25-15. Insurer prohibited from penalizing agent for apprising policy owner of alternatives to lapse or surrender of individual life insurance policy.

Cross references. — Definition of life insurance, § 33-7-4. Offering of life insurance by fraternal benefit societies, § 33-15-60. Industrial life insurance, T. 33, C. 26. Group life insurance, T. 33, C. 27. Annuity and pure endowment contracts, T. 33, C. 28.

Law reviews. — For article discussing life insurance trusts, particularly in terms of tax considerations, see 4 Ga. St. B.J. 221 (1967). For article, "Estate Planning: The Use of Insurance to Fund Stock Purchase Agreements," see 9 Ga. St. B.J. 303 (1973). For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Decedent's Intent to Change Beneficiary of Life Insurance Policy, 1 POF2d 437.

Fraudulent Cancellation of Life Insurance, 5 POF2d 587.

Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Fact of Death, 28 POF2d 81.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Litigating the Suicide Exclusion in Life Insurance Policies, 20 POF3d 705.

Insurer's Liability for Improper Issuance or Maintenance of Life Insurance Policy, Prompting Murder or Attempted Murder of Insured, 37 POF3d 149.

Substantial Compliance with Requirements of Life Insurance Policy Regarding Change of Beneficiary, 44 POF3d 377.

ALR. — Upon whom rests duty to pay premiums on policy of life insurance assigned as collateral, 1 A.L.R. 1673.

Validity, construction, and effect of provisions in life or accident policy in relation to military service, 4 A.L.R. 848.

Ignorance of other members as to existence, or terms, of policy of insurance taken out in favor of society or association by a member, as excusing performance of conditions after loss, 13 A.L.R. 1391.

Insurance: death or injury resulting from insured's voluntary act as caused by accident or accidental means, 14 A.L.R. 788; 35 A.L.R. 1191; 42 A.L.R. 243; 45 A.L.R. 1528; 71 A.L.R. 1437; 111 A.L.R. 628.

Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

Statutory provisions relating to the amount or basis of computation upon settlement of life insurance policies, 17 A.L.R. 960.

Death as within provision exempting insurer or limiting liability in case of injury or disability intentionally inflicted, 22 A.L.R. 299.

Insurance: illustrations concerning accumulations, dividends, surplus, 22 A.L.R. 1284; 127 A.L.R. 1464.

Liability of insurer under policy payable to representatives or estate as between domiciliary and ancillary representative, 24 A.L.R. 148.

Effect of unsuccessful attempt to change beneficiary of life insurance, 24 A.L.R. 750.

Validity of option provisions in life insurance policy which vary from the statutory provisions, 26 A.L.R. 103; 115 A.L.R. 1389.

Insurance: applicability of provisions as to injuries intentionally inflicted, where insured is injured because of mistake of identity, 26 A.L.R. 129.

Statutory provision that no one but insured can defeat his direction that proceeds of life insurance be paid to a designated beneficiary as affecting equitable rights of creditors or persons whose money was wrongfully used in paying premiums, 26 A.L.R. 1408.

Date from which life insurance premium periods are to be computed, 32 A.L.R. 1253; 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

Refusal of original beneficiary to surrender policy as affecting attempted change of beneficiary, 36 A.L.R. 771.

"Permanent disability" within insurance policy as confined to disability lasting until death, 40 A.L.R. 1386; 97 A.L.R. 126.

Insurance: effect of incontestable clause on supplemental contracts, 45 A.L.R. 1369.

Group insurance, 55 A.L.R. 1245.

Meaning of "personal representative," "lawful representative," or term of similar import, in insurance policy, bond, or other contract, 59 A.L.R. 838.

Contractual provision for lapse of policy or certificate in event of disappearance of insured or his failure to report to insurer, 65 A.L.R. 1038.

War risk, life, and disability insurance, 73 A.L.R. 319; 81 A.L.R. 933.

Presumption of death of insured in relation to time of death as affecting failure to pay premiums during seven-year period, 75 A.L.R. 630.

Rights and remedies of beneficiary after death of insured who had pledged policy to secure debt, 83 A.L.R. 77; 160 A.L.R. 1389; 91 A.L.R.2d 496.

Right of third person who voluntarily or upon request pays life insurance premiums or loans money to insured for such purpose as against beneficiary or proceeds of policy payable to beneficiary where there was no assignment, 88 A.L.R. 239.

Provision for autopsy in policy of life or accident insurance, 88 A.L.R. 984.

Disability feature of insurance contract as subject of rescission apart from life insurance feature, 91 A.L.R. 1470.

Assignment of policy insuring life of minor, 95 A.L.R. 205.

Burden of proof as regards payment or nonpayment of renewal premiums or assessments on policy of life or accident insurance, 95 A.L.R. 745.

Time of operation of suicide clause as affected by reinstatement of policy, 98 A.L.R. 344.

When insured deemed to be totally and continuously disabled or unable to transact all business duties, 98 A.L.R. 788.

Construction, application, and effect of provisions of war risk insurance precluding or terminating, because of misconduct, the right of one otherwise entitled to benefits, 99 A.L.R. 1284.

Validity and enforceability of promise by beneficiary of life insurance to insured to pay proceeds, in whole or part, to third person, 102 A.L.R. 588.

Life insurance as assets under Bankruptcy Act, 103 A.L.R. 239; 169 A.L.R. 1380.

Retroactive effect of statute prescribing terms or rights under life insurance policies, 106 A.L.R. 46.

Form and contents of notice or proof that will satisfy requirement of "due proof of disability" in provision of life insurance policy with disability features, 109 A.L.R. 825.

Presumption and burden of proof regarding provision of policy of life insurance that it shall not take effect unless insured is in good health, 109 A.L.R. 921.

Change in, renewal of, or substitution for original policy of life insurance as affecting time limitation prescribed by original policy in respect of defenses available to insurer, 110 A.L.R. 1139.

What constitutes bodily injury within policy of accident insurance or accident feature of life policy, 117 A.L.R. 739.

False answer in application for life insurance to question regarding previous rejection, 120 A.L.R. 1425.

Requisites and sufficiency of proofs of loss where disease or other physical condition which in itself is not within, or is expressly excluded from, the coverage of an accident policy or double indemnity provision of a life policy results from, or is attributable to, a clause within the coverage, 126 A.L.R. 616.

Assignment by insured of life policy reserving right to change beneficiary, as affected by failure to comply with provisions of policy respecting change of beneficiary, 135 A.L.R. 1040.

Period of indemnity benefits for total and permanent disability under provisions of life insurance policy in that regard, 135 A.L.R. 1228.

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, 138 A.L.R. 404; 78 A.L.R.2d 1044.

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.

Insanity of insured as excusing lack of, or delay in, notice or proof of accident or disability, 142 A.L.R. 852.

Construction and application of "exchange of policy" or "conversion" clauses in term policy or other life policy, 142 A.L.R. 1260.

Right on death of insured to present commuted value of insurance payable by terms of policy in instalments, 145 A.L.R. 944.

Life insurance benefits as within power of courts to hasten enjoyment of trust funds, 145 A.L.R. 1374.

Validity, construction, and effect of provision in application for life insurance respecting consultation with or treatment by physician since medical examination by insurer's physician, 148 A.L.R. 461.

Excess payment and receipt of life insurance premiums as carrying additional insurance benefits, 161 A.L.R. 1000.

Provision of life insurance policy limiting insurer's liability under specified conditions to return of premiums, as subject to waiver or estoppel by reason of agent's knowledge of breach of condition respecting insured's health, 163 A.L.R. 691.

Application of community property system to problems arising in connection with life insurance policies, 168 A.L.R. 342.

Trust receipts, 168 A.L.R. 359.

Revocability by insured of provisions of life or endowment policy respecting payment of proceeds, 171 A.L.R. 758.

Rights and remedies under contract by party to procure insurance on his own life, 12 A.L.R.2d 983.

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.

Capacity of minor insured to effect a change of beneficiary, 14 A.L.R.2d 375.

Change of beneficiary in old line insurance policy as affected by failure to comply with requirements as to manner of making change, 19 A.L.R.2d 5.

Power of guardian of incompetent to change beneficiary in ward's life insurance policy, 21 A.L.R.2d 1191.

Right with respect to proceeds of life insurance of one whose funds have been wrongfully used to pay premiums, 24 A.L.R.2d 672.

Construction and effect of clause of life, health, or similar policy insuring against "loss of business time," 31 A.L.R.2d 1222.

Gift of life insurance policy, 33 A.L.R.2d 273.

Death or injury resulting from insured's voluntary act in taking overdose of medicine, drugs, or the like, as caused by accident or accidental means, 52 A.L.R.2d 1083.

Effect of provision for coverage or double indemnity in case of injury or death in consequence of burning of building, 55 A.L.R.2d 398.

Hernia following exertion or exercise as within terms of accident provision of insurance policy, 55 A.L.R.2d 1180.

Provision in life insurance policy excluding or limiting liability if insured is not in sound health on date or delivery of policy as confined to change in condition after making or acceptance of application, 60 A.L.R.2d 1429.

State succession, transfer, inheritance, or estate tax in respect of life insurance and annuities, 73 A.L.R.2d 157.

Arteriosclerosis as affecting right to recovery under accident policy or accident provision of life policy, 82 A.L.R.2d 611.

Death or injury resulting from shock, fright, or other "psychic trauma," as within coverage of accident policy or accident provisions of life policy, 93 A.L.R.2d 578.

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.

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.

Insurance on life of partner as partnership asset, 56 A.L.R.3d 892.

Payment of premiums by corporation on corporate officer's life insurance policy as affecting right to policy, 56 A.L.R.3d 1086.

Who is "fare-paying passenger" within coverage provision of life or accident insurance policy, 60 A.L.R.3d 1273.

Insurance: term "children" as used in beneficiary clause of life insurance policy as including illegitimate child, 62 A.L.R.3d 1329.

Elimination of particular coverage, or termination, of health, hospitalization, or medical care insurance policy as affecting insurer's liability for insured continuing hospitalization or medical expenses relating to previously covered illness, 66 A.L.R.3d 1205.

Right of named beneficiary, upon change of beneficiary, to recover premiums paid on life insurance policy, 92 A.L.R.3d 1330.

Liability of insurer for damages resulting from delay in passing upon an application for life insurance, 1 A.L.R.4th 1202.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy, 1 A.L.R.4th 1319.

Property settlement agreement as affecting divorced spouse's right to recover as named beneficiary under former spouse's life insurance policy, 31 A.L.R.4th 59.

Insurer's tort liability for wrongful or negligent issuance of life policy, 37 A.L.R.4th 972.

Failure to disclose terminal illness as basis for life insurer's avoidance of high-risk, high-premium policy requiring no health warranties or proof of insurability, 42 A.L.R.4th 158.

Divorce and separation: method of valuation of life insurance policies in connection with trial court's division of property, 54 A.L.R.4th 1203.

Credit life insurer's punitive damage liability for refusing payment, 55 A.L.R.4th 246.

Accident or life insurance: death by

autoerotic asphyxiation as accidental, 62 A.L.R.4th 823.

Estoppel of, or waiver by, issuer of life insurance policy to assert defense of lack of insurable interest, 86 A.L.R.4th 828.

33-25-1. "Contract of life insurance" defined.

A "contract of life insurance" is one whereby the insurer, for a consideration, assumes an obligation to be performed upon the death of the insured or upon the death of another in the continuance of whose life the insured has an insurable interest, whether such obligation is one to pay a sum of money, to perform services, or to furnish goods, wares, or merchandise, or other things of value, and whether the cost or value of the undertaking on the part of the insurer is more or less than the consideration flowing to him.

History. — Orig. Code 1863, § 2768; Code 1868, § 2776; Code 1873, § 2818; Code 1882, § 2818; Civil Code 1895, § 2114; Civil Code 1910, § 2496; Code 1933, § 56-901; Code 1933, § 56-2501, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, § 56-901, are included in the annotations for this Code section.

Purpose, effect, contents, and import determine if contract is insurance. — Whether a contract is one of insurance is to be determined by the contract's purpose, effect, contents, and import and not necessarily by the terminology used and even though it contains declarations to the contrary. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935) (decided under former Code 1933, § 56-901).

Policy of insurance on which premium has been paid is a contract between the insurer and the insured based on a valuable consideration. Sledd v. Pilot Life Ins. Co., 52 Ga. App. 326, 183 S.E. 199 (1935) (decided under former Code 1933, § 56-901).

Contract payable in goods or services. — Contract may be one of life insurance though payable in goods or services of value. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935); South Ga. Funeral Homes v. Harrison, 183 Ga. 379, 188 S.E. 529 (1936) (decided under former Code 1933, § 56-901).

Cardinal rule for construction of such contract is to ascertain the intention of the parties. Bullard v. Life & Cas. Ins. Co., 178 Ga. 673, 173 S.E. 855, answer conformed to, 49 Ga. App. 27, 174 S.E. 256 (1934) (decided under former Code 1933, § 56-901).

Contract will be construed most favorably for contractee. — When the contract is ambiguous on the question of whether the contract 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 favorable to the company on this question. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935) (decided under former Code 1933, § 56-901).

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 the contractee's benefit and is a contract on which the contractee, in case of breach, may assert a cause of action. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935) (decided under former Code 1933, § 56-901).

Life insurance in its pure form is when members pay premiums which when invested would, if the member lived exactly the average life, produce the sum agreed to be paid; those who do not reach the expected age gain and those who exceed the age lose, but in the long run there can be neither gain nor loss. South Ga. Funeral Homes v. Harrison, 183 Ga. 379, 188 S.E. 529 (1936) (decided under former Code 1933, § 56-901).

Insurable interest required only at inception of insurance contract. — One may insure the life of another in the continuance of whose life one has an interest; this section says nothing about the continuance of such insurable interest, but seems to require only an insurable interest at the inception of the insurance contract. Chapman v. Lipscomb-Ellis Co., 194 Ga. 640, 22 S.E.2d 393 (1942) (decided under former Code 1933, § 56-901).

One who has no insurable interest in life of another person cannot procure and maintain a policy of insurance on the life of such person, naming oneself as the beneficiary. Gulf Life Ins. Co. v. Davis, 52 Ga. App. 464, 183 S.E. 640 (1936) (decided under former Code 1933, § 56-901).

Brother has no insurable interest in life of his sister merely because of such relationship; in order for a brother to have such insurable interest, it must appear that he is her heir at law or dependent on her in some way, or that the relation of debtor and creditor exists between them. Gulf Life Ins. Co. v. Davis, 52 Ga. App. 464, 183 S.E. 640 (1936) (decided under former Code 1933, § 56-901).

Premium on policy required and issued by lender not illegal or usurious. — When lender requires, as collateral security for loan, that borrower obtain at the borrower's own expense a policy of insurance on the borrower's own life or that of some other person with a reputable insurance company doing business in this state, and the lender, being itself such a company, issues to the borrower a policy on the life of the borrower's son, which is assigned to the lender to secure the loan, the specified rate of interest charged on the loan being 2 percent below the maximum rate of interest that could be charged, and the amount of the annual premium for the insurance not being any more than the customary rate when policies of that kind were issued by the lender as an insurer to nonborrowers, such premium could not be counted as a charge by the lender for the money lent, thereby rendering the interest and charges for the loan more than the legal rate and therefore usurious. Sledd v. Pilot Life Ins. Co., 52 Ga. App. 326, 183 S.E. 199 (1935) (decided under former Code 1933, § 56-901).

"Duplicate" insurance policy rendered the original contract of insurance void, and evidence showed that it was the intent of both parties to include the same table of guaranteed values found in the original policy within the terms of the "new" policy. Brannen v. Gulf Life Ins. Co., 201 Ga. App. 241, 410 S.E.2d 763 (1991).

Stock certificates providing burial services held life insurance policies. — Under the evidence, the judge was authorized to find that the contracts issued by the 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 by-laws of the company. Benevolent Burial Ass'n v. Harrison, 181 Ga. 230, 181 S.E. 829 (1935) (decided under former Code 1933, § 56-901).

Contracts issued by funeral company constituted life insurance policies. — When it was shown that in consideration of the initial and installment payments provided for by the contract the defendants had agreed that so long as the contract remained of force the defendants 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 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) (decided under former Code 1933, § 56-901).

Employer's agreement not life insurance contract. — In an action by a former employee to enforce an agreement by a 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).

Cited in Parker v. West View Cem. Ass'n, 195 Ga. 237, 24 S.E.2d 29 (1943); United Ins. Co. of Am. v. Hadden, 126 Ga. App. 362, 190 S.E.2d 638 (1972); Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205 (5th Cir. 1977).

OPINIONS OF THE ATTORNEY GENERAL

Agreement to cancel debt in the event of the death of debtor is insurance. 1967 Op. Att'y Gen. No. 67-170.

If payment is to be made upon death of insured, it constitutes a life insurance contract. 1967 Op. Att'y Gen. No. 67-170.

Credit union has no power or authority to act legally as guarantor of insurer of loans and deposits of the credit union. 1967 Op. Att'y Gen. No. 67-170.

Association which provides for payments to beneficiaries upon death of member is engaged in business of insurance, and subject to regulation by the Insurance Commissioner. 1954-56 Op. Att'y Gen. p. 433.

Cemetery company contracts constitute life insurance policies contrary to law. — When a private company engaged in the business of maintaining a cemetery and selling cemetery lots gave to each purchaser a supplemental written agreement to the effect that if any one or more of the 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 were in arrears, the contract was a contract of insurance and such a contract may not be lawfully made by a concern which was not licensed to engage in the life insurance business, in view of former Code 1933, § 56-2404 (see O.C.G.A. § 33-24-43). 1963-65 Op. Att'y Gen. p. 367.

Contract between college and student on life of sponsor for tuition grant. — When 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.

Debt cancellation contract conditioned on borrower's death. — 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.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 5.

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 158.

C.J.S. — 44 C.J.S., Insurance, § 23 et seq.

ALR. — Liability under policy of life insurance where insured is executed for crime, 36 A.L.R. 1255.

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

Validity and effect as against creditors of change of beneficiary or assignment of insurance policy from estate to individual, 106 A.L.R. 596.

Who entitled to proceeds of life insurance under policy naming two or more beneficiaries, in event of death of one or more but less than all of them before insured, 112 A.L.R. 729.

Insurance: construction of "sane or insane" provision of suicide exclusion, 9 A.L.R.3d 1015.

Insurable interest of brother or sister in life of sibling, 60 A.L.R.3d 98.

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

33-25-2. Inclusion of application for insurance or constitution, bylaws, or other rules of insurer in policies; receipt in evidence.

(a) Except for group life insurance policies, all life insurance policies which contain any reference to the application for insurance or to the constitution, bylaws, or other rules of the insurer as forming part of or as affecting the contract between the parties shall include or have attached to the policy a correct copy of the application signed by the applicant and of the constitution, bylaws, and rules to which reference is made.

(b) Unless included in or attached to the policy, no application, constitution, bylaws, or rules shall be considered a part of the contract or as an independent contract, nor shall they be received in evidence either as part of or as affecting the contract or as an independent contract in any controversy between the parties to or interested in the policy. This Code section shall not apply to applications for reinstatement.

History. — Ga. L. 1906, p. 107, § 1; Civil Code 1910, § 2471; Code 1933, § 56-904; Code 1933, § 56-2502, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 936, § 2.

Law reviews. — For note, "Misrepresentations and Nondisclosures in the Insurance Application," see 13 Ga. L. Rev. 876 (1979).

For comment on National Life & Accident Ins. Co. v. Camp, 77 Ga. App. 667, 49 S.E.2d 670 (1948), see 11 Ga. B.J. 349 (1949).

JUDICIAL DECISIONS

Analysis

General Considerations
Fraud in Unattached Applications
Misrepresentation in Attached Applications

General Considerations

This section is restrictive of the common-law right to contract and should be strictly construed; it is in the nature of the statute of frauds, designed for the protection of persons, insuring their lives or property, and restricts the right to make part of the contract of insurance to those things specifically mentioned, viz., "the application for insurance," and the "Constitution, bylaws, or other rules of the insurer." State Life Ins. Co. v. Tyler, 147 Ga. 287, 93 S.E. 415 (1917); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934).

Statements made in application do not constitute warranties. — Meaning of this section as to application for insurance is that statements made therein do not constitute warranties, the falsity of which will void the contract when the application is not attached to and made a part of the policy. Guest v. Kennesaw Life & Accident Ins. Co., 97 Ga. App. 840, 104 S.E.2d 633 (1958).

This section deals with insurance policy after issuance, and does not concern itself with interim protection afforded by the application and binder receipt on payment of the first full premium and acceptance of the risk by the insurance company. Guest v. Kennesaw Life & Accident Ins. Co., 97 Ga. App. 840, 104 S.E.2d 633 (1958).

This section does not limit the expression "independent contract." Gulf Life Ins. Co. v. Bloodworth, 73 Ga. App. 102, 35 S.E.2d 662 (1945).

Copy of application not part of policy unless attached thereto. — Under this section, the application on which an insurance policy is based is not to be considered as a part of the insurance contract, unless a copy of the application is attached to or accompanies the policy; and this is true even though it is sought by the express terms of the policy itself to make such unattached application a part of the agreement. Bankers Health & Life Ins. Co. v. Murray, 22 Ga. App. 495, 96 S.E. 347 (1918); Wilkins v. National Life & Accident Ins. Co., 23 Ga. App. 191, 97 S.E. 879 (1919); Couch v. National Life & Accident Ins. Co., 34 Ga. App. 543, 130 S.E. 596 (1925); Interstate Life & Accident Co. v. Bess, 35 Ga. App. 723, 134 S.E. 804 (1926); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934).

Policy falls along with application if latter attached thereto. — When, in conformity with this section, the application is attached to the policy and by the terms of the contract is made a part thereof, and when the authority of the medical examiner is limited, the beneficiary, in suing upon the policy, cannot impeach the application as thus integrated therein; if the application falls, so does the policy, and in founding the beneficiary's action upon the policy the beneficiary is committed to the proposition that the answers were made by the insured as set forth in the application. This rule is not changed by the fact that the plaintiff fails to include the application in the copy of the policy attached as an exhibit to the plaintiff's pleading. Metropolitan Life Ins. Co. v. James, 37 Ga. App. 678, 141 S.E. 500 (1928).

Plaintiff's failure to include application in copy of policy in pleading. — When it appears that the application was in fact attached to the policy, and was by its terms made a part thereof, the mere fact that the plaintiff fails to include the application in the copy of the policy as attached to the plaintiff's pleading would not alter the rule. Wilkins v. National Life & Accident Ins. Co., 23 Ga. App. 191, 97 S.E. 879 (1919).

Agreement in application not attached to policy. — When an application for an insurance policy provides that the insured agrees "that no agent of the Company or other person has any authority to waive or dispense with full, true, and complete answers hereon to any of the questions herein set forth, whether such questions relate to matters already known to said agent or not," the insertion of such an agreement is not effective as notice to the insured of limitations on the authority of an agent inasmuch as the application is not attached to the policy; otherwise, to allow this agreement contained in the application to serve as notice to the insured would have the effect of circumventing this section. Gulf Life Ins. Co. v.

General Considerations (Cont'd)

Bloodworth, 73 Ga. App. 102, 35 S.E.2d 662 (1945).

Penalty for noncompliance with section. — Only penalty fixed by this section for failing to attach to a policy of insurance a correct copy of the application therefor, and of any bylaws, rules, or documents therein referred to, is that they may not be received in evidence either as a part of the policy or as an independent contract, and cannot be considered as part of the policy or contract between the parties. This rule does not apply to fraternal associations. Sovereign Camp of Woodmen of the World v. Keen, 16 Ga. App. 703, 86 S.E. 88 (1915); but see Heralds of Liberty v. Bowen, 8 Ga. App. 325, 68 S.E. 1008 (1910).

Effect of noncompliance with this section on the part of the insurance company is that the application shall not be considered a part of the insurance contract. Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934).

Merely by accepting policy, insured did not become bound by stipulation contained in unattached application, "that any misrepresentations or concealment of fact shall render any policy issued null and void and that no obligation shall exist against the company under such policy until the policy is actually issued and delivered to me while the person to be insured is alive and in sound health." Family Fund Life Ins. Co. v. Rogers, 90 Ga. App. 278, 82 S.E.2d 870 (1954).

Meaning of requirement that insured be in sound health. — Requirement in policy of insurance that the insured be in sound health at the date of the issuance of the policy refers to a change in health between the time of taking the application for insurance and the date of the issuance of the policy, when the policy is issued without medical examination and without the application for insurance being attached to and made a part of the policy of insurance. Family Fund Life Ins. Co. v. Rogers, 90 Ga. App. 278, 82 S.E.2d 870 (1954).

Admissibility of attached application only after issuance of policy. — If application for insurance policy contains an agreement that the application shall form a part of any policy issued thereunder, then the application would form a part of that policy so as to permit the application to be introduced in evidence in an action on the policy; until issuance of the policy, however, this rule of evidence does not come into effect, and the agreement as to the protection afforded remains as set forth in the application and binder receipt, the subject matter of which is the undelivered insurance policy. Guest v. Kennesaw Life & Accident Ins. Co., 97 Ga. App. 840, 104 S.E.2d 633 (1958).

Interim protection agreements not rendered illegal by section. — Agreements providing for interim protection between the acceptance of the risk by the company and the actual delivery of the policy of insurance are not rendered illegal by this section. Guest v. Kennesaw Life & Accident Ins. Co., 97 Ga. App. 840, 104 S.E.2d 633 (1958).

Unnecessary to attach copy of anything contained in policy. — In actions to recover money on insurance policies which come under this section, it is not necessary to attach a copy of anything written or printed upon the policy, or to set up anything other than what appears upon the face or in the body of the policy. Sovereign Camp of Woodmen of the World v. Keen, 16 Ga. App. 703, 86 S.E. 88 (1915).

Benefit certificates issued by fraternal associations not controlled by section. — Former Civil Code 1910, § 2471 (see O.C.G.A. § 33-25-2) declared what shall constitute the policy of insurance, and was a distinct provision of the law of life insurance, and former Civil Code 1910, § 2869 (see O.C.G.A. § 33-15-82) had the effect to take from its operation benefit certificates issued by fraternal beneficiary orders or associations as defined in former Civil Code 1910, § 2866 (see O.C.G.A. § 33-15-1); it follows that, when a benefit certificate of a fraternal association refers to the application, constitution, and bylaws of the association as being a part of the contract, in an action on such benefit certificate, the application, constitution, and bylaws of the association are receivable in evidence as part of the contract of insurance. Fraternal Life &

Accident Ass'n v. Evans, 140 Ga. 284, 78 S.E. 915 (1913); Supreme Ruling of Fraternal Mystic Circle v. Blackshear, 13 Ga. App. 329, 79 S.E. 210 (1913); Sovereign Camp of Woodmen of the World v. Keen, 16 Ga. App. 703, 86 S.E. 88 (1915); but see Heralds of Liberty v. Bowen, 8 Ga. App. 325, 68 S.E. 1008 (1910).

When a certificate of insurance was issued by a voluntary fraternal benefit association, former Code 1933, § 56-904 (see O.C.G.A. § 33-25-2) was not applicable, but former § 33-15-16 (see O.C.G.A. § 33-15-63) controlled. Sovereign Camp W.O.W. v. Reid, 53 Ga. App. 618, 186 S.E. 759 (1936).

Cited in Bankers Health & Life Ins. Co. v. Griffeth, 59 Ga. App. 740, 1 S.E.2d 771 (1939); Hubbard v. Kennesaw Life & Accident Ins. Co., 110 Ga. App. 870, 140 S.E.2d 237 (1965); Prudential Ins. Co. of Am. v. Perry, 121 Ga. App. 618, 174 S.E.2d 570 (1970).

Fraud in Unattached Applications

Statements made in the application are not to be treated as warranties or covenants on account of the failure or falsity of which the policy may be voided, unless a copy of the application is attached to the policy or accompanies the policy, though representations contained in the application, if fraudulently made, may give to the insurance company the right to void the policy. Bankers Health & Life Ins. Co. v. Murray, 22 Ga. App. 495, 96 S.E. 347 (1918); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934).

Insurer may void policy for fraudulent procurement though application unattached. Thus, it has been held that while it is true that the representations as made in such an unattached application cannot be treated as a part of the contract, and are not to be taken as covenants or warranties, still, if such statements furnished the actual basis on which the policy was issued, and the statements were not only false but were also fraudulently made by the applicant acting on the applicant's behalf, the insurer may set up such facts as a means of voiding the policy, not under and by virtue of the terms of the contract, but for the reason that the insurance is thus shown to have been fraudulently procured. Johnson v. American Nat'l Life Ins. Co., 134 Ga. 800, 68 S.E. 731 (1910); Wilkins v. National Life & Accident Ins. Co., 23 Ga. App. 191, 97 S.E. 879 (1919); Life Ins. Co. v. Pate, 23 Ga. App. 232, 97 S.E. 874 (1919); Mutual Benefit Health & Accident Ass'n v. Bell, 49 Ga. App. 640, 176 S.E. 124 (1934).

Insurer may offer unattached application in evidence in action based on fraud. — When a copy of the application is not attached to a policy of life insurance, the application does not form a part of the contract of insurance, and consequently the statements therein contained are not to be treated as warranties, and the statements' falsity would not void the policy as a matter of contract. National Life & Accident Ins. Co. v. Sneed, 40 Ga. App. 131, 149 S.E. 68 (1929).

When the application was not attached to and made a part of the policy, representations made by the insured in answering questions as to the insured's present state of health, previous illness, and other material matters, would not be considered as warranties or covenants by the insured, and the policy would not be voided on account of the untruthfulness of such statements, as a matter of contract, even when material to the risk; but if the insured had made such false statements for the purpose of fraudulently inducing the insurer to issue the policy, then the policy could be voided on account of the policy's fraudulent procurement. National Life & Accident Ins. Co. v. McKenney, 52 Ga. App. 466, 183 S.E. 659 (1936).

When an insurance company is seeking to cancel a policy on the ground of fraud in the policy's procurement, the company is not precluded from offering the application in evidence, although not attached. New York Life Ins. Co. v. Odom, 93 F.2d 641 (5th Cir. 1937), cert. denied, 304 U.S. 566, 58 S. Ct. 948, 82 L. Ed. 1532 (1938); Life & Cas. Ins. Co. v. Davis, 62 Ga. App. 832, 10 S.E.2d 129 (1940).

Application not having been attached to or made a part of the contract of insurance, the policy is not voidable because of the falsity of representations made by the insured as to the insured's state of health and whether or not the insured had had

Fraud in Unattached Applications (Cont'd)

any previous illness, even though such statements are as to facts material to the risk, unless the act of the applicant for insurance was fraudulent. Bankers Health & Life Ins. Co. v. Griffeth, 59 Ga. App. 740, 1 S.E.2d 771 (1939).

When application was not attached to insurance policy nor made part of the contract, representations or concealments, although false and material to the risk, would not defeat recovery unless fraudulently made to obtain insurance, the rule in such cases being that when the insured has made false and fraudulent statements as to matters that are material to the risk, or fraudulently concealed such matters from the insurer, for the purpose of obtaining the insurance, and has thereby induced the insurer to issue the policy, the policy is void, not as a matter of contract, but because the policy has been procured by fraud. National Life & Accident Ins. Co. v. Dorsey, 69 Ga. App. 734, 26 S.E.2d 654 (1943).

Evidence justified finding of no fraudulent intent on part of applicant. — When the evidence was sufficient to show that the answers given by the parent of the insured in applying for life insurance on the life of a child were made in good faith, that if the insured was afflicted with epilepsy as the insurance company contended, the parent did not know it, and that the agent who took the application was acquainted with the insured, and, being in a position to get first hand knowledge of the insured's health, gave it as the agent's opinion, both in an endorsement on the application and in the agent's testimony on the trial, that the applicant was in good health and was a good risk, the jury was authorized to find that there was no willful concealment or fraudulent intent by the plaintiff parent. National Life & Accident Ins. Co. v. Dorsey, 69 Ga. App. 734, 26 S.E.2d 654 (1943).

Misrepresentation in Attached Applications

Misrepresentations by agent on application imputable to insured when application part of contract. — When, in conformity with this section, an application is actually attached to the policy of insurance, and by the terms of the contract is made a part thereof, any misrepresentation made by the agent in the application will be imputed to the insured, and the insured should not be permitted to claim under the contract without being held to have had knowledge of the statements made in the application actually attached to and forming an integral part of the contract as delivered, accepted, and sued on. Wilkins v. National Life & Accident Ins. Co., 23 Ga. App. 191, 97 S.E. 879 (1919); Southern Sur. Co. v. Fortson, 46 Ga. App. 265, 167 S.E. 335 (1933).

When agent who filled out application and delivered policy to insured had actual knowledge of such incorrect statements in the application, the insurer will be held to have had notice thereof and to be estopped from asserting the invalidity of the policy because of such incorrect statements in the application. Southern Sur. Co. v. Fortson, 46 Ga. App. 265, 167 S.E. 335 (1933).

Agent's willful misrepresentation on application imputable to insurer. — When soliciting and forwarding applications for policies of insurance were within the scope of the duties of an agent of an insurance company, and such agent undertook to prepare for another an application for insurance, not attached to the policy, and willfully inserted therein a false answer to a material question, the agent will be regarded in so doing as the agent of the company, and not of the applicant, and the agent's knowledge of the falsity of the answer will be imputed to the company and the company will not be allowed to void the policy on the ground of a false warranty. National Life & Accident Ins. Co. v. Sneed, 40 Ga. App. 131, 149 S.E. 68 (1929).

Misrepresentation in application attached to policy may defeat recovery. — When an application for life insurance is attached to and made a part of a policy, any misrepresentation in the application which changes the nature and character of the risk as contemplated in the policy may defeat a recovery, regardless of good faith on the part of the insured. Preston v. National Life & Accident Ins. Co., 196 Ga. 217, 26 S.E.2d 439 (1943).

Test regarding misrepresentations. — Test in a case of false representation is not whether the matter represented shall have actually contributed to the contingency or event on which the policy is to become payable, but is whether it changed the nature and character of the risk and increased it as against the insurer under the particular policy, and by increase in risk is meant an increase that is at least substantial. While a false statement as to consultation or treatment for a slight or trivial ailment may not, without more, be considered as a material misrepresentation so as to void the policy, the illness need not be shown to have been serious, the true criterion being, as in case of misrepresentations as to other matters, substantial increase in risk. Metropolitan Life Ins. Co. v. Joye, 77 Ga. App. 357, 48 S.E.2d 751 (1948).

When the application is attached to and made a part of the policy, and false statements or representations are contained in such application, as a result of which the risk is increased, a recovery on the policy may be defeated on such grounds whether the statements and representations were made in good faith or fraudulently. Metropolitan Life Ins. Co. v. Joye, 77 Ga. App. 357, 48 S.E.2d 751 (1948).

RESEARCH REFERENCES

ALR. — Insurance: incontestable clause as excluding a defense based upon public policy, 13 A.L.R. 674; 35 A.L.R. 1491; 170 A.L.R. 1040.

Application for reinstatement as within statute requiring application to be endorsed upon, or attached to, policy, 67 A.L.R. 1489.

Effect on provisions of insurance policy as to vacancy, of agent's representations made, or knowledge acquired, prior to issuance of policy, 96 A.L.R. 1259.

Insurance: sufficiency of insurer's compliance with statutory requisites as to attaching copy of application to, or making it part of, policy, 18 A.L.R.3d 760.

Negligent misrepresentation as "accident" or "occurrence" warranting insurance coverage, 58 A.L.R.5th 483.

33-25-3. Required policy provisions generally.

(a) Except as provided in subsection (b) of this Code section, no policy of life insurance shall be delivered or issued for delivery in this state unless it contains in substance the following provisions:

(1) **Grace period.** A provision that the insured is entitled to a grace period of not less than 30 days within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in force; but if a claim arises under the policy during the grace period, the amount of any premium due or overdue may be deducted from any amount payable under the policy in settlement;

(2) **Incontestability.** A provision that the policy exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means shall be incontestable, except for nonpayment of premiums, after it has been in

force during the lifetime of the insured for a period of two years from its date of issue;

(3) **Misstatement of age.** A provision that, if the age of the person insured or of any other person whose age is considered in determining the premium or benefit has been misstated, any amount payable or any benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages;

(4) **Dividends.** A provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy. Except as provided in this paragraph, any dividend becoming payable shall at the option of the party entitled to elect such option be either payable in cash or applied to any one of such other dividend options as may be provided by the policy. If any other dividend options are provided, the policy shall further state which option shall be automatically effective if the party shall not have elected some other option. If a policy specifies a period within which the other option may be elected, the period shall be not less than 30 days following the date on which the dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash within the meaning set forth in this paragraph, even though the policy provides that payment of the dividend is to be deferred for a specified period, provided the period does not exceed six years from the date of apportionment and that interest will be added to the dividend at a specified rate. If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under the nonforfeiture provision shall be applied in the manner set forth in the policy;

(5) **Policy loan.** A provision that after three full years' premiums have been paid, and after the policy has a cash surrender value, and while no premium is in default beyond the grace period for payment, the insurer will loan on the execution of a proper note or loan agreement by the owner of the policy, and on proper assignment of the policy and on the sole security of the policy, at a specified rate of interest, a sum equal to or, at the option of the owner of the policy, less than the cash value of the policy at the end of the current policy year including any dividend additions to the policy. The company may deduct from the loan value or from the proceeds of the loan any existing indebtedness on or secured by the policy not already deducted in determining the cash value, including interest due or accrued, and any unpaid balance of the premium for the current policy year, and may collect interest in advance of the loan through

the end of the current policy year. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six months after application for such deferment. The policy may also provide that if interest on any indebtedness is not paid when due, it shall then be added to the existing indebtedness and shall bear interest at the same rate, and that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value of the policy, then the policy shall terminate and become void, but not until at least 30 days' notice shall have been mailed by the insurer to the last known address of the insured or policy owner and to that of any assignee of record at the home office of the insurer. The policy, at the insurer's option, may provide for an automatic premium loan, subject to an election of the party entitled to elect. No condition other than as provided in this paragraph shall be exacted as a prerequisite to any loan. This provision shall not apply to term insurance or to term insurance benefits provided by rider or supplemental policy provisions;

(6) **Tables of installments.** In case the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments;

(7) **Tables of options and values.** In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefits, if any, available under the policy on each policy anniversary, either during the first 20 policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy;

(8) **Reinstatement.** A provision that unless the policy has been surrendered for its cash surrender value or its cash surrender value has been exhausted, or unless the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three years from the date of premium default upon written application for reinstatement, the production of evidence of insurability satisfactory

to the insurer, the payment of all premiums in arrears, and the payment or reinstatement of any other indebtedness to the insurer upon the policy all with interest not exceeding 6 percent per annum compounded annually;

(9) **Title.** On each such policy there shall be placed a title which shall briefly and accurately describe the nature and form of the policy;

(10) **Payment of premiums.** A provision relative to the payment of premiums;

(11) **Payment of claims.** A provision that, when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy and proof of the interest of the claimant. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, the period shall not exceed two months from the receipt of such proofs;

(12) **Entire contract.** A provision that, if any reference is made to the application for insurance or to the constitution, bylaws, or rules of the insurer as forming part of or as affecting the policy between the parties, there shall be included in or attached to the policy, when issued, a correct copy of the application signed by the applicant and of the constitution, bylaws, and rules to which reference is made.

(b) Any of the provisions enumerated in subsection (a) of this Code section or portions thereof not applicable to single premium or term policies shall to that extent not be incorporated in single premium or term policies. This Code section shall not apply to credit or group insurance, or to any provision of a life insurance policy, or contract supplemental to a life insurance policy, relating to disability benefits or to additional benefits in event of death by accident or accidental means.

History. — Code 1933, § 56-2503, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 650, § 2; Ga. L. 1983, p. 3, § 24.

Law reviews. — For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979).

JUDICIAL DECISIONS

This section requires that policies be incontestable after two years; within that period, parties are free to agree to any lesser period. Smith v. New York Life Ins. Co., 579 F.2d 1267 (5th Cir. 1978).

Effect of incontestability clause. — Under an incontestability clause, the insurer is, except as to certain conditions as to premiums, precluded from setting up any defense based upon misrepresentations or warranties made by the insured in the application, whether fraudulent or otherwise; and such a clause manifests the intention of the parties that all grounds of defense, save nonpayment of premium, shall be cut off by the clause. Riley v. Industrial Life & Health Ins. Co., 190 Ga. 891, 11 S.E.2d 20 (1940).

After the period of incontestability has

run, the insurer is only barred from contesting the validity of the policy itself, e.g., on grounds of fraud in the procurement, etc.; the insurer still reserves the right to deny any claim if the claim is not within the coverage as stated under the policy's terms, and this is true regardless of the import of any statements made in the application for insurance. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Georgia legislature and judiciary fully intend to treat the question of incontestability the same regardless of the type of policy issued. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Incontestability clause excludes operation of additional clause that in order for policy to take effect, the insured must have been in good health on its date, even though at that time the insured was in bad health and was afflicted with an incurable disease, from which the insured died after the time limit stated in the incontestability clause. Riley v. Industrial Life & Health Ins. Co., 190 Ga. 891, 11 S.E.2d 20 (1940).

Limitation includes time which might ensue without contest. — Limitation in an incontestability clause relates to the right of contest within a period of two years from the date of the policy, and does not exclude the time which might ensue without a contest subsequent to the death of the insured. Riley v. Industrial Life & Health Ins. Co., 190 Ga. 891, 11 S.E.2d 20 (1940).

Contesting policy on ground of insured's having fatal disease upon issue. — If an insured dies within two years of the date of the policy, proof of death is filed immediately, and the company in accordance with an exception to liability stated in the policy refuses to pay the claim on the ground that the insured was afflicted with a fatal disease on the date of the policy, such refusal to pay having been in ample time to allow action on the policy to be filed before the expiration of two years from the date of the policy, in action on policy after two years from the date of the policy, the insurance company, by virtue of the company's two-year incontestability clause, is not permitted to contest the policy on the ground that the insured was afflicted with a fatal disease on the date of the policy. Riley v. Industrial Life & Health Ins. Co., 190 Ga. 891, 11 S.E.2d 20 (1940).

Mere refusal to pay claim does not constitute contest of liability. — When the insured dies within the two-year period of contestability provided by an incontestability clause in a policy, a mere refusal within the two-year period to pay a claim, on the ground that the insurer is not liable because of another provision in the policy, will not suffice to serve as a contest of liability; such a mere refusal to pay, while manifesting the insurer's conception of the insurer's rights and the insurer's purpose to maintain those rights, does not constitute an attack upon the validity of the continued protection afforded by the contract of insurance, which requires some affirmative or defensive action in court. Riley v. Industrial Life & Health Ins. Co., 190 Ga. 891, 11 S.E.2d 20 (1940).

Contract becomes effective upon company's acceptance of premium and issuance of policy. — When a receipt is given to an applicant for insurance by a local agent of a life insurance company for the first premium upon a policy of insurance, and the money is forwarded to the home office of the company and there accepted as the first payment upon the policy, and the policy is issued and forwarded to the local agent for delivery to the insured, the contract of insurance becomes effective upon the acceptance of the premium by the company and the issuance of the policy, notwithstanding that the policy may, according to the policy's terms, take effect at a later date. Interstate Life & Accident Ins. Co. v. McMahon, 50 Ga. App. 543, 179 S.E. 132 (1935).

Insurer is not barred by incontestability clauses from arguing that policies are void ab initio because the proposed insured, who was then an adult, neither signed the applications nor consented in writing to the issuance of the coverage as required by O.C.G.A. § 33-24-6(a). Guarantee Trust Life Ins. Co. v. Wood, 631 F. Supp. 15 (N.D. Ga. 1984).

Insurer not barred from seeking tort damages for fraud and deceit. — Incontestability clauses in policies do not bar the insurer, who has paid the proceeds of those policies to the beneficiary, from affirming the insurance contracts and seeking damages in tort for the fraud and deceit of the beneficiary with regard to representations made in the policy applications. Guarantee Trust Life Ins. Co. v. Wood, 631 F. Supp. 15 (N.D. Ga. 1984).

Grace period. — In a case in which a life insurance policy lapsed for nonpayment of premiums before the insured died and the beneficiaries, relying on O.C.G.A. § 33-25-3(a)(1), asserted that the insured died during the contestability time period, the beneficiaries had no right to recover under the contract. The insurance company's letter to the insured did not indicate that the grace period was extended, only that the lapsed coverage could be reinstated, and O.C.G.A. § 33-25-3(a)(1) only required that a 30 day grace period be included in life insurance contracts, and there was no dispute that the contract at issue met that prerequisite. White v. New York Life Ins. Co., 564 F. Supp. 2d 1372 (S.D. Ga. 2008).

Cited in Gulf Life Ins. Co. v. Lanier, 114 Ga. App. 277, 151 S.E.2d 161 (1966); Robertson v. Southland Life Ins. Co., 130 Ga. App. 807, 204 S.E.2d 505 (1974); Liberty Nat'l Life Ins. Co. v. Davis, 146 Ga. App. 38, 245 S.E.2d 316 (1978); Phillips v. Old Republic Life Ins. Co., 155 Ga. App. 537, 271 S.E.2d 676 (1980); Goodley v. Fireman's Fund Am. Life Ins. Co., 173 Ga. App. 277, 326 S.E.2d 7 (1985).

RESEARCH REFERENCES

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C.J.S. — 45 C.J.S., Insurance, § 1053.

ALR. — Insurance: incontestable clause as excluding a defense based upon public policy, 13 A.L.R. 674; 35 A.L.R. 1491; 170 A.L.R. 1040.

Life insurance: forfeiture for nonpayment of premiums or assessments as affected by physical or mental disability, 15 A.L.R. 318.

Date from which life insurance premium periods are to be computed, 32 A.L.R. 1253; 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

Requirement of "positive" proof of death of insured as excluding circumstantial evidence, 60 A.L.R. 592.

Misdescription of status, or relationship to insured, of beneficiary named in contract of life insurance or mutual life insurance, 60 A.L.R. 977.

Flat life insurance premium rate regardless of age, or failure to apply rate applicable according to age, as discrimination, 84 A.L.R. 525.

Time when incontestable clause in life insurance policy becomes effective; death of insured before end of contestable period, 85 A.L.R. 234; 105 A.L.R. 992.

Who are within term "heirs" in designation of beneficiaries of life insurance, 88 A.L.R. 624.

Dividends as applicable to extension of period of extended insurance, or to purchase of paid-up insurance, 92 A.L.R. 702.

Retroactive effect of statute prescribing terms or rights under life insurance policies, 106 A.L.R. 46.

Validity of provisions of life insurance policy which discriminates, as regards options allowed, between borrowing and nonborrowing insurants, 106 A.L.R. 1537.

Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

Change in, renewal of, or substitution for original policy of life insurance as affecting time limitation prescribed by original policy in respect of defenses available to insurer, 110 A.L.R. 1139.

Who entitled to proceeds of life insurance under policy naming two or more beneficiaries, in event of death of one or more but less than all of them before insured, 112 A.L.R. 729.

Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

Payment or tender, after lapse of policy for nonpayment of premium, of amount of loan on policy as affecting computation of paid-up or extended insurance, 114 A.L.R. 901.

Conclusiveness or controlling effect of table of surrender values contained in policy of insurance, 116 A.L.R. 793.

Delivery of policy of life insurance without payment of premium as waiver of condition that policy shall not be in force until payment of first premium, 118 A.L.R. 1072.

Statutory or contractual limitation where presumption of death of the insured from seven years' absence is relied upon, 119 A.L.R. 1308.

Incontestable clause of statute or policy as applicable to claims other than for death benefits, 121 A.L.R. 1437; 147 A.L.R. 1015.

Provision or option for payment in instalments of amount of life insurance policy as creating "annuity," 128 A.L.R. 981.

Validity, construction, and application of automatic premium loan provision in life insurance policy, 129 A.L.R. 1105.

Age adjustment clause of policy as affected by incontestable clause or statute against avoidance of policy because of misrepresentation, 135 A.L.R. 445.

Provision in life insurance policy excluding or limiting liability if insured is not in sound health on date of delivery of policy as confined to change in condition after making or acceptance of application, 136 A.L.R. 1516; 60 A.L.R.2d 1429.

Insurer's failure to deduct future premiums from proceeds of loan as permitted or provided by policy or statute, as affecting subsequent lapse of policy for nonpayment of premium, 137 A.L.R. 836.

Effect of insurer's wrongful rejection of insured's claim under disability clause of life policy, 140 A.L.R. 781.

Compounding interest on a policy loan under a life insurance policy, 161 A.L.R. 433.

Excess payment and receipt of life insurance premiums as carrying additional insurance benefits, 161 A.L.R. 1000.

Date at which coverage begins upon reinstatement, renewal, or revival of insurance policy after default, 167 A.L.R. 333.

Right of insurer to restitution of payments made under mistake, 167 A.L.R. 470.

Admissibility against beneficiary of life or accident insurance policy of statements of third persons included in or with proof of death, 1 A.L.R.2d 365.

Incontestable clause as applicable to suit to reform insurance policy, 7 A.L.R.2d 504.

Form and sufficiency of proof of death in case of insured's disappearance, 26 A.L.R.2d 1073.

Right of life insurance beneficiary against estate of insured who used policy as collateral, 91 A.L.R.2d 496.

Insured's exercise of election afforded under life insurance policy as affected by his death before complete consummation of option, 15 A.L.R.3d 1317.

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.

Construction and effect of "visible sign of injury" and similar clauses in accident provision of insurance policy, 28 A.L.R.3d 413.

Liability under life or accident policy not containing a "violation of the law" clause, for death or injury resulting from violation of law by insured, 43 A.L.R.3d 1120.

33-25-3.1. Policy loan interest rates on life insurance policies; definitions; construction and applicability.

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

(1) "Policy" means a contract of life insurance, a life benefit certificate issued by a fraternal benefit society, or an annuity contract.

(2) "Policyholder" means the owner of the policy or the person designated on the records of the company as the person responsible to pay the premiums.

(3) "Policy loan" means a cash loan or a premium loan made by an insurer on a policy in accordance with the provisions of this title.

(4) "Policy loan interest rate" means the interest rate charged on a policy loan made in accordance with the provisions of this title including the interest rate charged on reinstatement of a policy loan for the period during and after any lapse of the policy.

(5) "Published monthly average" means:

(A) Moody's Corporate Bond Yield Average — Monthly Average Corporates as published by Moody's Investors Service, Inc., or by any successor thereto; or

(B) In the event that Moody's Corporate Bond Yield Average — Monthly Average Corporates, or any successor thereto, is no longer published, "published monthly average" means any substantially similar average which the Commissioner shall, by rule or regulation, designate to be used in its place.

(b) No policy of life insurance which provides for policy loans shall be issued, delivered, or issued for delivery in this state on or after July 1, 1983, unless it contains one of the following provisions relating to policy loan interest rates:

(1) A provision permitting a specified rate of interest on policy loans, not to exceed 8 percent per annum, in accordance with the provisions of paragraph (5) of subsection (a) of Code Section 33-25-3 and the rules and regulations promulgated by the Commissioner pursuant thereto; or

(2) A provision permitting an adjustable maximum policy loan interest rate established from time to time by the insurer in accordance with subsection (c) of this Code section.

(c) If the policy provides for an adjustable maximum policy loan interest rate as allowed under paragraph (2) of subsection (b) of this Code section, the insurer shall also be required to comply with the following requirements:

(1) The policy loan interest rate charged shall not exceed the higher of the following:

(A) The published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(B) The rate used to calculate the cash surrender values under the policy during the applicable period plus 1 percent per annum.

(2) The policy shall contain a provision setting forth the frequency at which the policy loan interest rate is to be determined for that policy;

(3) The maximum policy loan interest rate for each policy must be determined at regular intervals at least once every 12 months, but not more frequently than once in any three-month period;

(4) At the intervals specified in the policy:

(A) The policy loan interest rate being charged may be increased whenever such increase as determined by this Code section would increase the policy loan interest rate by 1/2 percent or more per annum; and

(B) The policy loan interest rate being charged must be reduced whenever such reduction as determined in this Code section would reduce the policy loan interest rate by 1/2 percent or more per annum;

(5) The insurer shall:

(A) Notify the policyholders, at the time a cash loan is made, of the initial policy loan interest rate applicable to the loan;

(B) Notify the policyholder who makes a premium loan of the initial policy loan interest rate as soon as it is reasonably practical to do so after the making of the initial loan. Notice need not be given to the policyholder when a further premium loan is made unless there is an increase in the policy loan interest rate, in which case notice shall be given in accordance with subparagraph (C) of this paragraph;

(C) Send policyholders with policy loans reasonable advance notice of any increase in the policy loan interest rate; and

(D) Include in the notice required to be sent under subparagraph (C) of this paragraph a statement concerning the applicable policy loan interest rate and the frequency at which such rate is determined; and

(6) A statement concerning the applicable policy loan interest rate and the frequency at which such rate is determined shall be included in the policy.

(d) Notwithstanding any provisions of this title which might be construed to the contrary, no policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(e) Notwithstanding any provisions of the laws of this state which might be construed to the contrary, the maximum rate of interest which may be charged on a policy loan shall be governed exclusively by the provisions of this Code section unless such other laws are specifically made applicable to policy loans.

(f) No insurer shall be permitted to issue policies with adjustable maximum policy loan interest rates as allowed under paragraph (2) of subsection (b) of this Code section unless such insurer also makes available policies, which may or may not be on the same type of policy form, with specified rates of interest on policy loans in accordance with the provisions of paragraph (1) of subsection (b) of this Code section.

(g) The provisions of this Code section shall not apply to any policy issued before July 1, 1983, unless the policyholder agrees in writing to the applicability of such provisions in accordance with such requirements as may be established by the Commissioner.

History. — Code 1981, § 33-25-3.1, enacted by Ga. L. 1983, p. 616, § 1.

33-25-4. Required nonforfeiture provisions.

(a)(1) Except as provided in subsection (f) of this Code section, no policy of life insurance issued on or after January 1, 1966, shall be delivered or issued for delivery in this state unless it shall contain the following provisions, or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the defaulting or surrendering policyholder as are in the minimum requirements hereinafter specified and are essentially in compliance with subsection (h) of this Code section:

(A) A provision that, in the event of default in any premium payment, the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as specified in subsection (c) of this Code section. In lieu of such stipulated paid-up nonforfeiture benefit, the insurer may substitute, upon proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits;

(B) A provision that, upon surrender of the policy, within 60 days after the due date of any premium payment in default, after premiums have been paid for at least three full years, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash

surrender value of such amount as specified in subsection (b) of this Code section;

(C) A provision that a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default;

(D) A provision that, if the policy shall have become paid up by completion of all premium payments, or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as specified in subsection (b) of this Code section;

(E) An explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions, credited to the policy, or any indebtedness to the insurer on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the supervisory insurance official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which the values and benefits are consecutively shown in the policy.

(2) Any of the provisions or portions thereof set forth in subparagraphs (a)(1)(A) through (a)(1)(E) of this Code section not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(3) The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

(b)(1) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (a) of this Code section, shall be an amount not less than the excess, if any, of the present value on the anniversary of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of the then present value of the adjusted premiums as defined in subsections (d) and (e) of this Code section, corresponding to premiums which would have fallen due on and after the anniversary and the amount of any indebtedness to the insurer on account of or secured by the policy.

(2) Provided, however, that for any policy issued on or after the operative date of subsection (e) of this Code section as defined in subsection (e) of this Code section which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in paragraph (1) of this subsection for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in paragraph (1) of this subsection for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(3) Provided, further, that for any family policy issued on or after the operative date of subsection (e) of this Code section as defined in subsection (e) of this Code section which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age 71, the cash surrender value referred to in paragraph (1) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in paragraph (1) of this subsection for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in paragraph (1) of this subsection for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(4) Any cash surrender value available within 30 days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (a) of this Code section, shall be an amount not less than the present value on the anniversary of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy.

(c) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of the anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this Code section in the absence of the condition that premiums shall have been paid for at least a specified period.

(d)(1) This subsection shall not apply to policies issued on or after the operative date of subsection (e) of this Code section as defined in subsection (e) of this Code section, except that, with respect to such policies for which the gross premium during the first policy year

includes any additional amounts for which no comparable additional benefit is provided during that year, this subsection shall continue to apply until the effective date of subsection (h) of this Code section. Except as provided in paragraph (3) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage or percentages of the respective premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy and excluding any additional amounts payable during the first policy year for which there are no comparable additional insurance benefits provided during that year, that the present value at the date of issue of the policy of all such adjusted premiums shall be equal to the sum of (A) the then present value of the future guaranteed benefits provided for by the policy; (B) 2 percent of the amount of the insurance if the insurance be uniform in amount, or of the equivalent uniform amount, as defined in paragraph (3) of this subsection, if the amount of insurance varies with the duration of the policy; (C) 40 percent of the adjusted premium for the first policy year; (D) 25 percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less, reduced by (E) any additional amounts payable during the first policy year for which there are no comparable additional insurance benefits provided during that year.

(2) The adjusted premiums shall be a single uniform percentage of the respective premiums specified in the policy for each policy year, unless the adjusted premiums result in cash surrender values which are smaller than endowment amounts provided by the policy prior to maturity as of the date or dates such endowment amounts are provided, in which event the adjusted premiums shall be determined as uniform percentages of the respective premiums specified in the policy such that no cash surrender value is smaller than any endowment amount provided by the policy prior to maturity as of the date or dates such endowment amount is provided. For the purposes of this paragraph, the Commissioner may treat any cash surrender value actually provided by the policy as equivalent to an endowment amount; provided, however, that in applying the percentages specified in items (C) and (D) of paragraph (1) of this subsection no adjusted premium shall be deemed to exceed 4 percent of the amount of insurance or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this Code section shall be the date as of which the rated age of the insured is determined.

(3) In the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform

amount of insurance, for the purpose of this subsection, shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration, and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, however, that, in the case of a policy providing a varying amount of insurance issued on the life of a child under age ten, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten was the amount provided by the policy at age ten. In the case of a policy which provides pure endowment benefits which are payable without reducing the amount of insurance provided by the policy and which may be applied to provide additional amounts of paid-up life insurance, the equivalent uniform amount of insurance shall be determined on the amounts of insurance which would be effective if all the pure endowment benefits were applied to provide such additional amounts of paid-up life insurance.

(4) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (A) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (B) the adjusted premiums for such term insurance, items (A) and (B) of this paragraph being calculated separately and as specified in paragraphs (1) through (3) of this subsection, except that, for the purpose of items (B), (C), and (D) of paragraph (1) of this subsection, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in item (B) of this paragraph shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in item (A) of this paragraph.

(5) All adjusted premiums and present values referred to in this Code section shall, for all policies of ordinary insurance, be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table, provided that, for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. Such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table; provided, however, that any insurer may file with the Commissioner a written notice of its election that such adjusted premiums and present values shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality

Table, after a specified date before January 1, 1968, and, whether or not any election has been made, such calculations for all policies of industrial insurance, issued on or after January 1, 1968, shall be made on the basis of the Commissioners 1961 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such rate of interest shall not exceed 3 1/2 percent per annum, except that a rate of interest not exceeding 4 percent per annum may be used for policies issued on or after July 1, 1973; and prior to July 1, 1979, a rate of interest not exceeding 5 1/2 percent per annum may be used for policies issued on or after July 1, 1979; and for any single premium whole life or endowment insurance policy, a rate of interest not exceeding 6 1/2 percent per annum may be used. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed in the case of ordinary policies may not be more than those shown in the Commissioners 1958 Extended Term Insurance Table and in the case of industrial policies may not be more than 130 percent of the rates of mortality according to the 1941 Standard Industrial Mortality Table. After January 1, 1968, when the Commissioners 1961 Standard Industrial Mortality Table becomes applicable, such rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Commissioner.

(e)(1) As used in this subsection, the term "operative date of the valuation manual" has the same meaning as in paragraph (2) of subsection (o) of Code Section 33-10-13.

(1.1) This subsection shall apply to any life insurance policy issued on or after January 1, 1989, or such earlier date as may have been elected by the insurer with respect to such policy in accordance with the provisions of paragraph (11) of this subsection. Except as provided in paragraph (3) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (A) the then present value of the future guaranteed

benefits provided for by the policy; (B) one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and (C) 125 percent of the nonforfeiture net level premium as defined in this subsection; provided, however, that in applying the percentage specified in item (C) of this paragraph no nonforfeiture net level premium shall be deemed to exceed 4 percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(3) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that the future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in paragraph (7) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (A) 1 percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (B) 125 percent of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where:

(A) Equals the sum of:

(i) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(ii) The present value of the increase in future guaranteed benefits provided for by the policy; and

(B) Equals the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(8) All adjusted premiums and present values referred to in this Code section shall for all policies of ordinary insurance be calculated on the basis of (A) the Commissioners 1980 Standard Ordinary Mortality Table or (B) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year; provided, however, that:

(A) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year;

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (a) of this Code section, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(C) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values;

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance;

(E) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables;

(F) For policies issued prior to the operative date of the valuation manual, any Commissioners standard ordinary mortality tables 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 nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture

standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual; and

(G) For policies issued prior to the operative date of the valuation manual, any Commissioners standard industrial mortality tables 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 nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioners standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the Commissioner approves by regulation any Commissioners standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(9) The nonforfeiture interest rate is defined as follows:

(A) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to 125 percent of the calendar year statutory valuation interest rate for such policy as defined in Code Section 33-10-13, the Standard Valuation Law, rounded to the nearer one quarter of 1 percent; provided, however, that the nonforfeiture interest rate shall not be less than 4 percent.

(B) For policies issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(10) Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(11) After November 1, 1982, any insurer may file with the Commissioner a written notice of its election to comply with the provisions of this subsection with respect to specified policy forms after a specified date before January 1, 1989, which shall be the operative date of this subsection for such specified policy forms. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1989.

(f) 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 which is of such a nature that minimum values cannot be determined by the methods described in subsections (a), (b), (c), (d), or (e) of this Code section, then:

(1) The Commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by subsections (a) through (e) of this Code section;

(2) The Commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(3) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Code section, as determined by regulations promulgated by the Commissioner.

(g) Any cash surrender value and any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary, except that, in the case of industrial insurance, proportionate increases in value may be calculated on the basis of quarter-year payment. All values referred to in subsections (b) through (e) of this Code section may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding subsection (b) of this Code section, additional benefits payable (1) in the event of death or dismemberment by accident or accidental means; (2) in the event of total and permanent disability; (3) as reversionary annuity or deferred reversionary annuity benefits; (4) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this Code section would not apply; (5) as term insurance on the life of a

child, or on the lives of children provided in a policy on the life of a parent of the child, if the term insurance expires before the child attains age 26, is uniform in amount after the child attains age one and has not become paid up by reason of the death of a parent of the child; or (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this Code section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(h)(1) This subsection, in addition to all other applicable subsections of this Code section, shall apply to all policies issued on or after January 1, 1986, except that, with respect to such policies for which the gross premium during the first policy year includes any additional amounts for which no comparable additional benefit is provided during that year, this subsection shall apply to any such policies issued after a specified operative date before January 1, 1986, as defined in subsection (e) of this Code section. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two tenths of 1 percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (A) the greater of zero and the basic cash value hereinafter specified and (B) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

(2) The basic cash value shall be equal to the present value on such anniversary of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary; provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (b) or (d) of this Code section, whichever is applicable, shall be the same as are the effects specified in subsection (b) or (d) of this Code section, whichever is applicable, on the cash surrender values defined in that subsection.

(3) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (d) or (e) of this Code section, whichever is applicable. Except as is required by paragraph (4) of this subsection, such percentage:

(A) Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two tenths of 1 percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

(B) Must be such that no percentage after the later of the two policy anniversaries specified in subparagraph (A) of this paragraph may apply to fewer than five consecutive policy years.

(4) Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (d) or (e) of this Code section, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(5) All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this Code section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

(6) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (a), (b), (c), (e), and (g) of this Code section. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (1) through (6) in subsection (g) of this Code section shall conform with the principles of this subsection.

(i) This Code section shall not apply to any of the following:

(1) Reinsurance;

(2) Group insurance;

(3) Pure endowment;

(4) Annuity or reversionary annuity contract;

(5) Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years

or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(6) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (d) and (e) of this Code section, is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy; or

(7) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (b), (c), (d), and (e) of this Code section, exceeds 2 1/2 percent of the amount of insurance at the beginning of the same policy year.

For purposes of determining the applicability of this Code section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

History. — Code 1933, § 56-2504, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1962, p. 487, §§ 2, 3; Ga. L. 1973, p. 617, § 2; Ga. L. 1979, p. 1407, § 2; Ga. L. 1981, p. 936, §§ 3, 4; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 650, § 3; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1986, p. 10, § 33; Ga. L. 2015, p. 846, § 2/HB 185; Ga. L. 2017, p. 774, § 33/HB 323; 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 "has the same meaning as in paragraph (2) of subsection (o) of Code Section 33-10-13" for "means January 1 of the first calendar year that the valuation manual as defined in Code Section 33-1-10 becomes effective" in paragraph (e)(1).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1985, in paragraph (e)(6) a colon was inserted at the end of the introductory language, and in paragraph (i)(6) "or" was substituted for "nor" at the end of the paragraph.

Administrative rules and regulations. — Life and Annuity Tables, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-39.

JUDICIAL DECISIONS

Right of insured under life insurance policy to cash surrender value is matter of contract only. Penn Mut. Life Ins. Co. v. Taggart, 41 Ga. App. 200, 152 S.E. 307 (1930).

Cash surrender value not collectable absent policy provision or statute. — When contract of insurance, as expressed in the policy, contains no provision for the payment of a cash value upon the surrender of the policy, and there is no statute giving this right, neither the insured nor the insured's assignee can, as a matter of right, demand and collect from the insurance company whatever cash surrender value the policy may possess. Penn Mut. Life Ins. Co. v. Taggart, 41 Ga. App. 200, 152 S.E. 307 (1930).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 171 et seq. 44 Am. Jur. 2d, Insurance, §§ 719 et seq., 728 et seq.

C.J.S. — 45 C.J.S., Insurance, §§ 809 et seq., 1043.

ALR. — Refusal of insurer to consent to change of beneficiary in life policy as affecting right of trustee in bankruptcy of insured, 20 A.L.R. 256.

Date from which life insurance premium periods are to be computed, 32 A.L.R. 1253; 80 A.L.R. 957; 111 A.L.R. 1420; 169 A.L.R. 290.

Forfeiture of life or accident insurance for nonpayment of premium due to failure or neglect of one authorized by insured pay same, 67 A.L.R. 180.

Flat life insurance premium rate regardless of age, or failure to apply rate applicable according to age, as discrimination, 84 A.L.R. 525.

Period of indemnity benefits for total and permanent disability under provisions of life insurance policy in that regard, 106 A.L.R. 1089; 135 A.L.R. 1228.

Validity and construction of provisions of life insurance policy regarding surrender charges or deductions, other than loan or indebtedness, in determining cash surrender, paid-up insurance or extended insurance upon default in payment of premiums, 111 A.L.R. 972.

Right of assignee of policy to cash surrender value, 114 A.L.R. 775.

Payment or tender, after lapse of policy for nonpayment of premium, of amount of loan on policy as affecting computation of paid-up or extended insurance, 114 A.L.R. 901.

Surrender of life policy in order to exercise option for cash value or other option as affecting right to benefits under disability feature of policy, 136 A.L.R. 924.

Provision in life insurance policy excluding or limiting liability if insured is not in sound health on date of delivery of policy as confined to change in condition after making or acceptance of application, 136 A.L.R. 1516; 60 A.L.R.2d 1429.

Validity and effect of preliminary term provision in whole life policy, as regards computation of cash surrender value, paid-up insurance, or extended insurance, 143 A.L.R. 1072.

Insured's exercise of election afforded under life insurance policy as affected by his death before complete consummation of option, 15 A.L.R.3d 1317.

33-25-5. Inclusion of provisions excluding or restricting liability for death.

(a) No policy of life insurance, except as stated in subsection (c) of this Code section, shall be delivered or issued for delivery in this state if it contains a provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that the policy may contain provisions excluding or restricting coverage as specified therein in event of death under any one or more of the following circumstances:

(1) Death as a result, directly or indirectly, of war, declared or undeclared, or of any act or hazard of such war;

(2) Death as the result of aviation or any air travel or flight;

(3) Death as a result of a specified hazardous occupation or occupations;

(4) Death while the insured is a resident outside the continental United States and Canada; or

(5) Death within two years from the date of issue of the policy as a result of suicide, while sane or insane.

(b) A policy which contains any exclusion or restriction pursuant to subsection (a) of this Code section shall also provide that in the event of death under circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the Commissioner's reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits or, if the policy provides no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy with adjustment for indebtedness or dividend credit.

(c) This Code section shall not apply to group life insurance, reinsurance, annuities, or to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits, or to additional benefits in the event of death by accident or accidental means.

(d) Nothing contained in this Code section shall prohibit any provision which in the opinion of the Commissioner is more favorable to the policyholder than a provision permitted by this Code section.

History. — Code 1933, § 56-2507, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1984, p. 22, § 33.

Cross references. — Effect of "living will" on life insurance policy, § 31-32-9.

Law reviews. — For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979).

For comment, "Having an Affair May Shorten Your Life: The Ashley Madison Suicides," see 33 Georgia St. U. L. Rev. 455 (2017).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Civil Code 1910, § 2500, are included in the annotations for this Code section.

Policy behind O.C.G.A. § 33-25-5 is to preserve actuarial stability. Midland Nat'l Life Ins. Co. v. Citizens & S. Nat'l Bank, 641 F. Supp. 516 (M.D. Ga. 1986).

Law never presumes suicide from the fact of self-destruction. Mutual Life Ins. Co. v. Durden, 9 Ga. App. 797, 72 S.E. 295 (1911); Supreme Forest Woodmen Circle v. Newsome, 63 Ga. App. 550, 11 S.E.2d 480 (1940); Liberty Nat'l Life Ins. Co. v. Tidmore, 71 Ga. App. 271, 30 S.E.2d 668 (1944); South Ga. Brokers, Inc. v. Fidelity Bankers Life Ins. Co., 153 Ga. App. 503, 265 S.E.2d 815 (1980) (decided under former Civil Code 1910, § 2500).

Burden is upon insurer to establish the contrary by a preponderance of the evidence. Mutual Life Ins. Co. v. Durden, 9 Ga. App. 797, 72 S.E. 295 (1911) (decided under former Civil Code 1910, § 2500).

Presumption against suicide is not conclusive and will vanish upon proof of physical facts clearly inconsistent therewith. Supreme Forest Woodmen Circle v. Newsome, 63 Ga. App. 550, 11 S.E.2d 480 (1940).

Meaning of provision excluding liability for suicide. — When a contract of insurance provides that the policy shall be void in the event the insured commits suicide within a certain time, whether at the time of committing suicide the insured is either sane or insane, the meaning is that, regardless of the insured's sanity or insanity, the voluntary self-destruction of the insured within the time set out shall void the policy. Supreme Forest Woodmen

Circle v. Newsome, 63 Ga. App. 550, 11 S.E.2d 480 (1940).

Theory of accident over suicide adopted. — When the fact of death is established, and the evidence points equally or indifferently to accident or suicide as the cause of death, the theory of accident rather than of suicide is to be adopted. Supreme Forest Woodmen Circle v. Newsome, 63 Ga. App. 550, 11 S.E.2d 480 (1940).

Sanity of suicide at time of death immaterial. — Words "die by his own hand or act," as used in a life insurance policy, are synonymous with "voluntary suicide," and convey the idea of intentional self-destruction; but when such words are coupled with the provision "whether sane or insane," it is immaterial whether the insured at the time of the self-destruction was sane, or whether the insured's mental faculties were so impaired as to destroy his moral responsibility. Supreme Forest Woodmen Circle v. Newsome, 63 Ga. App. 550, 11 S.E.2d 480 (1940).

When two-year period in suicide clause commenced. — Ambiguity created when a conditional receipt purported to make certain provisions effective on one date and the policy purported to make the same provisions effective on a different date was construed against the insurer, and the two-year period in the suicide clause commenced on the date coverage became effective under the conditional receipt, rather than on the issue date of the policy. Midland Nat'l Life Ins. Co. v. Citizens & S. Nat'l Bank, 641 F. Supp. 516 (M.D. Ga. 1986).

Evidence insufficient to warrant disturbing verdict for plaintiff. — Upon proof that the insured died by external and violent means, when there are conflicts in the evidence as to the physical facts surrounding the death, and the evidence does not demand the finding that the death was by suicide, a verdict for the plaintiff, having the approval of the trial judge, will not be disturbed. Gulf Life Ins. Co. v. Fetzer, 59 Ga. App. 176, 200 S.E. 165 (1938).

Waiver of statutory contestability period. — When an insurance policy contained the clause, "The company shall not be liable hereunder, in the event of the insured's death by his own act, whether sane or insane, during the period of one year after the issuance of the policy," the benefit of former Civil Code 1910, § 2500 (see O.C.G.A. § 33-25-5) was waived, unless such waiver was against public policy. Mutual Life Ins. Co. v. Durden, 9 Ga. App. 797, 72 S.E. 295 (1911).

In the present case, there is no clearly defined public policy opposed to the waiver of former Civil Code 1910, § 2500 (see O.C.G.A. § 33-25-5), and there is a clear and vitally important public policy demanding the enforcement of the contract according to the contract's terms and the intention of the parties. Mutual Life Ins. Co. v. Durden, 9 Ga. App. 797, 72 S.E. 295 (1911).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 523 et seq.

C.J.S. — 46 C.J.S., Insurance, § 1671 et seq.

ALR. — Death as within provision exempting insurer, or limiting liability in case of "injury" intentionally inflicted, 6 A.L.R. 1338; 22 A.L.R. 299.

Insurance: constitutionality of statute precluding defense of suicide in action on policy of life or accident insurance, 13 A.L.R. 787.

Death from "suicide" as an accident, or due to accidental means, within policy of accident insurance, 16 A.L.R. 1402.

Insanity of insured as affecting provision against liability for death in consequence of the violation of law, 25 A.L.R. 190.

Liability under policy of life insurance where insured is executed for crime, 36 A.L.R. 1255.

Right of insurer to directed verdict on issue of suicide, 37 A.L.R. 171.

Provision in policy of life or accident insurance as to "self-destruction," "death by not own hand," and other forms no employing term "suicide," as applicable to death by accident, 37 A.L.R. 1088.

Death or injury resulting from insured's

voluntary act as caused by accident or accidental means, 71 A.L.R. 1437; 111 A.L.R. 628.

Rescission of policy of life or accident insurance after death of insured by agreement, express or implied, with beneficiaries, 80 A.L.R. 185.

War risk life and disability insurance, 81 A.L.R. 933.

Time of operation of suicide clause as affected by reinstatement of policy, 98 A.L.R. 344.

Physical condition which in itself is not within, or is expressly excluded from, the coverage of an insurance policy, a within such coverage when it results from or is directly attributable to a cause within the coverage, 108 A.L.R. 6.

What amounts to a claim under a war risk policy within the contemplation of the World War Veterans' Act in that regard, 117 A.L.R. 945.

Validity, construction, and effect of provisions in life or accident policy in relation to military service, 137 A.L.R. 1263; 36 A.L.R.2d 1018.

Insurance: death or injury in battle as due to accident or accidental means, 137 A.L.R. 1286; 140 A.L.R. 1533; 141 A.L.R. 1510.

National Service Life Insurance Act, 153 A.L.R. 1413; 155 A.L.R. 1445; 156 A.L.R. 1445; 157 A.L.R. 1445; 158 A.L.R. 1445.

Construction and application of provisions of life or accident policy relating to aeronautics, 155 A.L.R. 1026; 17 A.L.R.2d 1041.

Insurance: "accidental means" as distinguishable from "accident," "accidental result," "accidental death," "accidental injury," etc., 166 A.L.R. 469.

Meaning of term "duration" or "end of war" employed in contract, 168 A.L.R. 173.

Insurance: coroner's verdict or report as evidence on issue of suicide, 28 A.L.R.2d 352.

Presumption against suicide as overcome as a matter of law by physical facts related to death in action on accident or life insurance policy, 85 A.L.R.2d 722.

Construction and effect of provisions in life or accident insurance policies referring to "assault," "felony," "fighting," etc., by insured, 86 A.L.R.2d 443.

Insurance: construction of "sane or insane" provision of suicide exclusion, 9 A.L.R.3d 1015.

Construction and effect of provision of life or accident insurance policy specifically excluding liability for injury or death from poison, 14 A.L.R.3d 783.

Suicide clause of life or accident insurance as affected by incontestable clause, 37 A.L.R.3d 337.

Liability under life or accident policy not containing a "violation of the law" clause, for death or injury resulting from violation of law by insured, 43 A.L.R.3d 1120.

Life or accident insurance: sufficiency of showing that death from drowning was due to accident or accidental means, 43 A.L.R.3d 1168.

Insured's nondisclosure of information regarding value of property as ground for avoiding liability under property insurance policy, 15 A.L.R.4th 1109.

Construction and application of provision of liability insurance policy expressly excluding injuries intended or expected by insured, 31 A.L.R.4th 957.

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.

What constitutes medical or surgical treatment, or the like, within exclusionary clause of accident policy or accidental-death feature of life policy, 56 A.L.R.5th 471.

33-25-6. When issuance of participating and nonparticipating policies permissible.

A life insurer may issue both participating and nonparticipating policies only if the right or absence of right to participate is reasonably related to the premium charged.

History. — Code 1933, § 56-1521, enacted by Ga. L. 1960, p. 289, § 1.

33-25-7. Effect of incontestable clause.

A clause in any policy of life insurance which provides that the policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not the restrictions or exclusions are excepted in the clause.

History. — Code 1933, § 56-2509, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979).

JUDICIAL DECISIONS

Georgia legislature and judiciary fully intend to treat the question of incontestability the same regardless of the type of policy issued. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

To determine the coverage of a policy is not to contest the policy, but to apply the policy properly. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

After period of incontestability has run, insurer is only barred from contesting validity of policy itself, e.g., on grounds of fraud in the procurement, etc.; it still reserves the right to deny any claim if it is not within the coverage as stated under the policy's terms, and this is true regardless of the import of any statements made in the application for insurance. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Validity of insurance policy is all that becomes incontestable, while conditions of insurance and coverage are unaffected; the fact that the policy had become incontestable would not operate to change the rule, since, though incontestable, the liability, in the absence of any waiver, is measured by the terms and provisions of the policy itself. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Insurance company is not precluded from showing that particular claim is not covered within the terms and provisions of the policy because of restrictions and exclusions therein, although the company would have been precluded from asserting as a defense the invalidity of the policy because of the fraud in the policy's procurement or any other ground affecting the validity of the policy as a whole. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Cited in Gulf Life Ins. Co. v. Lanier, 114 Ga. App. 277, 151 S.E.2d 161 (1966); Ballinger v. C & S Bank, 139 Ga. App. 686, 229 S.E.2d 498 (1976); Schulman v. Federated Life Ins. Co., 154 Ga. App. 479, 268 S.E.2d 704 (1980).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 749 et seq.

C.J.S. — 46 C.J.S., Insurance, § 1222 et seq.

ALR. — Insurance: incontestable clause as excluding a defense based upon public policy, 13 A.L.R. 674; 35 A.L.R. 1491; 170 A.L.R. 1040.

Time when incontestable clause in life insurance policy becomes effective; death

of insured before and of contestable period, 31 A.L.R. 108; 85 A.L.R. 234; 105 A.L.R. 992.

Incontestable clause in life or accident policy as affected by statute invalidating agreements fixing period of limitation different from that prescribed by the statute of limitations, 41 A.L.R. 1105.

Insurance: effect of incontestable clause on supplemental contracts, 45 A.L.R. 1369.

Express exception in incontestability clause as negativing other exceptions thereto, 88 A.L.R. 773.

Applicability of incontestable clause to defense based on false impersonation or mistake as to identity of person insured, 98 A.L.R. 710.

Incontestable clause as applicable to suit to reform insurance policy, 7 A.L.R.2d 504.

Incontestability clause as precluding insurer from defending on ground of particular clause in life policy limiting or precluding insurer's liability because of other life insurance, 22 A.L.R.2d 809.

What amounts to contest within contemplation of incontestable clause, 95 A.L.R.2d 420.

Misrepresentation as to employer-employee relationship as within incontestability clause of group insurance, 26 A.L.R.3d 632.

Suicide clause of life or accident insurance as affected by incontestable clause, 37 A.L.R.3d 337.

Liability under life or accident policy not containing a "violation of the law" clause, for death or injury resulting from violation of law by insured, 43 A.L.R.3d 1120.

33-25-8. Right of person to whom policy or contract issued to return policy or contract and receive premium refund; effect of return; proof of return.

(a) Every individual life insurance policy or contract issued for delivery in this state, except those issued in connection with a credit transaction, shall have printed on or attached to the contract a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days after receipt thereof and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason.

(b) If the purchaser, pursuant to such notice, returns the policy or contract to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

(c) Without limiting any other method of returning a policy or contract under this Code section, it shall be prima-facie evidence of the fact and date of return of a policy or contract if the policy or contract is dispatched by certified mail or statutory overnight delivery to the insurer or agent, as provided in this Code section, and a return receipt provided by the United States Postal Service or the commercial delivery company is obtained.

(d) A person shall be deemed to have received a policy or contract for purposes of subsection (a) of this Code section if there has elapsed a

period of six months from the effective date of the policy or contract or if there has elapsed a period of time from the effective date of the policy or contract during which there have been sent to the person two premium notices or other such statements of policy or contract activity, whichever period is longer.

History. — Code 1933, § 56-2511, enacted by Ga. L. 1979, p. 786, § 3; Ga. L. 1993, p. 483, § 7; Ga. L. 2000, p. 1589, § 8; Ga. L. 2019, p. 386, § 80/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1979" following "delivery in this state" near the middle of subsection (a).

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (c) is applicable with respect to notices delivered on or after July 1, 2000.

33-25-9. Issuance or delivery of life insurance policies as part of or in combination with other contracts, agreements, or plans.

Except as expressly provided in this Code section, no life insurance policy shall be issued or delivered in this state, as a part of or in combination with any insurance, endowment, or annuity contract, any agreement or plan additional to the rights, dividends, and benefits arising out of any such insurance, endowment, or annuity contract:

(1) Which provides for the accumulation of profits over a period of years and for payment of all or any part of the accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified period of years;

(2) Which provides that on the death of anyone other than a beneficiary or a person insured thereunder the owner or beneficiary of the policy shall receive the payment or granting of anything of value;

(3) Which provides that the whole or any part of the premiums or consideration for the policy, dividends, coupons, reserves, special reserves, lapses, or the excess interest therefrom, or any funds or money in excess of the normal reserve required to meet the contractual guarantees of the policy are to be placed or invested in special funds or segregated accounts and the funds or earnings therefrom divided among those taking the policy, their beneficiaries, or assignees; or

(4) Which provides for the sale, solicitation, or delivery of any stock or shares of stock in any company or which provides for a benefit certificate, securities, or any special advisory board contract or other contracts or resolutions of similar nature or which provides for policy

dividends bearing a stated relationship to dividends on the stock of any company as an inducement to or in connection with the sale or acceptance of such policy.

History. — Code 1933, § 56-2508, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

RESEARCH REFERENCES

ALR. — Validity of provisions of life insurance policy which discriminates, as regards options allowed, between borrowing and nonborrowing insurants, 106 A.L.R. 1537.

33-25-10. Payment of interest on proceeds or payments under policies.

(a) Each insurer admitted to transact life insurance in this state shall pay interest on proceeds or payments under any individual policy of life insurance, payable to a beneficiary residing in this state or to a beneficiary under a policy issued in this state or to a beneficiary under a policy insuring a person resident in this state at the time of death.

(b) Interest payable pursuant to subsection (a) of this Code section shall be computed from the insured's death until the date of payment and shall be at the following rate of interest:

(1) In the event an action to recover the proceeds due under such policy is commenced and results in a judgment against the insurer, interest shall be computed at the legal rate of interest; or

(2) In the event no such action has been commenced, interest shall be computed daily at the greater of the rate of 6 percent per annum or the highest interest rate currently paid by the insurer on proceeds left under an interest settlement option; provided, however, that when a claim for the policy proceeds is filed with the insurer, interest shall be computed daily from 30 days after the date the claim is filed until the date of payment at the rate of 12 percent.

(c) This Code section shall not:

(1) Apply to proceeds under any such policy paid within 30 days after the date of death of the insured;

(2) Require the payment of interest in an amount of less than $5.00;

(3) Apply to policies of credit life insurance;

(4) Require the payment of interest for any period during which an insurer is required to pay interest under any state or federal law pertaining to interpleader; or

(5) Apply to any individual policy issued within 12 months of the death of the insured.

(d) For the purposes of this Code section, payment shall be deemed to have been received by a resident when manually delivered by an agent or representative of the insuring company or when deposited by the insuring company in the United States mail, postage prepaid, and directed to the resident at his last known address as evidenced by the business records of the insuring company.

(e)(1) For the purposes of this Code section, a claim shall be deemed to have been filed with an insurer on the date that the insurer receives a substantially completed application or other written notice for the policy proceeds and reasonable proof of death of the insured.

(2) In cases of group life insurance, a claim shall be deemed to have been filed on the date that the insurer receives the information provided in paragraph (1) of this subsection and receives from the group policyholder written evidence of eligibility for coverage.

History. — Code 1933, § 56-2503.1, enacted by Ga. L. 1978, p. 2297, § 1; Ga. L. 1991, p. 1055, § 1; Ga. L. 1992, p. 1293, § 1; Ga. L. 1993, p. 91, § 33.

JUDICIAL DECISIONS

No prejudgment interest if insured dies within 12 months of issuance of policy. — O.C.G.A. § 33-25-10 governs the entitlement to prejudgment interest on life insurance proceeds and does not require the payment of prejudgment interest when the insured dies within 12 months of issuance of the policy. Southwestern Life v. Middle Ga. Neurological, 262 Ga. 273, 416 S.E.2d 496 (1992).

In an insurer's 28 U.S.C. § 1335 interpleader suit to determine whether a trust, a 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, the trust, which was determined to be entitled to the proceeds, was not entitled to interest under O.C.G.A. § 33-25-10(b)(2) as that statute specifically stated that interest on policy proceeds did not accrue during the pendency of an interpleader action. Nat'l Life Ins. Co. v. Alembik-Eisner, 582 F. Supp. 2d 1362 (N.D. Ga. 2008).

Cited in Equicor, Inc. v. Stamey, 216 Ga. App. 375, 454 S.E.2d 550 (1995).

RESEARCH REFERENCES

ALR. — Who are "blood relatives" within statute or rules as to beneficiaries of insurance in mutual benefit societies, 10 A.L.R. 864.

Liability of insurer for damages resulting from delay in passing upon an application for life insurance, 1 A.L.R.4th 1202.

33-25-11. Cash surrender value and proceeds of life insurance policies and annuity contracts not liable to attachment, garnishment, or legal process in favor of creditors; proceeds becoming part of insured's estate.

(a) Whenever any person residing in the state shall die leaving insurance on his or her life, such insurance shall inure exclusively to the benefit of the person for whose use and benefit such insurance is designated in the policy, and the proceeds thereof shall be exempt from the claims of creditors of the insured unless the insurance policy or a valid assignment thereof provides otherwise. Whenever the insurance, by designation or otherwise, is payable to the insured or to the insured's estate or to his or her executors, administrators, or assigns, the insurance proceeds shall become a part of the insured's estate for all purposes and shall be administered by the personal representative of the estate of the insured in accordance with the probate laws of the state in like manner as other assets of the insured's estate.

(b) Payments as directed in this Code section shall, in every such case, discharge the insurer from any further liability under the policy, and the insurer shall in no event be responsible for, or be required to see to, the application of such payments.

(c) The cash surrender values of life insurance policies issued upon the lives of citizens or residents of this state, upon whatever form, shall not in any case be liable to attachment, garnishment, or legal process in favor of any creditor of the person whose life is so insured unless the insurance policy was assigned to or was effected for the benefit of such creditor or unless the purchase, sale, or transfer of the policy is made with the intent to defraud creditors.

History. — Ga. L. 1933, p. 181, § 1; Code 1933, § 56-905; Code 1933, § 56-2505, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2006, p. 885, § 1/HB 1304.

Law reviews. — For annual survey on insurance law, see 64 Mercer L. Rev. 151 (2012). For article, "Consumer Bankruptcy Panel: Hot Consumer Bankruptcy Plan Issues," see 28 Emory Bankr. Dev. J. 333 (2012). For annual survey on bankruptcy law, see 64 Mercer L. Rev. 849 (2013). For annual survey of bankruptcy law, see 67 Mercer L. Rev. 819 (2016).

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Scope of protection. — O.C.G.A. § 33-25-11 more narrowly protects cash surrender value from "attachment, garnishment, and legal process," but does not purport to exempt it from all claims of creditors. Roach v. Ryan (In re Ryan), No. 11-40712, 2012 Bankr. LEXIS 784 (Bankr. S.D. Ga. Jan. 17, 2012).

Bankruptcy court did not err in concluding that O.C.G.A. § 33-25-11 did not provide the bankruptcy debtor an exemption from the bankruptcy estate because O.C.G.A. § 44-13-100 prevailed over the more general provisions of § 33-25-11. McFarland v. Wallace, 516 B.R. 665 (S.D. Ga. 2014).

No application when policy fraudulently assigned. — O.C.G.A. § 33-25-11

does not apply when the policy has been fraudulently assigned with the intent to defraud creditors. Ambase Int'l Corp. v. Bank S., N.A., 196 Ga. App. 336, 395 S.E.2d 904 (1990).

This section creates no exemption of a debtor's property from execution, but rather a special cause of action for a creditor against one who is not the creditor's principal debtor. United States v. Truax, 223 F.2d 229 (5th Cir. 1955).

This section does not seek to protect the bankrupt, but the statute protects rights of beneficiary or assignee of the insurance policy from the creditors of the insured. In re Hausman, 209 F. Supp. 219 (M.D. Ga. 1962).

Does not apply in bankruptcy. — O.C.G.A. § 44-13-100, by the statute's express terms, applies to bankruptcy debtors. By contrast, nothing in the history or language of O.C.G.A. § 33-25-11(c) indicates the legislature intended that statute to apply in bankruptcy; therefore, § 33-25-11(c) is unavailable for purposes of exempting property from a debtor's bankruptcy estate. In re Dean, 470 B.R. 643 (Bankr. M.D. Ga. 2012).

Insurance policy must be claimed as exempt property by bankrupt. — Bankrupt must claim the insurance policy as exempt property; the trustee is without power or authority to set aside as exempt property that which the bankrupt has not requested to be set aside. In re Hausman, 209 F. Supp. 219 (M.D. Ga. 1962).

Fact that claimant is "person so effecting" insurance on bankrupt does not remove claimant from the bounds of protection afforded beneficiaries and assignees of life insurance policies by this section, which removes persons effecting insurance on the life of another from the statute's protection only when such "person so effecting" the insurance is the debtor against whom creditors are seeking relief; the mere fact that the claimant happens to be the person who effected the insurance on the bankrupt's life does not disentitle the claimant to its proceeds as against the debtor's creditors. In re Hausman, 209 F. Supp. 219 (M.D. Ga. 1962).

Claim to insurance proceeds for which another is named beneficiary. — Named beneficiary in life insurance policy becomes vested with title to the insurance proceeds upon the death of the insured; thus, it would seem that malicious interference with the right of a named beneficiary to insurance proceeds would fall within the scope of tortious interference with contractual relations. It does not necessarily follow, however, that one commits a tort by bringing an action, regardless of the action's merit, in which claims are made to insurance proceeds for which another is the named beneficiary. Aetna Life Ins. Co. v. Harley, 365 F. Supp. 1210 (N.D. Ga. 1973).

Trial court erred in denying a term life insurance policy beneficiary's motion for summary judgment against the employer of the beneficiary's parent when the employer accused the parent of having obtained the policy from funds which the parent embezzled from the employer because O.C.G.A. § 33-25-11 precluded the claim of the employer from defeating the designated beneficiary to the proceeds of the life insurance policy and the fraud exception authorized by the statute was not applicable. McCrary v. Middle Ga. Mgmt. Servs., 315 Ga. App. 247, 726 S.E.2d 740 (2012).

When an investor asserted fraudulent transfer and related claims against the beneficiaries of a life insurance policy on the life of a deceased consultant who allegedly defrauded the investor, the claims were properly dismissed because: (1) under O.C.G.A. § 33-25-11(a), which was vague, the investor was a "creditor," as the term was used in the statute; and (2) the statute insulated life insurance proceeds from the creditors' claims. Speedway Motorsports, Inc. v. Pinnacle Bank, 315 Ga. App. 320, 727 S.E.2d 151 (2012).

O.C.G.A. § 44-13-100 prevails over O.C.G.A. § 33-25-11. — O.C.G.A. § 44-13-100 is the statute specific to bankruptcy exemptions and therefore that statute prevails over the more general provisions of O.C.G.A. § 33-25-11; the Georgia General Assembly drafted the exemption statute, § 44-13-100, specifically with bankruptcy in mind. In doing

so, the General Assembly struck the intended balance between allowing a debtor in bankruptcy to exempt a limited amount of property in exchange for receiving a bankruptcy discharge; in striking this balance, the General Assembly limited the aggregate exemption in such policies to $2,000. In re Sapp, No. 11-30468, 2012 Bankr. LEXIS 2773 (Bankr. S.D. Ga. June 15, 2012).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, §§ 719 et seq., 809.

C.J.S. — 46A C.J.S., Insurance, § 1967.

ALR. — Refusal of insurer to consent to change of beneficiary in life policy as affecting right of trustee in bankruptcy of insured, 20 A.L.R. 256.

Rights and remedies of beneficiary after death of insured who had pledged policy to secure debt, 83 A.L.R. 77; 160 A.L.R. 1389; 91 A.L.R.2d 496.

Insurable interest of creditors in debtor's life as affected by discharge in bankruptcy or insolvency, or expiration of period of limitation as regards debt, 91 A.L.R. 876.

Validity, construction, and effect of by-law, statute, or other provision of life insurance contract which prevents payment to creditor of insured or beneficiary, 92 A.L.R. 911.

Retroactive effect of statute relating to exemption of proceeds of life or benefit insurance, 92 A.L.R. 1388.

Exemption of property purchased with exempt proceeds of insurance, 96 A.L.R. 410.

Validity and enforceability of promise by beneficiary of life insurance to insured to pay proceeds, in whole or part, to third person, 102 A.L.R. 588.

Accident insurance as life insurance within exemption law, 111 A.L.R. 61.

Statutory limitation of amount of proceeds of life insurance payable to estate or representatives of insured which is exempt from debts of insured as affected by fact that insured had a policy payable to another beneficiary, 141 A.L.R. 893.

Proceeds of life insurance left with insurer after maturity of policy as subject to claims of creditors of beneficiary, 164 A.L.R. 914.

Right of creditors of life insured as to options or other benefits available to him during his lifetime, 37 A.L.R.2d 268.

Testamentary direction for payment of debts or expenses of administration as affecting life insurance proceeds payable to estate, 56 A.L.R.2d 865.

Enforceability, in forum, of extraterritorial waiver of debtor's exemption valid where made, 60 A.L.R.2d 1449.

Qualification of life insurance proceeds held by insurer for federal estate tax marital deduction, 78 A.L.R.2d 1029.

What constitutes state or local law that is applicable on date of filing of bankruptcy petition for purposes of applying 11 U.S.C.A. § 522(b)(3)(A) or its predecessor in opt-out states, 76 A.L.R. Fed. 2d 333.

33-25-12. Contesting of policy after reinstatement.

A reinstated policy of life insurance may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

History. — Code 1933, § 56-2510, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 768 et seq.

C.J.S. — 46 C.J.S., Insurance, § 1222 et seq.

ALR. — Insurance: incontestable clause as excluding a defense based upon public policy, 13 A.L.R. 674; 35 A.L.R. 1491; 170 A.L.R. 1040.

Insurance: effect of incontestable clause on supplemental contracts, 45 A.L.R. 1369.

Express exception in incontestability clause as negativing other exceptions thereto, 88 A.L.R. 773.

Applicability of incontestable clause to defense based on false impersonation or mistake as to identity of person insured, 98 A.L.R. 710.

Change in, renewal of, or substitution for original policy of life insurance as affecting time limitation prescribed by original policy in respect of defenses available to insurer, 110 A.L.R. 1139.

Grounds for cancellation or rescission of annuity agreement, or for recovery back of property conveyed, or money paid, thereunder, 131 A.L.R. 424.

What amounts to contest within contemplation of incontestable clause, 95 A.L.R.2d 420.

33-25-13. Receipt of benefits from insurance policy of deceased by person found guilty of committing murder or voluntary manslaughter.

No person who commits murder or voluntary manslaughter or who conspires with another to commit murder shall receive any benefits from any insurance policy on the life of the deceased, even though the person so killing or conspiring be named beneficiary in the insurance policy. A plea of guilty or a judicial finding of guilt not reversed or otherwise set aside as to any of such crimes shall be prima-facie evidence of guilt in determining rights under this Code section. All right, interest, estate, and proceeds in such an insurance policy shall go to the other heirs of the deceased who may be entitled thereto by the laws of descent and distribution of this state, unless secondary beneficiaries be named in the policy, in which event such secondary beneficiaries shall take.

History. — Code 1933, § 56-2506, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Homicide generally, § 16-5-1 et seq.

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004).

For note, "Vesting Title in a Murderer: Where is the Equity in the Georgia Supreme Court's Interpretation of the Slayer Statute in Levenson?," see 45 Ga. L. Rev. 877 (2011).

JUDICIAL DECISIONS

Primary purpose of this section is to reduce the profits of crime. National Life & Accident Ins. Co. v. Thornton, 125 Ga. App. 589, 188 S.E.2d 435 (1972).

Murderer of insured cannot claim proceeds of policy on insured's life. — There exists throughout the United States a common-law principle that one who has murdered an insured cannot thereafter

claim the proceeds of the policy of insurance on the victim's life. Moore v. Moore, 228 Ga. 489, 186 S.E.2d 531 (1971).

It is a well settled rule that a beneficiary in a life insurance policy who murders or feloniously causes the death of the insured forfeits all rights which the beneficiary may have in or under the policy. This rule is based upon public policy and upon the principle that no one shall be allowed to benefit from his or her own wrong; it is applicable in both state and federal jurisdictions. Moore v. Moore, 228 Ga. 489, 186 S.E.2d 531 (1971).

Language was the same in both Ga. L. 1960, p. 289, § 1 and former Code 1933, § 113-909 (see O.C.G.A. § 33-25-13). — Former Code 1933, § 113-909 could or could not throw the assets there specified into the estate, depending upon the instrument executed by the decedent, but if the assets were a part of the estate, then the right to administer the assets was in the administrator or executor but former Code 1933, §§ 56-905 and 56-2505 (see O.C.G.A. § 33-25-11) specifically excluded the proceeds of life insurance policies made payable to beneficiaries (other than the insured, the insured's administrator, or the person procuring the policy) from the estate and established the right of the beneficiary as paramount to that of creditors and representatives of the insured. National Life & Accident Ins. Co. v. Thornton, 125 Ga. App. 589, 188 S.E.2d 435 (1972).

Rights of those who kill by accident or negligence not impaired. — Statutes that embody the public policy of Georgia of prohibiting wrongdoers from profiting from their crimes, O.C.G.A. §§ 17-14-31, 33-25-13, and 53-1-5, only prevent those who feloniously and intentionally kill, O.C.G.A. § 53-1-5(a), or those who commit murder or voluntary manslaughter, O.C.G.A. § 33-25-13, from sharing, respectively, in the decedent's estate or insurance policy proceeds; if a public policy may be gleaned from these statutes, it is a policy that prohibits those who commit murder or voluntary manslaughter from profiting from the victim's death, but these statutes do not impair the rights of those who kill by accident or negligence, who kill in self-defense or pursuant to any other legal justification, or who kill while legally insane because simply admitting to having committed a homicide does not make one a wrongdoer under Georgia law. Bruscato v. O'Brien, 307 Ga. App. 452, 705 S.E.2d 275 (2010).

Insured must affirmatively indicate that estate is intended as beneficiary. — Legislative scheme under former Code 1933, § 56-2506 (see O.C.G.A. § 33-25-13) and former Code 1933, § 113-909 was clear that, unless the insured affirmatively indicated that the estate was intended as beneficiary, the policy proceeds go to the beneficiary as against the claims of creditors or personal representatives of the deceased; this was generally true even when no beneficiary was named in the policy but a statute indicated for whose benefit the proceeds were to be used in such event. National Life & Accident Ins. Co. v. Thornton, 125 Ga. App. 589, 188 S.E.2d 435 (1972).

Payment to insured's estate when insured killed beneficiary and then committed suicide. — When insured could have changed beneficiary at any time, this section does not prohibit the payment of proceeds from life insurance policies to the insured's estate when the insured killed the policies' beneficiary and then committed suicide. Willis v. Frazier, 128 Ga. App. 748, 197 S.E.2d 830 (1973).

Evidence of conviction. — Certified copies of judgment entered on a cobeneficiary's manslaughter conviction in the death of the insured was prima facie evidence of cobeneficiary's guilt and sufficient to establish that cobeneficiary was not entitled to life insurance benefits. Stephens v. Adkins, 214 Ga. App. 653, 448 S.E.2d 734 (1994).

Under O.C.G.A. § 33-25-13, an individual's conviction in a criminal prosecution for a murder or voluntary manslaughter of an insured may serve as prima facie evidence of guilt in a civil proceeding brought pursuant to § 33-25-13 upon either the exhaustion of the individual's right to a direct appeal or the expiration of time within which a first direct appeal could have been timely filed; this construction furthers the public policy upon which § 33-25-13 is based, to insure that the individual shall not be allowed to

benefit from the individual's own wrong, and affords the individual the opportunity to challenge a criminal conviction through a direct appeal before imperiling the individual's rights to any insurance benefits. Slakman v. Cont'l Cas. Co., 277 Ga. 189, 587 S.E.2d 24 (2003).

Because a husband had been convicted of killing his wife, the estate executors were entitled to summary judgment for an order of distribution of life insurance proceeds under O.C.G.A. § 33-25-13. The husband's criminal conviction was prima facie evidence under former O.C.G.A. § 24-4-3 (see O.C.G.A. § 24-14-3) that he was guilty of his wife's murder for the purpose of determining that he could not receive proceeds of an insurance policy on her life. Cont'l Cas. Co. v. Adamo, 286 Fed. Appx. 625 (11th Cir. 2008) (Unpublished).

Certified copy of spouse's involuntary manslaughter conviction may not be considered as evidence that the spouse was innocent of an intentional homicide. Neal v. Neal, 160 Ga. App. 771, 287 S.E.2d 109 (1982).

When substantial fact issues existed as to whether an insurance policy provision transferring ownership to the insured was activated in an apparent murder/suicide case, and whether the insured had murdered the insured's spouse, the owner of the policy, it was error of the court to grant summary judgment. Bland v. Ussery, 172 Ga. App. 131, 322 S.E.2d 335 (1984).

Existence of genuine issue of fact as to whether beneficiary was perpetrator. — Summary judgment was improperly granted to a beneficiary in an insurer's interpleader action to determine whether the beneficiary was entitled to the life insurance policy proceeds of the insured, the beneficiary's wife, because evidence that the insured died of a gunshot wound while in Mexico, that the beneficiary was carrying a gun while in Mexico, and that the beneficiary lied about the insured's cause of death created a genuine issue of fact as to whether the beneficiary's recovery was barred under O.C.G.A. § 33-25-13; the fact that the beneficiary had been acquitted of the insured's murder had no impact on the outcome of the civil case because the civil case had a different burden of proof. Cantera v. Am. Heritage Life Ins. Co., 274 Ga. App. 307, 617 S.E.2d 259 (2005).

Murder-suicide. — When the risk for which the insured and insurer contracted included coverage only for accidental injury and excluded coverage for the intentional acts of a named beneficiary, the intentional homicide of one spouse by the other, suicidal spouse, a named beneficiary, was excluded from coverage under the contract terms and no proceeds were due to the victim's estate. Continental Cas. Co. v. Young, 181 Ga. App. 791, 354 S.E.2d 1 (1987).

Cited in Fannin v. Fannin, 133 Ga. App. 681, 212 S.E.2d 16 (1975); Stephens v. Adkins, 226 Ga. App. 648, 487 S.E.2d 440 (1997); Tolbert v. State, 282 Ga. 254, 647 S.E.2d 555 (2007); Levenson v. Word, 294 Ga. App. 104, 668 S.E.2d 763 (2008).

OPINIONS OF THE ATTORNEY GENERAL

Proceeds from state life insurance policy not payable to murderer. — When the surviving spouse of a state employee has been convicted of the employee's murder, and the surviving spouse was the beneficiary in the employee's state life insurance policy, the proceeds should be paid to the employee's estate, rather than to the surviving spouse; survivor's benefits under the retirement system, however, must be paid to the surviving spouse. 1972 Op. Att'y Gen. No. U72-61.

RESEARCH REFERENCES

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, §§ 1671 et seq., 2028.

C.J.S. — 46 C.J.S., Insurance, § 1231.

ALR. — Effect of unsuccessful attempt to change beneficiary of life insurance, 24 A.L.R. 750.

Construction and effect of provision relieving insurer if insured dies by hand of

beneficiary, "except by accident," 28 A.L.R. 832.

Right to proceeds of life insurance, as between estate of murdered insured and alternative beneficiary named in policy, where murderer was made primary beneficiary, 26 A.L.R.2d 987.

Killing of insured by beneficiary as affecting life insurance or its proceeds, 27 A.L.R.3d 794.

33-25-14. Unclaimed life insurance benefits; purpose; definitions; insurer conduct.

(a) This Code section shall be known and may be cited as the "Unclaimed Life Insurance Benefits Act."

(b) This Code section shall require recognition of the escheat or unclaimed property statutes of this state and require the complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits regulated by the Department of Insurance; provided, however, that neither the Commissioner nor the State Treasurer shall promulgate regulations or issue bulletins that impose, or interpret this Code section to impose, additional duties and obligations on insurers, beyond those set forth in this Code section, or otherwise attempt to expand the requirements of this Code section.

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

(1) "Account owner" means the owner of a retained asset account who is a resident of this state.

(2) "Annuity" means an annuity contract issued in this state. The term "annuity" shall not include any annuity contract used to fund an employment-based retirement plan or program where the insurer takes direction from the plan sponsor and plan administrator.

(3) "Death Master File" means the Social Security Administration's Death Master File or any other data base or service that is at least as comprehensive as the Social Security Administration's Death Master File for determining that a person has reportedly died.

(4) "Death Master File match" means a search of the Death Master File that results in a match of a person's name and social security number or the name and date of birth.

(5) "Insurer" means a life insurance company authorized to transact the class of insurance designated in Code Section 33-3-5 as Class (1).

(6) "Knowledge of death" means, for purposes of this chapter and Article 5 of Chapter 12 of Title 44:

(A) A receipt of an original or valid copy of a certified death certificate; or

(B) A Death Master File match validated by a secondary source by the insurer.

(7) "Person" means the policy owner, insured, annuity owner, annuitant, or account owner, as applicable under the policy, annuity, or retained asset account subject to this Code section.

(8) "Policy" means any policy or certificate of life insurance issued in this state. The term "policy" shall not include:

(A) Any policy or certificate of life insurance that provides a death benefit under an employee benefit plan subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1002, as periodically amended, or under any federal employee benefit program;

(B) Any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement;

(C) Any policy or certificate of credit life or accidental death insurance; or

(D) Any policy issued to a group master policyholder for which the insurer does not provide record keeping services.

(9) "Record keeping services" means those circumstances under which the insurer has agreed with a group policyholder to be responsible for obtaining, maintaining, and administering in its own systems information about each individual insured under an insured's group insurance contract, or a line of coverage thereunder, at least the following information:

(A) Social security number or name and date of birth;

(B) Beneficiary designation information;

(C) Coverage eligibility;

(D) Benefit amount; and

(E) Premium payment status.

(d)(1)(A) An insurer shall perform a comparison of its in-force policies, annuities, and retained asset accounts issued in this state against a Death Master File, on at least a semiannual basis, to identify potential Death Master File matches.

(B) An insurer may comply with the requirements of this subsection by using the full Death Master File once and thereafter using the Death Master File update files for future comparisons.

(C) Nothing in this subsection shall limit the insurer from requesting a valid death certificate as part of any claims validation process.

(2)(A) If an insurer learns of the possible death of a person, through a Death Master File match or otherwise, then the insurer shall within 90 days:

(i) Complete a good faith effort, which shall be documented by the insurer, to confirm the death of the person against other available records and information;

(ii) Review its records to determine whether the deceased person had purchased any other products with the insurer;

(iii) Determine whether benefits may be due in accordance with any applicable policy, annuity, or retained asset account; and

(iv) If the beneficiary or other authorized representative has not communicated with the insurer within the 90 day period, take reasonable steps, which shall be documented by the insurer, to locate and contact the beneficiary or beneficiaries or other authorized representative on any such policy, annuity, or retained asset account, including but not limited to sending the beneficiary information regarding the insurer's claims process, including the need to provide an official death certificate if applicable under the policy, annuity, or retained asset account.

(B) In the event the insurer is unable to confirm the death of a person following a Death Master File match, an insurer may consider such policy, annuity, or retained asset account to be in-force in accordance with its terms.

(3) To the extent permitted by law, an insurer may disclose minimum necessary personal information about a person or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(4) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a Death Master File search or verification of a Death Master File match conducted pursuant to this subsection.

(5) The benefits from a life insurance policy, annuity, or retained asset account, plus any applicable accrued interest, shall be payable pursuant to the terms of the contract or, if applicable, in accordance with probate law. In the event the proper recipients cannot be found, the benefits shall escheat to the state as unclaimed property pursuant to Code Section 44-12-198. Interest payable under Code Section 33-25-10 shall not be payable as unclaimed property under Code Section 44-12-198.

(6) The Commissioner may adopt such rules and regulations as may be reasonably necessary to implement the provisions of this subsection.

(7) The Commissioner may, in his or her reasonable discretion, make an order:

(A) Limiting an insurer's Death Master File comparisons required under paragraph (1) of this subsection to the insurer's electronic searchable files or approving a plan and timeline for conversion of the insurer's files to electronic searchable files;

(B) Exempting an insurer from the Death Master File comparisons required under paragraph (1) of this subsection or permitting an insurer to perform such comparisons less frequently than semiannually upon a demonstration of financial hardship by the insurer; or

(C) Phasing in compliance with this subsection according to a plan and timeline approved by the Commissioner.

(8) Failure to meet any requirement of this subsection with such frequency as to constitute a general business practice is a violation of Chapter 6 of this title. Nothing herein shall be construed to create or imply a private cause of action for a violation of this subsection.

(e) In the event that an insurer:

(1) Has identified a person as deceased through a Death Master File match through a search described in paragraph (1) of subsection (d) of this Code section or other information source;

(2) Has validated such information through a secondary information source; and

(3) Is unable to locate a beneficiary located in this state under the policy, annuity, or retained asset account after conducting reasonable search efforts during the period of up to one year after the insurer's validation of the Death Master File match, or if no beneficiary, if the person, as applicable for unclaimed reporting purposes, has a last known address in this state,

then the insurer is authorized to report and remit the proceeds of such policy, annuity, or retained asset account due to this state on an early reporting basis, without further notice or consent by the state, after attempting to contact such beneficiary pursuant to Code Section 44-12-198. Once reported and proceeds remitted, the insurer shall be relieved and indemnified from any and all additional liability to any person relating to the proceeds reported and remitted, including but not limited to any liability under Code Section 44-12-214 for all proceeds reported and remitted to the state pursuant to this subsection. This

indemnification from liability shall be in addition to any other protections provided by law.

History. — Code 1981, § 33-25-14, enacted by Ga. L. 2014, p. 233, § 1/HB 920; Ga. L. 2019, p. 337, § 1-93/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in subsection (b).

Editor's notes. — Ga. L. 2014, p. 233, § 2/HB 920, not codified by the General Assembly, provides: "This Act shall be applicable to policies issued or renewed on or after January 1, 2015."

33-25-15. Insurer prohibited from penalizing agent for apprising policy owner of alternatives to lapse or surrender of individual life insurance policy.

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

(1) "Agent" means a person that is the agent of record of a policy or that has a business relationship with the policy owner or insured.

(2) "Insurer" means the insurance company that issued or currently insures the policy.

(3) "Person" means an individual or a legal entity.

(4) "Policy" means an individual life insurance policy owned by an individual who is a resident of this state, regardless of whether such individual life insurance policy has been issued, delivered, or renewed in this state.

(b) No insurer or any other person shall terminate, fine, or otherwise penalize an agent for:

(1) Apprising a policy owner or his or her designee of options under the policy terms to the lapse or surrender of the policy; or

(2) Assisting a policy owner with securing any benefits under the policy terms.

History. — Code 1981, § 33-25-15, enacted by Ga. L. 2016, p. 211, § 1/HB 193.

CHAPTER 26

INDUSTRIAL LIFE INSURANCE

Sec.
33-26-1. "Industrial life insurance" defined.
33-26-2. Required and prohibited provisions generally.
33-26-3. Provision of disability benefits.
33-26-4. Notice of right of person to whom policy or contract issued to return policy or contract and receive premium refund; effect of return of policy or contract; proof of return.
33-26-5. Right of beneficiaries and assigns of insurance policies to proceeds as against creditors and representatives of insured.
33-26-6. Applicability of Code Sections 33-25-4, 33-25-5, 33-25-7, 33-25-9, 33-25-10, and 33-25-12.
33-26-6.1. Limits on aggregate face amount of policies insuring the life of one person.
33-26-6.2. Premium payment cap on whole life insurance policies.
33-26-7. Offering or delivering of policies or contracts in violation of chapter.

Cross references. — Definition of life insurance, § 33-7-4. Life insurance generally, T. 33, C. 25. Group life insurance, T. 33, C. 27. Annuity and pure endowment contracts, T. 33, C. 28.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Decedent's Intent to Change Beneficiary of Life Insurance Policy, 1 POF2d 437.

Fraudulent Cancellation of Life Insurance, 5 POF2d 587.

Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Litigating the Suicide Exclusion in Life Insurance Policies, 20 POF3d 705.

Insurer's Liability for Improper Issuance or Maintenance of Life Insurance Policy, Prompting Murder or Attempted Murder of Insured, 37 POF3d 149.

Substantial Compliance with Requirements of Life Insurance Policy Regarding Change of Beneficiary, 44 POF3d 377.

ALR. — Applicability to industrial life insurance of statutory provision making notice a condition of forfeiture or cancellation of insurance for nonpayment of premium, 7 A.L.R. 1562.

Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

Insurance: illustrations concerning accumulations, dividends, surplus, etc., 22 A.L.R. 1284; 127 A.L.R. 1464.

33-26-1. "Industrial life insurance" defined.

Industrial life insurance is that form of insurance under which not more than $2,000.00 on a single life, exclusive of additional benefits in the event of death from accidental means, is payable on any such policy for which the premiums are payable monthly or more frequently and which bears the words "industrial policy" or "weekly premium policy" or

words of similar import imprinted on the face of the policy as a part of the descriptive matter.

History. — Ga. L. 1905, p. 96, § 1; Civil Code 1910, § 2502; Ga. L. 1924, p. 51, § 1; Code 1933, § 56-1301; Code 1933, § 56-2901, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 936, § 1.

Law reviews. — For article surveying developments in Georgia insurance law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 143 (1981).

33-26-2. Required and prohibited provisions generally.

(a) No policy of industrial life insurance shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or contains provisions which in the opinion of the Commissioner are more favorable to policyholders:

(1) **Grace period.** A provision that the insured is entitled to a grace period of not less than 30 days within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in force. If a claim arises under the policy during such period of grace, the amount of any premium due or overdue may be deducted from any amount payable under the policy in settlement;

(2) **Incontestability.** A provision that the policy (exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means) shall be incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of two years from its date of issue;

(3) **Alteration of contract.** A provision that no agent shall have the power or authority to waive, change, or alter any of the terms or conditions of any policy, except that at the option of the insurer, prior to the issuance of a policy, the terms or conditions may be changed by an endorsement or rider which is signed by a duly authorized officer of the insurer and receipt of which is acknowledged by the applicant in writing;

(4) **Misstatement of age.** A provision that, if the age of the person insured or of any other person whose age is considered in determining the premium or benefit has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages;

(5) **Dividends.** A provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified

in the policy. Except as provided in this Code section, any dividend becoming payable shall, at the option of the party entitled to elect such option, be either payable in cash or applied to any one of such other dividend options as may be provided by the policy. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party has not elected some other option. If a policy specifies a period within which such other option may be elected, such period shall be not less than 30 days following the date on which such dividend is due and payable. The annually apportioned dividend shall be deemed to be payable in cash even though the policy provides that payment of such dividend is to be deferred for a specified period, provided that such period does not exceed six years from the date of apportionment and that interest will be added to such dividend at a specified rate. If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under such nonforfeiture provision shall be applied in the manner set forth in the policy;

(6) **Policy loans.** A provision that after three full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will loan on the execution of a proper note or loan agreement by the owner of the policy and on proper assignment of the policy and on the sole security thereof, at a specified rate of interest, a sum equal to or, at the option of the owner of the policy, less than the cash value of the policy at the end of the current policy year and of any dividend additions thereto. The policy shall further provide that the company may deduct from such loan value or from the proceeds of the loan any existing indebtedness on or secured by the policy not already deducted in determining such cash value, including interest due or accrued and any unpaid balance of the premium for the current policy year, and that the company may collect interest in advance of the loan to the end of the current policy year. The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six months after the application therefor. The policy may also provide that if interest on any indebtedness is not paid when due it shall then be added to the existing indebtedness and shall bear interest at the same rate. The policy may provide that if and when the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value thereof, then the policy shall terminate and become void, but not until at least 30 days' notice shall have been mailed by the insurer to the last known address of the insured or policy owner; of the individual identified by the policy

owner or insured as an additional contact, if any; and of any assignee of record at the home office of the insurer. The policy, at the insurer's option, may provide for an automatic premium loan, subject to an election of the party entitled to elect. No condition other than as provided in this paragraph shall be exacted as a prerequisite to any such loan. This paragraph shall not apply to term insurance or to term insurance benefits provided by rider or supplemental policy provisions or to any policy with a loan value of less than $25.00;

(7) **Tables of options and values.** A statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, reduced paid-up value, if any, and the extended term value, if any, available under the policy on each policy anniversary, either during the first 20 policy years or during the term of the policy, whichever is shorter. Upon written request, the company will furnish an extension of such table beyond the year shown in the policy. Such values and benefits shall be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy;

(8) **Reinstatement.** A provision that unless the policy has been surrendered for its cash surrender value or its cash surrender value has been exhausted or unless the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three years from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears, and the payment or reinstatement of any other indebtedness to the insurer upon the policy. All such sums may bear interest not exceeding 6 percent per annum compounded annually; provided, however, that acceptance of all or any part of a premium more than 30 days in arrears by the agent or company without requiring reinstatement application shall continue the policy in force without showing any lapse of time;

(9) **Title.** On each such policy there shall be placed a title which shall briefly and accurately describe the nature and form of the policy;

(10) **Payment of premiums.**

(A) A provision that all premiums shall be payable in advance either at the home or district office or to any agent of the company upon delivery of a receipt signed by the agent. Such receipt shall bear the agent's license number and the signature of one or more of the officers who shall be named in the policy;

(B) In the case of weekly premium policies, there shall be a provision that while premiums on the policy are not in default

beyond the grace period and upon proper notice to the insurer of the intention to pay future premiums directly to the insurer at its home office or any office designated by the insurer for the purpose, the insurer will, at the end of a period of 26 weeks from the due date of the first premium so paid and for any additional weekly premium payment thereafter, for which period such premiums are so paid continuously without default beyond the grace period, refund a stated percentage of the premiums in an amount which fairly represents the savings in collection expense.

(11) **Payment of claims.** A provision that, when a policy shall become a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and, at the insurer's option, surrender of the policy or proof of the interest of the claimant or both. If an insurer specifies a particular period prior to the expiration of which settlement shall be made, such period shall not exceed two months from the receipt of such proofs;

(12) **Entire contract.** A provision that, if any reference is made to the application for insurance or to the constitution, bylaws, or rules of the insurer as forming part of or affecting the policy between the parties, then there shall be included in or attached to said policy when issued a correct copy of the application signed by the applicant and the constitution, bylaws, and rules referred to. All statements made by the applicant in the application shall be deemed to be representations and not warranties. No statement in the application shall be used to void the policy or deny payment of a claim unless a copy of such application has been attached to and made a part of such policy when issued;

(13) **Conversion privilege.** A provision that, upon written request and without evidence of insurability (except for any additional amount of insurance), an industrial life insurance policyholder is guaranteed the privilege of converting any industrial insurance policy to any form of ordinary life insurance with less frequent premium payments regularly issued by the insurer and is guaranteed the privilege of converting small industrial policies with the same insurer into one larger policy with combined benefits; and

(14) **Space for name of designated beneficiary.** There shall be a space on the front or back page of the policy for the name of the designated beneficiary.

(b) Any of such required provisions or portions thereof not applicable to single premium or term policies or to provisions relating to disability benefits or to additional benefits in the event of death or dismemberment by accidental means shall to that extent not be incorporated therein.

(c) No policy of industrial life insurance shall contain any of the following provisions:

(1) A provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer;

(2) A provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical, or surgical treatment or attention. However, a policy may contain a provision which gives the insurer the right to declare the policy void if the insured has, within two years prior to the issuance of the policy, received institutional, hospital, medical, or surgical treatment or attention and the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk. The policy may also contain a provision that the policy shall not become effective if on the date of the application for the policy the insured had knowledge that he was afflicted with any serious disease tending to shorten life, which fact was not shown on the application for the policy; or

(3) A provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right is conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

(d) An exact copy of the application shall be given to the applicant at the time of the sale, which application shall disclose and contain the following information and language:

(1) An itemized list of all policies presently in force with all insurers, showing company names, premiums charged, amounts of insurance, total premiums, and total amounts of insurance provided;

(2) The premium cost of the insurance policy purchased;

(3) The premium cost for each optional additional benefit, if any, shall be shown separately and conspicuously apart from the premium charge for the basic natural death benefit; and

(4) The following statements shall appear on the applicant's copy in not less than ten-point type:

(A) "You may wish to compare the total cost of this insurance policy with your net income."

(B) "I hereby certify, as signed below, that I was given an exact copy of this application at the time this application was made to the

agent of record whose signature appears below.

_____

Applicant's Signature"

(C) "I, as the agent of record, hereby certify as signed below, that I gave the applicant, whose signature appears above, an exact copy of this application at the time this application was taken. I further certify that I have inquired of the applicant as to all policies in force and that I have listed all such policies on said application.

_____

Agent's Signature

_____

Agent's License Number"

(e) Policyholders or insureds who are 65 years of age and older shall have the option to provide the name and address of a person as an additional contact to the insurer who shall also be notified by the insurer in writing by mail to the last known address of such person prior to the lapse, termination, or cancellation of any industrial life insurance policy by the insurer.

History. — Code 1933, § 56-2902, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, §§ 56-2902, 56-2903, enacted by Ga. L. 1981, p. 936, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2002, p. 572, §§ 1, 2.

Law reviews. — For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979).

JUDICIAL DECISIONS

Insured's sibling's action when sibling was neither executor nor administrator. — Insured's sibling was not entitled to maintain action on industrial life insurance policy containing facility of payment clause giving insurer right to make payment to any one of a designated class equitably entitled thereto, including sibling of insured, when policy named as beneficiary only executor or administrator of insured, and sibling did not show that sibling was proceeding in either capacity. Simmons v. Metropolitan Life Ins. Co., 62 Ga. App. 55, 7 S.E.2d 824 (1940).

Question of contractual capacity determined by condition of insured's mind at time the change of beneficiary form was executed; but, in determining such an issue, it is permissible to receive and consider evidence as to the state of the insured's mind for a reasonable period both before and after the transaction under investigation. Cobb v. Garner, 158 Ga. App. 110, 279 S.E.2d 280 (1981).

Evidence of convictions for driving while intoxicated irrelevant. — Standing alone, the mere fact that the insured was intoxicated while driving a vehicle on two occasions in a previous year has no relevancy whatever on the issue of the insured's mental capacity to contract or whether the insured was under another's undue influence when the insured changed the beneficiary on the insured's life insurance policy. Cobb v. Garner, 158 Ga. App. 110, 279 S.E.2d 280 (1981).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 486 et seq.

ALR. — Forfeiture of life or accident insurance for nonpayment of premium

due to failure or neglect of one authorized by insured to pay same, 67 A.L.R. 180.

Physical condition which in itself is not within, or is expressly excluded from, the coverage of an insurance policy, a within such coverage when it results from or is directly attributable to a cause within the coverage, 108 A.L.R. 6.

Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

Incontestable clause of statute or policy as applicable to claims other than for death benefits, 121 A.L.R. 1437; 147 A.L.R. 1015.

Burden of proof in action upon accident policy, or accident feature of life policy, as to whether injury or death was result of antecedent disease or other abnormal bodily or mental condition, 144 A.L.R. 1416.

Right of insurer to restitution of payments made under mistake, 167 A.L.R. 470.

Change of beneficiary in old line insurance policy as affected by failure to comply with requirements as to manner of making change, 19 A.L.R.2d 5.

Incontestability clause as precluding insurer from defending on ground of particular clause in life policy limiting or precluding insurer's liability because of other life insurance, 22 A.L.R.2d 809.

Misrepresentation as to employer-employee relationship as within incontestability clause of group insurance, 26 A.L.R.3d 632.

33-26-3. Provision of disability benefits.

Any policy of industrial life insurance may provide a weekly benefit for disability, caused by sickness or accident, not greater than $40.00 per week.

History. — Code 1933, § 56-2904, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-2905, as redesignated by Ga. L. 1981, p. 936, § 1.

RESEARCH REFERENCES

C.J.S. — 46 C.J.S., Insurance, §§ 1591, 1745 et seq.

ALR. — Mental incapacity or disease as constituting total or permanent disability within insurance coverage, 22 A.L.R.3d 1000.

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.

33-26-4. Notice of right of person to whom policy or contract issued to return policy or contract and receive premium refund; effect of return of policy or contract; proof of return.

(a) Every industrial life policy or contract issued for delivery in this state shall have printed thereon or attached thereto a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days after receipt thereof and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason.

(b) If the purchaser, pursuant to such notice, returns the policy or contract to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

(c) Without limiting any other method of returning a policy or contract under this Code section, it shall be prima-facie evidence of the fact and date of return of a policy or contract if the policy or contract is dispatched by at least first-class mail to the insurer or agent, as provided in this Code section and a receipt provided by the United States Postal Service is obtained.

History. — Code 1933, § 56-2906, enacted by Ga. L. 1979, p. 786, § 5; Code 1933, § 56-2907, as redesignated by Ga. L. 1981, p. 936, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, a hyphen was inserted in the phrase "first-class mail" in subsection (c).

33-26-5. Right of beneficiaries and assigns of insurance policies to proceeds as against creditors and representatives of insured.

The proceeds and avails of any industrial life insurance policy shall be free from the claims of creditors and representatives of the insured and of persons effecting the same to the same extent and under the same conditions as provided for in the case of other life insurance policies under Code Section 33-25-11.

History. — Code 1933, § 56-2905, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-2906, as redesignated by Ga. L. 1981, p. 936, § 1.

RESEARCH REFERENCES

ALR. — Enforceability, in forum, of extraterritorial waiver of debtor's exemption valid where made, 60 A.L.R.2d 1449.

33-26-6. Applicability of Code Sections 33-25-4, 33-25-5, 33-25-7, 33-25-9, 33-25-10, and 33-25-12.

In addition to the requirements specifically set forth in this chapter, no policy of industrial life insurance shall be delivered or issued for delivery in this state unless it complies with Code Sections 33-25-4, 33-25-5, 33-25-7, 33-25-9, 33-25-10, and 33-25-12.

History. — Code 1933, § 56-2903, enacted by Ga. L. 1960, p. 289, § 1; Code 1933, § 56-2904, as redesignated by Ga. L. 1981, p. 936, § 1.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 486 et seq.

33-26-6.1. Limits on aggregate face amount of policies insuring the life of one person.

No insurer shall knowingly issue an industrial life insurance policy insuring the life of a person if the issuance of such policy would cause the aggregate face amount of industrial life insurance payable on the life of such person under any and all such policies issued by such insurer to exceed the sum of $2,000.00, exclusive of additional benefits in the event of death from accidental means.

History. — Code 1933, § 56-2901, enacted by Ga. L. 1981, p. 936, § 1.

33-26-6.2. Premium payment cap on whole life insurance policies.

(a) No insurer shall issue a policy which allows for the collection or payment of premiums which in the aggregate will be greater than 150 percent of the face amount of the policy.

(b) This Code section shall apply to industrial whole life policies, which are policies which may be kept in force for a person's whole life and which pay a benefit upon the person's death, whenever such death occurs, or policies which may have a designated age certain, as specified in the policy, when premium payments would cease.

History. — Code 1981, § 33-26-6.2, enacted by Ga. L. 2002, p. 572, § 3.

33-26-7. Offering or delivering of policies or contracts in violation of chapter.

Any company, agent, representative, or solicitor for the company, agent, or representative who shall write, offer to the public, or deliver to any insured any policy or contract of insurance which in form or legal effect is contrary to or in violation of this chapter with respect to cash surrender value, extended insurance, or other benefits in case of lapsed industrial life insurance policies shall be guilty of a misdemeanor.

History. — Code 1933, § 56-9909, enacted by Ga. L. 1960, p. 289, § 1.

CHAPTER 27

GROUP LIFE INSURANCE

Sec.
33-27-1. Group requirements generally.
33-27-2. Extension of policy coverage to dependents of employees or members.
33-27-3. Required policy provisions.
33-27-4. Payment of interest on proceeds or payments under policies of group life insurance.
33-27-5. Notification of policyholder of right to convert group policy to individual life insurance policy.
33-27-6. Assignment of incidents of ownership in group life insurance policies.
33-27-7. Right of beneficiaries and assignees of insurance policies to proceeds as against creditors and representatives of insured.
33-27-8. Standards and requirements for rating of small groups under group life insurance; exemptions.
33-27-9. Notices of life insurance premium increases to be mailed or delivered to group life insurance policyholder.

Cross references. — Definition of life insurance, § 33-7-4. Life insurance generally, T. 33, C. 25. Industrial life insurance, T. 33, C. 26. Annuity and pure endowment contracts, T. 33, C. 28.

Law reviews. — For note on 1990 amendment of Code sections within this chapter, see 7 Ga. St. U.L. Rev. 320 (1990).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Decedent's Intent to Change Beneficiary of Life Insurance Policy, 1 POF2d 437.

Fraudulent Cancellation of Life Insurance, 5 POF2d 587.

Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Litigating the Suicide Exclusion in Life Insurance Policies, 20 POF3d 705.

Insurer's Liability for Improper Issuance or Maintenance of Life Insurance Policy, Prompting Murder or Attempted Murder of Insured, 37 POF3d 149.

Substantial Compliance with Requirements of Life Insurance Policy Regarding Change of Beneficiary, 44 POF3d 377.

ALR. — Apportionment or contribution as between specific and blanket insurance policies, 169 A.L.R. 387.

33-27-1. Group requirements generally.

No policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) **Employee groups.** A policy issued to an employer or to the trustees of a fund established by an employer, which employer or trustee shall be deemed the policyholder, to insure employees of the

employer for the benefit of persons other than the employer, subject to the following requirements:

(A) The employees eligible for insurance under the policy shall be all of the employees of the employer or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors, or partnerships, if the business of the employer and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership or contract or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(B) The premium for the policy shall be paid by the policyholder either from the employer's own funds or from charges collected from the insured employee specifically for such insurance or from funds contributed by both the employer and the employee. A policy in which no part of the premium is to be derived from funds contributed by the insured employee must insure each eligible employee, except for any employee as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at least two employees at date of issue; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees or by the employer or trustee.

(2) **Debtor groups.** A policy issued to a creditor or to a trustee or agent appointed by two or more creditors, which creditor, trustee, or agent shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements:

(A) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable either in installments, including any extraordinary payment of an installment or lease-purchase obligation, or in one sum at the end of a period not in excess of 24 months from the initial date of debt

or all of any class or classes thereof determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" shall include the debtors of one or more subsidiary corporations and the debtors of one or more affiliated corporations, proprietors, or partnerships, if the business of the policyholder and of such affiliated corporations, proprietors, or partnerships is under common control through stock ownership, contract, or otherwise. No debtor shall be eligible unless the indebtedness constitutes an irrevocable obligation to repay which is binding upon him during his lifetime at the time the insurance becomes effective upon his life;

(B) The premium for the policy shall be paid by the policyholder either from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least 75 percent of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges must insure all eligible debtors or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy may be issued only if the policy reserves to the insurer the right to require evidence of individual insurability if less than 75 percent of the new entrants become insured. The policy may exclude from the classes eligible for insurance classes of debtors determined by age;

(D) The amount of insurance on the life of any debtor shall at no time exceed the amount owed by him which is repayable in installments, the amount of the unpaid indebtedness, or $75,000.00, whichever is less. Where the indebtedness is repayable in one sum to the creditor, the insurance on the life of any debtor shall in no instance be in effect for a period in excess of 24 months, except that such insurance may be continued for an additional period not exceeding six months in the case of default, extension, or recasting of the loan; and

(E) The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

(3) **Mortgagee group.** A policy issued to a creditor, or to a trustee or agent appointed by two or more creditors, which creditor, trustee,

or agent shall be deemed the policyholder, to insure mortgagors of the creditor. The insurance must be written in connection with a credit transaction that is secured by a first mortgage or deed of trust; made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for the purpose; and shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid mortgage of the mortgagor to the extent of such payment.

(4) **Agricultural loans.** Notwithstanding the provisions of this Code section, group life insurance in connection with agricultural loans may be written up to the amount of the loan or loan commitment on the nondecreasing or level term plan; however, the amount of insurance on the life of any such debtor shall not on any anniversary date of the insurance exceed the amount then owed by him which is repayable in installments, the amount of the then unpaid indebtedness, or $75,000.00, whichever is less.

(5) **Labor union groups.** A policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives, or agents, subject to the following requirements:

(A) The members eligible for insurance under the policy shall be all of the members of the union or all of any class or classes thereof determined by conditions pertaining to their employment or to membership in the union, or both;

(B) The premium for the policy shall be paid by the policyholder either wholly from the union's funds or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at least 25 members at date of issue; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union.

(6) **Trustee groups.** A policy issued to the trustees of a fund established by two or more employers or by one or more labor unions or by one or more employers and one or more labor unions, which

trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(A) The persons eligible for insurance shall be all of the employees of the employers, all of the members of the unions, or all of any class or classes of employees or union members determined by conditions pertaining to their employment, to membership in the unions, or to both. The policy may provide that the term "employees" shall include retired employees and the individual proprietor or partners if an employer is an individual proprietor or a partnership. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(B) The premium for the policy shall be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons, by the union or unions, or by both or partly from such funds and partly from funds contributed by the insured persons. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured persons specifically for their insurance. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons or all except any as to whom evidence of individual insurability is not satisfactory to the insurer;

(C) The policy must cover at date of issue at least 100 persons; and, if the fund is established by the members of an association of employers, the policy may be issued only if either the participating employers constitute at date of issue at least 60 percent of those employer members whose employees are not already covered for group life insurance or the total number of persons covered at date of issue exceeds 600; and the policy shall not require that, if a participating employer discontinues membership in the association, the insurance of his employees shall cease solely by reason of the discontinuance; and

(D) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions.

(7) **Association groups.** The lives of a group of individuals may be insured under a policy issued to an association, which shall be deemed the policyholder, to insure members of such association for the benefit of persons other than the association. As used in this paragraph, the term "association" means an association of governmental or public employees, an association of employees of a common employer, or an organization formed and operated in good faith for purposes other than that of procuring insurance and composed of members engaged in a common trade, business, or profession. The policy shall be subject to the following requirements:

(A) The members eligible for insurance under the policy shall be all of the members of the association or all of any class or classes of the association determined by conditions pertaining to their employment, to their trade, business, or profession, to their membership in the association, or to any two or more of such conditions. The policy may provide that officers and employees of the association who are bona fide members may be insured under the policy;

(B) The policy must cover at least 25 members at date of issue;

(C) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the association or by the members; and

(D) The premium for the policy shall be paid by the policyholder either from the association's own funds, or from charges collected from the insured members specifically for the insurance, or from both.

(8) **Bank and credit union groups.** A bank authorized to do business in this state may carry insurance upon its depositors for amounts not to exceed the savings deposit balances of each depositor or $5,000.00, whichever is less, and a credit union organized pursuant to the laws of this state or the Federal Credit Union Act may carry insurance upon its members for amounts not to exceed the share and deposit balances of each member or $5,000.00, whichever is less. Such insurance shall be subject to the requirements of subparagraphs (A) through (D) of paragraph (7) of this Code section.

(9) **Multiple employer welfare arrangements.**

(A) The lives of a group of individuals may be insured under a policy issued to a legal entity providing a multiple employer welfare arrangement. As used in this paragraph, the term "multiple employer welfare arrangement" means any employee benefit plan which is established or maintained for the purpose of offering or providing life insurance benefits to the employees of two or more employers, including self-employed individuals and their depen-

dents. The term does not apply to any plan or arrangement which is established or maintained by a tax-exempt rural electric cooperative or a collective bargaining agreement.

(B) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees, employers, or trustee.

(10) **Special employee groups.** An entity or a trustee of a trust established by an entity which has an insurable interest in employees pursuant to subsection (d) of Code Section 33-24-3 and authority to effectuate insurance on employees pursuant to paragraph (4) or (5) of subsection (a) of Code Section 33-24-6 may establish an employee group to effectuate group life insurance policies on employees when such corporation or trustee of a trust is providing life, health, disability, retirement, or similar benefits to employees, provided that the premium for such group policies is wholly paid by the corporation or trustee of the trust and the proceeds of such policies are used to provide supplemental funding for such employee benefit plans.

(11) **Discretionary groups.** Group life insurance offered to a resident of this state under a group life insurance policy issued to a group other than one described in paragraphs (1) through (10) of this Code section shall be subject to the following requirements:

(A) No such group life insurance policy shall be delivered in this state unless the Commissioner finds that:

(i) The issuance of such group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged;

(B) No such group life insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or such other state having requirements substantially similar to those contained in divisions (i) through (iii) of subparagraph (A) of this paragraph has made a determination that the requirements have been met;

(C) The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both; and

(D) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

History. — Code 1933, § 56-2701, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 1814, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 464, §§ 1, 2; Ga. L. 1985, p. 616, § 1; Ga. L. 1987, p. 1333, § 1; Ga. L. 1987, p. 1486, §§ 1-5; Ga. L. 1989, p. 883, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1990, p. 1402, § 1; Ga. L. 1993, p. 1721, § 5; Ga. L. 1994, p. 97, § 33; Ga. L. 1998, p. 768, § 1; Ga. L. 2005, p. 481, § 4/HB 291; Ga. L. 2006, p. 869, § 3/HB 1484; Ga. L. 2013, p. 762, § 1/HB 103.

U.S. Code. — The Federal Credit Union Act, referred to in this Code section, is codified as 12 U.S.C. § 1751 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).

JUDICIAL DECISIONS

Debtors groups. — This section refers to "debtor groups" and is for purpose of avoiding discrimination between members of such a group; failure to meet this restriction results in prohibition against delivery of the policy in this state. Parramore Farms, Inc. v. John Deere Co., 159 Ga. App. 774, 285 S.E.2d 233 (1981).

This section prohibits an insured employee from naming "the employer" as beneficiary of group policy; sole shareholders of the employer corporation are not encompassed within the meaning of "employer." Bohannon v. Manhattan Life Ins. Co., 555 F.2d 1205 (5th Cir. 1977).

Cited in Schulman v. Federated Life Ins. Co., 154 Ga. App. 479, 268 S.E.2d 704 (1980); Gowen v. Georgia Int'l Life Ins. Co., 163 Ga. App. 75, 293 S.E.2d 729 (1982); Connecticut Gen. Life Ins. Co. v. Wood, 631 F. Supp. 9 (N.D. Ga. 1984).

OPINIONS OF THE ATTORNEY GENERAL

Premium charges other than those approved by Commissioner unauthorized. — Any premium charge made to the debtor other than as filed with and approved by the Commissioner of Insurance and consistent with the premium rate charged by the insurer is unauthorized. 1965-66 Op. Att'y Gen. No. 66-184.

Elements of unfair discrimination in premiums charged. — Unfair discrimination in premiums for life insurance, accident insurance, or sickness insurance was prohibited by former Code 1933, § 56-701 (see O.C.G.A. § 33-6-1); however, for unfair discrimination to exist, 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 could be different and at the same time could also be legal. 1974 Op. Att'y Gen. No. 74-81.

Eligible employees may include nonresidents of state. — Paragraph (5) of this section authorizes group policies issued to "trustee groups" to include eligible employees, as defined in this section, who are not residents of this state; and paragraph (6) of this Code section likewise authorizes the inclusion of such nonresidents in group policies issued to "association groups." 1962 Op. Att'y Gen. p. 291.

Directors not includable unless otherwise eligible as bona fide employees. — Group policy issued to employer to cover employees under this section may not legally include directors who are not otherwise eligible as bona fide employees performing duties other than those of directors. 1963-65 Op. Att'y Gen. p. 663.

All holders of particular brand of credit card do not appear to constitute a permissible group for which a group policy of life insurance may be issued. 1972 Op. Att'y Gen. No. 72-66.

RESEARCH REFERENCES

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, §§ 1831 et seq., 1872 et seq.

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 291.

C.J.S. — 44 C.J.S., Insurance, § 486 et seq. 45 C.J.S., Insurance, § 676 et seq.

ALR. — Group life insurance policy for benefit of union members, 17 A.L.R.2d 927.

Group insurance: construction of provision limiting coverage to full-time employees, 57 A.L.R.3d 801.

Construction and application of Federal Credit Union Act of 1934 (FCUA) (12 U.S.C.A. §§ 1751 to 1795k), 89 A.L.R. Fed. 2d 357.

33-27-2. Extension of policy coverage to dependents of employees or members.

(a) Any policy issued pursuant to paragraphs (1), (4), and (5) of Code Section 33-27-1 may be extended to insure the employees or members against loss due to the death of their spouses and dependent or minor children or any class or classes thereof, subject to the following requirements:

(1) The premium for the insurance shall be paid by the policyholder either from the employer's or union's funds or funds contributed by the insured employees or members, or from both. If no part of the premium is to be derived from funds contributed by the employees or members, all eligible employees or members, excluding any as to whose family members' evidence of insurability is not satisfactory to the insurer, must be insured with respect to their spouses and children;

(2) The insurance must be based on some plan precluding individual selection by the employees or members or by the policyholder, employer, or union;

(3) Upon termination of the insurance with respect to the members of the family of any employee or member by reason of the employee's or member's termination of employment, termination of membership in the class or classes eligible for coverage under the policy, or death, the spouse shall be entitled to have issued by the insurer without evidence of insurability an individual policy of life insurance without disability or other supplementary benefits, providing application for the individual policy shall be made and the first premium paid to the insurer within 31 days after such termination, subject to the requirements of paragraph (8) of subsection (a) of Code Section 33-27-3. If the group policy terminates or is amended so as to terminate the insurance of any class of employees or members and the employee or member is entitled to have issued an individual policy under paragraph (9) of subsection (a) of Code Section 33-27-3, the spouse shall

also be entitled to have issued by the insurer an individual policy, subject to the conditions and limitations provided in this Code section. If the spouse dies within the period during which the spouse would have been entitled to have an individual policy issued in accordance with this provision, the amount of life insurance which the spouse would have been entitled to have issued under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

(b) Notwithstanding paragraph (7) of subsection (a) of Code Section 33-27-3, only one certificate need be issued for delivery to an insured person if a statement concerning any dependent's coverage is included in the certificate.

History. — Code 1933, § 56-2703, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1969, p. 22, § 1; Ga. L. 1969, p. 430, § 1; Ga. L. 1969, p. 612, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 822, §§ 1, 2; Ga. L. 1985, p. 998, § 1; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2013, p. 762, § 2/HB 103.

RESEARCH REFERENCES

ALR. — 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.

33-27-3. Required policy provisions.

(a) No policy of group insurance shall be delivered in this state unless it contains in substance the following provisions or provisions which in the opinion of the Commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(1) A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue and that no statement made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance, with respect

to which the statement was made, after the insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him or her;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or to his or her beneficiary;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of his or her coverage;

(5) A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(6) A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except as otherwise provided in paragraph (11) of this subsection, subject to the provisions of the policy, in the event there is no designated beneficiary living at the death of the person insured, as to all or any part of such sum and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding $500.00 to any person appearing to the insurer to be entitled equitably thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured;

(7) A provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which he or she is entitled, the person to whom the insurance benefits are payable, and the rights and conditions set forth in paragraphs (8) through (10) of this subsection;

(8) A provision that, if the insurance or any portion of it on a person covered under the policy other than the child of an employee insured pursuant to Code Section 33-27-2 ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the person shall be entitled to have issued to him or her by the insurer without evidence of insurability an individual policy of life insurance without disability or other

supplementary benefits. Application for the individual policy shall be made and the first premium paid to the insurer within 31 days after termination of employment or of membership in the class or classes eligible for coverage under the policy. The individual policy shall at the option of the person be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for. The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of the termination, less the amount of any life insurance for which such person is or becomes eligible within 31 days after termination under the same or any other group policy, provided that any amount of insurance which shall have matured on or before the date of the termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not for the purposes of this paragraph be included in the amount which is considered to cease because of such termination. The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to his or her age attained on the effective date of the individual policy;

(9) A provision that, if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured under the group policy at the date of such termination, other than a child of an employee insured pursuant to Code Section 33-27-2, whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued to him or her by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by paragraph (8) of this subsection, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he or she is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after such termination, and $2,000.00;

(10) A provision that, if a person insured under the group policy dies during the period within which he or she would have been entitled to have an individual policy issued to him or her in accordance with paragraph (8) or (9) of this subsection, before such an individual policy shall have become effective, the amount of life insurance which he or she would have been entitled to have issued to him or her under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made; and

(11) An entity or trustee of a trust having an insurable interest pursuant to subsection (d) of Code Section 33-24-3 and effectuation authority pursuant to paragraph (4) or (5) of subsection (a) of Code Section 33-24-6, providing life, health, disability, retirement, or similar benefits to employees may designate the beneficiary of a group life insurance policy, provided that the corporation or trustee of a trust uses the insurance proceeds to provide life, health, disability, retirement, or similar benefits to such employees. As used in this paragraph, the term "employees" shall include directors, officers, employees, retired employees, or the dependents of such persons. The term "employee" shall include any former employee, but only for the purpose of replacing existing life insurance that will be surrendered in exchange for new life insurance in an amount not exceeding the insurance being surrendered.

(b)(1) The provisions of paragraphs (6), (8), (9), and (10) of subsection (a) of this Code section shall not apply to policies issued to a creditor to insure debtors or mortgagors of such creditor.

(2) The standard provisions required for individual life insurance policies shall not apply to group insurance policies.

(3) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the Commissioner is or are equitable to the insured persons and to the policyholder, but nothing in this Code section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

(4) The provisions of paragraphs (6), (7), (8), (9), and (10) of subsection (a) of this Code section shall not apply to policies issued to a corporation or trustee of a trust pursuant to paragraph (9) of Code Section 33-27-1.

History. — Code 1933, § 56-2704, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 3, § 24; Ga. L. 1985, p. 149, § 33; Ga. L. 1993, p. 1721, §§ 6, 7; Ga. L. 1995, p. 776, § 4; Ga. L. 2005, p. 481, § 5/HB 291; Ga. L. 2006, p. 869, § 4/HB 1484.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1993, in paragraph (b)(4), "Code section" was substituted for "Code Section" and "paragraph (9)" was substituted for "subsection (9)".

Law reviews. — For article surveying developments in Georgia contracts law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 67 (1981).

For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979). For note on the 1995 amendment of this Code section, see 12 Ga. St. U.L. Rev. 264 (1995).

JUDICIAL DECISIONS

Incontestability clauses contained in policies do not bar insurance companies from raising the defense that an insured neither applied for nor consented in writing to the insurance contracts. Wood v. New York Life Ins. Co., 255 Ga. 300, 336 S.E.2d 806 (1985).

Cited in Trust Co. v. Guardian Life Ins. Co. of Am., 124 Ga. App. 465, 184 S.E.2d 363 (1971); Rainey v. Guardian Life Ins. Co. of Am., 168 Ga. App. 577, 309 S.E.2d 649 (1983); Republic Nat'l Life Ins. Co. v. Taylor, 752 F.2d 523 (11th Cir. 1985).

RESEARCH REFERENCES

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, § 1831 et seq.

C.J.S. — 45 C.J.S., Insurance, §§ 631, 843 et seq. 46A C.J.S., Insurance, § 2122 et seq.

ALR. — Right of second wife to take under policy designating "wife" or "widow" as beneficiary, issued during life of first wife, 20 A.L.R. 959.

Forfeiture of life or accident insurance for nonpayment of premium due to failure or neglect of one authorized by insured to pay same, 67 A.L.R. 180.

Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

Right of insurer to restitution of payments made under mistake, 167 A.L.R. 470.

Group insurance: failure of employer or insurer to notify employee dropped from pay roll of necessity for and time of contribution to premium, 2 A.L.R.2d 852.

Incontestability clause as precluding insurer from defending on ground of particular clause in life policy limiting or precluding insurer's liability because of other life insurance, 22 A.L.R.2d 809.

Misrepresentation as to employer-employee relationship as within incontestability clause of group insurance, 26 A.L.R.3d 632.

Construction and effect of "visible sign of injury" and similar clauses in accident provision of insurance policy, 28 A.L.R.3d 413.

Change of beneficiary in group life insurance policy as affected by failure to comply with policy requirements as to manner of making change, 78 A.L.R.3d 466.

Group insurance: binding effects of limitations on or exclusions of coverage contained in master group policy but not in literature given individual insureds, 6 A.L.R.4th 835.

33-27-4. Payment of interest on proceeds or payments under policies of group life insurance.

Each insurer admitted to transact life insurance in this state shall pay interest on proceeds or payments under any policy of group life insurance payable to a beneficiary residing in this state, to a beneficiary under a policy issued in this state, or to a beneficiary under a policy insuring a person resident in this state at the time of death, in accordance with Code Section 33-25-10.

History. — Code 1933, § 56-2503.1, enacted by Ga. L. 1978, p. 2297, § 1.

RESEARCH REFERENCES

ALR. — Who are "blood relatives" within statute or rules as to beneficiaries of insurance in mutual benefit societies, 10 A.L.R. 864.

Liability of insurer for damages resulting from delay in passing upon an application for life insurance, 1 A.L.R.4th 1202.

33-27-5. Notification of policyholder of right to convert group policy to individual life insurance policy.

(a) If any individual insured under a group insurance policy delivered in this state becomes entitled under the terms of the policy to have an individual policy of life insurance issued to him or her without evidence of insurability, subject to making of application therefor and payment of the first premium within the period specified in such policy and, if such individual is not given notice of the existence of the right at least 15 days prior to the expiration date of the period, in such event the individual shall have an additional period within which to exercise the right, but nothing contained in this Code section shall be construed to continue any insurance beyond the period provided in the policy. This additional period shall expire 15 days after such individual is given notice, but in no event shall the additional period extend beyond 60 days after the expiration date of the period provided in the policy.

(b) Written notice presented to the individual or mailed by the policyholders to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder shall constitute notice for the purpose of this Code section.

(c) Nothing in this Code section shall have the effect of extending the time within which a death claim shall be paid under the policy as provided in paragraph (10) of subsection (a) of Code Section 33-27-3.

(d) Inclusion of a statement of this conversion privilege in the insurance certificate issued to the individual insured shall constitute a notice of conversion privileges to the individual insured as required by this Code section.

History. — Code 1933, § 56-2705, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 81/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (a), in the first sentence, deleted "hereafter" following "group insurance policy" near the beginning, inserted "or her" near the middle, substituted "if such individual" for "if the individual" in the middle and revised punctuation, and substituted "after such individual is given notice, but" for "after the individual is given notice but" near the middle of the second sentence.

RESEARCH REFERENCES

ALR. — Group insurance: construction, application, and effect of policy provision extending conversion privilege to employee after termination of employment, 32 A.L.R.4th 1037.

33-27-6. Assignment of incidents of ownership in group life insurance policies.

Nothing in this title or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of his or her incidents of ownership under the policy, including, but not limited to, the privilege to have issued to him or her an individual policy of life insurance pursuant and subject to paragraphs (8) and (9) of subsection (a) of Code Section 33-27-3 and Code Section 33-27-5 and the right to name a beneficiary. Subject to the terms of the policy or agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership under the policy, an assignment made by an insured is valid for the purpose of vesting in the assignee, in accordance with any provisions included in the policy as to the time at which it is to be effective, all of the incidents of ownership so assigned without prejudice to the insurer on account of any payment it may make or individual policy it may issue in accordance with paragraphs (8) and (9) of subsection (a) of Code Section 33-27-3 prior to receipt of notice of the assignment.

History. — Code 1933, § 56-2707, enacted by Ga. L. 1969, p. 32, § 1; Ga. L. 2019, p. 386, § 82/SB 133.

The 2019 amendment, effective July 1, 2019, in the first sentence, inserted "or her" in two places, inserted a comma following "including" and "but not limited to", and substituted "an assignment made by an insured is valid" for "an assignment by an insured made either before or after July 1, 1969, is valid" in the middle of the second sentence.

RESEARCH REFERENCES

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, §§ 1869 et seq., 1884 et seq.

C.J.S. — 45 C.J.S., Insurance, § 733 et seq.

ALR. — Law governing assignment of life insurance policy or of rights thereunder, 97 A.L.R.2d 1399.

Change of beneficiary in group life insurance policy as affected by failure to comply with policy requirements as to manner of making change, 78 A.L.R.3d 466.

33-27-7. Right of beneficiaries and assignees of insurance policies to proceeds as against creditors and representatives of insured.

(a) The proceeds and avails of any group life insurance policy shall be free from the claims of creditors and representatives of the insured and

of the person effecting the same to the same extent and under the same conditions as provided for in the case of other life insurance policies under Code Section 33-25-11.

(b) This Code section shall not apply to group life insurance issued to a creditor covering his debtors to the extent that the proceeds are applied to payment of the obligation for the purpose of which the insurance was issued.

History. — Code 1933, § 56-2706, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, §§ 802 et seq., 1671 et seq., 1738.

C.J.S. — 46A C.J.S., Insurance, § 1967.

ALR. — Statutory limitation of amount of proceeds of life insurance payable to estate or representatives of insured which is exempt from debts of insured as affected by fact that insured had a policy payable to another beneficiary, 141 A.L.R. 893.

Testamentary direction for payment of debts or expenses of administration as affecting life insurance proceeds payable to estate, 56 A.L.R.2d 865.

Enforceability, in forum, of extraterritorial waiver of debtor's exemption valid where made, 60 A.L.R.2d 1449.

33-27-8. Standards and requirements for rating of small groups under group life insurance; exemptions.

(a) As used in this Code section, the term "small group" means a group or subgroup of 50 or fewer employees, members, or enrollees.

(b) The claims experience produced by small groups covered under group life insurance for each insurer shall be fully pooled for rating purposes. Except to the extent that the claims experience of an individual small group affects the overall experience of the small group pool, the claims experience produced by any individual small group of an insurer shall not be used in any manner for rating purposes or solely as a reason for termination of any individual small group.

(c) Each insurer's small group pool shall consist of each insurer's total claims experience produced by all small groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group life insurance. The pool shall include the experience generated under separate group contracts; contracts issued to trusts, multiple employer trusts, or association groups or trusts; or any other group-type coverage. The experience produced under multiple employer trusts or arrangements through contracts issued in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement for all the Georgia small groups shall be fully pooled for rating purposes. Multiple

employer trusts or arrangements shall include any group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, for sole proprietors, employers, or both.

(d) Notwithstanding subsection (b) of this Code section, age, sex, area, industry, occupational, and avocational factors may be considered in the initial and renewal rating of each small group. Durations since issue and tier factors may not be considered. Substandard rating in accordance with recognized underwriting practices may be applied to each employee, member, or enrollee and to each dependent member of the small group in the initial underwriting of a new or replacement group or when the member or dependent enters the small group for the first time but shall not be used for renewal rating purposes. Notwithstanding subsection (b) of this Code section, the total premium calculated for any individual small group may deviate from the pool rate by not more than plus or minus 25 percent based upon individual small group experience factors. The direct premium result of select or substandard underwriting practices shall not be considered a deviation from the pool rate.

(e) If standard or substandard rating cannot be offered to any individual according to recognized underwriting practices, coverage may be declined if the balance of the small group is accepted.

(f) This Code section shall not apply to:

(1) Policies issued to an employer in another state which provides coverage for employees of this state employed by such employer policyholder;

(2) Policies issued to true association groups, which shall be defined as an association of governmental or public employees, an association of employees of a common employer, or an organization formed and operated in good faith for purposes other than that of procuring insurance and composed of members engaged in a common trade, business, or profession; or

(3) A policy negotiated in connection with a collective bargaining agreement.

History. — Code 1981, § 33-27-8, enacted by Ga. L. 1990, p. 1402, § 2.

Editor's notes. — Ga. L. 1990, p. 1402, § 6, not codified by the General Assembly, provides that this Code section shall be applicable to all contracts or policies of insurance issued or renewed on or after October 1, 1990.

33-27-9. Notices of life insurance premium increases to be mailed or delivered to group life insurance policyholder.

Notice of the maximum amount of a group life insurance premium increase shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the group policy not less than 60 days prior to the effective date of the premium increase.

History. — Code 1981, § 33-27-9, enacted by Ga. L. 1990, p. 1402, § 2; Ga. L. 2019, p. 386, § 83/SB 133.

The 2019 amendment, effective July 1, 2019, inserted "life insurance" near the beginning of this Code section.

Editor's notes. — Ga. L. 1990, p. 1402, § 6, not codified by the General Assembly, provides that this Code Section shall be applicable to all contracts or policies of insurance issued or renewed on or after October 1, 1990.

CHAPTER 28

ANNUITY AND PURE ENDOWMENT CONTRACTS

Sec.
33-28-1. Definitions.
33-28-2. Standard provisions for annuity contracts.
33-28-3. Standard nonforfeiture provisions for individual deferred annuities.
33-28-4. Scope of incontestable clause.
33-28-5. Contesting of contract after reinstatement.
33-28-6. Right of person to whom contract issued to return contract and receive premium refund; effect of return; proof of return.
33-28-7. Proceeds of annuity, reversionary annuity, or pure endowment contracts not liable to attachment, garnishment, or legal process in favor of creditors of beneficiary.

Cross references. — Definition of life insurance, § 33-7-4. Life insurance generally, T. 33, C. 25. Industrial life insurance, T. 33, C. 26. Group life insurance, T. 33, C. 27.

RESEARCH REFERENCES

ALR. — Respective rights of insured and beneficiary in endowment, accumulation, and tontine policies, 19 A.L.R. 654; 72 A.L.R.2d 1311.

Consideration paid for annuity obligation as "premium" within contemplation of tax statutes, 109 A.L.R. 1060; 135 A.L.R. 1248.

Apportionment of annuities in respect of time, 116 A.L.R. 135.

Rights as between insurer and employer in respect to termination of group annuity insurance agreement, 41 A.L.R.2d 772.

Interest upon arrearages or unpaid accumulations of annuities, 66 A.L.R.2d 857.

33-28-1. Definitions.

As used in this chapter, the term:

(1) "Annuity" means a contract by which one party in return for a stipulated payment or payments promises to pay periodic installments for a stated certain period of time or for the life or lives of the person or persons specified in the contract. The term does not cover the proceeds of life insurance no matter how payable.

(2) "Pure endowment" means a contract under which one party in return for stipulated payment is obligated to pay a fixed sum if and only if the person designated in the contract survives a certain period specified in the contract.

(3) "Reversionary annuity" means an annuity contract under which the person otherwise entitled to the proceeds is not to receive

any payments unless that person survives another person or persons specified in the contract.

History. — Code 1933, § 56-2601, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Annuities were not insurance in Georgia prior to 1960. Chatham County Hosp. Auth. v. John Hancock Mut. Life Ins. Co., 325 F. Supp. 614 (S.D. Ga. 1971).

Cited in King v. Travelers Ins. Co., 202 Ga. App. 568, 415 S.E.2d 176 (1992); Silliman v. Cassell, 292 Ga. 464, 738 S.E.2d 606 (2013).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 1C Am. Jur. Pleading and Practice Forms, Annuities, § 1 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 4, 5.

ALR. — Annuitant's right to corpus or capital sum in lieu of annuity, 54 A.L.R.2d 361.

33-28-2. Standard provisions for annuity contracts.

(a) No annuity, reversionary annuity, or pure endowment contract, other than group annuities and except as stated in this Code section, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in subsection (b) of this Code section or contains provisions which in the opinion of the Commissioner are more favorable to contract holders. Any of the provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated in the policy. This Code section shall not apply to contracts for deferred annuities included in or upon the lives of beneficiaries under life insurance policies.

(b)(1) **Grace period.** A provision that there shall be a grace period of not less than 30 days within which any stipulated payment to the insurer falling due after the first may be made during which grace period the contract shall continue in force but, if a claim arises under the contract during the period of grace, the amount of the payments may be deducted from any amount payable under the contract in settlement except that, in the case of reversionary annuities, the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue or deferred payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract.

(2) **Incontestability.** A provision that the contract shall be incontestable after it has been in force for a period of two years from its date of issue during the life of the person or of each of the persons

upon whose life or lives the contract is made except for nonpayment of stipulated payments to the insurer. Provisions relating to benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident or accidental means may also be excepted.

(3) **Entire contract.** A provision that if any reference is made to the application for the contract or to the constitution, bylaws, or the rules of the insurer as forming part of or as affecting the contract between the parties there shall be included in or attached to the contract, when issued, a correct copy of the application signed by the applicant and of the constitution, bylaws, and rules referred to.

(4) **Misstatement of age or sex.** A provision that if the age or sex of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex; and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount of the overpayment or overpayments with interest at the rate to be specified in the contract, but not exceeding 6 percent per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

(5) **Dividends.** If the contract is participating, there shall be a provision that beginning not later than the end of the third contract year the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

(6) **Reinstatement.** A provision that the contract may be reinstated at any time within one year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding 6 percent per annum compounded annually and, in cases where applicable, the insurer may also include a requirement of evidence of insurability satisfactory to the insurer. This paragraph shall not apply to reversionary annuities.

(7) **Reversionary annuities; reinstatement.** In reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid or, within the limits permitted by the

then cash values of the contract, reinstated with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding 6 percent per annum compounded annually.

(8) **Payment of certain claims.** For any cash refund annuity, refund annuity, or any other annuity which provides for a lump sum settlement upon the death of the annuitant, a provision that interest shall be payable on the amount of such lump sum settlement in the same manner, at the same rate, and subject to the same conditions as provided by Code Section 33-25-10 for payment of interest on proceeds or payments under an individual policy of life insurance.

History. — Code 1933, § 56-2602, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1999, p. 536, § 1.

Editor's notes. — Ga. L. 1999, p. 536, § 3, not codified by the General Assembly, provides that: "This Act shall apply to contracts issued, delivered, or issued for delivery on or after July 1, 1999."

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

ALR. — Apportionment of divisible surplus of insurance company between different policies, 108 A.L.R. 1212.

Right of estate of named beneficiary to payments of annuity or income during period between his death and the death of third person or other event by reference to which the period of payment is limited by the terms of will or other instrument, 112 A.L.R. 581.

Incontestable clause of statute or policy as applicable to claims other than for death benefits, 121 A.L.R. 1437; 147 A.L.R. 1015.

Provision or option for payment in installments of amount of life insurance policy as creating "annuity," 128 A.L.R. 981.

Grounds for cancellation or rescission of annuity agreement, or for recovery back of property conveyed, or money paid, thereunder, 131 A.L.R. 424.

Date at which coverage begins upon reinstatement, renewal, or revival of insurance policy after default, 167 A.L.R. 333.

Annuitant's right to corpus or capital sum in lieu of annuity, 54 A.L.R.2d 361.

Respective rights of insured and beneficiary in endowment, accumulation and tontine policies, 72 A.L.R.2d 1311.

33-28-3. Standard nonforfeiture provisions for individual deferred annuities.

(a) This Code section shall be known and may be cited as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(b) This Code section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership 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, premium deposit fund, variable annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

(c) No contract of annuity, except as stated in subsection (b) of this Code section, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the contract holder upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, the company shall grant a paid-up annuity benefit on a plan stipulated in such contract of such value as is specified in subsections (e) through (h) and (j) of this Code section;

(2) If a contract provides for a lump sum settlement at maturity or at any other time, that upon surrender of such contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections (e) through (h) and (j) of this Code section and that interest shall be payable on such amount in the same manner, at the same rate, and subject to the same conditions as provided by Code Section 33-25-10 for payment of interest on proceeds or payments under an individual policy of life insurance. Subject to the provisions of this paragraph, the company shall reserve the right to defer the payment of the cash surrender benefit for a period of six months after demand for the benefit with surrender of the contract. The provisions of this paragraph requiring the payment of interest shall not apply to variable contracts which provide for annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the company as to such contract;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract together with sufficient information to determine the amounts of the benefits;

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which such contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts

credited by the company to such contract, any indebtedness to the company on such contract, or any prior withdrawals from or partial surrenders of such contract; and

(5) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in such contract arising from considerations paid prior to such period would be less than $20.00 monthly, the company may at its option terminate such contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by the payment shall be relieved of any further obligation under such contract.

(d) The minimum values as specified in subsections (e) through (h) and (j) of this Code section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined by the Commissioner by rule and regulation based upon interest rates set by the Commissioner to reflect current and prevailing economic and financial conditions; provided, however, that such interest rates shall not be less than 1 percent per annum nor more than 3 percent per annum.

(e) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(f) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of such contract, such present value being calculated on the basis of an interest rate not more than 1 percent higher than the interest rate specified in such contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on such contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to such contract. In no event shall any cash surrender benefit be less than the minimum

nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(g) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in such contract for accumulating the net considerations to determine the maturity value and increased by any existing additional amounts credited by the company to such contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(h) For the purpose of determining the benefits calculated under subsections (f) and (g) of this Code section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(i) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(j) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed, scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(k) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the

minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subsections (e) through (h) and (j) of this Code section, additional benefits payable in the event of total and permanent disability as reversionary annuity or deferred reversionary annuity benefits or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this Code section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

History. — Code 1933, § 56-2602.1, enacted by Ga. L. 1979, p. 1407, § 3; Ga. L. 1982, p. 3, § 33; Ga. L. 1990, p. 8, § 33; Ga. L. 1999, p. 536, § 2; Ga. L. 2000, p. 1486, § 1; Ga. L. 2003, p. 577, § 1; Ga. L. 2004, p. 578, § 1; Ga. L. 2019, p. 386, § 84/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "such contract" for "the contract" throughout subsections (c), (f) and (g); substituted "No" for "In the case of contracts issued on or after July 1, 2000, no" at the beginning of the introductory paragraph of subsection (c); substituted "company shall" for "company will" in paragraph (c)(1) and in the first sentence of paragraph (c)(2).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation at the end of paragraph (c)(5).

Editor's notes. — Ga. L. 1999, p. 536, § 3, not codified by the General Assembly, provides that: "This Act shall apply to contracts issued, delivered, or issued for delivery on or after July 1, 1999."

U.S. Code. — Section 408 of the Internal Revenue Code, referred to in this Code section, is codified as 26 U.S.C. § 408.

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

33-28-4. Scope of incontestable clause.

A clause in any annuity contract providing that the contract shall be incontestable after a specified period shall preclude only a contest of the validity of the contract and shall not preclude the assertion at any time of defenses based upon provisions in the contract which exclude or restrict coverage, whether or not the restrictions or exclusions are excepted in the clause.

History. — Code 1933, § 56-2604, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

ALR. — Grounds for cancellation or rescission of annuity agreement, or for recovery back of property conveyed, or money paid, thereunder, 131 A.L.R. 424.

33-28-5. Contesting of contract after reinstatement.

A reinstated annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the contract provides with respect to contestability after original issuance.

History. — Code 1933, § 56-2510, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 768 et seq.

C.J.S. — 46 C.J.S., Insurance, § 1222 et seq.

ALR. — Insurance: incontestable clause as excluding a defense based upon public policy, 13 A.L.R. 674; 35 A.L.R. 1491; 170 A.L.R. 1040.

Insurance: effect of incontestable clause on supplemental contracts, 45 A.L.R. 1369.

Express exception in incontestability clause as negativing other exceptions thereto, 88 A.L.R. 773.

Applicability of incontestable clause to defense based on false impersonation or mistake as to identity of person insured, 98 A.L.R. 710.

Change in, renewal of, or substitution for original policy of life insurance as affecting time limitation prescribed by original policy in respect of defenses available to insurer, 110 A.L.R. 1139.

Grounds for cancelation or rescission of annuity agreement, or for recovery back of property conveyed, or money paid, thereunder, 131 A.L.R. 424.

What amounts to contest within contemplation of incontestable clause, 95 A.L.R.2d 420.

33-28-6. Right of person to whom contract issued to return contract and receive premium refund; effect of return; proof of return.

(a) Every annuity, reversionary annuity, or pure endowment contract issued for delivery in this state, except group annuities, shall have printed on or attached to the contract a notice stating in substance that the person to whom the annuity or contract is issued shall be permitted to return the annuity or contract within ten days after receipt thereof and to have the premium paid refunded if, after examination of the annuity or contract, the purchaser is not satisfied with it for any reason.

(b) If the purchaser, pursuant to such notice, returns the annuity or contract to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and

the parties shall be in the same position as if no annuity or contract had been issued.

(c) Without limiting any other method of returning an annuity or contract under this Code section, it shall be prima-facie evidence of the fact and date of return of an annuity or contract if the annuity or contract is dispatched by certified mail or statutory overnight delivery to the insurer or agent, as provided in this Code section, and a return receipt provided by the United States Postal Service or the commercial delivery company is obtained.

History. — Code 1933, § 56-2605, enacted by Ga. L. 1979, p. 786, § 4; Ga. L. 1982, p. 3, § 33; Ga. L. 2000, p. 1589, § 9.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (c) is applicable with respect to notices delivered on or after July 1, 2000.

33-28-7. Proceeds of annuity, reversionary annuity, or pure endowment contracts not liable to attachment, garnishment, or legal process in favor of creditors of beneficiary.

The proceeds of annuity, reversionary annuity, or pure endowment contracts issued to citizens or residents of this state, upon whatever form, shall not in any case be liable to attachment, garnishment, or legal process in favor of any creditor of the person who is the beneficiary of such annuity contract unless the annuity contract was assigned to or was effected for the benefit of such creditor or unless the purchase, sale, or transfer of the policy is made with the intent to defraud creditors.

History. — Code 1933, § 56-2603, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2006, p. 885, § 2/HB 1304.

Law reviews. — For article, "Consumer Bankruptcy Panel: Hot Consumer Bankruptcy Plan Issues," see 28 Emory Bankr. Dev. J. 333 (2012).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarities of the statutory provisions, decisions under former Code 1933, §§ 56-901 and 56-905, are included in the annotations for this Code section.

This section creates no exemption of a debtor's property from execution, but rather a special cause of action for a creditor against one who is not the principal debtor. United States v. Truax, 223 F.2d 229 (5th Cir. 1955) (decided under former Code 1933, §§ 56-901 and 56-905).

Bankruptcy. — There is no indication that the Georgia General Assembly intended to amend or supplement the bankruptcy specific exemptions found in O.C.G.A. § 44-13-100 by way of the more general Georgia Insurance Code provisions. Rather, it appears that the General Assembly intended the Georgia Insurance Code to apply to nonbankruptcy situations with the bankruptcy specific exemptions in § 44-13-100 applying in bankruptcy cases. In re Allen, No. 10-50827-JPS, 2010 Bankr. LEXIS 3563 (Bankr. M.D. Ga. Oct. 4, 2010).

Cited in King v. Travelers Ins. Co., 202

Ga. App. 568, 415 S.E.2d 176 (1992); Silliman v. Cassell (In re Cassell), 443 B.R. 200 (Bankr. N.D. Ga. 2010).

RESEARCH REFERENCES

C.J.S. — 46A C.J.S., Insurance, § 1951.

ALR. — Purchase of annuity by debtor as fraud on creditors, 154 A.L.R. 727.

Endowment policy as life insurance within exemption law, 30 A.L.R.2d 751.

Enforceability, in forum, of extraterritorial waiver of debtor's exemption valid where made, 60 A.L.R.2d 1449.

Qualification of life insurance proceeds held by insurer for federal estate tax marital deduction, 78 A.L.R.2d 1029.

What constitutes state or local law that is applicable on date of filing of bankruptcy petition for purposes of applying 11 U.S.C.A. § 522(b)(3)(A) or its predecessor in opt-out states, 76 A.L.R. Fed. 2d 333.

CHAPTER 29

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

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33-29-19. Rate modification on individual accident and sickness policies providing for optional loss ratio guarantee.
33-29-20. Insurance coverage for treatment of temporomandibular joint dysfunction or surgery for deformities of maxilla or mandible.
33-29-21. Renewal or continuation at option of insured.
33-29-21.1. Availability of accident and sickness policy upon termination of dependent coverage based on age of dependent.
33-29-22. Notice of premium increase.

Cross references. — Definition of accident and sickness insurance, § 33-7-2. Offering of accident, sickness, and disability insurance by fraternal benefit societies, § 33-15-60. Contents of accident and sickness, insurance policies generally, § 33-24-20 et seq.

Administrative rules and regulations. — Credit life, accident and sickness insurance, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Insurance Department, Chapters 120-2-13, 120-2-27.

Law reviews. — For note, "Paying the Piper: Third-party Payor Liability for Medical Treatment Decisions," see 25 Ga. L. Rev. 861 (1991).

For comment criticizing Gaskins v. New York Life Ins. Co., 235 La. 461, 104 So. 2d 171 (1958), holding death caused by anaphylactic shock produced by rare blood transfusion reaction was "accidental," see 10 Mercer L. Rev. 209 (1958).

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Business Travel Insurance, 17 POF3d 489.

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.

Insurance: death or injury resulting from insured's voluntary act as caused by accident or accidental means, 14 A.L.R. 788; 35 A.L.R. 1191; 42 A.L.R. 243; 45 A.L.R. 1528; 71 A.L.R. 1437; 111 A.L.R. 628.

Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

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.

Death as within provision exempting insurer or limiting liability in case of injury or disability intentionally inflicted, 22 A.L.R. 299.

Accident insurance: provision for reduced indemnity for injury while doing act pertaining to more hazardous occupation, 22 A.L.R. 780; 26 A.L.R. 123.

Accident insurance: when insured deemed to be totally and continuously unable to transact all business duties, 24 A.L.R. 203.

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.

Attempt to board or alight from moving train, car, or locomotive, as within general provisions of accident policy avoiding liability for policyholder's negligence or exposure to obvious danger, 29 A.L.R. 712.

"Permanent disability" within insurance policy as confined to disability lasting until death, 40 A.L.R. 1386; 97 A.L.R. 126.

Provision in accident insurance policy in relation to train wreck, 51 A.L.R. 1331.

Provision limiting indemnity to permanent disability as affected by clause providing for payment for life and during disability, 54 A.L.R. 294.

Burden of proof as regards payment or nonpayment of renewal premiums or assessments on policy of life or accident insurance, 95 A.L.R. 745.

When insured deemed to be totally and continuously disabled or unable to transact all business duties, 98 A.L.R. 788.

What constitutes bodily injury within policy of accident insurance or accident feature of life policy, 117 A.L.R. 739.

Failure or refusal of insured to submit to corrective surgical or medical treatment as affecting right to recover insurance benefits, or to avoid payment of premiums, 126 A.L.R. 136.

Requisites and sufficiency of proofs of loss where disease or other physical condition which in itself is not within, or is expressly excluded from, the coverage of an accident policy or double indemnity provision of a life policy results from, or is attributable to, a cause within the coverage, 126 A.L.R. 616.

Necessity of payment of loss by reinsured as prerequisite to recovery from reinsurer, 127 A.L.R. 181.

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.

Insurance: death or injury in battle as due to accident or accidental means, 137 A.L.R. 1286; 140 A.L.R. 1533; 141 A.L.R. 1510.

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, 138 A.L.R. 404; 78 A.L.R.2d 1044.

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 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.

Insanity of insured as excusing lack of, or delay in, notice or proof of accident or disability, 142 A.L.R. 852.

Burden of proof in action upon accident policy, or accident feature of life policy, as to whether injury or death was result of antecedent disease or other abnormal bodily or mental condition, 144 A.L.R. 1416.

Construction and application of provision of accident policy or accident feature of life policy extending benefits to one disabled from engaging in any occupation or employment for wage or profit, 149 A.L.R. 7; 153 A.L.R. 430.

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 of clause of insurance policy covering injuries sustained from being "accidentally thrown from" a vehicle, 24 A.L.R.2d 1454.

Construction and effect of clause of life, health, or similar policy insuring against "loss of business time," 31 A.L.R.2d 1222.

Rupture of blood vessel following exertion or exercise as within terms of accident provision of insurance policy, 35 A.L.R.2d 1105.

Death or injury from sunstroke as accident or result of accidental means within terms of accident provision of insurance policy, 36 A.L.R.2d 1090.

Repeated absorption of poisonous substance as "accident" within coverage clause of comprehensive general liability policy, 49 A.L.R.2d 1263.

Death or injury resulting from insured's voluntary act in taking overdose of medicine, drugs, or the like, as caused by accident or accidental means, 52 A.L.R.2d 1083.

Effect of provision for coverage or double indemnity in case of injury or death in consequence of burning of building, 55 A.L.R.2d 398.

What constitutes "hernia" within exclusionary clause of health or accident insurance policy, 55 A.L.R.2d 1020.

Hernia following exertion or exercise as within terms of accident provision of insurance policy, 55 A.L.R.2d 1180.

Coverage and exceptions under student accident policy, 74 A.L.R.2d 1253.

Arteriosclerosis as affecting right to recovery under accident policy or accident provision of life policy, 82 A.L.R.2d 611.

Preexisting physical condition as affecting liability under accident policy or accident feature of life policy, 84 A.L.R.2d 176.

Provision of accident or health insurance policy that insured shall be under care of physician or surgeon, 84 A.L.R.2d 375.

Death or injury resulting from shock, fright, or other "psychic trauma," as within coverage of accident policy or accident provisions of life policy, 93 A.L.R.2d 578.

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 expense clause in liability policy, 11 A.L.R.3d 1115.

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.

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.

Life or accident insurance: sufficiency of showing that death from drowning was due to accident or accidental means, 43 A.L.R.3d 1168.

What is "conveyance," "passenger conveyance," or "public conveyance" within coverage of accident policy, 60 A.L.R.3d 858.

Who is "fare-paying passenger" within coverage provision of life or accident insurance policy, 60 A.L.R.3d 1273.

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.

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.

Death allegedly resulting from surgery as accidental or from accidental means within coverage of health or accident insurance policy, 91 A.L.R.3d 1042.

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.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy, 1 A.L.R.4th 1319.

Applicability of other insurance benefits exclusion, from coverage of hospital or health and accident policy, to governmental insurance benefits to which insured would have been entitled by prior subscription, 29 A.L.R.4th 361.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

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.

Coverage under medical and health insurance plans for services performed by dentists, oral surgeons, and orthodontists, 43 A.L.R.5th 657.

33-29-1. "Accident and sickness policy" defined; applicability of chapter.

(a) As used in this chapter, the term "accident and sickness policy" means any policy insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future.

(b) Nothing in this chapter shall apply to or affect:

(1) Any policy of workers' compensation insurance or any policy of workers' insurance or any policy of liability insurance with or without supplementary expense coverage on the policy;

(2) Any policy or contract of reinsurance;

(3) Any policy, the renewal of which is subject to continuation of employment with a specified employer, or any blanket or group policy of insurance, or any policy issued pursuant to the exercise of conversion privileges provided for in group insurance policies; or

(4) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance which provide additional benefits in case of death or dismemberment or loss of sight by accident, or which operate to safeguard such contracts against lapse or give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract.

History. — Code 1933, § 56-3001, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 85/SB 133.

The 2019 amendment, effective July 1, 2019, added "or" at the end of paragraph (b)(3), substituted a period for a semicolon at the end of paragraph (b)(4), and deleted former paragraphs (b)(5) and (b)(6), which read: "(5) Companies, organizations, or associations provided for in Chapters 18 and 19 of this title; or

"(6) Any policy of accident, sickness, or hospitalization insurance issued prior to January 1, 1961."

Cross references. — Accident and sickness insurance, § 33-7-2.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 7 et seq., 559 et seq.

C.J.S. — 46 C.J.S., Insurance, § 1234 et seq.

ALR. — Accident insurance: when insured deemed to be totally and continuously unable to transact all business duties, 24 A.L.R. 203.

Infection through boil, or similar condition, as an accident or accidental means within accident policy, 24 A.L.R. 730.

Construction of provision in accident insurance policy in relation to injury incident to robbery, burglary, etc., 36 A.L.R. 1124; 46 A.L.R. 1083.

Accident and disability insurance: when insured deemed to be totally and continuously unable to transact all business duties, 37 A.L.R. 151; 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.

Provision in policy of life or accident

insurance as to "self-destruction," "death by own hand," and other forms not employing term "suicide," as applicable to death by accident, 37 A.L.R. 1088.

Statute precluding defense of suicide as applied to accident insurance, 41 A.L.R. 1523.

Insurance: death or injury resulting from insured's voluntary act as caused by accident or accidental means, 45 A.L.R. 1528; 71 A.L.R. 1437; 111 A.L.R. 628.

Group insurance, 55 A.L.R. 1245.

Accident insurance as life insurance within exemption law, 111 A.L.R. 61.

What constitutes bodily injury within policy of accident insurance or accident feature of life policy, 117 A.L.R. 739.

Right to compensation under Workmen's Compensation Act as affected by pension, insurance, gratuities, or other benefits derived from the act itself, 119 A.L.R. 920.

Insurance: "accidental means" as distinguishable from "accident," "accidental result," "accidental death," "accidental injury," etc., 166 A.L.R. 469.

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.

Liability insurance: "accident" or "accidental" as including loss resulting from ordinary negligence of insured or his agent, 7 A.L.R.3d 1262.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy, 1 A.L.R.4th 1319.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

What constitutes medical or surgical treatment, or the like, within exclusionary clause of accident policy or accidental-death feature of life policy, 56 A.L.R.5th 471.

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.

33-29-2. Requirements as to policies generally.

(a) No policy of accident and sickness insurance shall be delivered or issued for delivery in this state unless it meets the following requirements:

(1) The entire money and other considerations for the policy are expressed in such policy;

(2) The time at which the insurance takes effect and terminates is expressed in such policy;

(3) It purports to insure only one person, provided that a policy may insure, originally or by subsequent amendment upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children, under a specified age which shall not exceed 19 years, and any other person dependent upon the policyholder; provided, further, that, if a policy purports to insure a dependent child of the policyholder, the child shall continue to be insured up to and including age 25 so long as the policy continues in effect, the child remains a dependent of the policyholder, and the child, in each calendar year since reaching the age specified in the policy for termination of benefits as a dependent of the policyholder, has been enrolled for five calendar months or

more as a full-time student in a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury;

(4) The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than 120 point. The text shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. When a policy is renewable only at the option of the insurer, such fact shall be made known in prominent lettering on the face of the policy;

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Code Sections 33-29-3 and 33-29-4, are printed, at the insurer's option, either with the benefit provisions to which they apply or under an appropriate caption such as "exceptions," or "exceptions and reductions," provided that, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks or short-rate table filed with the Commissioner;

(8) It contains no provision purporting to exclude or reduce coverage provided an otherwise insurable person solely for the reason that the person is eligible for or receiving medical assistance, as defined in Code Section 49-4-141. Any such provision appearing in an individual accident and sickness insurance policy shall be null and void; and

(9) It contains no provision relating to insurance with other insurers, provided that group conversion policies and major medical policies may contain provisions relating to other insurance benefits payable under group or blanket accident and sickness insurance policies.

(b) Individual major medical policies, including franchise and conversion policies, shall make available to each applicant for such coverage optional cash deductible amounts up to at least $5,000.00. No such policy shall contain any provision in which the length of the cash deductible accumulation period is not reasonable in relation to the amount of the cash deductibles. An insurer may offer higher optional deductibles to existing policyholders as a means of reducing the cost of such policies or to offset premium increases.

History. — Code 1933, § 56-3002, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1978, p. 1149, §§ 1, 5; Ga. L. 1978, p. 1522, § 1; Ga. L. 1981, p. 1009, § 2; Ga. L. 1983, p. 3, § 24; Ga. L. 1985, p. 149, § 33; Ga. L. 1988, p. 1760, § 2; Ga. L. 1990, p. 1402, § 3; Ga. L. 2005, p. 481, § 6/HB 291; Ga. L. 2017, p. 164, § 37/HB 127; Ga. L. 2019, p. 386, § 86/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted ", subsequent to July 1, 1978," following "insurance policy" near the end of paragraph (a)(8); and substituted "Reserved." for the former provisions of subsection (c), which read: "This Code section shall not be construed so as to impair the obligation of any contract in existence prior to January 1, 1979."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former subsection (c) which was designated as reserved.

Law reviews. — For note on 1990 amendment of this Code section, see 7 Ga. St. U.L. Rev. 320 (1990).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 269 et seq.

C.J.S. — 44 C.J.S., Insurance, § 486 et seq.

ALR. — Accident insurance: injury by insect, 9 A.L.R. 529.

Construction of provision in accident insurance policy in relation to injury incident to robbery, burglary, etc., 36 A.L.R. 1124; 46 A.L.R. 1083.

Right to recover under policy of accident insurance as affected by inability to assign time when, or place at which, injury was received, 64 A.L.R. 966.

Clause in health and accident, or similar, policy reducing amount of, or terminating, periodic payments after insured reaches specified age, as applicable to disability incurred before such age was reached, 53 A.L.R.2d 552.

What constitutes medical or surgical treatment, or the like, within exclusionary clause of accident policy or accidental death feature of life policy, 65 A.L.R.2d 1449.

Liability insurance: "accident" or "accidental" as including loss resulting from ordinary negligence of insured or his agent, 7 A.L.R.3d 1262.

Validity and construction of statutes relating to style or prominence with which provisions must be printed in insurance policy, 36 A.L.R.3d 464.

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.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

33-29-3. Required policy provisions.

(a) Each accident and sickness policy delivered or issued for delivery in this state shall contain the provisions specified in subsection (b) of this Code section in the words in which the same appear in subsection

(b) of this Code section, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the captions appearing in this Code section, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(b)(1) **Entire contract; changes.** This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) **Time limit on certain defenses.**

(A) After two years from the date of issue of this policy and in the absence of fraud, no misstatements made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year period. In order for the insurer to void the policy or to deny a claim for loss incurred or disability based upon an applicant's fraudulent misstatement in an application, a copy of such application must be furnished to the policyholder or his or her beneficiary, and such fraudulent misstatement must have been in writing, must be material to the risk assumed by the insurer, and, in the case of a claim, must also relate to the specific type of loss or disability for which the claim is made.

(i) The policy provision in subparagraph (A) of this paragraph shall not be so construed as to affect any legal requirements for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of paragraphs (1) through (3) of subsection (b) of Code Section 33-29-4 in the event of misstatement with respect to age or occupation or other insurance. For purposes of this paragraph, fraud means the willful misrepresentation of a material fact.

(ii) A policy which the insurer has the right to continue in force subject to its terms by the timely payment of premium until at

least age 60 or, in the case of a policy issued after age 54, for at least five years from its date of issue may contain in lieu of the provisions of subparagraph (A) of this paragraph the following provision, from which the clause in brackets may be omitted at the insurer's option, under the caption "incontestable": In the absence of fraud and after this policy has been in force for a period of two years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application.

(B) In the absence of fraud, no claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) **Grace period.** A grace period of _____ days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. The insurer shall insert in the blank space a number not less than "seven" for weekly premium policies, "ten" for monthly premium policies and "30" for all other policies. A policy in which the insurer reserves the right to refuse renewal shall have at the beginning of the above provision the following language: "unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted…."

(4) **Reinstatement.**

(A) If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of any premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from any accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after that date. In all other respects the insured and insurer shall have the same rights thereunder as

they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

(B) The last sentence of subparagraph (A) of this paragraph may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums, until at least age 60, or, in the case of a policy issued after age 54, for at least five years from its date of issue.

(5) **Notice of claim.**

(A) Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(B) In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following provision between the first and second sentences of subparagraph (A) of this paragraph:

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall at least once in every six months after having given notice of claim give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given."

(6) **Claim forms.** The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If the forms are not furnished within ten working days after the giving of the notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for

filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(7) **Proofs of loss.** Written proof of loss must be furnished to the insurer at its office, in case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable and, in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) **Time of payment of claims.** The policy shall include a provision incorporating and restating the substance of the provisions of subsections (b) and (c) of Code Section 33-24-59.5, relating to time limits for payment of claims for benefits under health benefit policies and sanctions for failure to pay timely. If a policy provides benefits for loss of time, such policy shall also provide that, subject to proof of such loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(9) **Payment of claims.**

(A) Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(B) The following provisions, or either of them, may be included with the provisions of subparagraph (A) of this paragraph at the option of the insurer:

(i) If any indemnity of this policy shall be payable to the estate of the insured or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which shall not exceed $1,000.00), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled

thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment;

(ii) Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, or medical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) **Physical examinations and autopsy.** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) **Legal action.** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) **Change of beneficiary.** Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(c) The first clause of paragraph (12) of subsection (b) of this Code section, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(d) The provisions of this Code section shall also apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any other similar entity.

History. — Code 1933, § 56-3004, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 1678, §§ 2, 5; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33; Ga. L. 1990, p. 8, § 33; Ga. L. 1995, p. 745, § 2.8; Ga. L. 1998, p. 1064, § 7; Ga. L. 1999, p. 289, § 3; Ga. L. 2017, p. 164, § 38/HB 127.

Editor's notes. — Ga. L. 1981, p. 1009, § 3, not codified by the General Assembly, provides that the amendment of this Code section shall apply to policies issued, delivered, issued for delivery, renewed, or amended in this state on or after July 1, 1981.

Ga. L. 1999, p. 289, § 6, not codified by the General Assembly, provides that this Act shall apply to plans, policies, or con-

tracts issued, delivered, issued for delivery, or renewed on or after July 1, 1999.

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

For note, "Incontestability Clauses in Georgia Insurance Contracts," see 13 Ga. L. Rev. 850 (1979). For note, "Wrongful Refusal to Pay Insurance Claims in Georgia," see 13 Ga. L. Rev. 935 (1979).

JUDICIAL DECISIONS

Application. — In an action by an insurer seeking rescission of a policy, O.C.G.A. § 33-29-3 did not apply since the policy was issued and delivered in another state. World Ins. Co. v. Branch, 966 F. Supp. 1203 (N.D. Ga. 1997), vacated on other grounds, 156 F.3d 1142 (11th Cir. 1998).

If applicant for insurance does not read application, applicant is still charged with the knowledge of the application's contents. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Implied waiver and estoppel unavailable. — Doctrines of implied waiver and of estoppel, based upon the conduct or action of the insurer, or the insurer's agent, are not available to bring within the coverage of a policy risks not covered by the policy's terms, or risks expressly excluded therefrom. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Grace period as part of policy. — Paragraph (b)(3) of O.C.G.A. § 33-29-3 provides that as to each premium after the first, there shall be a 30-day grace period on policies whose premiums are not payable weekly or monthly, which provision is as much a part of the policy of insurance as though written therein. Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966).

Payment of premium after grace period no defense. — When the liability attaches under the contract of insurance during the grace period, the fact that the premium is not paid or tendered until after the grace period expires is no defense to an action on the policy for a loss sustained while the policy was in full force. Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966).

Waiver of timely notice by insurer. — Causing the insured to procure and transmit information regarding medical history, physician's statements, and admission and discharge statements from the hospital amounts to a waiver of timely notice by the insurer. Browder v. Aetna Life Ins. Co., 126 Ga. App. 140, 190 S.E.2d 110 (1972).

After period of incontestability has run, insurer is only barred from contesting validity of policy itself, e.g., on grounds of fraud in the procurement, etc.; it still reserves the right to deny any claim if the claim is not within the coverage as stated under the policy's terms, and this is true regardless of the import of any statements made in the application for insurance. Keaten v. Paul Revere Life Ins. Co., 648 F.2d 299 (5th Cir. 1981).

Pay or notify provisions not triggered without completed claim form. — Medical bills submitted by the insured to the insurer did not trigger the pay or notify provisions of paragraph (b)(8) of O.C.G.A. § 33-29-3, since the bills were not accompanied by a completed claim form. Vulcan Life Ins. Co. v. Davenport, 191 Ga. App. 79, 380 S.E.2d 751, cert. denied, 191 Ga. App. 923, 380 S.E.2d 751 (1989).

Incontestability clauses are valid and render contracts of insurance incontestable, precluding all defenses, inclusive of fraud, save as those defenses may come within clear exceptions. Blue Cross & Blue Shield of Ga., Inc. v. Sheehan, 215 Ga. App. 228, 450 S.E.2d 228 (1994).

Two-year period of incontestability in a health insurance policy was not tolled by the insured's fraudulent misrepresentations on the application and subsequent failure to file claims for more than two years. Blue Cross & Blue Shield of Ga., Inc. v. Sheehan, 215 Ga. App. 228, 450 S.E.2d 228 (1994).

Cited in Thompson v. Metropolitan Life Ins. Co., 115 Ga. App. 724, 155 S.E.2d 728 (1967); Mutual Benefit Health & Accident

Ass'n v. Reed, 144 Ga. App. 853, 242 S.E.2d 731 (1978).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 540 et seq. 44A Am. Jur. 2d, Insurance, § 1046 et seq.

C.J.S. — 44 C.J.S., Insurance, § 486 et seq. 45 C.J.S., Insurance, § 882. 46A C.J.S., Insurance, §§ 1783, 1788, 1789, 1974, 1975.

ALR. — Accident insurance: reasonableness of time of notice of accident or injury as a question for the jury, 7 A.L.R. 186.

Provisions for autopsy in policy of life or accident insurance, 15 A.L.R. 614; 88 A.L.R. 984; 30 A.L.R.2d 837.

Denial of liability as waiver of proofs of loss required by insurance policy, 22 A.L.R. 407; 49 A.L.R.2d 161.

Liability of insurer under policy payable to representatives or estate as between domiciliary and ancillary representative, 24 A.L.R. 148.

Accident insurance: time for giving notice of accident as affected by delay in learning that disability or death was due to accident, 29 A.L.R. 500.

Death or injury resulting from insured's voluntary act as caused by accident or accidental means, 35 A.L.R. 1191; 42 A.L.R. 243; 45 A.L.R. 1528; 71 A.L.R. 1437; 111 A.L.R. 628.

Construction of provision in accident insurance policy in relation to injury incident to robbery, burglary, etc., 36 A.L.R. 1124; 46 A.L.R. 1083.

Incontestable clause as affecting failure to comply with provisions as to proofs of loss, 41 A.L.R. 382.

Accident insurance: when insured deemed to be totally and continuously unable to transact all business duties, 41 A.L.R. 1376; 51 A.L.R. 1048; 79 A.L.R. 857; 98 A.L.R. 787; 39 A.L.R.3d 1026.

Effect of insured's failure to demand the payments at the time they are due under an accident policy providing for period payments of indemnity, 49 A.L.R. 1527.

Right to recover under policy of accident insurance as affected by inability to assign time when, or place at which, injury was received, 64 A.L.R. 966.

Forfeiture of life or accident insurance for nonpayment of premium due to failure or neglect of one authorized by insured to pay same, 67 A.L.R. 180.

Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

Date at which coverage begins upon reinstatement, renewal, or revival of insurance policy after default, 167 A.L.R. 333.

Right of insurer to restitution of payments made under mistake, 167 A.L.R. 470.

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.

Power of court to order disinterment and autopsy or examination for evidential purposes in civil case, 21 A.L.R.2d 538.

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.

Injury to or death of insured while assaulting another as due to accident or accidental means, 26 A.L.R.2d 399.

Time for making autopsy or demand therefor under insurance policy, 30 A.L.R.2d 837.

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.

Physician's duties and liabilities to person examined pursuant to physician's contract with such person's prospective or actual employer or insurer, 10 A.L.R.3d 1071.

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.

Construction and effect of "visible sign of injury" and similar clauses in accident provision of insurance policy, 28 A.L.R.3d 413.

Life or accident insurance: sufficiency of showing that death from drowning was due to accident or accidental means, 43 A.L.R.3d 1168.

Liability insurance: timeliness of notice of accident by additional insured, 47 A.L.R.3d 199.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy, 1 A.L.R.4th 1319.

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.

33-29-3.1. Coverage for human heart transplants; optional endorsement; requirements; guidelines.

(a) Every insurer authorized to issue individual accident and sickness insurance plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for human heart transplants, including any charges for acquisition, transportation, or donation of a human heart when a human heart transplant is performed. Such coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(b) The optional endorsement required to be made available under subsection (a) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to human heart transplants unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, the optional endorsement may contain a waiting period for the coverage or a delayed eligibility date of not more than 12 months from the effective date of the endorsement.

(c) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar individual accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an individual accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(d) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for human heart transplants that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

History. — Code 1981, § 33-29-3.1, enacted by Ga. L. 1988, p. 960, § 1; Ga. L. 2019, p. 386, § 87/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1988," following "or renewed" in the middle of the first sentence of subsection (a).

33-29-3.2. Coverage for mammograms, Pap smears, and prostate-specific antigen tests.

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

(1) "Female at risk" means a woman:

(A) Who has a personal history of breast cancer;

(B) Who has a personal history of biopsy proven benign breast disease;

(C) Whose grandmother, mother, sister, or daughter has had breast cancer; or

(D) Who has not given birth prior to age 30.

(2)(A) "Mammogram" means any low-dose radiologic screening procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician's interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology.

(B) Reimbursement for a mammogram authorized under this Code section shall be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by this state.

(C) Policies subject to this Code section shall contain coverage for mammograms made with at least the following frequency:

(i) Once as a base-line mammogram for any female who is at least 35 but less than 40 years of age;

(ii) Once every two years for any female who is at least 40 but less than 50 years of age;

(iii) Once every year for any female who is at least 50 years of age; and

(iv) When ordered by a physician for a female at risk.

(3) "Pap smear" or "Papanicolaou smear" means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

(4) "Policy" means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(5) "Prostate-specific antigen test" means a measurement, in accordance with standards established by the American College of Pathologists, of a substance produced by the epithelium to determine if there is any benign or malignant prostate tissue.

(b)(1) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for mammograms and Pap smears for the covered females which at least meets the minimum requirements of this Code section.

(2) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any male shall include as a part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for annual prostate-specific antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older, if ordered by a physician.

(c) The coverage required under subsection (b) of this Code section may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner.

(d) Nothing in this Code section shall be construed to prohibit the issuance of individual accident and sickness insurance policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to individual accident and sickness insurance policies issued by a fraternal benefit

society, a health care plan, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

History. — Code 1981, § 33-29-3.2, enacted by Ga. L. 1990, p. 1057, § 1; Ga. L. 1992, p. 1975, § 1; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2017, p. 164, § 39/HB 127; Ga. L. 2019, p. 386, § 88/SB 133.

The 2019 amendment, effective July 1, 2019, designated the existing provisions of the first through third sentences of paragraph (a)(2) as present subparagraphs (a)(2)(A) through (a)(2)(C), respectively, redesignated former subparagraphs (a)(2)(A) through (a)(2)(D) as present divisions (a)(2)(C)(i) through (a)(2)(C)(iv), respectively; substituted "'Prostate-specific" for "'Prostate specific" at the beginning of paragraph (a)(5); deleted "on or after July 1, 1992," following "or renewed" in paragraphs (b)(1) and (b)(2); and substituted "prostate-specific" for "prostate specific" in paragraph (b)(2).

Law reviews. — For note on 1990 enactment of this Code section, see 7 Ga. St. U.L. Rev. 317 (1990). For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 280 (1992).

33-29-3.3. Coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease; optional endorsement; requirements; guidelines; applicability.

(a) Every insurer authorized to issue individual accident and sickness insurance plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. Such coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(b) The optional endorsement required to be made available under subsection (a) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to bone marrow transplants for the treatment of breast cancer and Hodgkin's disease unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(c) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar individual accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an individual accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(d) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

(e) The provisions of this Code section shall apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any similar entity.

History. — Code 1981, § 33-29-3.3, enacted by Ga. L. 1995, p. 459, § 1; Ga. L. 2017, p. 164, § 40/HB 127; Ga. L. 2019, p. 386, § 89/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1995," following "or renewed" in the middle of the first sentence of subsection (a).

33-29-3.4. Insurance coverage for child wellness services.

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

(1) "Child wellness services" means the periodic review of a child's physical and emotional status conducted by a physician or conducted pursuant to a physician's supervision, but shall not include periodic dental examinations or other dental services. The review shall include a medical history, complete physical examination, developmental assessment, appropriate immunizations, anticipatory guidance for the parent or parents, and laboratory testing in keeping with prevailing medical standards.

(2) "Policy" means any health care plan, subscriber contract, or accident and sickness plan, contract, or policy by whatever name called other than a disability income policy, a long-term care insurance policy, a medicare supplement policy, a health insurance policy written as a part of workers' compensation equivalent coverage, a specified disease policy, a credit insurance policy, a hospital indemnity policy, a limited accident policy, or other type of limited accident and sickness policy.

(b) Every insurer authorized to issue an individual accident and sickness policy in this state shall include, either as a part of or as a required endorsement to each basic medical or hospital expense, major medical, or comprehensive medical expense policy issued, delivered, issued for delivery, or renewed in this state basic coverage for child wellness services for an insured child from birth through the age of five years. Any such policy may provide that the child wellness services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. The Commissioner shall define by regulation the basic coverage for child wellness services and may consider the current recommendations for preventive pediatric health care by the American Academy for Pediatrics and any other relevant data or information in the promulgation of such regulation.

(c) The coverage required under subsection (b) of this Code section may be subject to exclusions, reductions, or other limitations as to coverages or coinsurance provisions as may be approved by the Commissioner, but shall not be subject to deductibles.

(d) Nothing in this Code section shall be construed to prohibit the issuance of individual accident and sickness policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to individual basic medical or hospital expense, major medical, or comprehensive medical expense insurance policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

History. — Code 1981, § 33-29-3.4, enacted by Ga. L. 1995, p. 1011, § 6; Ga. L. 1995, p. 1348, § 3; Ga. L. 1996, p. 6, § 33; Ga. L. 2017, p. 164, § 41/HB 127; Ga. L. 2019, p. 386, § 90/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1995," following "or renewed in this state" in the middle of the first sentence of subsection (b); and substituted "Reserved." for the former provisions of subsection (g), which read: "Beginning July 1, 2000, the Commissioner shall conduct a review of the cost associated with the coverage required by this Code section and shall provide the members of the General Assembly with such information not later than December 31, 2000."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former

subsection (g) which was designated as reserved.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, Code Section 33-29-3.3, as enacted by Ga. L. 1995, p. 1011, § 6, was redesignated as Code Section 33-29-3.4.

Editor's notes. — Ga. L. 1995, p. 1348, § 10, not codified by the General Assembly, provides: "In the event another Act requiring insurance coverage for child wellness services is enacted by the General Assembly during the 1995 regular session, it is the specific intent of the General Assembly that Sections 3 and 4 of this Act requiring insurance coverage for child wellness services shall be given effect and shall control over the provisions of such other Act requiring such coverage."

Ga. L. 1995, p. 1348, § 3, which enacted this Code section, was passed later in time than the version of this Code section as passed by Ga. L. 1995, p. 1011, § 6, effective July 1, 1995, which also related to coverage for child wellness services, and the version passed in Ga. L. 1995, p. 1348, § 3, controls as to Ga. L. 1995, p. 1011, § 6, and has been set out above.

33-29-4. Optional policy provisions.

(a) No accident and sickness policy delivered or issued for delivery in this state shall contain provisions respecting the matters set forth in this Code section unless such provisions are in the words in which the same appear in subsection (b) of this Code section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this Code section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in such a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(b)(1) **Change of occupation.** If the insured is injured or contracts sickness after having changed his or her occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer shall pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his or her occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, shall reduce the premium rate accordingly and shall return the excess pro rata unearned premium from the date of change of

occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer, prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued. If, however, such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in the state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) **Misstatement of age.** If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) **Other insurance with this insurer.**

(A) If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured is in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $_____ (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for the excess shall be returned to the insured or to his or her estate;

or, in lieu thereof:

(B) Insurance effective at any one time on the insured under a like policy or policies with this insurer is limited to the one such policy elected by the insured, his or her beneficiary, or his or her estate, as the case may be, and the insurer will return all premiums paid for all other policies.

(4) **Relation of earnings to insurance.**

(A) If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of the monthly earnings or the average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of that part of the

premiums paid during such two years which exceeds the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all the coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified in the coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(B) The policy provision of subparagraph (A) of this paragraph may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 60 or, in the case of a policy issued after age 54, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of that definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(5) **Unpaid premium.** Upon the payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted therefrom.

(6) **Return of premium on cancellation.** If the insured cancels this policy, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(7) **Conformity with state statutes.** Any provision of this policy which, on its effective date, is in conflict with the statutes of the state, District of Columbia, or territory in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.

(8) **Illegal occupation.** The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(9) **Intoxicants and narcotics.** The insurer shall not be liable for any loss sustained or contracted in consequence of the insured being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(10) **Cancellation of travel accident policies.** With respect only to travel accident insurance policies, the following optional provisions may be inserted in the policy:

"The insurer reserves the right to cancel this policy under the provisions set forth in Code Section 33-24-44."

History. — Code 1933, § 56-3005, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1981, p. 1009, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1983, p. 3, § 24; Ga. L. 1985, p. 149, § 33; Ga. L. 1988, p. 1760, § 3; Ga. L. 2019, p. 386, § 91/SB 133.

The 2019 amendment, effective July 1, 2019, inserted "or her" throughout subsection (b); in paragraph (b)(1), substituted "shall" for "will" once in the first sentence and twice in the second sentence, in the third sentence, substituted "insurer" for "insured" and substituted "was issued. If, however," for "was issued; but, if" in the middle.

Editor's notes. — Ga. L. 1981, p. 1009, § 3, not codified by the General Assembly, provided that the amendment to this section shall apply to policies issued, delivered, issued for delivery, renewed, or amended in this state on or after July 1, 1981.

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

Health insurance policy exclusion for injuries resulting from being "drunk" did not apply to injuries sustained by the insured in a traffic accident although the insured's blood alcohol content was .19 percent at the time of the accident and the insured pled guilty to driving under the influence of alcohol. Vulcan Life Ins. Co. v. Davenport, 191 Ga. App. 79, 380 S.E.2d 751, cert. denied, 191 Ga. App. 923, 380 S.E.2d 751 (1989).

Insured's social security disability benefits did not constitute benefits derived from "valid loss of time coverage" under a "relation of earnings to insurance" clause which was intended to be utilized to compute monthly benefits only when the insured was receiving benefits under more than one disability insurance policy. Walters v. Time Ins. Co., 738 F. Supp. 493 (M.D. Ga. 1990), aff'd, 932 F.2d 978 (11th Cir. 1991).

Cited in Life & Cas. Ins. Co. v. Hulsey, 109 Ga. App. 15, 134 S.E.2d 880 (1964).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 719 et seq.

C.J.S. — 44 C.J.S., Insurance, § 474 et seq. 45 C.J.S., Insurance, §§ 877, 881, 1067, 1092. 46 C.J.S., Insurance, § 1564.

ALR. — Death or injury resulting from insured's voluntary act as caused by accident or accidental means, 35 A.L.R. 1191; 42 A.L.R. 243; 45 A.L.R. 1528; 71 A.L.R. 1437; 111 A.L.R. 628.

Prorating life or accident insurance, 50 A.L.R. 1380.

Applicability of option provisions to double indemnity and disability features of life or accident insurance, 91 A.L.R. 1064; 128 A.L.R. 552.

Validity, construction, and effect of provisions in life or accident policy in relation to military service, 137 A.L.R. 1263; 36 A.L.R.2d 1018.

Insurer's liability for loss which is within coverage of its policy unless excluded because it is within the more specific coverage of the policy of another insurer, 150 A.L.R. 636.

Apportionment or contribution as between specific and blanket insurance policies, 169 A.L.R. 387.

Accident insurance policy provisions for diminution of indemnity where insured engages in, or does act pertaining to, a more hazardous occupation, 8 A.L.R.2d 481.

Clause in life, accident, or health policy excluding or limiting liability in case of insured's use of intoxicants or narcotics, 13 A.L.R.2d 987.

Apportionment of losses among automobile liability insurers under policies containing pro rata clauses, 21 A.L.R.2d 611.

Injury to or death of insured while assaulting another as due to accident or accidental means, 26 A.L.R.2d 399.

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.

Coverage of policy insuring against liability under dramshop acts, 14 A.L.R.3d 858.

Insured's receipt of or right to workmen's compensation benefits as affecting recovery under accident, hospital, or medical expense policy, 40 A.L.R.3d 1012.

Liability under life or accident policy not containing a "violation of the law" clause, for death or injury resulting from violation of law by insured, 43 A.L.R.3d 1120.

Liability insurance: failure or refusal of insured to attend trial or to testify as breach of cooperation clause, 9 A.L.R.4th 218.

Resolution of conflicts, in non-automobile liability insurance policies, between excess or pro-rata "other insurance" clauses, 12 A.L.R.4th 993.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

Death or injury from taking illegal drugs or narcotics as accidental or result of accidental means within insurance coverage, 32 A.L.R.5th 629.

33-29-5. Order of printing of provisions.

The provisions which are the subject of Code Sections 33-29-3 and 33-29-4, or any corresponding provisions which are used in lieu thereof in accordance with such Code sections, shall be printed in consecutive order of the provisions in such Code sections or, at the option of the insurer, any such provisions may appear as a unit in any part of the policy, with other provisions to which they may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

History. — Code 1933, § 56-3011, enacted by Ga. L. 1960, p. 289, § 1.

33-29-6. Provision in policies for medical or surgical services.

(a) The benefits on account of medical or surgical services provided by an individual policy of accident and sickness insurance may be limited by its terms to services performed by specifically defined professions, provided that in the absence of such definitions the term "physician" or "surgeon," as used in such policy, shall not be deemed

limited solely to medical practitioners licensed under Chapter 34 of Title 43.

(b) When an individual policy of accident and sickness insurance, except policies providing special coverage for limited diseases, accident protection only, or dental policies, provides for hospital care, there may be included within the scope of coverage hospital care rendered on account of mental illnesses and hospital care rendered by any psychiatric hospital duly licensed by this state. If such coverage is not included in the policy, a statement that the policy does not cover mental illnesses shall be printed in the policy in boldface type or stamped on the face of the policy and printed or stamped on any identification card issued pursuant to any such policy.

(c) Any other laws to the contrary notwithstanding, whenever the term "physician" or "surgeon" is used in any policy of health or accident and sickness insurance issued in this state or in any contract for health care, services, or benefits existing under, and by virtue of, any laws of this state, said term shall include, within its meaning, medical practitioners licensed under and in accordance with Chapter 11 of Title 43, relating to dentists, in respect to any care, services, procedures, or benefits covered by said policy of insurance or health care contract which the said persons are licensed to perform, any provisions in any such policy of insurance or health care contract to the contrary notwithstanding. This subsection shall be applicable to all policies in this state, regardless of date of issue.

History. — Code 1933, § 56-3016, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1970, p. 526, § 1; Ga. L. 1974, p. 436, § 1; Ga. L. 1980, p. 1251, § 1; Ga. L. 1981, p. 991, § 2; Ga. L. 1996, p. 6, § 33; Ga. L. 2019, p. 386, § 92/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (c), in the first sentence, inserted "and sickness" near the middle, and deleted "issued by any health, medical, or other service corporation" following "services, or benefits" in the middle.

Editor's notes. — Ga. L. 1970, p. 526, § 3, provides that no provision of Section 1 of Ga. L. 1970 "shall be construed to affect any policy issued prior to July 1, 1970."

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Limitation on reimbursement. — Reimbursement mandated by this section is limited to a doctor's professional services and does not include facility costs. 1980 Op. Att'y Gen. No. 80-103.

Reimbursable fees of dentists must be for services performed at listed facilities. — Reimbursement of the professional fees of dentists licensed pursuant to T. 43, Ch. 11 for medical and surgi-

cal procedures is mandated if performed at one of the types of outpatient facilities listed in this section. 1980 Op. Att'y Gen. No. 80-103.

RESEARCH REFERENCES

ALR. — Infection through boil, or similar condition, as an accident or accidental means within accident policy, 24 A.L.R. 730.

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.

Mental incapacity or disease as constituting total or permanent disability within insurance coverage, 22 A.L.R.3d 1000.

What constitutes a "hospital" within coverage or exclusionary clauses of hospitalization policy, 46 A.L.R.3d 1244.

33-29-7. Provision in policies for refusal of renewal generally.

(a) Subject to Code Section 33-29-21, each policy, covered by this chapter, except accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide, in substance, in a provision of the policy entitled "renewability," that, subject to the right to terminate the policy upon nonpayment of premiums when due, the right to refuse renewal shall not be exercised before the renewal date occurring on, or after and nearest, each anniversary or, in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force.

(b) The insurer shall not amend or endorse the policy prior to the anniversary date in a manner tending to restrict or lower the benefits, add exclusions, or increase the premium.

History. — Code 1933, § 56-3006, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2005, p. 481, § 7/HB 291.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 378 et seq.

ALR. — Express provisions in life, accident, or health policies that authorize refusal of renewal premium or otherwise make renewal optional with insurer, 119 A.L.R. 530; 161 A.L.R. 193.

33-29-8. Provision in policies renewable or cancelable at option of insurer for refund of premiums.

(a) Except as provided in subsection (b) of this Code section, every insurer delivering or issuing for delivery in this state policies of accident and sickness insurance which are renewable at the option of

the insurer or cancelable at the option of the insurer shall provide in said policies a provision as follows:

"If the company cancels or refuses to renew this policy except for nonpayment of premiums prior to age _____ (insert age which shall not be less than 60), it will refund 75 percent of the premiums paid in excess of the benefits received. The requirements of this provision shall not apply to cancellation or refusal to accept renewal premiums because of change in occupation of the insured to an occupation generally classified by the insurer as to all applicants as uninsurable."

(b) This Code section shall not apply to and the provision prescribed in subsection (a) of this Code section need not be included in any major medical policy which provides that the insurer may cancel or refuse to renew the policy as of an anniversary date when also canceling or refusing to renew all policies with the same provisions and premium rate basis in the jurisdiction in which the insured resides, and then only if either or both of the following conditions are applicable:

(1) The insured is or could be covered by benefits, substantially similar in both kind and amount to those of the policy, in accordance with any federal or state governmental health insurance program; or

(2) The insurer is prevented by any law or any regulation or ruling of a governmental agency from applying to the policy a table of premium rates which the insurer certifies, based on its experience, is reasonable in relation to the benefits provided.

(c) For the purpose of this chapter, a major medical policy is any policy which provides benefits of at least 75 percent of necessary, reasonable, and customary charges for medical care, including hospitalization in semiprivate accommodations, with maximum lifetime benefit of at least $100,000.00, subject only to such exceptions, restrictions, limitations, and deductible as the Commissioner may deem reasonable.

History. — Code 1933, § 56-3009, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1973, p. 499, § 7; Ga. L. 1975, p. 415, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2005, p. 481, § 8/HB 291.

33-29-9. Requirements as to references in policies to noncancelable nature or guaranteed renewability nature; exception for certain matters concerning renewability of individual accident and sickness policies; rules and regulations.

(a) No policy of accident or sickness insurance shall refer to its noncancelable nature without at the same time disclosing all options

the insurer may have in regard to renewability; and the guaranteed renewable nature of any such policy shall not be referred to unless the reference at the same time discloses the qualifications on the guarantee of renewability, including any age limits, any right to change premium rates by class, any aggregate provisions, and any other limitations on the right to renewal in a manner which shall not minimize or render obscure the qualifying conditions.

(b) An insurer operating in the major medical or comprehensive, guaranteed renewable business in this state shall permit an insured to change his or her major medical or comprehensive coverage, upon election at any renewal, to a comparable product offered by that insurer or a product offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. If such product, benefit, or deductible change is elected by the insured during the 60 day required period after notice of renewal premium increase but before renewal date, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage.

(c) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section.

History. — Code 1933, § 56-3010, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2006, p. 183, § 1/HB 1456; Ga. L. 2019, p. 386, § 93/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (b), in the first sentence, substituted "this state" for "the State of Georgia" near the middle, and twice deleted "currently" preceding "offered" in the middle.

33-29-10. Operation of provision establishing age for termination of coverage generally; effect of misstatement of age of insured.

(a) If any accident and sickness policy delivered or issued for delivery in this state contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and, if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force until the end of the period for which premium has been accepted.

(b) In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

History. — Code 1933, § 56-3003, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, § 1046 et seq.

C.J.S. — 46 C.J.S., Insurance, § 1234 et seq.

ALR. — Clause in health and accident, or similar, policy reducing amount of, or terminating, periodic payments after insured reaches specified age, as applicable to disability incurred before such age was reached, 53 A.L.R.2d 552.

33-29-11. Right of person to whom policy or contract issued to return policy or contract and receive premium refund; effect of return; proof of return.

(a) Every individual accident and sickness policy or contract, except single premium nonrenewable policies or contracts, issued for delivery in this state by an insurer shall have printed on or attached to the policy or contract a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason.

(b) If the insured or purchaser, pursuant to such notice, returns the policy or contract to the insurer at its home or branch office, or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued. Without limiting any other method of returning a policy or contract under this Code section, it shall be prima-facie evidence of the fact and date of return of a policy or contract if the policy or contract is dispatched by certified mail or statutory overnight delivery to the insurer or agent, as provided in this Code section, and a return receipt provided by the United States Postal Service or commercial delivery company is obtained.

History. — Code 1933, § 56-3007, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2000, p. 1589, § 10; Ga. L. 2019, p. 386, § 94/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after January 1, 1961," following "delivery in this state" in subsection (a); and, in subsection (b), in the second sentence, twice substituted "a policy" for "an annuity", and substituted "the policy" for "the annuity".

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (b) is applicable with respect to notices delivered on or after July 1, 2000.

33-29-12. Policies issued for delivery or delivered within state by foreign or alien insurers; policies of domestic insurers issued for delivery in other states or countries.

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than those provisions contained in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of the other state or country.

History. — Code 1933, § 56-3013, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

ALR. — 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.

33-29-13. Furnishing of written outline of coverage to applicants for insurance; approval of outline.

Every insurer shall furnish to any applicant for accident and sickness insurance in this state a written outline showing the major coverage of the policy applied for, the major exclusions of the policy applied for, the renewal provisions of the policy applied for, and a reference to the policy with respect to further provisions. The written outline shall be given to the applicant at the time of signing the application for the policy and the forms of the outlines shall be subject to the same requirements for filing and approval as are set forth for the filing and approval of policy forms as required in Code Sections 33-24-9 and 33-24-10.

History. — Code 1933, § 56-3008, enacted by Ga. L. 1960, p. 289, § 1.

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Handing information to applicant in person not required. — This section, properly interpreted, does not require that information be handed to an applicant in person by an agent of the soliciting company at the time the application is signed. 1968 Op. Att'y Gen. No. 68-414.

RESEARCH REFERENCES

ALR. — Blood poisoning traceable to attendance upon patient as within coverage extended by accident policy, 61 A.L.R. 1072.

What constitutes medical or surgical treatment, or the like, within exclusionary clause of accident policy or accidental death feature of life policy, 65 A.L.R.2d 1449.

Liability insurance: "accident" or "accidental" as including loss resulting from ordinary negligence of insured or his agent, 7 A.L.R.3d 1262.

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.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

33-29-14. Application for, and ownership of, policies by persons other than insured.

This chapter shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such policy to any indemnities, benefits, and rights provided in the policy.

History. — Code 1933, § 56-3012, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 358 et seq.

ALR. — Election of option under insurance policy where person otherwise entitled is dead, incompetent, or an infant, 127 A.L.R. 454; 136 A.L.R. 1045.

33-29-15. Exemption of policy proceeds from liability for debts of insured and beneficiary.

(a) The proceeds or avails of all accident and sickness policies and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts, except credit accident and sickness policies and credit life policies, shall be exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his or her use.

(b) The exemption of income benefits payable as the result of disability shall not exceed an average of $250.00 of such benefits per month of the period of disability.

History. — Code 1933, § 56-3015, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2019, p. 386, § 95/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (a), substituted "contracts" for "contract" in the middle, and inserted "or her" near the end.

RESEARCH REFERENCES

ALR. — Bankruptcy or insolvency of insured as affecting right of person injured to proceeds of indemnity insurance, in absence of provision in policy in that regard, 59 A.L.R. 1123.

Accident insurance as life insurance within exemption law, 111 A.L.R. 61.

Enforceability, in forum, of extraterritorial waiver of debtor's exemption valid where made, 60 A.L.R.2d 1449.

33-29-16. Compliance with chapter by attachment of rider or endorsement to policy.

The requirements of this chapter may be complied with by the insurer by attaching to the policy such rider or endorsement as may be necessary for the purpose.

History. — Code 1933, § 56-3017, enacted by Ga. L. 1960, p. 289, § 1.

33-29-17. Validity and construction of policies delivered or issued for delivery in violation of chapter; effect of conflict between provisions subject to chapter and other provisions.

(a) No policy provision which is not subject to this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(b) A policy delivered or issued for delivery to any person in this state in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by this chapter.

History. — Code 1933, § 56-3014, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Iowa State Travelers Mut. Ass'n v. Cadwell, 113 Ga. App. 128, 147 S.E.2d 461 (1966).

RESEARCH REFERENCES

ALR. — 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.

33-29-18. Franchise insurance.

(a) As used in this Code section, the term "employees" means the officers, managers, and employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

(b) Accident and sickness insurance on a franchise plan is that form of accident and sickness insurance issued to:

(1) Two or more employees of any corporation, copartnership, or individual employer or any governmental corporation, agency, or department thereof; or

(2) Ten or more members, employees, or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years, where the association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance; where the persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by the persons under an arrangement whereby the premiums on the policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association or union for its members, or by some designated person acting on behalf of such employee or association or union.

History. — Code 1933, § 56-3018, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1987, p. 1486, § 6.

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General Assembly intended word "may" in this section to be permissive, and a franchise accident and sickness policy form may be approved according to this interpretation. 1968 Op. Att'y Gen. No. 68-322.

33-29-19. Rate modification on individual accident and sickness policies providing for optional loss ratio guarantee.

(a) This Code section shall apply only to the filing of rate modifications for individual accident and sickness policies which provide for an optional loss ratio guarantee.

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

(1) "Expected loss ratio" in an experience period means the ratio of: (A) the sum of expected claims in the experience period for each year of issue, based on the corresponding loss ratio standards as recited in

accordance with paragraph (1) of subsection (d) of this Code section, to (B) the earned premium in the experience period.

(2) "Loss ratio" means the ratio of incurred claims to earned premium.

(c) Rate modification on individual accident and sickness policies which provide for an optional loss ratio guarantee must be filed with the Commissioner prior to implementation.

(d) At the time of filing new premium rates on any previously approved form for individual accident and sickness insurance policies which provide for an optional loss ratio guarantee, the benefits provided by the policies shall be deemed reasonable as to the premium charged so long as the insurer complies with the terms of a loss ratio guarantee filed with the Commissioner. The loss ratio guarantee shall be in writing and shall include at least the following:

(1) A recitation of the loss ratio standards included in the original actuarial memorandum filed with the policy form at the time of the initial approval of the policy form. Such loss ratio standards must be given for each of the first ten years after issue;

(2) A guarantee that the actual loss ratios in this state for each experience period will meet or exceed the expected loss ratio in the experience period. If the annual earned premium volume in this state under a policy form is less than $1 million, the loss ratio guarantee shall be based on the actual loss ratio for the aggregate of states having less than $1 million of earned premium for the policy form. If such aggregate annual earned premium is less than $1 million, the experience period shall be extended until the end of the calendar year in which $1 million of earned premium is attained;

(3) A guarantee that the actual loss ratio results for each calendar year the rates are in effect shall be independently audited during the second quarter of the following year at the expense of the insurer. The audited results shall be reported to the Commissioner no later than the date for filing the applicable accident and sickness policy experience exhibit. The Commissioner may disapprove the audit for reasonable cause;

(4) A guarantee that affected policyholders in this state shall be issued a refund proportional to premiums paid in an amount such that when added to incurred claims will bring the actual loss ratio up to the expected loss ratio in the experience period. If aggregate loss ratios are used, the total amount refunded in this state shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in this state on the policy form and divided by the total premiums earned in all aggregated

states on the policy form. The refund shall be made to all policyholders insured under the applicable policy form as of the last day of the applicable experience period and whose individual refund would equal $10.00 or more. The refund shall include interest at the maximum interest rate permitted by law in the valuation of whole life insurance issued on the last date of the applicable experience period calculated from the last day of the applicable experience period until the date of payment, which shall be during the third quarter of the following year; and

(5) A guarantee that refunds of less than $10.00 shall be aggregated by the insurer and paid to the Department of Insurance.

History. — Code 1981, § 33-29-19, enacted by Ga. L. 1992, p. 1648, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 2019, p. 337, § 1-93/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" at the end of paragraph (d)(5).

Code Commission notes. — As enacted by Ga. L. 1992, p. 1648, § 1, this Code section contained two subsections designated as subsection (b). Pursuant to Code Section 28-9-5, in 1992, the second subsection (b) was redesignated as subsection (c) and subsection (c) was redesignated as subsection (d).

33-29-20. Insurance coverage for treatment of temporomandibular joint dysfunction or surgery for deformities of maxilla or mandible.

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

(1) "Functional deformity" means a deformity of the bone or joint structure of the maxilla or mandible such that the normal character and essential function of such bone structure is impeded.

(2) "Policy" means any major medical benefit plan, contract, or policy except a credit insurance policy, disability income policy, specified disease policy, hospital indemnity policy, limited accident policy, or other similarly limited accident and sickness policy.

(3) "Temporomandibular joint" means the connection of the mandible and the temporal bone through the articular disc surrounded by the joint capsule and associated ligaments and tendons.

(4) "Temporomandibular joint dysfunction" means congenital or developed anomalies of the temporomandibular joint.

(b) No policy may be issued or issued for delivery in this state which:

(1) Excludes medically necessary surgical or nonsurgical treatment for the correction of temporomandibular joint dysfunction by physicians or dentists professionally qualified by training and experience; or

(2) Excludes medically necessary surgery for the correction of functional deformities of the maxilla and mandible.

(c) The provisions of this Code section shall not cover cosmetic or elective orthodontic or periodontic care or general dental care.

(d)(1) The coverage under paragraph (1) of subsection (b) of this Code section may contain such types of exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to other benefits under the accident and sickness insurance benefit plan, policy, or contract.

(2) Basic coverage for the nonsurgical treatment of temporomandibular joint dysfunction under paragraph (1) of subsection (b) of this Code section may be limited to history and examination; radiographs, which must be diagnostic for temporomandibular joint dysfunction; splint therapy with necessary adjustments, provided that removable appliances designed for orthodontic purposes would not be reimbursable under a major medical plan; and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.

(e) Except as provided in paragraph (1) of subsection (c) of Code Section 33-30-23, for policies limited only to dental coverage, nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

History. — Code 1981, § 33-29-20, enacted by Ga. L. 1994, p. 474, § 1; Ga. L. 2019, p. 386, § 96/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "the Georgia Basic Health Plan," following "policy except" near the middle of paragraph (a)(2).

Cross references. — Group or blanket insurance coverage for treatment of temporomandibular joint dysfunction or surgery for deformities of maxilla or mandible, § 33-30-14.

Editor's notes. — Ga. L. 1994, p. 474, § 3, not codified by the General Assembly, provides that the Act shall be applicable to individual, group, or blanket major medical policies issued or issued for delivery on or after July 1, 1994.

33-29-21. Renewal or continuation at option of insured.

Pursuant to the provisions of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and subject to applicable rules and regulations as issued by the Centers for Medicare and Medicaid Services, all insurers which issue, issue for delivery, deliver, or renew existing individual policies, certificates, or contracts of accident and sickness insurance in this state shall, subject only to timely payment of premiums, renew or continue such coverage at the option of the insured. Such other exemptions and exclusions as are permitted by

the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, Section 2742 shall also apply to individual accident and sickness insurance and insurers in this state.

History. — Code 1981, § 33-29-21, enacted by Ga. L. 1997, p. 1462, § 4; Ga. L. 2002, p. 415, § 33; Ga. L. 2019, p. 386, § 97/SB 133.

The 2019 amendment, effective July 1, 2019, in the first sentence of this Code section, deleted "on and after July 1, 1997," following "Medicaid Services," near the middle, and substituted "this state" for "the State of Georgia" in the middle.

Cross references. — Conversion privileges and continuation rights, § 33-24-21.1. Individual health insurance coverage availability, T. 33, C. 29A. Continuation of similar coverage, § 33-30-15.

Editor's notes. — Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that that Act, which enacted 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; and further provides that the Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

33-29-21.1. Availability of accident and sickness policy upon termination of dependent coverage based on age of dependent.

Every policy which contains a provision for termination of coverage of a dependent upon the reaching of a certain age shall contain a provision to the effect that, upon the date of the dependent reaching the age at which coverage would terminate under the provisions of the policy, the dependent shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 45 days following the date the dependent reaches the age at which coverage would terminate and upon the payment of the appropriate premium, an individual or family policy of accident and sickness insurance then being issued by the insurer which provides coverage most nearly similar to the coverage contained in the policy which was terminated by reason of such dependent reaching a certain age or any similar individual or family policy then being issued by the insurer which contains lesser coverage. Any and all probationary or waiting periods set forth in such an individual or family policy shall be considered as being met to the extent coverage was in force under the prior policy.

History. — Code 1981, § 33-29-21.1, enacted by Ga. L. 2006, p. 183, § 2/HB 1456; Ga. L. 2019, p. 386, § 98/SB 133.

The 2019 amendment, effective July 1, 2019, inserted "such" near the end of the first sentence of this Code section.

33-29-22. Notice of premium increase.

Notice of any premium increase shall be mailed or delivered to each holder of an individual accident and sickness insurance policy not less than 60 days prior to the effective date of such increase.

History. — Code 1981, § 33-29-22, enacted by Ga. L. 1999, p. 289, § 4; Ga. L. 2013, p. 1100, § 1/SB 236; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2016, p. 864, § 33/HB 737.

Editor's notes. — Ga. L. 1999, p. 289, § 6, not codified by the General Assembly, provides that this Act shall apply to plans, policies, or contracts issued, delivered, issued for delivery, or renewed on or after July 1, 1999.

CHAPTER 29A

INDIVIDUAL HEALTH INSURANCE COVERAGE

Article 1

Availability and Assignment System

Sec.

33-29A-1. Intent; federal references.
33-29A-2. Definitions.
33-29A-3. Condition to licensure.
33-29A-4. Georgia Health Insurance Assignment System.
33-29A-5. Georgia Health Benefits Assignment System.
33-29A-6. Contracting between managed care organizations.
33-29A-7. Moratorium on required issuance of coverage.
33-29A-8. Rules and regulations; compensation to licensed insurance agents.
33-29A-9. Discontinuance of state assignment system benefit plans.

Article 2

Commission on the Georgia Health Insurance Risk Pool

33-29A-20 through 33-29A-22 [Repealed].

Article 3

Individual Accident and Sickness Insurance

Sec.

33-29A-30. Legislative findings and purpose; increasing availability of health insurance for uninsured individuals.
33-29A-31. Definitions.
33-29A-32. Commissioner to authorize insurers to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states.
33-29A-33. Satisfaction of actuarial standards set by National Association of Insurance Commissioners (NAIC); policies must comply with regulations and requirements promulgated by Commissioner; authority of Commissioner.
33-29A-34. Certain language required in policies and policy applications.
33-29A-35. Adoption of rules and regulations by Commissioner; application of dispute resolution mechanism or provision.

Cross references. — Conversion privileges and continuation rights, § 33-24-21.1. Renewal or continuation of option of insured, § 33-29-21. Continuation of similar coverage, § 33-30-15.

Editor's notes. — Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that that Act, which enacted this Chapter, 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; and further provides that the Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance, 23 POF2d 53.

Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance, 3 POF3d 367.

Use of Federal Estoppel Doctrine to Establish Coverage Under Group Health Insurance Policy, 43 POF3d 261.

ALR. — Coverage under medical and health insurance plans for services performed by dentists, oral surgeons, and orthodontists, 43 A.L.R.5th 657.

ARTICLE 1

AVAILABILITY AND ASSIGNMENT SYSTEM

33-29A-1. Intent; federal references.

(a) It is the intention of this chapter together with Code Section 33-24-21.1 to provide an acceptable alternative mechanism for the availability of individual health insurance coverage, as contemplated by Section 2741 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-41. This chapter shall be construed and administered so as accomplish such intention.

(b) Any reference in this chapter to any federal statute shall refer to that federal statute as it existed on January 1, 1997, including its amendment by the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

History. — Code 1981, § 33-29A-1, enacted by Ga. L. 1997, p. 1462, § 5.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999 and in 2000, "Section" was inserted following "U.S.C.A." in subsection (a).

33-29A-2. Definitions.

(a) As used in this chapter, the terms:

(1) "Creditable coverage" and "eligible individual" have the same meaning as specified in Sections 270l and 2741 of the federal Public Health Service Act, 42 U.S.C.A. Sections 300gg and 300gg-41 except that a person shall not be an eligible individual under this chapter if such person is eligible for or has declined any continuation or conversion coverage or has terminated any such coverage prior to its exhaustion.

(2) "Health insurance issuer" and "health maintenance organization" have the same meaning as specified in Section 2791 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92.

(3) "Health insurer" means any health insurance issuer which is not a managed care organization.

(4) "Managed care organization" means a health maintenance organization or a nonprofit health care corporation.

(b) Any other term which is used in this chapter and which is also defined in Section 2791 of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-92, and not otherwise defined in this chapter shall have the same meaning specified in said Section 2791.

History. — Code 1981, § 33-29A-2, enacted by Ga. L. 1997, p. 1462, § 5.

33-29A-3. Condition to licensure.

Each health insurer and managed care corporation which is licensed to and does offer health insurance coverage in the individual market in this state shall as a condition of such licensure agree to participation in its respective assignment system provided by this chapter. This Code section shall not apply to an entity which offers only excepted benefits as specified in Section 2791(c) of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-91(c).

History. — Code 1981, § 33-29A-3, enacted by Ga. L. 1997, p. 1462, § 5.

33-29A-4. Georgia Health Insurance Assignment System.

(a) Each eligible individual in this state whose most recent creditable coverage was provided by an entity other than a managed care organization shall be entitled to participate in the Georgia Health Insurance Assignment System (sometimes referred to as GHIAS in this chapter) created pursuant to this Code section. Each eligible individual in this state whose most recent creditable coverage was provided by a managed care organization shall be entitled to participate in the Georgia Health Benefits Assignment System created pursuant to Code Section 33-29A-5.

(b) The Commissioner shall develop the GHIAS system which shall provide for the equitable assignment of eligible individuals who are entitled to and desirous of participating in the system to health insurers offering coverage in the individual market in the state. Such assignment shall be based primarily on the pro rata volume of individual health insurance business done in this state by each such health insurer. The system may include other factors for equitable assignment, as determined to be appropriate by the Commissioner, including but not limited to the geographic area or areas in the state normally served by a health insurer.

(c) Upon assignment of an eligible individual to a health insurer, the eligible individual shall have the right to purchase and the health insurer shall have the obligation to sell either of the standard health insurance policies provided for in subsection (d) of this Code section at a premium not to exceed the maximum specified in said subsection.

(d) The Commissioner shall develop two standard health insurance policies to be provided by health insurers to which eligible individuals are assigned pursuant to this Code section. The actuarial value of the benefits under each such coverage shall be at least 85 percent of the average actuarial value of the benefits provided by all individual health insurance coverage issued by all issuers in the state. Except to the extent specifically provided to the contrary in this chapter, all laws of this state relating to the normal provision of such coverage in the individual market shall apply to the provision of such coverage under this chapter. The Commissioner shall fix a maximum premium to be charged for each such standard policy which shall be not more than 150 percent of the average premium which is or would be charged by all issuers in the state for the same or similar coverage issued other than under this Code section, as determined by the Commissioner. The Commissioner may authorize a health insurer to charge a premium in excess of said 150 percent maximum if and only if the insurer demonstrates to the Commissioner that the application of the 150 percent maximum would endanger the financial solvency of that health insurer.

(e) Nothing in this Code section shall be construed to require a health insurer to offer to an eligible individual any coverage other than one of the two standard health insurance plans developed under subsection (d) of this Code section. Nothing in this Code section shall be construed to prohibit any insurer from offering to any individual any otherwise lawful coverage.

History. — Code 1981, § 33-29A-4, enacted by Ga. L. 1997, p. 1462, § 5.

33-29A-5. Georgia Health Benefits Assignment System.

(a) Each eligible individual in this state whose most recent creditable coverage was provided by a managed care organization shall be entitled to participate in the Georgia Health Benefits Assignment System (sometimes referred to as GHBAS in this chapter) created pursuant to this Code section. Each eligible individual in this state whose most recent creditable coverage was provided by an entity other than a managed care organization shall be entitled to participate in the Georgia Health Insurance Assignment System created pursuant to Code Section 33-29A-4.

(b) The Commissioner shall develop the GHBAS system which shall provide for the equitable assignment of eligible individuals who are entitled to and desirous of participating in the system to managed care organizations doing business in the state. Such assignment shall be based primarily on the pro rata volume of individual business done in this state by each such managed care organization and the geographic area or areas in the state normally served by a managed care organi-

zation. The system may include other factors for equitable assignment, as determined to be appropriate by the Commissioner. No managed care organization shall be required to provide coverage outside the geographic area or areas normally served by that managed care organization. However, where this geographic limitation makes it impossible to assign to a managed care organization its equitable share of eligible individuals, a managed care organization may be required by the Commissioner to contract for provision of coverage of eligible individuals, as provided for in Code Section 33-29A-6.

(c) Upon assignment of an eligible individual to a managed care organization, the eligible individual shall have the right to purchase and the managed care organization shall have the obligation to sell enrollment in either of the standard health benefit plans provided for in subsection (d) of this Code section at a premium not to exceed the maximum specified in said subsection.

(d) The Commissioner shall develop two standard health benefit plans to be provided by managed care organizations to which eligible individuals are assigned pursuant to this Code section. The actuarial value of the benefits under each such health benefit plan shall be at least 85 percent of the average actuarial value of the benefits provided by all health benefit plans issued in the individual market by all managed care organizations in the state. Except to the extent specifically provided to the contrary in this chapter, all laws of this state relating to the normal provision of such coverage in the individual market shall apply to the provision of such coverage under this chapter. The Commissioner shall fix a maximum premium to be charged for each such standard health benefit plan which shall be not more than 150 percent of the average premium which is or would be charged by all managed care organizations in the state for the same or similar coverage issued other than under this Code section, as determined by the Commissioner. The Commissioner may authorize a managed care organization to charge a premium in excess of said 150 percent maximum if and only if the managed care organization demonstrates to the Commissioner that the application of the 150 percent maximum would endanger the financial solvency of that managed care organization.

(e) Nothing in this Code section shall be construed to require a managed care organization to offer to an eligible individual any coverage other than one of the two standard health benefit plans developed under subsection (d) of this Code section. Nothing in this Code section shall be construed to prohibit any managed care organization from offering to any individual any otherwise lawful coverage.

History. — Code 1981, § 33-29A-5, enacted by Ga. L. 1997, p. 1462, § 5.

33-29A-6. Contracting between managed care organizations.

Any combination of one or more health insurers and one or more managed care organizations may contract with each other for the assumption by one or more health insurers of the obligations otherwise imposed by this chapter on one or more managed care organizations. Under any such contract the responsibility for providing the coverage required by this chapter shall be with a health insurer licensed to do business in this state. Where the obligations of a managed care organization are contractually assumed by a health insurer, the assuming health insurer may substitute coverage under a standard policy of health insurance for coverage under a standard health benefit plan, and provision of such substituted coverage shall satisfy the obligation otherwise owed to an affected eligible individual.

History. — Code 1981, § 33-29A-6, enacted by Ga. L. 1997, p. 1462, § 5.

33-29A-7. Moratorium on required issuance of coverage.

The Commissioner may impose a moratorium upon the required issuance of coverage by a health insurer or managed care organization, if the Commissioner determines after public notice and hearing that the continuation of such required issuance by that entity will endanger the solvency of that entity.

History. — Code 1981, § 33-29A-7, enacted by Ga. L. 1997, p. 1462, § 5.

33-29A-8. Rules and regulations; compensation to licensed insurance agents.

(a) The Commissioner shall adopt rules and regulations for the implementation of this chapter. Notwithstanding any provision of Chapter 2 of this title or any other law to the contrary, such rules and regulations shall be adopted in exact compliance with the procedures specified in Article 1 of Chapter 13 of Title 50, the "Georgia Administrative Procedure Act." In addition to any other materials submitted under subsection (e) of Code Section 50-13-4, there shall be so submitted the full text of the Georgia Health Insurance Assignment System, the Georgia Health Benefits Assignment System, the standard health insurance policies provided for in Code Section 33-29A-4, and the standard health benefit plans provided for in Code Section 33-29A-5.

(b) The rules and regulations developed by the Commissioner shall include provisions for applications for GHIAS and GHBAS to be submitted by licensed insurance agents and for such agents to be compensated at a commission rate of not less than 3 percent from the

premiums received by the issuing health insurer or managed care organization. For purposes of applications for GHIAS and GHBAS, licensed agents shall not be subject to the certificate of authority requirements of Code Section 33-23-26.

History. — Code 1981, § 33-29A-8, enacted by Ga. L. 1997, p. 1462, § 5; Ga. L. 1998, p. 1064, § 8; Ga. L. 2001, p. 925, § 5.

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

33-29A-9. Discontinuance of state assignment system benefit plans.

(a) Upon the effective date whereupon guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, a health insurer or managed care organization shall not be required to offer health care policies under the Georgia Health Insurance Assignment System and Georgia Health Benefits Assignment System.

(b) Each health insurer or managed care organization that has offered health care policies under the Georgia Health Insurance Assignment System and the Georgia Health Benefits Assignment System may terminate, cancel, or nonrenew such existing policies as of the date upon which guaranteed issue coverage is available pursuant to the federal Patient Protection and Affordable Care Act, provided that the health insurer or managed care organization provides at least 90 days' notice prior to the termination of the coverage to all policyholders and to the Commissioner.

(c) An insurer may not terminate, cancel, or nonrenew any policy under this subsection if, at the end of the 90 day cancellation period, the insured would not have at least 90 days of remaining open enrollment to obtain insurance coverage through an exchange created pursuant to the federal Patient Protection and Affordable Care Act.

History. — Code 1981, § 33-29A-9, enacted by Ga. L. 2013, p. 873, § 3/HB 389; Ga. L. 2014, p. 866, § 33/SB 340.

Editor's notes. — Ga. L. 2013, p. 873, § 1/HB 389, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Georgia Health Insurance Enhancement Act of 2013.'"

U.S. Code. — The Patient Protection and Affordable Care Act, referred to in this Code section, is codified throughout the United States Code and primarily in T. 42.

ARTICLE 2

COMMISSION ON THE GEORGIA HEALTH INSURANCE RISK POOL

33-29A-20 through 33-29A-22.

Reserved. Repealed by Ga. L. 2019, p. 337, § 2-1/SB 132, effective July 1, 2019 and by Ga. L. 2019, p. 919, § 14-1/HB 553, effective July 1, 2019.

Editor's notes. — This article consisted of Code Sections 33-29A-20 through 33-29A-22, relating to Commission on Georgia Health Insurance Risk Pool, and was based on Code 1981, §§ 33-29A-20 through 33-29A-22, enacted by Ga. L. 2005, p. 1215, § 1/HB 320; Ga. L. 2013, p. 141, § 33/HB 79.

Ga. L. 2019, p. 337, § 2-2/SB 132, not codified by the General Assembly, provides: "Any assets of the Commission on the Georgia Health Insurance Risk Pool 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 Commission on the Georgia Health Insurance Risk Pool 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."

Ga. L. 2019, p. 919, § 14-2/HB 553, not codified by the General Assembly, provides: "Any assets of the Commission on the Georgia Health Insurance Risk Pool 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 Commission on the Georgia Health Insurance Risk Pool 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."

ARTICLE 3

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Administrative rules and regulations. — Sale of individual health insurance products approved in other states, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Chapter 120-2-99.

Law reviews. — For article on the 2011 enactment of this article, see 28 Ga. St. U.L. Rev. 35 (2011).

33-29A-30. Legislative findings and purpose; increasing availability of health insurance for uninsured individuals.

The General Assembly recognizes the high level of uninsured individuals in this state and the need for individuals or other purchasers of health insurance coverage in this state to have the opportunity to choose health insurance plans that are more affordable and flexible than existing market policies offering accident and sickness insurance coverage. Therefore, the General Assembly seeks to increase the availability of health insurance coverage by allowing insurers authorized to transact insurance in Georgia to issue individual accident and

sickness policies in Georgia that are currently approved for issuance in another state.

History. — Code 1981, § 33-29A-30, enacted by Ga. L. 2011, p. 789, § 1/HB 47; Ga. L. 2012, p. 775, § 33/HB 942.

33-29A-31. Definitions.

For purposes of this article, the term "individual accident and sickness insurance policy" means any policy insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future but does not include limited benefit insurance policies exempted from the definition of the term "health benefit policy" in Code Section 33-1-2. The term "individual accident and sickness insurance policy" shall also include comprehensive major medical coverage for medical and surgical benefits, and also includes "high deductible health plans" sold or maintained under the applicable provisions of Section 223 of the Internal Revenue Code.

History. — Code 1981, § 33-29A-31, enacted by Ga. L. 2011, p. 789, § 1/HB 47; Ga. L. 2019, p. 337, § 1-92/SB 132.

The 2019 amendment, effective July 1, 2019, in this Code section, deleted "paragraph (1.1) of" preceding "Code Section 33-1-2" near the end of the first sentence, and substituted "'high deductible health plans'" for "'High Deductible Health Plans'" in the middle of the second sentence.

33-29A-32. Commissioner to authorize insurers to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states.

The Commissioner shall approve for sale in Georgia any individual accident and sickness insurance policy that is currently approved for issuance in another state where the insurer or the insurer's affiliate or subsidiary is authorized to transact insurance so long as the insurer or the insurer's affiliate or subsidiary filing and issuance such policy in Georgia is also authorized to transact insurance in this state pursuant to Chapter 3 of this title and provided that any such policy meets the requirements set forth in this article. Additionally, any insurer authorized to transact insurance in this state can offer an individual accident and sickness insurance policy with benefits equivalent to those in any policy approved for sale in Georgia under this article, provided that any such offered policy meets the requirements set forth in this article.

History. — Code 1981, § 33-29A-32, enacted by Ga. L. 2011, p. 789, § 1/HB 47.

33-29A-33. Satisfaction of actuarial standards set by National Association of Insurance Commissioners (NAIC); policies must comply with regulations and requirements promulgated by Commissioner; authority of Commissioner.

(a) Any insurer selling an insurance policy pursuant to this article, and any policy approved pursuant to this article, shall satisfy actuarial standards set forth by the National Association of Insurance Commissioners (NAIC) and any regulation promulgated by the Commissioner that is not inconsistent with such NAIC standards. Any insurer selling an insurance policy pursuant to this article, and any policy approved pursuant to this article, shall, except as otherwise provided in this article, comply with the requirements of this title and the regulations promulgated by the Commissioner.

(b) The Commissioner shall have the authority to determine whether an insurer satisfies the standards required by this Code section and may not approve a plan that he or she finds lacks compliance with this Code section. The Commissioner shall have the authority to determine whether the plan sold pursuant to this article continues to satisfy the requirements set forth in this Code section in the same manner as he or she does with an individual accident and sickness insurance policy approved pursuant to another applicable chapter in this title.

(c) Any policy sold pursuant to this article shall comply with paragraph (3) of subsection (c) of Code Section 9-9-2 and shall not require the insured or his or her beneficiary to arbitrate disputes arising under the policy.

History. — Code 1981, § 33-29A-33, enacted by Ga. L. 2011, p. 789, § 1/HB 47.

33-29A-34. Certain language required in policies and policy applications.

(a) Each written application for a policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

> "The benefits of this policy may primarily be governed by the laws of a state other than Georgia; therefore, all of the laws applicable to policies filed in this state may not apply to this policy. Any purchase of individual health insurance should be considered carefully since future medical conditions may make it impossible to qualify for another individual health insurance policy."

(b) Each policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

"The benefits of this policy providing your coverage may be governed primarily by the laws of a state other than Georgia. The benefits covered may be different from other policies you can purchase. Please consult your insurance agent or insurer to determine which health benefits are covered under this policy."

(c) Each individual accident and sickness policy sold pursuant to this article shall contain a side-by-side chart that compares the definitions of each benefit covered by the policy that has been sold in the other state with the definitions of the benefits covered under current Georgia laws and regulations where the specified benefit is similarly termed but defined differently.

History. — Code 1981, § 33-29A-34, enacted by Ga. L. 2011, p. 789, § 1/HB 47.

33-29A-35. Adoption of rules and regulations by Commissioner; application of dispute resolution mechanism or provision.

(a) The Commissioner shall adopt rules and regulations necessary to implement this article, which shall include, but shall not be limited to, standard forms for the disclosure of benefits, and preserve the intent and effect of Code Sections 33-24-27, 33-24-27.1, and 33-24-59.12 and subsection (c) of Code Section 33-29-6.

(b) Any dispute resolution mechanism or provision for notice and hearing in this title shall apply to insurers issuing and delivering policies pursuant to this article.

History. — Code 1981, § 33-29A-35, enacted by Ga. L. 2011, p. 789, § 1/HB 47; Ga. L. 2012, p. 775, § 33/HB 942.

CHAPTER 29B

HEALTH CARE COVERAGE FOR CHILDREN

Sec.
33-29B-1 through 33-29B-8 [Repealed].

33-29B-1 through 33-29B-8.

Repealed by Ga. L. 2012, p. 617, § 1/HB 1166, effective January 1, 2014.

Editor's notes. — This chapter consisted of Code Sections 33-29B-1 through 33-29B-8, relating to health care coverage for children, and was based on Code 1981, §§ 33-29B-1 through 33-29B-8, enacted by Ga. L. 2012, p. 617, § 1/HB 1166.

CHAPTER 30

GROUP OR BLANKET ACCIDENT AND SICKNESS INSURANCE

Article 1

General Provisions

Sec.

33-30-1. "Group accident and sickness insurance" defined; "true association" defined.
33-30-1.1. Applicability.
33-30-2. Effect of chapter upon other provisions.
33-30-3. "Blanket accident and sickness insurance" defined.
33-30-4. Required provisions generally.
33-30-4.1. Coverage for human heart transplants; optional endorsement; requirements; guidelines.
33-30-4.2. Insurance coverage for mammograms, Pap smears, and prostate-specific antigen tests.
33-30-4.3. Utilization of mail-order pharmaceutical distributors in policies, plans, contracts, or funds; utilization of other providers of pharmaceutical services under same terms and conditions.
33-30-4.4. Coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease; optional endorsement; requirements; guidelines; applicability.
33-30-4.5. Coverage for child wellness services.
33-30-5. Direct payment for hospital or medical services.
33-30-6. Authority to issue blanket accident and sickness policies; filing of form; required provisions; applicability of Code section to similar entities.
33-30-7. Provision in group or blanket policies for medical or surgical services generally.
33-30-8. Requirement of application for policy and issuance of certificate for blanket accident and sickness insurance.
33-30-9. Payment of benefits under blanket accident and sickness policies.
33-30-10. Exemption of group and blanket policy proceeds from liability for debts of insured and beneficiary.
33-30-11. Applicability of Chapter 29 of title to group or blanket policies.
33-30-12. Standards and requirements for rating of small groups under accident and sickness insurance; exemptions.
33-30-13. Notices of premium increases to be mailed or delivered to group policyholder; notification of impact of federal Patient Protection and Affordable Care Act.
33-30-13.1. Furnishing claims experience to policyholders.
33-30-14. Insurance coverage for treatment of temporomandibular joint dysfunction or surgery for deformities of maxilla or mandible.
33-30-15. Continuation of similar coverage; preexisting conditions; procedures and guidelines.

Article 2

Preferred Provider Arrangements

33-30-20. Short title.
33-30-21. Legislative intent.
33-30-22. Definitions.
33-30-23. Standards; payments or reimbursement for noncontracting provider of covered services; filing requirements for unlicensed entities; provision for payment solely to provider.
33-30-24. Health benefit plans providing incentives to use services

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of preferred providers; minimum requirements.
33-30-25. Reasonable limits on number or classes of preferred providers.
33-30-26. Applicability of Title 33 and related rules and regulations to health care insurers.
33-30-27. Promulgation of rules and regulations.
33-30-28 and 33-30-29. Redesignated.

Cross references. — Definition of accident and sickness insurance, § 33-7-2. Contents of accident, sickness and insurance policies generally, § 33-24-20 et seq.

Editor's notes. — Ga. L. 1988, p. 1483, § 1, designated Code Sections 33-30-1 through 33-30-11 as Article 1.

Law reviews. — For article discussing the development of group marketing of insurance, with emphasis on recent attempts in the area of property and liability insurance, see 20 J. of Pub. L. 479 (1971).

For note on 1990 amendment and enactment of Code sections within this chapter, see 7 Ga. St. U.L. Rev. 320 (1990). For note, "Paying the Piper: Third-party Payor Liability for Medical Treatment Decisions," see 25 Ga. L. Rev. 861 (1991).

RESEARCH REFERENCES

ALR. — 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.

Duty of insurer to give notice of termination of agency, 14 A.L.R. 846.

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.

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.

Insurance: death or injury 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.

Group insurance, 63 A.L.R. 1034; 85 A.L.R. 1461.

"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.

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, 138 A.L.R. 404; 78 A.L.R.2d 1044.

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.

Apportionment or contribution as between specific and blanket insurance policies, 169 A.L.R. 387.

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.

Construction and effect of clause of life, health, or similar policy insuring against "loss of business time," 31 A.L.R.2d 1222.

What constitutes permanent or total disability within coverage of insurance policy issued to physical laborer or workman, 32 A.L.R.2d 922.

Rupture of blood vessel following exertion or exercise as within terms of accident provision of insurance policy, 35 A.L.R.2d 1105.

Repeated absorption of poisonous substance as "accident" within coverage clause of comprehensive general liability policy, 49 A.L.R.2d 1263.

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.

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.

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 is "conveyance," "passenger conveyance," or "public conveyance" within coverage of accident policy, 60 A.L.R.3d 858.

Who is "fare-paying passenger" within coverage provision of life or accident insurance policy, 60 A.L.R.3d 1273.

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.

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.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy, 1 A.L.R.4th 1319.

Liability of employer to employee in connection with selection or retention of group insurer, 10 A.L.R.4th 1267.

Applicability of other insurance benefits exclusion, from coverage of hospital or health and accident policy, to governmental insurance benefits to which insured would have been entitled by prior subscription, 29 A.L.R.4th 361.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

Construction and application of provision of liability insurance policy expressly excluding injuries intended or expected by insured, 31 A.L.R.4th 957.

Accident insurance: what is "loss" of body member, 51 A.L.R.4th 156.

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.

Coverage under medical and health insurance plans for services performed by dentists, oral surgeons, and orthodontists, 43 A.L.R.5th 657.

ARTICLE 1

GENERAL PROVISIONS

33-30-1. "Group accident and sickness insurance" defined; "true association" defined.

(a) "Group accident and sickness insurance" is that form of accident and sickness insurance covering the groups of persons listed in paragraphs (1) through (7) of this subsection, with or without one or more members of their families or one or more of their dependents or covering one or more members of the families or one or more dependents of persons in such groups, and issued upon the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring at least two employees of such employer for the benefit of persons other than the employer. As used in this paragraph, the term "employees" includes the officers, managers, and employees of the employer; the individual proprietor or partners, if the employer is an individual proprietor or partnership; the officers, managers, and employees of subsidiary or affiliated corporations; and the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(2) Under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least ten members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. As used in this paragraph, the term "employees" may include retired employees;

(3) Under a policy issued to the trustees of a fund established by two or more employers in the same industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association, as defined in paragraph (2) of this subsection, which trustees shall be deemed the policyholder, to insure not less than ten employees of the employers or members of the union or of such association or of members of such association for the benefit of persons other than the employers or other unions or such associations. As used in this paragraph, the term "employees" includes the officers, managers, and employees of the employer and the individual

proprietor or partners, if the employer is an individual proprietor or partnership. The term may include retired employees. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy;

(5) Under a policy issued to a creditor, or to a trustee or agent appointed by two or more creditors, which creditor, trustee, or agent shall be deemed to be the policyholder, to insure mortgagors of the creditor. The insurance must be written in connection with a credit transaction that is secured by a first mortgage or deed of trust; must be made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose; and shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid mortgage of the mortgagor to the extent of such payment;

(6) Under a policy issued to cover any other substantially similar group which in the discretion of the Commissioner may be subject to the issuance of a group accident and sickness policy or contract; or

(7)(A) Under a policy issued to a legal entity providing a multiple employer welfare arrangement, which means any employee benefit plan which is established or maintained for the purpose of offering or providing accident and sickness benefits to the employees of two or more employers, including self-employed individuals, individuals whose compensation is reported on federal Internal Revenue Service Form 1099, and their spouses or dependents. The term shall not apply to any plan or arrangement which is established or maintained by a tax-exempt rural electric cooperative or a collective bargaining agreement.

(B) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the employees, employers, or trustee.

(b) As used in this chapter, the term "true association" means an organization that:

(1) Has been in existence for at least five years;

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(3) Does not condition membership in the association on any health status related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status related factor relating to such members (or individual eligible for coverage through a member);

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(6) Meets such additional requirements as may be imposed under Georgia law or regulation.

History. — Code 1933, § 56-3101, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1987, p. 1486, § 7; Ga. L. 1989, p. 883, § 2; Ga. L. 1990, p. 1402, § 4; Ga. L. 1991, p. 94, § 33; Ga. L. 1997, p. 1462, § 6; Ga. L. 1998, p. 1064, § 9; Ga. L. 2005, p. 481, § 9/HB 291; Ga. L. 2011, p. 595, §§ 2, 3/HB 167; Ga. L. 2012, p. 775, § 33/HB 942.

Cross references. — Definition of accident and sickness insurance, § 33-7-2.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "paragraphs (1) through (7)" was substituted for "paragraphs (1) through (6)" in subsection (a) and, in paragraph (a)(5), "Under a" was substituted for "A", "must be" was inserted preceding "made to finance" and a semicolon was substituted for a period at the end.

Editor's notes. — Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that that 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; and further provides that the Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

Ga. L. 2011, p. 595, § 1/HB 167, not codified by the General Assembly, provides that: "This Act shall be known and may be cited as the 'Insurance Delivery Enhancement Act of 2011.'"

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

JUDICIAL DECISIONS

Employer prohibited from being beneficiary. — When a corporate stockholder, director, and executive vice-president was listed in a group accident policy as an employee, the corporate employer was prohibited from being a beneficiary. Johnson, Lane, Space, Smith & Co. v. Trosdal, 170 Ga. App. 456, 317 S.E.2d 294 (1984).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 291.

ALR. — Limit of liability of members of insurance associations, 10 A.L.R. 750.

What constitutes "continuous employment" within provision of group insurance policy prescribing condition of disability benefits, 124 A.L.R. 1494.

Insurance: "accidental means" as distinguishable from "accident," "accidental result," "accidental death," "accidental injury," etc., 166 A.L.R. 469.

Coverage and exceptions under student accident policy, 74 A.L.R.2d 1253.

Group insurance: provision excluding from coverage part-time or temporary employees, 41 A.L.R.3d 1419.

Group insurance: construction of provision limiting coverage to full-time employees, 57 A.L.R.3d 801.

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.

Termination of employee's individual coverage under group policy for nonpayment of premiums, 22 A.L.R.4th 321.

33-30-1.1. Applicability.

This chapter shall apply to policies of insurance, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance, issued by an insurer, delivered, or issued for delivery in this state except for policies issued to an employer in another state which provides coverage for employees of this state employed by such employer policyholder.

History. — Code 1981, § 33-30-1.1, enacted by Ga. L. 1997, p. 1462, § 6.

Editor's notes. — Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that that Act, which enacted 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; and further provides that the Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

33-30-2. Effect of chapter upon other provisions.

Nothing in this chapter validates any charge or practice illegal under any rule of law or regulation governing usury, small loans, retail installment sales, or the like or extends the application of any statute, rule, or regulation to any transaction not otherwise subject thereto.

History. — Code 1933, § 56-3101, enacted by Ga. L. 1960, p. 289, § 1.

33-30-3. "Blanket accident and sickness insurance" defined.

"Blanket accident and sickness insurance" is that form of group accident and sickness insurance covering the groups of persons listed in paragraphs (1) through (6) of this Code section and issued upon the following basis:

(1) Under a group policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on such common carrier or such means of transportation;

(2) Under a group policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees, dependents,

or guests defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents, or guests similarly defined;

(3) Under a group policy or contract issued to a school or other institution of learning, a camp, the sponsor of the institution of learning or camp, or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers; and supervisors and employees may be included;

(4) Under a group policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization;

(5) Under a group policy or contract issued to a sports team or sponsors thereof, which shall be deemed the policyholder, covering members, officials, and supervisors; or

(6) Under a group policy or contract issued to cover any other risk or class of risks which in the discretion of the Commissioner may be properly eligible for blanket accident and sickness insurance. The discretion of the Commissioner may be exercised on an individual risk basis or class of risks, or both.

History. — Code 1933, § 56-3104, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2005, p. 481, § 10/HB 291.

Cross references. — Definition of accident and sickness insurance, § 33-7-2.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "of this Code section" was inserted following "paragraphs (1) through (6)" in the introductory paragraph.

RESEARCH REFERENCES

ALR. — Coverage and exceptions under student accident policy, 74 A.L.R.2d 1253.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means, 29 A.L.R.4th 1230.

33-30-4. Required provisions generally.

Each group accident and sickness policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the group policy or contract, all statements made by the policyholder shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder, a copy of which has been furnished to the policyholder;

(2) A provision that the insurer will furnish to the policyholder, for delivery to each employee or member of the insured group, an individual certificate setting forth in summary form a statement of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents or family members are included in the coverage, additional certificates need not be issued for delivery to the dependents or family members;

(3) A provision that from time to time eligible new employees or members or dependents, in accordance with the terms of the policy, may be added to the group originally insured;

(4) A provision that, with respect to termination of benefits for, or coverage of, any person who is a dependent child of an insured, the child shall continue to be insured up to and including age 25 so long as the coverage of the member continues in effect, the child remains a dependent of the insured parent or guardian, and the child, in each calendar year since reaching any age specified for termination of benefits as a dependent, has been enrolled for five calendar months or more as a full-time student at a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury. This paragraph shall not apply to group policies under which an employer provides coverage for dependents of its employees and pays the entire cost of the coverage without any charge to the employee or dependents; and

(5) A provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first, during which grace period the policy shall continue in force unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

History. — Code 1933, § 56-3102, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1978, p. 1149, § 1; Ga. L. 1983, p. 3, § 24; Ga. L. 1989, p. 675, § 1; Ga. L. 2005, p. 481, § 11/HB 291.

JUDICIAL DECISIONS

Insurer not responsible for way employer imparts information to employee. — Having furnished to the party acting for and on behalf of the employee full and accurate information as to the terms of the contract it would make, the insurer is not required to go further and cannot be held responsible for the way in which the employer imparted the information to the employee for whom the employer was acting. Rider v. Westinghouse Elec. Corp., 152 Ga. App. 805, 264 S.E.2d

276 (1979), modified, 155 Ga. App. 70, 270 S.E.2d 288 (1980).

Controlling master policy is subject to employee's inspection to determine full details of the policy's coverage and exclusions. Rider v. Westinghouse Elec. Corp., 155 Ga. App. 61, 270 S.E.2d 288 (1980).

Master policy and certificate must be construed together. — Contract of group insurance is made up of the master group policy and the certificate, which must be construed together, and the certificate holder is bound by the provisions of the group policy, the certificate being evidence of coverage thereunder. Morrison Assurance Co. v. Armstrong, 152 Ga. App. 885, 264 S.E.2d 320 (1980).

Provisions of master policy hold over conflicting terms of certificate upon which the group insured has relied. Morrison Assurance Co. v. Armstrong, 152 Ga. App. 885, 264 S.E.2d 320 (1980).

RESEARCH REFERENCES

ALR. — Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

33-30-4.1. Coverage for human heart transplants; optional endorsement; requirements; guidelines.

(a) Every insurer authorized to issue group accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed on or after July 1, 1988, coverage for human heart transplants, including any charges for acquisition, transportation, or donation of a human heart when a human heart transplant is performed. Such coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(b) The optional endorsement required to be made available under subsection (a) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to human heart transplants unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, the optional endorsement may contain a waiting period for the coverage or a delayed eligibility date of not more than 12 months from the effective date of the endorsement.

(c) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar group accident and

sickness insurance benefit plan, policy, or contract from issuing or continuing to issue a group accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(d) The requirements of this Code section shall be satisfied if the coverage specified in subsections (a) and (b) of this Code section is made available to the master policyholder of the group plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or to make available such coverage to any insured under such group or blanket plan, policy, or contract.

(e) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for human heart transplants that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

(f) The provisions of this Code section shall also apply to group accident and sickness insurance policies or contracts issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any other similar entity.

History. — Code 1981, § 33-30-4.1, enacted by Ga. L. 1988, p. 960, § 2; Ga. L. 2017, p. 164, § 42/HB 127.

33-30-4.2. Insurance coverage for mammograms, Pap smears, and prostate-specific antigen tests.

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

(1) "Female at risk" means a woman:

(A) Who has a personal history of breast cancer;

(B) Who has a personal history of biopsy proven benign breast disease;

(C) Whose grandmother, mother, sister, or daughter has had breast cancer; or

(D) Who has not given birth prior to age 30.

(2)(A) "Mammogram" means any low-dose radiologic screening procedure for the early detection of breast cancer provided to a

woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician's interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology.

(B) Reimbursement for a mammogram authorized under this Code section shall be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by this state.

(C) Policies subject to this Code section shall contain coverage for mammograms made with at least the following frequency:

(i) Once as a base-line mammogram for any female who is at least 35 but less than 40 years of age;

(ii) Once every two years for any female who is at least 40 but less than 50 years of age;

(iii) Once every year for any female who is at least 50 years of age; and

(iv) When ordered by a physician for a female at risk.

(3) "Pap smear" or "Papanicolaou smear" means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

(4) "Policy" means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(5) "Prostate-specific antigen test" means a measurement, in accordance with standards established by the American College of Pathologists, of a substance produced by the epithelium to determine if there is any benign or malignant prostate tissue.

(b)(1) Every insurer authorized to issue a group accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for mammograms and Pap smears for the covered females which at least meets the minimum requirements of this Code section.

(2) Every insurer authorized to issue a group accident and sickness insurance policy in this state which includes coverage for any

male shall include as a part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for annual prostate-specific antigen tests for the covered males who are 45 years of age or older or for covered males who are 40 years of age or older, if ordered by a physician.

(c) The coverage required under subsection (b) of this Code section may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner.

(d) Nothing in this Code section shall be construed to prohibit the issuance of group accident and sickness insurance policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to group accident and sickness insurance policies issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of this chapter, relating to preferred provider arrangements.

History. — Code 1981, § 33-30-4.2, enacted by Ga. L. 1990, p. 1057, § 2; Ga. L. 1992, p. 1975, § 2; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2017, p. 164, § 43/HB 127; Ga. L. 2019, p. 386, § 99/SB 133.

The 2019 amendment, effective July 1, 2019, redesignated the former first through third sentences of paragraph (a)(2) as present subparagraphs (a)(2)(A) through (a)(2)(C), respectively; redesignated former subparagraphs (a)(2)(A) through (a)(2)(D) as divisions (a)(2)(C)(i) through (a)(2)(C)(iv), respectively; substituted "'Prostate-specific" for "'Prostate specific" at the beginning of paragraph (a)(5); deleted "on or after July 1, 1992," following "or renewed" in paragraphs (b)(1) and (b)(2); and substituted "prostate-specific" for "prostate specific" near the end of paragraph (b)(2).

Law reviews. — For note on 1990 enactment of this Code section, see 7 Ga. St. U.L. Rev. 317 (1990). For note on 1992 amendment of this Code section, see 9 Ga. St. U.L. Rev. 280 (1992).

33-30-4.3. Utilization of mail-order pharmaceutical distributors in policies, plans, contracts, or funds; utilization of other providers of pharmaceutical services under same terms and conditions.

(a) For the purposes of this Code section, the term "health care insurer" means an insurer, including a fraternal benefit society, a health care plan, or a health maintenance organization authorized to

sell accident and sickness insurance policies, subscriber certificates, or other contracts of accident and sickness insurance by whatever name called.

(b) A group or blanket accident and sickness insurance policy, plan, contract, or fund may not be issued, delivered, issued for delivery, or renewed by a health care insurer if such policy, plan, contract, or fund requires that insureds thereunder obtain pharmaceutical services, including prescription drugs, exclusively from a mail-order pharmaceutical distributor. Insureds who do not utilize a mail-order pharmaceutical distributor shall not be required to pay a different copayment fee or have imposed any varying conditions for the receipt of pharmaceutical services, including prescription drugs, when that payment or condition is not imposed upon those insureds who utilize a mail-order pharmaceutical distributor for those services if the provider of pharmaceutical services utilized by the insured has agreed to the same terms and conditions as applicable to the mail-order pharmaceutical distributor and has agreed to accept payment or reimbursement from the health care insurer at no more than the same amount which would have been paid to the mail-order pharmaceutical distributor for the same pharmaceutical services.

(c) Any health care insurer who issues a group or blanket accident and sickness policy, plan, contract, or fund that provides coverage for pharmaceutical services, including prescription drugs, by a mail-order pharmaceutical distributor shall issue to each insured under such policy, plan, contract, or fund an explanation of the payment or reimbursement method applicable to mail-order pharmaceutical distributors as compared to other providers of pharmaceutical services. For those health care insurers which provide benefit booklets to their insureds, the inclusion of such an explanation in any such benefit booklet shall constitute compliance with this subsection.

(d) Any health care insurer who contracts with a mail-order pharmaceutical distributor to provide pharmaceutical services, including prescription drugs, under a group or blanket accident and sickness policy, plan, contract, or fund shall include in such contract a provision requiring the mail-order pharmaceutical distributor in its initial written correspondence with an insured to include a notice that the insured may obtain pharmaceutical services, including prescription drugs, from other providers of pharmaceutical services and that the exclusive utilization of the mail-order pharmaceutical distributor is not required.

(e) A provider of pharmaceutical services who desires to provide services to insureds in their service area shall, upon written request to the health care insurer, be provided information pertaining to the terms and conditions applicable to mail-order pharmaceutical services available in such service area. If the provider of pharmaceutical services

agrees to such terms and conditions in writing and agrees to be paid or reimbursed at no more than the same amount which would be paid to a mail-order pharmaceutical distributor for the same services, the provider of pharmaceutical services will be paid or reimbursed at no more than the same amount paid to the mail-order pharmaceutical distributor for the same pharmaceutical services.

History. — Code 1981, § 33-30-4.3, enacted by Ga. L. 1991, p. 1901, § 1; Ga. L. 2017, p. 164, § 44/HB 127; Ga. L. 2019, p. 386, § 100/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1991," following "health care insurer" in the middle of the first sentence of subsection (b).

33-30-4.4. Coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease; optional endorsement; requirements; guidelines; applicability.

(a) Every insurer authorized to issue group accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed on or after July 1, 1995, coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. Such coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(b) The optional endorsement required to be made available under subsection (a) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to bone marrow transplants for the treatment of breast cancer and Hodgkin's disease unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(c) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar group accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue a group accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which

provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(d) The requirements of this Code section shall be satisfied if the coverage specified in subsections (a) and (b) of this Code section is made available to the master policyholder of the group plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or to make available such coverage to any insured under such group or blanket plan, policy, or contract.

(e) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

(f) The provisions of this Code section shall also apply to group accident and sickness insurance policies or contracts issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any other similar entity.

History. — Code 1981, § 33-30-4.4, enacted by Ga. L. 1995, p. 459, § 2; Ga. L. 2017, p. 164, § 45/HB 127.

33-30-4.5. Coverage for child wellness services.

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

(1) "Child wellness services" means the periodic review of a child's physical and emotional status conducted by a physician or conducted pursuant to a physician's supervision, but shall not include periodic dental examinations or other dental services. The review shall include a medical history, complete physical examination, developmental assessment, appropriate immunizations, anticipatory guidance for the parent or parents, and laboratory testing in keeping with prevailing medical standards.

(2) "Policy" means any medical expense plan, subscriber contract, or accident and sickness plan, contract, or policy by whatever name called other than a disability income policy, a long-term care insurance policy, a medicare supplement policy, a health insurance policy written as a part of workers' compensation equivalent coverage, a specified disease policy, a credit insurance policy, a blanket accident and sickness policy, a franchise policy issued on an individual basis to a member of a true association as defined in Code Section 33-30-12, a

hospital indemnity policy, a limited accident policy, or other similar limited accident and sickness policy.

(b) Every insurer authorized to issue a group accident and sickness policy in this state shall include, either as a part of or as a required endorsement to each such basic medical or hospital expense, major medical, and comprehensive medical expense insurance policy issued, delivered, issued for delivery, or renewed in this state basic coverage for child wellness services for an insured child from birth through the age of five years. Any such policy may provide that the child wellness services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. The Commissioner shall define by regulation the basic coverage for child wellness services and may consider the recommendations for preventive pediatric health care by the American Academy for Pediatrics and any other relevant data or information in the promulgation of such regulation.

(c) The coverage required under subsection (b) of this Code section may be subject to exclusions, reductions, or other limitations as to coverages or coinsurance provisions as may be approved by the Commissioner, but shall not be subject to deductibles.

(d) Nothing in this Code section shall be construed to prohibit the issuance of group accident and sickness policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to group basic medical or hospital expense, major medical, or comprehensive medical expense insurance policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of this chapter, relating to preferred provider arrangements.

History. — Code 1981, § 33-30-4.5, enacted by Ga. L. 1995, p. 1011, § 7; Ga. L. 1995, p. 1348, § 4; Ga. L. 2017, p. 164, § 46/HB 127; Ga. L. 2019, p. 386, § 101/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, in subsection (b), deleted "on or after July 1, 1995," following "renewed in this state" near the end of the first sentence, deleted "current" preceding "recommendations" in the middle of the third sentence; and substituted "Reserved." for the former provisions of subsection (g),

which read: "Beginning July 1, 2000, the Commissioner shall conduct a review of the cost associated with the coverage required by this Code section and shall provide the members of the General Assembly with such information not later than December 31, 2000."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in the first sentence of subsection (b) and deleted former subsection (g) which was designated as reserved.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, Code Section 33-30-4.4, as enacted by Ga. L. 1995, p. 1011, § 7, was redesignated as Code Section 33-30-4.5.

Editor's notes. — Ga. L. 1995, p. 1348, § 10, not codified by the General Assembly, provides: "In the event another Act requiring insurance coverage for child wellness services is enacted by the General Assembly during the 1995 regular session, it is the specific intent of the General Assembly that Sections 3 and 4 of this Act requiring insurance coverage for child wellness services shall be given effect and shall control over the provisions of such other Act requiring such coverage."

Ga. L. 1995, p. 1348, § 4, which enacted this Code section, was passed later in time than the version of this Code section as passed by Ga. L. 1995, p. 1011, § 7, effective July 1, 1995, which also related to coverage for child wellness services, and the version passed in Ga. L. 1995, p. 1348, § 4, controls as to Ga. L. 1995, p. 1011, § 6, and has been set out above.

33-30-5. Direct payment for hospital or medical services.

Any group accident and sickness policy may provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, or medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy shall not require that the service be rendered by a particular hospital or person. Payments so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

History. — Code 1933, § 56-3103, enacted by Ga. L. 1960, p. 289, § 1.

33-30-6. Authority to issue blanket accident and sickness policies; filing of form; required provisions; applicability of Code section to similar entities.

(a) Any insurance company authorized to write accident and sickness insurance in this state shall have the power to issue blanket accident and sickness insurance. No blanket policy may be issued or delivered in this state unless a copy of the form of the blanket policy shall have been filed in accordance with Code Section 33-24-9.

(b) Every blanket and group policy, certificate of insurance, or by whatever name called shall contain provisions which in the opinion of the Commissioner are at least as favorable to the policyholder and the individual insured as the following:

(1) A provision that the policy and the application shall constitute the entire contract between the parties, and that all statements made

by the policyholder shall, in absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the terms of the group policy or contract, be deemed representations and not warranties, and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application;

(2) A provision that written notice of sickness or of injury must be given to the insurer within 20 days after the date when such sickness or injury occurred. Failure to give notice within that time shall neither invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give the notice and that notice was given as soon as was reasonably possible;

(3) A provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of ten working days after the giving of notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(4) A provision that in the case of claim for loss of time for disability, written proof of the loss must be furnished to the insurer within 30 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of the loss must be furnished to the insurer within 90 days after the date of the loss. Failure to furnish the proof within such time shall neither invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish the proof and that the proof was furnished as soon as was reasonably possible;

(5) A provision incorporating and restating the substance of the provisions of subsections (b) and (c) of Code Section 33-24-59.5, relating to time limits for payment of claims for benefits under health benefit policies and sanctions for failure to pay timely. If a policy provides benefits for loss of time, such policy shall also provide that, subject to proof of such loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof;

(6) A provision that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and

so often as it may reasonably require during the pendency of a claim under the policy and shall also have the right and opportunity to make an autopsy in case of death, if an autopsy is not prohibited by law;

(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy, and that no action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished; and

(8) A provision that, with respect to termination of benefits for, or coverage of, any person who is a dependent child of an insured, the child shall continue to be insured up to and including age 25 so long as the coverage of the insured parent or guardian continues in effect, the child remains a dependent of the parent or guardian, and the child, in each calendar year since reaching any age specified for termination of benefits as a dependent, has been enrolled for five months or more as a full-time student at a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury.

(c) The provisions of this Code section shall also apply to group and blanket accident and sickness insurance policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any other similar entity.

History. — Code 1933, § 56-3105, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1978, p. 1149, § 3; Ga. L. 1982, p. 1678, §§ 3, 6; Ga. L. 1984, p. 22, § 33; Ga. L. 1995, p. 745, § 2.9; Ga. L. 1999, p. 289, § 5; Ga. L. 2005, p. 481, § 12/HB 291; Ga. L. 2017, p. 164, § 47/HB 127.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1999, a semicolon was substituted for a period at the end of paragraph (b)(5).

JUDICIAL DECISIONS

Policies from outside state. — Former Code 1933, § 56-3105 (see O.C.G.A. § 33-30-6) was not applicable when a policy was solicited, written, and delivered outside of this state and did not expressly contemplate coverage of the insured in this state when written, pursuant to subsection (d) of former Code 1933, § 56-302 (see O.C.G.A. § 33-3-2). Sloan v. Continental Cas. Co., 131 Ga. App. 377, 205 S.E.2d 925 (1974).

Claim for prejudgment interest not preempted by ERISA. — Claim of a plan beneficiary under O.C.G.A. § 33-30-6 to recover prejudgment interest on unpaid benefits was not preempted by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. Boyer v.

Metropolitan Life Ins. Co., 889 F. Supp. 496 (S.D. Ga. 1995).

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

RESEARCH REFERENCES

ALR. — Limit of liability of members of insurance associations, 10 A.L.R. 750.

Accident insurance: when insured deemed to be totally and continuously unable to transact all business duties, 24 A.L.R. 203.

Forfeiture of life or accident insurance for nonpayment of premium due to failure or neglect of one authorized by insured pay same, 67 A.L.R. 180.

Constitutionality, construction, and application of statutes relating to contractual time limitation provisions of insurance policies, 112 A.L.R. 1288.

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.

Right of insurer to restitution of payments made under mistake, 167 A.L.R. 470.

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.

Physician's duties and liabilities to person examined pursuant to physician's contract with such person's prospective or actual employer or insurer, 10 A.L.R.3d 1071.

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.

Construction and effect of "visible sign of injury" and similar clauses in accident provision of insurance policy, 28 A.L.R.3d 413.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy, 1 A.L.R.4th 1319.

What constitutes total disability within coverage of disability insurance policy issued to lawyer, 6 A.L.R.4th 422.

Termination of employee's individual coverage under group policy for nonpayment of premiums, 22 A.L.R.4th 321.

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.

33-30-7. Provision in group or blanket policies for medical or surgical services generally.

(a) The benefits on account of medical or surgical services provided by a group or blanket policy of accident and sickness insurance may be limited by its terms to services performed by specifically defined professions, provided that in the absence of such definitions, the term "physician" or "surgeon," as used in such a policy, shall not be deemed limited solely to medical practitioners licensed under Chapter 34 of Title 43.

(b) When a group or blanket policy of accident and sickness insurance, except policies providing special coverage for limited diseases, accident protection only, or dental policies, provides for hospital care, there may be included within the scope of coverage hospital care rendered on account of mental illnesses and hospital care rendered by any psychiatric hospital duly licensed by this state. If the coverage is not included in the policy, a statement that the policy does not cover

mental illnesses shall be printed in the policy in boldface type or stamped on the face of the policy and printed or stamped on any identification card issued pursuant to the policy.

(c) Any other laws to the contrary notwithstanding, whenever the term "physician" or "surgeon" is used in any policy of health or accident insurance issued in this state or in any contract for the provision of health care, services, or benefits issued by any health, medical, or other service corporation existing under, and by virtue of, any laws of this state, said term shall include, within its meaning, medical practitioners licensed under and in accordance with Chapter 11 of Title 43, relating to dentists, in respect to any care, services, procedures, or benefits covered by said policy of insurance or health care contract which the said persons are licensed to perform, any provisions in any such policy of insurance or health care contract to the contrary notwithstanding. This subsection shall be applicable to all policies in this state regardless of date of issue.

History. — Code 1933, § 56-3110, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1970, p. 526, § 2; Ga. L. 1974, p. 436, § 2; Ga. L. 1996, p. 6, § 33.

JUDICIAL DECISIONS

Cited in Blue Cross & Blue Shield of Ga./Atlanta, Inc. v. Dillon, 164 Ga. App. 724, 296 S.E.2d 210 (1982).

RESEARCH REFERENCES

ALR. — Mental incapacity or disease as constituting total or permanent disability within insurance coverage, 22 A.L.R.3d 1000.

33-30-8. Requirement of application for policy and issuance of certificate for blanket accident and sickness insurance.

An individual application shall not be required for a person to be covered under a blanket accident and sickness policy or contract, nor shall it be necessary for the insurer to furnish each person so insured a certificate.

History. — Code 1933, § 56-3106, enacted by Ga. L. 1960, p. 289, § 1.

33-30-9. Payment of benefits under blanket accident and sickness policies.

(a) All benefits under any group or blanket accident and sickness policy shall be payable to the person insured, to his designated beneficiary or beneficiaries, or to his estate, provided that if the person

insured is a minor or mental incompetent, the benefits may be made payable to his parent, guardian, or other person actually supporting him or, if the entire cost of the insurance has been borne by the employer, the benefits may be made payable to the employer.

(b) The policy may provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, and medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

History. — Code 1933, § 56-3107, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2005, p. 481, § 13/HB 291.

RESEARCH REFERENCES

ALR. — Statute precluding defense of suicide as applied to accident insurance, 41 A.L.R. 1523.

What constitutes "continuous employment" within provision of group insurance policy prescribing condition of disability benefits, 124 A.L.R. 1494.

33-30-10. Exemption of group and blanket policy proceeds from liability for debts of insured and beneficiary.

The proceeds or avails of all group or blanket accident and sickness policies shall be exempt from all liability for debt to the same extent and under the same conditions as provided for in the case of individual accident and sickness insurance by Code Section 33-29-15.

History. — Code 1933, § 56-3109, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

ALR. — Limit of liability of members of insurance associations, 10 A.L.R. 750.

Bankruptcy or insolvency of insured as affecting right of person injured to proceeds of indemnity insurance, in absence of provision in policy in that regard, 59 A.L.R. 1123.

33-30-11. Applicability of Chapter 29 of title to group or blanket policies.

Chapter 29 of this title shall not apply to group accident and sickness or blanket accident and sickness insurance policies; but, except as otherwise provided in this chapter, no policy of group or blanket accident and sickness insurance shall contain any provision relative to notice or proof of loss, to the time for paying benefits, or to the time

within which an action may be brought on the policy, which provision is less favorable to the individuals insured than would be permitted by the comparable provisions required for individual accident and sickness insurance policies.

History. — Code 1933, § 56-3108, 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).

33-30-12. Standards and requirements for rating of small groups under accident and sickness insurance; exemptions.

(a) As used in this Code section, the term "small group" means a group or subgroup of at least two and no more than 50 employees, members, or enrollees.

(b) Except as otherwise provided in this Code section, the claims experience produced by small groups covered under accident and sickness insurance for each insurer shall be fully pooled for rating purposes. Except to the extent that the claims experience of an individual small group affects the overall experience of the small group pool, the claims experience produced by any individual small group of each insurer shall not be used in any manner for rating purposes or solely as a reason for termination of any individual group.

(c) Each insurer's small group pool shall consist of each insurer's total claims experience produced by all small groups in this state, regardless of the marketing mechanism or distribution system utilized in the sale of the group insurance. The pool shall include the experience generated under any medical expense insurance coverage offered under separate group contracts; contracts issued to trusts, multiple employer trusts, or association groups or trusts; or any other group-type coverage. The experience produced under multiple employer trusts or arrangements through contracts issued in this state or provided by solicitation and sale to Georgia residents through an out-of-state multiple employer trust or arrangement for all the Georgia small groups shall be fully pooled for rating purposes. Multiple employer trusts or arrangements shall include any group or group-type coverage issued to a trust or association or to any other group policyholder where such group or group-type contract provides coverage, primarily or incidentally, for sole proprietors, employers, or both.

(d) Notwithstanding the requirements of subsection (b) of this Code section, age, sex, size, area, industry, occupational and avocational

factors, and any other factors deemed relevant by the Commissioner may be considered in the initial and renewal rating of each small group. Durations since issue and tier factors may not be considered. Substandard rating in accordance with recognized underwriting practices may be applied only when the employee, member, enrollee, or dependent enters the small group for the first time but shall not be used for renewal rating purposes. Any substandard rating may only be applied across the entire group such that similarly situated employees are charged the same rate. For the purposes of this Code section, an individual who qualifies as a "newly eligible employee," as defined in paragraph (4) of subsection (a) of Code Section 33-30-15, shall not be specified as entering the small group for the first time. Notwithstanding subsection (b) of this Code section, the total initial or renewal premium calculated for any individual small group may deviate from the pool rate by not more than plus or minus 25 percent based upon individual small group experience factors. The direct premium result of select or substandard underwriting practices shall not be considered a deviation from the pool rate.

(e) This Code section shall not apply to:

(1) Policies issued to an employer in another state which provides coverage for employees of this state employed by such employer policyholder;

(2) Policies issued to true associations, as defined in subsection (b) of Code Section 33-30-1;

(3) A policy negotiated in connection with a collective bargaining agreement; or

(4) Limited benefit insurance policies. For the purposes of this Code section, the term "limited benefit insurance" means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term "limited benefit insurance" includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, medicare supplement, specified disease, vision, and any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, or major medical insurance.

(f) The Commissioner is authorized to exempt insurers from one or more provisions of this Code section upon satisfactory demonstration that such exemption will not result in rates which are unreasonable, inequitable, or unfair under the circumstances and would not conflict with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191.

History. — Code 1981, § 33-30-28, enacted by Ga. L. 1990, p. 1402, § 5; Code 1981, § 33-30-12, as redesignated by Ga. L. 1991, p. 94, § 33; Ga. L. 1991, p. 1358, § 2; Ga. L. 1994, p. 858, § 2; Ga. L. 1997, p. 1462, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, a comma was inserted following "avocational factors" in the first sentence of subsection (d).

Editor's notes. — Former Code Section 33-30-12 (Ga. L. 1985, p. 1039, § 1), relating to group or blanket accident and sickness insurance, was repealed by Ga. L. 1986, p. 688, § 2, effective April 1, 1986.

Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that that Act, which enacted 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; and further provides that the Act shall be narrowly construed to achieve such purpose without otherwise limiting the state's legislative or regulatory powers with respect to insurance.

JUDICIAL DECISIONS

Private claims against insurer not subject to administrative exhaustion requirement. — As the Georgia Commissioner of Insurance had agreed with a small business that its health insurer had violated O.C.G.A. § 33-30-12 by using health status factors to calculate renewal premiums, the business was not aggrieved by an agency decision, and it was not required to pursue administrative remedies before filing its lawsuit against the insurer, alleging multiple claims arising from the insurer's practice under state law; additionally, the business's participation in a settlement with the insurer for such statutory violations did not preclude the action as the Commissioner did not have exclusive or primary jurisdiction over such vested legal disputes. Homes of Ga., Inc. v. Humana Empls. Health Plan of Ga., Inc., 282 Ga. App. 802, 640 S.E.2d 313 (2006).

No ERISA preemption. — Business that commenced an action based on state law and common law claims against its health insurer, asserting that the insurer had improperly relied on health status factors in determining the renewal premium rate in violation of O.C.G.A. § 33-30-12, was not preempted by the Employee Retirement Security Act of 1974, 29 U.S.C. § 1001 et seq., as amended, as the claims were directed at the business's health insurance contract rather than at the group health insurance plan. Homes of Ga., Inc. v. Humana Empls. Health Plan of Ga., Inc., 282 Ga. App. 802, 640 S.E.2d 313 (2006).

Class action certification not an abuse of discretion. — In a suit brought by various insureds, alleging that an insurance company and the company's related entities engaged in fraud with regard to allegedly fraudulently representing that the insureds were being provided group medical insurance coverage, the trial court did not abuse the court's discretion by certifying the insureds as a class as the reliance of the insureds was based on a uniform renewal document all received, which satisfied the commonality requirement, and differing defenses that the insureds may have did not defeat certification since common questions of law predominated. The reviewing court was satisfied that the trial court exercised judicial discretion in ruling that the computation of individual damages would not be so complex or fact-specific so as to bar certification. Fortis Ins. Co. v. Kahn, 299 Ga. App. 319, 683 S.E.2d 4 (2009), cert. denied, No. S09C1992, 2010 Ga. LEXIS 48 (Ga. 2010).

33-30-13. Notices of premium increases to be mailed or delivered to group policyholder; notification of impact of federal Patient Protection and Affordable Care Act.

(a) Notice of the maximum amount of a group premium increase shall be mailed or delivered to the group policyholder and to each employer group or subgroup insured under the group policy not less than 60 days prior to the effective date of the premium increase.

(b) The commissioner of community health shall also provide notice to each person covered under the health insurance plans established pursuant to Article 1 of Chapter 18 of Title 45 when any premium increase occurs of how much of such increase is attributable to the federal Patient Protection and Affordable Care Act.

History. — Code 1981, § 33-30-29, enacted by Ga. L. 1990, p. 1402, § 5; Code 1981, § 33-30-13, as redesignated by Ga. L. 1991, p. 94, § 33; Ga. L. 2013, p. 1100, § 2/SB 236; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2015, p. 5, § 33/HB 90.

U.S. Code. — The Patient Protection and Affordable Care Act, referred to in this Code section, is codified throughout the United States Code and primarily in T. 42.

33-30-13.1. Furnishing claims experience to policyholders.

(a) As used in this Code section, the term "insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, provider sponsored health care corporation, health maintenance organization, or any similar entity.

(b)(1) All insurers shall furnish, regardless of the rating methodology used, claims experience to group policyholders within 30 days of any policyholder's request unless such information has been furnished to the group policyholder within the preceding six months. Such claims experience shall be furnished for all groups of 51 or more covered employees, members, or enrollees, not including dependents, and shall include, but shall not be limited to:

(A) Earned premiums separated by policy year for at least the last two policy years, if applicable;

(B) Total paid claims and total incurred claims, inclusive of any high amount or pooled claims, including both capitated and noncapitated expenses set forth in the same manner as premiums; and

(C) Any amounts in excess of the individual pooling or stop-loss point applicable to the group.

(2) Insurers that utilize provider contracting methods including financial devices such as global fee arrangements to cover all medical

expenses may make application to the Commissioner for approval of the use of an alternative form of claims experience reporting. The insurer must still provide Georgia experience on a group-specific basis or on such other reasonable basis as the Commissioner may approve for such insurer, in advance, based upon a submission of an explanation and supporting documentation. Any insurer that received approval for an alternative form of group claims experience reporting to policyholders shall be required to seek the Commissioner's advance approval of a proposed response letter to group policyholders who request experience reporting. Such letter should describe the insurer's reasons for seeking an alternative reporting process and describe the alternative form of reporting approved by the Commissioner.

(3) Insurers may charge a reasonable fee for providing this information to group policyholders. The schedule or amount of fees to be charged group policyholders for providing this information shall be filed by each insurer with the Commissioner.

(4) In providing claims experience to group policyholders under this Code section, insurers shall adhere to all state and federal laws regarding disclosure of protected health or personal information.

History. — Code 1981, § 33-30-13.1, enacted by Ga. L. 2002, p. 8, § 4; Ga. L. 2017, p. 164, § 48/HB 127.

33-30-14. Insurance coverage for treatment of temporomandibular joint dysfunction or surgery for deformities of maxilla or mandible.

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

(1) "Functional deformity" means a deformity of the bone or joint structure of the maxilla or mandible such that the normal character and essential function of such bone structure is impeded.

(2) "Policy" means any major medical benefit plan, contract, or policy except the Georgia Basic Health Plan, a credit insurance policy, disability income policy, specified disease policy, hospital indemnity policy, limited accident policy, or other similarly limited accident and sickness policy.

(3) "Temporomandibular joint" means the connection of the mandible and the temporal bone through the articular disc surrounded by the joint capsule and associated ligaments and tendons.

(4) "Temporomandibular joint dysfunction" means congenital or developed anomalies of the temporomandibular joint.

(b) No policy may be issued or issued for delivery in this state which:

(1) Excludes medically necessary surgical or nonsurgical treatment for the correction of temporomandibular joint dysfunction by physicians or dentists professionally qualified by training and experience; or

(2) Excludes medically necessary surgery for the correction of functional deformities of the maxilla and mandible.

(c) The provisions of this Code section shall not cover cosmetic or elective orthodontic or periodontic care or general dental care.

(d)(1) The coverage under paragraph (1) of subsection (b) of this Code section may contain such types of exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to other benefits under the accident and sickness insurance benefit plan, policy, or contract.

(2) Basic coverage for the nonsurgical treatment of temporomandibular joint dysfunction under paragraph (1) of subsection (b) of this Code section may be limited to history and examination; radiographs, which must be diagnostic for temporomandibular joint dysfunction; splint therapy with necessary adjustments, provided that removable appliances designed for orthodontic purposes would not be reimbursable under a major medical plan; and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.

(e) Except as provided in paragraph (1) of subsection (c) of Code Section 33-30-23 for policies limited only to dental coverage, nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of this chapter, relating to preferred provider arrangements.

History. — Code 1981, § 33-30-14, enacted by Ga. L. 1994, p. 474, § 2.

Cross references. — Individual insurance coverage for treatment of temporomandibular joint dysfunction or surgery for deformities of maxilla or mandible, § 33-29-20.

Editor's notes. — Ga. L. 1994, p. 474, § 3, not codified by the General Assembly, provided that the Act shall be applicable to individual, group, or blanket major medical policies issued or issued for delivery on or after July 1, 1994.

33-30-15. Continuation of similar coverage; preexisting conditions; procedures and guidelines.

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

(1) "Affiliation period" means a period, used by health maintenance organizations in lieu of a preexisting condition exclusion clause, beginning on the enrollment date, which must expire before

health insurance coverage provided by a health maintenance organization becomes effective. The health maintenance organization is not required to provide health care benefits during such period, nor is it authorized to charge premiums over such a period.

(2) "Creditable coverage" under another health benefit plan means medical expense coverage with no greater than a 90 day gap in coverage under any of the following:

(A) Medicare or Medicaid;

(B) An employer based accident and sickness insurance or health benefit arrangement;

(C) An individual accident and sickness insurance policy, including coverage issued by a health maintenance organization, health care corporation, or fraternal benefit society;

(D) A spouse's benefits or coverage under medicare or Medicaid or an employer based health insurance or health benefit arrangement;

(E) A conversion policy;

(F) A franchise policy issued on an individual basis to a member of a true association as defined in subsection (b) of Code Section 33-30-1;

(G) A health plan formed pursuant to 10 U.S.C. Chapter 55;

(H) A health plan provided through the Indian Health Service or a tribal organization program or both;

(I) A state health benefits risk pool;

(J) A health plan formed pursuant to 5 U.S.C. Chapter 89;

(K) A public health plan; or

(L) A Peace Corps Act health benefit plan.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, health maintenance organization, or any similar entity and any self-insured health care 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.

(4) "Newly eligible group member" means a Georgia domiciled group member or the dependent of a currently enrolled Georgia domiciled group member who has creditable coverage and who first becomes eligible to elect coverage under a group sponsored comprehensive major medical or hospitalization plan. A newly eligible group member also includes:

(A) During a special enrollment period, existing group members and existing dependents of existing group members who declined coverage when first offered because of the existence of other creditable coverage, if all the following conditions are met:

(i) The group member or group member's dependent had creditable coverage at such time when the group coverage was first offered;

(ii) The group member stated in writing that such creditable coverage was the reason for declining enrollment in group coverage, if such statement is required by the policyholder;

(iii) The coverage of the group member or group member's dependent was under COBRA and has been exhausted or the creditable coverage was terminated as a result of loss of eligibility for the creditable coverage or policyholder contributions toward such creditable coverage were terminated; and

(iv) The group member requests such enrollment not later than 31 days after the date of exhaustion or termination of the creditable coverage; or

(B) In the case of marriage, if the group member requests such enrollment not later than 31 days following the date of marriage or the date dependent coverage is first made available, whichever is later, coverage of the spouse shall commence not later than the first day of the first month beginning after the date the completed request for enrollment is received.

(b) Notwithstanding any other provision of this title which might be construed to the contrary, all group basic hospital or medical expense, major medical, or comprehensive medical expense coverages which are issued, delivered, issued for delivery, or renewed in this state shall provide the following:

(1) Subject to compliance with the provisions of subsections (c) and (d) of this Code section, any newly eligible group member, subscriber, enrollee, or dependent who has had creditable coverage under another health benefit plan within the previous 90 days shall be eligible for coverage immediately upon completion of any policyholder imposed waiting period; and

(2) Once such creditable coverage terminates, including termination of such creditable coverage after any period of continuation of coverage required under Code Section 33-24-21.1 or the provisions of Title X of the Omnibus Budget Reconciliation Act of 1986, the insurer must offer a conversion policy to the eligible group member, subscriber, enrollee, or dependent.

(c) Notwithstanding any provisions of this Code section which might be construed to the contrary, such coverages may include a limitation for preexisting conditions not to exceed 12 months for group members who enroll when newly eligible and 18 months for group members who enroll late following the effective date of coverage; provided, however, that:

(1) Such coverages shall waive any time period applicable to the preexisting condition exclusion or limitation for the period of time an individual was previously covered by creditable coverage; or

(2) Such coverages shall waive any time period applicable to the preexisting condition exclusion or limitation in accordance with an insurer's election of an alternative method pursuant to Section 701(c)(3)(B) of the Employee Retirement Income Security Act of 1974.

(d) The preexisting condition limitation described in subsection (c) of this Code section shall not apply to pregnancies.

(e) The preexisting condition limitation described in subsection (c) of this Code section shall not apply to newborn children or newly adopted children where such children are added to the plan by the insured no later than 31 days following the date of birth or the date placed for adoption under order of the court of jurisdiction.

(f) In case of a group health plan offered by a health maintenance organization, an affiliation period may be offered in place of the preexisting condition limitation described in subsection (c) of this Code section, provided that the affiliation period:

(1) Is applied uniformly without regard to any health status related factors;

(2) Does not exceed:

(A) Two months for newly eligible group members and dependents; or

(B) Three months for group members who enroll late; and

(3) Runs concurrently with any policyholder imposed waiting period under the plan.

(g) The Commissioner shall promulgate appropriate procedures and guidelines by rules and regulations to implement the provisions of this Code section after notification and review of such regulations by the appropriate standing committees of the House of Representatives and Senate in accordance with the requirements of applicable law. The Commissioner may allow in such regulations methods other than that described in subsection (f) of this Code section for health maintenance organizations to address adverse selection, as authorized by the Employee Retirement Income Security Act of 1974, Section 701(g)(3).

History. — Code 1981, § 33-30-15, enacted by Ga. L. 1995, p. 1242, § 3; Ga. L. 1997, p. 1462, § 8; Ga. L. 1998, p. 1064, § 10; Ga. L. 2005, p. 481, § 14/HB 291; Ga. L. 2017, p. 164, § 49/HB 127; Ga. L. 2019, p. 386, § 103/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on and after July 1, 1998," following "to the contrary," in the middle of subsection (b).

Cross references. — Conversion privileges and continuation rights, § 33-24-21.1. Renewal or continuation of coverage at option of insured, § 33-29-21. Individual health insurance coverage availability, T. 33, C. 29A.

Editor's notes. — Ga. L. 1997, p. 1462, § 1, not codified by the General Assembly, provides that that Act, which enacted 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; and further provides that the 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. — Portability and renewability, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Insurance Commissioner, Subject 120-2-67.

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

ARTICLE 2

PREFERRED PROVIDER ARRANGEMENTS

Editor's notes. — Ga. L. 1988, p. 1483, § 2, not codified by the General Assembly, provided that: "This Act shall apply to any health benefit plan issued, delivered, issued for delivery, or renewed on or after January 1, 1989."

33-30-20. Short title.

This article shall be known and may be cited as the "Preferred Provider Arrangements Act."

History. — Code 1981, § 33-30-20, enacted by Ga. L. 1988, p. 1483, § 1.

JUDICIAL DECISIONS

Cited in Morrell v. Wellstar Health Sys., Inc., 280 Ga. App. 1, 633 S.E.2d 68 (2006); Nat'l Renal Alliance, LLC v. Blue Cross & Blue Shield of Ga., Inc., 598 F. Supp. 2d 1344 (N.D. Ga. 2009).

33-30-21. Legislative intent.

It is the intent of the General Assembly to encourage health care cost containment while preserving quality of care by allowing health care insurers to enter into preferred provider arrangements and by establishing minimum standards for preferred provider arrangements and the health benefit plans associated with those arrangements.

History. — Code 1981, § 33-30-21, enacted by Ga. L. 1988, p. 1483, § 1.

JUDICIAL DECISIONS

Judicial intervention refused. — Appellate court refused to intervene in allegations made by uninsured patients against a non-profit hospital that the uninsured patients were charged more than patients who were covered by insurance, Medicare, or Medicaid, as it refused to intervene in a commercial transaction for which the legislature has already established a policy favoring price-comparison by the patient, whereby judges and juries would be called on to set appropriate prices for hospitals to charge the hospitals' patients. Cox v. Athens Reg'l Med. Ctr., Inc., 279 Ga. App. 586, 631 S.E.2d 792 (2006).

33-30-22. 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) "Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

(3) "Health care insurer" means an insurer, a fraternal benefit society, a health care plan, or a health maintenance organization authorized to sell accident and sickness insurance policies, subscriber certificates, or other contracts of insurance by whatever name called under this title.

(4) "Health care provider" means any person duly licensed or legally authorized to provide health care services.

(5) "Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, chiropractic, psychological, and pharmaceutical services or products.

(6) "Preferred provider" means a health care provider or group of providers who have contracted to provide specified covered services.

(7) "Preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this article.

History. — Code 1981, § 33-30-22, enacted by Ga. L. 1988, p. 1483, § 1; Ga. L. 2005, p. 481, § 15/HB 291; Ga. L. 2017, p. 164, § 50/HB 127.

33-30-23. Standards; payments or reimbursement for noncontracting provider of covered services; filing requirements for unlicensed entities; provision for payment solely to provider.

(a) Notwithstanding any provisions of law to the contrary, any health care insurer may enter into preferred provider arrangements as provided in this article. Such arrangements shall:

(1) Establish the amount and manner of payment to the preferred provider;

(2) Include fair, reasonable, and equitable mechanisms for the assignment and payment of benefits to nonpreferred providers;

(3)(A) Include mechanisms which are designed to minimize the cost of the health benefit plan such as the review or control of utilization of health care services.

(B) Include procedures for determining whether health care services rendered are medically necessary;

(4) Provide to covered persons eligible to receive health care services under that arrangement a statement of benefits under the arrangement and, at least every 60 days, an updated listing of physicians who are preferred providers under the arrangement, which statement and listing may be made available by mail or by publication on an Internet service site made available by the health care insurer at no cost to such covered persons; and

(5) Require that the covered person, or that person's agent, parent, or guardian if the covered person is a minor, be permitted to appeal to a physician agent or employee of the health care insurer any decision to deny coverage for health care services recommended by a physician.

(b) Such arrangements shall not:

(1) Unfairly deny health benefits for medically necessary covered services;

(2) Have differences in benefit levels payable to preferred providers compared to other providers which unfairly deny benefits for covered services;

(3) Have differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers which differ by more than 30 percentage points;

(4) Have a coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers which exceeds 40 percent of the benefit levels under the policy for such services;

(5) Have an adverse effect on the availability or the quality of services; and

(6) Be a result of a negotiation with a primary care physician to become a preferred provider unless such physician shall be furnished with a schedule showing common office based fees payable for services under such arrangement.

(c)(1) Notwithstanding the provisions of paragraphs (3) and (4) of subsection (b) of this Code section, health benefit plans providing incentives for covered persons to use pharmaceutical or dental services of preferred providers shall contain a provision which clearly identifies that the payment or reimbursement for a noncontracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services; provided, however, the health benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the actual fee charged by the provider for the dental or pharmaceutical services rendered.

(2) Notwithstanding any provisions of this title to the contrary, paragraphs (3) and (4) of subsection (b) of this Code section shall not apply to routine physical examinations covered under a health benefit plan.

(d) If an entity enters into a contract providing covered services with a health care provider, but is not engaged in activities which would require it to be licensed as a health care insurer, such entity shall file with the Commissioner information describing its activities and a description of the contract or agreement it has entered into with the health care providers. Employers who enter into contracts with health care providers for the exclusive benefit of their employees and dependents are exempt from this requirement.

(e) Any other provision of law to the contrary notwithstanding, if a covered person provides in writing to a health care provider, whether the health care provider is a preferred provider or not, that payment for

health care services shall be made solely to the health care provider and be sent directly to the health care provider by the health care insurer, and the health care provider certifies to same upon filing a claim for the delivery of health care services, the health care insurer shall make payment solely to the health care provider and shall send said payment directly to the health care provider. This subsection shall not be construed to extend coverages or to require payment for services not otherwise covered.

History. — Code 1981, § 33-30-23, enacted by Ga. L. 1988, p. 1483, § 1; Ga. L. 1992, p. 1143, § 1; Ga. L. 1998, p. 1382, § 2; Ga. L. 2000, p. 802, § 2; Ga. L. 2019, p. 386, § 104/SB 133.

The 2019 amendment, effective July 1, 2019, in paragraph (b)(6), substituted "such" for "that" in two places, and deleted ", beginning on and after January 1, 2001," following "shall be furnished".

Cross references. — Payments sent directly to health care provider by insurer, § 33-24-59.3.

Editor's notes. — 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."

JUDICIAL DECISIONS

ERISA preemption. — When an insurer cut the insurer's reimbursement for out-of-network renal dialysis by 88 percent to levels below customary charges, under 29 U.S.C. § 1144(a), state law claims filed by dialysis treatment providers—including claims for breach of contract, misrepresentation, unfair trade practices, quantum meruit, and those arising under O.C.G.A. § 33-30-23(a)(2) — were preempted because the claims related to conduct intertwined with the refusal to pay benefits. Nat'l Renal Alliance, LLC v. Blue Cross & Blue Shield of Ga., Inc., 598 F. Supp. 2d 1344 (N.D. Ga. 2009).

Judicial intervention refused. — Appellate court refused to intervene in allegations made by uninsured patients against a non-profit hospital that uninsured patients were charged more than patients who were covered by insurance, Medicare, or Medicaid, as it refused to intervene in a commercial transaction for which the legislature has already established a policy favoring price-comparison by the patient, whereby judges and juries would be called on to set appropriate prices for hospitals to charge the hospitals' patients. Cox v. Athens Reg'l Med. Ctr., Inc., 279 Ga. App. 586, 631 S.E.2d 792 (2006).

33-30-24. Health benefit plans providing incentives to use services of preferred providers; minimum requirements.

Health care insurers may issue health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such policies or subscriber certificates shall contain at least the following provisions:

(1) A provision that if a covered person receives emergency care for services specified in the preferred provider arrangement and cannot

reasonably reach a preferred provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the health benefit plan, at benefit levels at least equal to those applicable to treatment by preferred providers for emergency care in an amount based on the usual, customary, and reasonable charges in the area where the treatment is provided; and

(2) A provision which clearly identifies the differences in benefit levels for health care services of preferred providers and benefit levels for health care services of nonpreferred providers.

For purposes of this Code section, when a request for emergency care is made through the emergency 9-1-1 system on behalf of a covered person and the ambulance service licensed under Chapter 11 of Title 31 that was dispatched in response to the request is not a preferred provider, for purposes of payment under paragraph (1) of this Code section, it shall be presumed that the covered person could not reasonably reach a preferred provider.

History. — Code 1981, § 33-30-24, enacted by Ga. L. 1988, p. 1483, § 1; Ga. L. 2006, p. 652, § 5/HB 1257.

33-30-25. Reasonable limits on number or classes of preferred providers.

Subject to the approval of the Commissioner under such procedures as he may develop, health care insurers may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex, or marital or corporate status, and provided, further, that all health care providers within any defined service area who are licensed and qualified to render the services covered by the preferred provider arrangement and who satisfy the standards set forth by the health care insurer shall be given the opportunity to apply and to become a preferred provider.

History. — Code 1981, § 33-30-25, enacted by Ga. L. 1988, p. 1483, § 1.

JUDICIAL DECISIONS

Approval of Insurance Commissioner to limit providers. — Applying the "Any Willing Provider" (AWP) statute to a health insurer did not conflict with O.C.G.A. § 33-30-25 because that statute required the approval of the Insurance Commissioner to limit providers in preferred provider arrangements. 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).

33-30-26. Applicability of Title 33 and related rules and regulations to health care insurers.

Health care insurers as defined in this article shall be subject to and shall be required to comply with all other applicable provisions of this title and rules and regulations promulgated pursuant to this title.

History. — Code 1981, § 33-30-26, enacted by Ga. L. 1988, p. 1483, § 1.

33-30-27. Promulgation of rules and regulations.

The Commissioner shall promulgate all rules and regulations necessary or appropriate to the administration and enforcement of this article.

History. — Code 1981, § 33-30-27, enacted by Ga. L. 1988, p. 1483, § 1.

33-30-28 and 33-30-29.

Redesignated as Code Sections 33-30-12 and 33-30-13 by Ga. L. 1991, p. 94, § 33, effective March 14, 1991.

Editor's notes. — Ga. L. 1991, p. 94, § 33, redesignated former Code Sections 33-30-28 and 33-30-29 as present Code Sections 33-30-12 and 33-30-13, respectively.

CHAPTER 30A

HEALTH PLAN PURCHASING COOPERATIVES

Sec.
33-30A-1. Definitions.
33-30A-2. Certificates of authority authorized and required.
33-30A-3. Areas of service.
33-30A-4. Membership; cooperative's powers, duties and responsibilities; fees; annual reports.
33-30A-5. Responsibilities of department.
33-30A-6. Notification to members; marketing materials.
33-30A-7. Nonprofit corporation status; certificate of existence.
33-30A-8. Surety bond required; guaranty of uninterrupted coverage.
33-30A-9. Regulations.
33-30A-10. Fees.
33-30A-11. Application of Chapter 6.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 540 et seq.

33-30A-1. Definitions.

As used in this chapter, the term:

(1) "Agent" shall be defined as provided in Code Section 33-23-1.

(2) "Carrier" means any entity that provides health insurance to employers in this state. For the purposes of this chapter, carrier includes an insurance company, hospital or medical service corporation, health care plan as defined in Code Section 33-20-3, fraternal benefit society, health maintenance organization, or any other licensed entity providing a plan of health insurance or health benefits subject to state insurance regulation.

(3) "Health benefit plan" means any hospital or medical insurance policy or certificate, health care plan contract or certificate, qualified higher deductible health plan, or health maintenance organization subscriber contract. Health benefit plan does not include policies issued in accordance with Chapter 31 of this title; disability income policies; policies issued in accordance with Code Section 34-9-14 or 34-9-122.1; limited accident and sickness insurance policies such as credit, dental, vision, medicare supplement, long-term care, hospital indemnity, or specified disease insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

(4) "Health plan purchasing cooperative," "purchasing cooperative," or "cooperative" means a nonprofit corporation authorized by

the Commissioner pursuant to this chapter and operated for the benefit of members located within a particular geographic area of the state by providing members with purchasing services and detailed information on comparative prices, usage, medical outcomes, quality, and enrollee satisfaction through selected health benefit plans. For purposes of Chapter 30 of this title, a health plan purchasing cooperative shall be considered as a true group and not as an association.

(5) "Medical outcome" means a change in an individual's health status after the provision of health services.

(6) "Premium" means all moneys paid by an employer and eligible employees as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan. Premiums shall not include fees for membership in the cooperative.

(7) "Small employer" means any person, firm, corporation, partnership, association, political subdivision, or sole proprietor that is actively engaged in a business that, at the time of application, on at least 50 percent of its working days during the preceding calendar quarter, employed no fewer than two and no more than 50 eligible employees, in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies or companies that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise provided, provisions of this chapter that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this paragraph. Nothing in this chapter shall be construed to prohibit a carrier from including self-employed individuals in its definition of small employer.

History. — Code 1981, § 33-30A-1, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-2. Certificates of authority authorized and required.

(a) On and after July 1, 1997, the Commissioner is authorized to issue certificates of authority to nonprofit corporations to operate as health plan purchasing cooperatives to provide services to members located within particular geographic areas of the state in accordance with the provisions of this chapter.

(b) A health plan purchasing cooperative authorized by the Commissioner pursuant to subsection (a) of this Code section may also offer other related employee benefits and services to its members, including continuation coverage administration and purchasing services for limited accident and sickness insurance coverages such as dental, vision, and long-term care; provided, however, that a purchasing cooperative offering such related benefits or services must provide separate and explicitly identified rate or fee schedules for such benefits and services to distinguish them from health benefit plan premiums and membership fees.

(c)(1) Any health benefit plan, limited accident and sickness policy, or other insurance offered through a cooperative must be provided by a carrier.

(2) A cooperative may not directly provide insurance or bear any risk associated with any health benefit plan or other insurance offered through the cooperative.

(d) No entity shall hold itself out as a health plan purchasing cooperative without a certificate of authority granted by the Commissioner. Any entity not authorized as a health plan purchasing cooperative by the Commissioner shall not use as part of its advertising or marketing any self-descriptive term which is confusingly similar to a health plan purchasing cooperative. Any entity not authorized as a health plan purchasing cooperative by the Commissioner and providing services substantially similar to those of a purchasing cooperative shall clearly indicate in its advertising and marketing materials that such entity is not a health plan purchasing cooperative. Failure to comply with this subsection shall be an unfair and deceptive act or practice in the business of insurance within the meaning of paragraph (1) of subsection (b) of Code Section 33-6-4.

(e) Nothing in this chapter shall be deemed to permit a health plan purchasing cooperative to act as an insurer as defined in Code Section 33-1-2 or as an agent as defined in Code Section 33-23-1.

History. — Code 1981, § 33-30A-2, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-3. Areas of service.

(a) Each health plan purchasing cooperative shall serve a particular geographic area of the state that consists of either one entire county or more than one contiguous entire county. The Commissioner shall not authorize any purchasing cooperative to serve a geographic area which divides any county or contains noncontiguous counties.

(b) Any purchasing cooperative which serves any portion of a metropolitan statistical area shall not serve less than all of that metropolitan statistical area. The Commissioner shall not authorize any purchasing cooperative to serve a geographic area which divides any metropolitan statistical area.

(c) The authority granted by the Commissioner to a purchasing cooperative to serve a particular geographic area shall be nonexclusive, and there shall be no limit upon the number of purchasing cooperatives which may be authorized to serve any particular geographic area.

(d) The Commissioner shall authorize service for any geographic service area as proposed by the applicant nonprofit corporation if such proposed service area meets the requirements of this Code section.

(e) Except as provided elsewhere in this Code section, nothing in this chapter shall restrict the geographic area served by a purchasing cooperative having less than 100,000 enrolled member subscribers. For purposes of this subsection, the purchasing cooperative shall report to the Commissioner, in a manner prescribed by the Commissioner, the number of member subscribers enrolled in the purchasing cooperative on an annual basis. For purchasing cooperatives having greater than 100,000 enrolled member subscribers, the purchasing cooperative shall demonstrate annually, to the satisfaction of the Commissioner, that permission to continue to enroll additional member subscribers will not have an adverse effect on the availability of private health benefit plan coverage offered outside the purchasing cooperative's geographic service area. Failure to provide satisfactory evidence shall result in the suspension of the purchasing cooperative's authority to enroll additional member subscribers in all or part of the purchasing cooperative's geographic service area, until such time as the Commissioner shall conclude that the requirements of this subsection have been satisfied.

(f) Officers, directors, or employees of a health plan purchasing cooperative shall not serve as officers, directors, or employees of another health plan purchasing cooperative.

(g) A geographic area may include one or more contiguous counties in an adjoining state.

History. — Code 1981, § 33-30A-3, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-4. Membership; cooperative's powers, duties and responsibilities; fees; annual reports.

(a)(1) Membership in a health plan purchasing cooperative shall be voluntary.

(2) A purchasing cooperative shall accept for membership in the cooperative any eligible small employer which agrees to pay the membership fee and a premium for coverage through the purchasing cooperative and which abides by the bylaws and rules of the purchasing cooperative.

(3) A purchasing cooperative may, at its option, accept for membership in the cooperative any otherwise eligible employer which does not qualify as a small employer because it employed more than 50 eligible employees during 50 percent or more of its working days during the previous calendar quarter.

(4) A purchasing cooperative may, at its option, accept for membership in the cooperative any otherwise eligible employer which does not qualify as a small employer because it is an individual or sole proprietor. If a purchasing cooperative chooses to accept such employers, the purchasing cooperative may not discriminate in the acceptance process based upon health status.

(5) A purchasing cooperative and its contracted carriers shall comply with the small group health insurance rating requirements provided for in Code Section 33-30-12.

(b) Each purchasing cooperative shall have the following powers, duties, and responsibilities:

(1) Establishing and clearly defining the conditions of membership and participation in the purchasing cooperative. Each cooperative shall establish conditions for small employers which must include, but need not be limited to, assurance that the group is a valid small employer and is not formed for the purpose of securing health benefit coverage and assurance that the individuals in the small employer group are employees and have not been added for the purpose of securing health benefit coverage. A purchasing cooperative shall not establish or enforce membership conditions or participation requirements, bylaws, rules, or policies, financial or otherwise, which have the effect of excluding or including membership on the basis of health status of otherwise eligible individuals or other risk characteristics, including, but not limited to, industry type, occupation, experience, age, gender, family composition, education, avocation, or income; nor shall a purchasing cooperative require any small employer, employee, self-employed individual, or dependent to subscribe to limited accident and sickness insurance policies, products, or services not related to health care;

(2) Providing to cooperative members clear, standardized information on each health benefit plan or other coverage offered by carriers through the cooperative to cooperative members, including information on price, enrollee costs, quality, patient satisfaction, enrollment,

and enrollee responsibilities and obligations and providing health benefit plan and other insurance comparison sheets in accordance with department rule;

(3) Annually offering to all members of the cooperative all health benefit plans and other insurance offered by carriers which meet the requirements of this chapter and which submit a responsive proposal as to information necessary for health benefit plans and other insurance comparison sheets and providing assistance to cooperative members in selecting and obtaining coverage with carriers that meet those requirements. A purchasing cooperative shall, whenever feasible, contract with multiple, unaffiliated carriers to offer health benefit plans and other insurance to its members. A purchasing cooperative may selectively contract with carriers based on the quality and cost effectiveness of services and other factors deemed to be relevant by the purchasing cooperative;

(4) Requesting proposals for health benefit plans and other insurance from carriers;

(5) Establishing administrative procedures and accounting procedures consistent with generally accepted accounting principles for the operation of the cooperative and members' services, preparing an annual cooperative budget, and preparing annual program and fiscal reports on cooperative operations as required by this chapter;

(6) Developing and implementing a marketing plan to publicize the cooperative to potential members;

(7) Developing grievance procedures to be used in resolving disputes between members and the cooperative and disputes between carriers and the cooperative. Any member of, or carrier that serves, a cooperative shall not be prohibited from filing grievances directly with the department;

(8) Ensuring that carriers have grievance procedures to be used in resolving disputes with members of the cooperative. A member may appeal to the cooperative any grievance that is not resolved by the carrier;

(9) Maintaining all records, reports, and other information required by this chapter or by department rule or other applicable laws;

(10) Contracting with qualified, independent third parties for any services necessary to carry out the powers and duties required by this chapter;

(11) Assisting agents or employees in enrolling eligible members, employees, and dependents in selected health benefit plans and other insurance and services, establishing procedures for collecting premi-

ums, collecting premiums, appropriately distributing collected premiums to participating carriers, and paying third-party contractors. The cooperative shall pay participating carriers their contracting premium amounts on a prepaid monthly basis or as otherwise mutually agreed upon; and

(12) Working with participating carriers to establish standard criteria for selecting participating licensed agents.

(c) Each cooperative may set and collect reasonable fees for membership in the cooperative which may finance reasonable and necessary costs incurred in administering the cooperative. Any such fee must be clearly identified and not inconsistent with the provisions of paragraph (1) of subsection (b) of this Code section.

(d)(1) Each cooperative shall provide semiannual financial statements and annual reports regarding cooperative programs and operations to the Commissioner.

(2) Each cooperative shall provide for annual independent audits by a certified public accountant and make reports of such audits available to the Commissioner and the public.

(3) Each purchasing cooperative shall file annually with the Commissioner, at such time and in such form and manner as specified by the Commissioner, evidence of adequate security and prudence in account, premium collection, and the handling and transfer of moneys and evidence of compliance with the provisions of this chapter, including a description of the specific services provided by the purchasing cooperative.

(e) Each purchasing cooperative shall maintain a trust account or accounts for the deposit of any premium moneys collected.

(f) Each purchasing cooperative shall disclose to the Commissioner any oral or written agreements made prior to its authorization as a purchasing cooperative.

(g) Any act of selling health benefit plans or other insurance shall be in accordance with Chapter 23 of this title.

History. — Code 1981, § 33-30A-4, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-5. Responsibilities of department.

The department shall assist health plan purchasing cooperatives. To this end, the department is responsible for:

(1) Initially and thereafter annually certifying that each cooperative complies with the provisions of this chapter and regulations

adopted pursuant to Code Section 33-30A-9. The department may decertify any cooperative if the cooperative fails to comply with the provisions of this chapter and the regulations adopted by the Commissioner;

(2) Conducting an annual review of the performance of each cooperative to ensure that the cooperative is in compliance with the provisions of this chapter and applicable regulations;

(3) Establishing criteria for plans to be offered through cooperatives to cooperative members. Such plans may include without limitation fee-for-service plans, preferred provider organizations, health maintenance organizations, provider sponsored health care corporation plans, and medical savings accounts;

(4) Receiving and reviewing appeals by members of a cooperative and carriers whose grievances were not resolved by the cooperative; and

(5) Providing annually to the House Committee on Insurance and the Senate Insurance and Labor Committee a detailed status report on the effect and administration of this chapter.

History. — Code 1981, § 33-30A-5, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-6. Notification to members; marketing materials.

(a) Each cooperative shall use appropriate, efficient, and standardized means to notify members of the availability of health benefit plan coverage offered through the cooperative.

(b)(1) Each cooperative shall make available to its members marketing materials prepared by or for the cooperative that accurately summarize the health benefit plans and other insurance and services that are offered through it to members, including descriptions and standardized comparisons of each plan or service and information on price, benefits, and measures of performance such as medical outcomes and consumer satisfaction. A purchasing cooperative shall disseminate such descriptive and comparative information to all members of the cooperative.

(2) Such marketing materials and measures of performance shall be filed with and approved by the Commissioner prior to the use or dissemination of such materials or measures of performance.

(c)(1) Each cooperative shall offer annually to each member all health benefit plans and other insurance and services available through the cooperative and provide each member with the appropriate materials relating thereto.

(2) Each purchasing cooperative shall adopt its own policy regarding whether member employers shall be permitted to limit the selection of carriers, health benefit plans, or other insurance for their employees from among those health benefit plans and other insurance policies offered through the purchasing cooperative. Any limitation imposed by an employer must be made without discrimination as to the health status of an individual or class.

History. — Code 1981, § 33-30A-6, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-7. Nonprofit corporation status; certificate of existence.

(a)(1) Each purchasing cooperative shall be a nonprofit corporation, and the provisions of Chapter 3 of Title 14 shall apply to each purchasing cooperative; provided, however, that the provisions of this chapter shall control to the extent of any conflict with the provisions of Chapter 3 of Title 14.

(2) Prior to authorization by the Commissioner to operate as a health plan purchasing cooperative, a nonprofit corporation must provide the Commissioner with a certificate of existence issued pursuant to Code Section 14-3-128.

(b) A purchasing cooperative may not amend its articles of incorporation to operate as a for profit corporation.

(c) Nothing in this Code section shall limit a cooperative from contracting with a for profit corporation to provide services specified in paragraph (10) of subsection (b) of Code Section 33-30A-4.

(d)(1) No person having had a financial interest in a purchasing cooperative's financing, marketing, or delivery of services, other than as a representative of a member employer or a consumer of services, during the immediately preceding 12 month period shall serve as a member of the board of directors of the purchasing cooperative.

(2) No person serving as a member of the board of directors of a purchasing cooperative shall have a financial interest in the purchasing cooperative's financing, marketing, or delivery of services, other than as a representative of a member employer or as a consumer of services, during his or her term as a board member.

(e) A purchasing cooperative may establish, as it deems necessary and appropriate, an advisory group to assist its board of directors in deliberations. Such advisory group may include health care providers, carriers, insurance agents, consumers, or other persons.

History. — Code 1981, § 33-30A-7, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-8. Surety bond required; guaranty of uninterrupted coverage.

(a) Prior to authorization by the Commissioner to operate as a health plan purchasing cooperative, a nonprofit corporation shall, directly or through a contractor which provides administrative services to the corporation, file with the Commissioner a corporate surety bond in an amount deemed adequate by the Commissioner to provide for administration of the proposed purchasing cooperative for a six-month period, in favor of the state and for the use and benefit of the state and of members and creditors of the cooperative. Such bond shall be for protection against insolvency; or against malfeasance, including fraud or theft of funds. The bond shall be conditioned as follows:

(1) For prompt payment of premiums due;

(2) For payment of all indebtedness of the corporation; and

(3) For payment of costs incurred by the state in the administration of the corporation.

(b) 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.

(c) Any health benefit plan offered through a purchasing cooperative must guarantee uninterrupted coverage for a six-month period in the event of the purchasing cooperative's insolvency, subject to timely payment of premiums due.

(d) Examinations, rehabilitation, receivership, orders, and administrative supervision of health plan purchasing cooperatives shall be in accordance with this title.

History. — Code 1981, § 33-30A-8, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-9. Regulations.

The Commissioner shall issue regulations in accordance with Code Section 33-2-9 for the administration of this chapter.

History. — Code 1981, § 33-30A-9, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-10. Fees.

Fees collected by the Commissioner under this chapter shall be as authorized under Chapter 8 of this title.

History. — Code 1981, § 33-30A-10, enacted by Ga. L. 1997, p. 1072, § 1.

33-30A-11. Application of Chapter 6.

Health plan purchasing cooperatives shall be subject to the provisions of Chapter 6 of this title.

History. — Code 1981, § 33-30A-11, enacted by Ga. L. 1997, p. 1072, § 1.

CHAPTER 30B

SPENDING ACCOUNT AND CONSUMER DRIVEN HEALTH PLAN ADVANCEMENT

Sec.
33-30B-1. Short title.
33-30B-2. Purpose.
33-30B-3. Definitions.
33-30B-4. Group or individual participation; administration of plan.
33-30B-5. Relationship between spending account and attachment point for insurance reimbursement.
33-30B-6. Requirements for insurance contract.
33-30B-7. Interpretation; renewal of policy.

RESEARCH REFERENCES

ALR. — 27 Am. Jur. 2d, Employment Relationships, § 68 et seq.

33-30B-1. Short title.

This chapter shall be known and may be cited as the "Spending Account and Consumer Driven Health Plan Advancement Act."

History. — Code 1981, § 33-30B-1, enacted by Ga. L. 2003, p. 912, § 1.

33-30B-2. Purpose.

The purposes of this chapter are to provide enabling provisions for spending accounts and consumer driven health plans, provide statutory authorization for the establishment of such plans, and facilitate the advancement of such plans as a response to escalating costs of health care plans in this state. This chapter shall be construed and interpreted liberally to effectuate these purposes in as broad a manner as possible.

History. — Code 1981, § 33-30B-2, enacted by Ga. L. 2003, p. 912, § 1.

33-30B-3. Definitions.

As used in this chapter, the term:

(1) "Consumer driven health plan" means a plan for the provision or reimbursement of health care services that makes available to enrolled individuals information on health, health care, the pricing of health care, and the pricing of health care services by particular providers. Such plan may, but is not required to, include a spending account feature and may either rely upon indemnity reimbursements

for services or contracted amounts for health care services from providers.

(2) "Plan" means an agreement between an individual and a plan sponsor or a declaration by an individual which defines services and benefit levels for which reimbursements will be made.

(3) "Plan sponsor" means the group or individual entering into a contract with an insurer under which the insurer provides reimbursement to the plan for expenditures or obligations incurred for the provision of health care services over and above a certain attachment point.

(4) "Spending account" includes, but is not limited to, medical spending accounts, health reimbursement arrangements, pre-tax benefit spending accounts, and other forms of funding for health care goods and services. As such, the source of funding may be from an individual, an employer, an employee, or a combination of sources, as appropriate.

History. — Code 1981, § 33-30B-3, enacted by Ga. L. 2003, p. 912, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "a" was substituted for "an" in the last sentence of paragraph (4).

33-30B-4. Group or individual participation; administration of plan.

(a) A spending account plan or consumer driven health plan may be written in this state for a group or for an individual. Such plan may contain a spending account feature which will provide the first-dollar payments for health care services up to a designated amount. Group plans may, but are not required to, provide for a uniform spending account limit. An individual plan may incorporate a spending account feature with a limit not exceeding $10,000.00 annually.

(b) All spending accounts shall be in the name of the individual for which the spending account has been established but may be administered in accordance with the applicable plan.

History. — Code 1981, § 33-30B-4, enacted by Ga. L. 2003, p. 912, § 1.

33-30B-5. Relationship between spending account and attachment point for insurance reimbursement.

For any plan having a spending account feature, the amount of the spending account is not required to be the same as the attachment point for insurance reimbursements. If the attachment point for insurance reimbursements to the plan is higher than the amount contained in the

spending account, a notice describing the monetary gap for which an individual will be liable shall be given to the holder of the spending account.

History. — Code 1981, § 33-30B-5, enacted by Ga. L. 2003, p. 912, § 1.

33-30B-6. Requirements for insurance contract.

The insurance contract providing reimbursements for expenditures for health care services incurred by the plan may be a stop-loss, specific excess and aggregate, or other similar contract. It may be written by an insurer licensed for life, accident, and sickness insurance under Code Section 33-7-2 or by an insurer licensed for casualty insurance under Code Section 33-7-3. In either case, the contract shall be in the name of the plan as the contract holder and shall contain at least the following:

(1) The attachment point after which the payments by the insurer will be made;

(2) The amounts for allowable spending accounts;

(3) An attachment containing the plan document;

(4) A conspicuous disclosure on the first page of the contract that it is not a policy of accident and sickness insurance; and

(5) All other relevant terms and conditions.

History. — Code 1981, § 33-30B-6, enacted by Ga. L. 2003, p. 912, § 1.

33-30B-7. Interpretation; renewal of policy.

(a) A stop-loss or specific excess and aggregate contract issued under this chapter shall not be construed or interpreted as an accident and sickness insurance policy.

(b) No stop-loss or specific excess and aggregate policy may be cancelled or nonrenewed because of the level of health care claims.

History. — Code 1981, § 33-30B-7, enacted by Ga. L. 2003, p. 912, § 1.

CHAPTER 31

CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND SICKNESS INSURANCE

Sec.
33-31-1. Definitions.
33-31-2. Applicability of chapter.
33-31-3. Issuance of policies generally.
33-31-4. Amount of insurance.
33-31-5. Date insurance becomes effective; duration and termination of insurance.
33-31-6. Requirements as to issuance or delivery of policies generally.
33-31-7. Issuance of policy or certificate of insurance; contents; delivery of policy or certificate to debtor; requirements as to provisions of policies.
33-31-8. Filing of forms with Commissioner; approval or disapproval.
33-31-9. Premiums; refunds and credits.
33-31-10. Filing and settlement of claims generally; manner of payment of claims.
33-31-11. Right of debtor to furnish insurance.
33-31-12. Promulgation of rules and regulations; enforcement of provisions; penalties for violations.

Cross references. — Definition of accident and sickness insurance, § 33-7-2. Definition of casualty insurance as including credit insurance, § 33-7-3(8). Definition of life insurance, § 33-7-4. Life insurance generally, T. 33, C. 25. Individual accident and sickness insurance, T. 33, C. 29.

Administrative rules and regulations. — Credit life, accident and sickness insurance, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Insurance Department, Subjects 120-2-13, 120-2-27.

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).

JUDICIAL DECISIONS

Intent of chapter. — This chapter evidences an intent that insured debtor have an interest in credit life insurance taken out on the insured's life. Betts v. Brown, 219 Ga. 782, 136 S.E.2d 365 (1964).

This chapter was passed for benefit of insured borrower, who pays premium for policy, as well as the creditor who makes the loan or extends the credit and the original creditor's successors. Universal Am. Life Ins. Co. v. Finance Corp. of Am., 118 Ga. App. 160, 162 S.E.2d 813 (1968).

Cited in Pioneer Homeowners Life Ins. Co. v. Hogan, 110 Ga. App. 887, 140 S.E.2d 212 (1965).

RESEARCH REFERENCES

ALR. — Insurance: illustrations concerning accumulations, dividends, surplus, etc., 22 A.L.R. 1284; 127 A.L.R. 1464.

Failure of creditor, or creditor's assignee, to secure credit insurance as affecting rights or liabilities of debtor, upon debtor's loss, 88 A.L.R.3d 794.

33-31-1. Definitions.

As used in this chapter, the term:

(1) "Credit accident and sickness insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(2) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(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 or any successor to the right, title, or interest of any such lender, vendor, or lessor and an affiliate, associate, or subsidiary of any of them or any director, officer, or employee of any of them or any other person in any way associated with any of them.

(4) "Debtor" 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.

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

History. — Code 1933, § 56-3302, enacted by Ga. L. 1960, p. 289, § 1.

Cross references. — Definition of accident and sickness insurance, § 33-7-2. Definition of life insurance, § 33-7-4.

Law reviews. — For survey article on insurance law for the period from June 1, 2002 through May 31, 2003, see 55 Mercer L. Rev. 277 (2003).

JUDICIAL DECISIONS

Paragraph (1) of this section makes it clear that it is the life of the debtor, not the debt itself, which is insured by credit life insurance. Betts v. Brown, 219 Ga. 782, 136 S.E.2d 365 (1964).

Paragraph (3) of former Code 1933, § 56-3302 (see O.C.G.A. § 33-31-1) and paragraph (2) of former Code 1933, § 56-3306 (see O.C.G.A. § 33-31-7(b)) clearly provide that the transferee of the loan becomes the creditor entitled, upon the death of the insured, to the proceeds of the policy necessary to pay the amount due upon the loan; no change in the creditor beneficiary originally designated in the policy or notice of the transfer to the insurance company is necessary to effect a valid transfer of the loan. Universal Am. Life Ins. Co. v. Finance Corp. of Am., 118 Ga. App. 160, 162 S.E.2d 813 (1968).

Insurable interest may not exceed indebtedness to be secured. — Creditor has, for the purpose of indemnification against loss, but for no other, an insurable interest in the life of a debtor; and this interest cannot exceed in amount that of the indebtedness to be secured. Such indebtedness may, however, include the cost of taking out and keeping up the insurance, if made a charge against the debtor or the debtor's estate, or upon the proceeds of the policy when collected. Vulcan

Life & Accident Ins. Co. v. United Banking Co., 118 Ga. App. 36, 162 S.E.2d 798 (1968).

Cited in Poe v. Founders Life Assurance Co., 145 Ga. App. 757, 245 S.E.2d 166 (1978); Credithrift of Am., Inc. v. Whitley, 190 Ga. App. 833, 380 S.E.2d 489 (1989); Printis v. Bankers Life Ins. Co., 276 Ga. 697, 583 S.E.2d 22 (2003); Flynt v. Life of the South Ins. Co., 312 Ga. App. 430, 718 S.E.2d 343 (2011).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 3, 6.

C.J.S. — 44 C.J.S., Insurance, §§ 9, 394 et seq. 46A C.J.S., Insurance, § 2229 et seq.

33-31-2. Applicability of chapter.

(a) Except as provided otherwise in subsection (c) of this Code section, all life insurance and all accident and sickness insurance sold in connection with loans or other credit transactions pursuant to a plan covering all debtors of a creditor or a class or classes of debtors shall be subject to this chapter, except such insurance sold in connection with a loan or other credit transaction of five years' duration or more.

(b) Nothing in this chapter is intended to prohibit or discourage reasonable competition.

(c) All life insurance and all accident and sickness insurance sold in connection with loans or other credit transactions pursuant to a plan covering all debtors of a creditor or a class or classes of debtors shall be subject to this chapter, except such insurance sold in connection with a loan or other credit transaction of more than ten years' duration.

History. — Code 1933, § 56-3301, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1991, p. 1092, § 1; Ga. L. 2019, p. 386, § 106/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on and after July 1, 1991," following "insurance sold" in two places in subsection (c).

JUDICIAL DECISIONS

Cited in Christian v. Carrollton Fed. Sav. & Loan Ass'n, 221 Ga. 119, 143 S.E.2d 391 (1965); Smith v. General Fin. Corp., 143 Ga. App. 390, 238 S.E.2d 694 (1977); Darden v. Ford Consumer Fin. Co., 200 F.3d 753 (11th Cir. 2000).

33-31-3. Issuance of policies generally.

Credit life insurance and credit accident and sickness insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan;

(2) Individual policies of accident and sickness insurance issued to debtors on a term plan or disability provisions in individual policies of credit life insurance;

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; and

(4) Group policies of accident and sickness insurance issued to creditors on a term plan insuring debtors or disability provisions in group life policies to provide the coverage.

History. — Code 1933, § 56-3303, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Insurable interest may not exceed indebtedness to be secured. — Creditor has, for the purpose of indemnification against loss, but for no other, an insurable interest in the life of a debtor; and this interest cannot exceed in amount that of the indebtedness to be secured. Such indebtedness may, however, include the cost of taking out and keeping up the insurance, if made a charge against the debtor or the debtor's estate, or upon the proceeds of the policy when collected. Vulcan Life & Accident Ins. Co. v. United Banking Co., 118 Ga. App. 36, 162 S.E.2d 798 (1968).

33-31-4. Amount of insurance.

(a) The amount of credit life insurance shall not exceed the indebtedness. Where indebtedness repayable in substantially equal installments is secured by an individual policy of credit life insurance, the amount of insurance shall not exceed the approximate unpaid indebtedness on the date of death and, where secured by a group policy of credit life insurance, shall not exceed the exact amount of unpaid indebtedness on that date.

(b) The amount of indemnity payable by credit accident and sickness insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

(c) The limitations set forth in subsections (a) and (b) of this Code section shall not apply to insurance regulated under Chapter 3 of Title 7 as to loans made under that chapter.

(d) Notwithstanding this Code section, credit life insurance in connection with agricultural loans not exceeding five years may be written up to the amount of the loan or loan commitment on the nondecreasing or level term plan.

History. — Code 1933, § 56-3304, enacted by Ga. L. 1960, p. 289, § 1.

Law reviews. — For article discussing methods of computation of finance charges in Georgia consumer credit contracts, see 30 Mercer L. Rev. 281 (1978).

JUDICIAL DECISIONS

Insurable interest may not exceed indebtedness to be secured. — Creditor has, for the purpose of indemnification against loss, but for no other, an insurable interest in the life of a debtor; and this interest cannot exceed in amount that of the indebtedness to be secured. Such indebtedness may, however, include the cost of taking out and keeping up the insurance, if made a charge against the debtor or the debtor's estate, or upon the proceeds of the policy when collected. Vulcan Life & Accident Ins. Co. v. United Banking Co., 118 Ga. App. 36, 162 S.E.2d 798 (1968).

Indebtedness is the total amount a consumer would pay over the course of the loan. — Insurance company did not illegally overcharge a policy holder for a credit life policy on a vehicle loan, because under O.C.G.A. § 33-31-1, indebtedness was defined as the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction, and this included the interest charged on the vehicle loan. Printis v. Bankers Life Ins. Co., 256 Ga. App. 266, 568 S.E.2d 85 (2002), aff'd, 276 Ga. 697, 583 S.E.2d 22 (2003).

RICO action against an insurer regarding the insurer's calculation of the premium for a credit life insurance policy issued in connection with an installment loan failed to state a cause of action under O.C.G.A. § 9-11-12(c) because applying the definition of "indebtedness" found in O.C.G.A. § 33-31-1(5) to the language in O.C.G.A. § 33-31-4(a), the insurer properly calculated the premium based on the total payments due through the life of the loan, a gross balance decreasing term coverage method. Printis v. Bankers Life Ins. Co., 276 Ga. 697, 583 S.E.2d 22 (2003).

Cited in Mason v. Service Loan & Fin. Co., 128 Ga. App. 828, 198 S.E.2d 391 (1973); Turpeau v. Fidelity Fin. Servs., Inc., 936 F. Supp. 975 (N.D. Ga. 1996).

33-31-5. Date insurance becomes effective; duration and termination of insurance.

The term of any credit life insurance or credit accident and sickness insurance shall commence, subject to acceptance by the insurer, on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to the indebtedness shall commence on the effective date of the policy. In no event, however, in the case of a contract obligation involving future delivery or performance, must the insurance become effective before the date of such delivery or completion of such performance or before the date when all of the terms of the indebtedness are set forth in the contract or instrument creating the indebtedness. The term of the insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness, except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled

maturity, a refund shall be paid or credited as provided in Code Section 33-31-9.

History. — Code 1933, § 56-3305, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1990, p. 8, § 33.

JUDICIAL DECISIONS

Credit life insurer was required to refund unearned premiums despite policy provision requiring written notice. — Credit life insurer's failure to refund unearned premiums unless an insured provided written notice to the insurer constituted a breach of the legal duty the insurer owed to the insureds to refund unearned premiums under O.C.G.A. § 33-31-5. The notice requirement in the policy was not a condition precedent or express stipulation of forfeiture, and failure to return unearned premiums was a breach of the insurer's obligation of good faith and fair dealing. Res. Life Ins. Co. v. Buckner, 304 Ga. App. 719, 698 S.E.2d 19 (2010).

Cited in Cherokee Credit Life Ins. Co. v. Glisson, 124 Ga. App. 527, 184 S.E.2d 479 (1971); Welmaker v. W.T. Grant Co., 365 F. Supp. 531 (N.D. Ga. 1972); Poe v. Founders Life Assurance Co., 145 Ga. App. 757, 245 S.E.2d 166 (1978); All Am. Assurance Co. v. Brown, 177 Ga. App. 402, 339 S.E.2d 611 (1985).

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Refinancing must present "pyramiding" problem for section to apply. — While a proposed practice might be a "refinancing" within the literal meaning of this section, if it does not present the "pyramiding" problem which concerned this section's framers it would not constitute the particular variety of refinancing to which this section was meant to apply. 1974 Op. Att'y Gen. No. 74-113.

33-31-6. Requirements as to issuance or delivery of policies generally.

All policies of credit life insurance and credit accident and sickness insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business in this state and shall be issued only through holders of licenses issued by the Commissioner.

History. — Code 1933, § 56-3309, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Cited in Christian v. Carrollton Fed. Sav. & Loan Ass'n, 221 Ga. 119, 143 S.E.2d 391 (1965).

33-31-7. Issuance of policy or certificate of insurance; contents; delivery of policy or certificate to debtor; requirements as to provisions of policies.

(a) All credit life insurance and credit accident and sickness insurance sold shall be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance and credit accident and sickness insurance, in addition to other requirements of law, shall set forth the name and home office address of the insurer; the identity by name or otherwise of the person or persons insured; the rate or amount of premium separately in connection with credit life insurance and credit accident and sickness insurance if an identifiable charge is made to the debtor; and a description of the coverage, including any exceptions, limitations, or restrictions; and it shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, shall state that any excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

(c) The individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in subsection (d) of this Code section.

(d) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred and if an identifiable charge is made to him or her for credit life insurance or credit accident and sickness insurance, a copy of the application for the policy signed by the debtor or a notice of proposed insurance setting forth the name and home office address of the insurer, the name or names of the debtor, the rate or amount of premium separately in connection with credit life insurance and credit accident and sickness insurance coverage, and a brief description of the coverage provided shall be delivered to the debtor at the time the indebtedness is incurred. The copy of the application or the notice of proposed insurance shall refer exclusively to insurance coverage and shall be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement unless the information required by this subsection is prominently set forth in the application or the notice of proposed insurance. Upon acceptance of the insurance and within 60 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state when the insurance shall become effective, which shall be determined as provided in Code Section 33-31-5.

(e) Unless an individual policy is incontestable from date of issue, it shall provide that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue and that no statement relating to insurability made by any person insured under the policy shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by the person; that a copy of the application, if any, of the policyholder shall be attached to the policy when issued; and that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or to his beneficiary.

(f) A provision specifying an equitable adjustment of premiums or of benefits or of both, to be made in the event the age of a person insured has been misstated, shall contain a clear statement of the method of adjustment to be used.

History. — Code 1933, § 56-3306, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 2005, p. 617, § 1/SB 166.

JUDICIAL DECISIONS

Purpose of section. — This section recognizes and seeks to protect the interest of the insured debtor in credit life insurance. Betts v. Brown, 218 Ga. 782, 136 S.E.2d 365 (1964).

Subsection (b) of former Code 1933, § 56-3306 (see O.C.G.A. § 33-31-7) and paragraph (3) of former Code 1933, § 56-3306 (see O.C.G.A. § 33-31-7(b)) clearly provide that the transferee of the loan becomes the creditor entitled, upon the death of the insured, to the proceeds of the policy necessary to pay the amount due upon the loan; no change in the creditor beneficiary originally designated in the policy or notice of the transfer to the insurance company was necessary to effect a valid transfer of the loan. Universal Am. Life Ins. Co. v. Finance Corp. of Am., 118 Ga. App. 160, 162 S.E.2d 813 (1968).

Construction of subsection (d). — Subsection (d) of former Code 1933, § 56-3306 (see O.C.G.A. § 33-31-7) must be construed in connection with former Code 1933, § 56-3305 (see O.C.G.A. § 33-31-5) to the effect that the term of any credit life insurance shall be subject to acceptance by the insurer. Coats v. Vulcan Life & Accident Ins. Co., 128 Ga. App. 731, 197 S.E.2d 788 (1973).

Policy of credit life insures life of debtor and not debt and such insurance is not wholly for the benefit of the creditor-beneficiary. National Life Assurance Co. v. Massey-Ferguson Credit Corp., 136 Ga. App. 311, 220 S.E.2d 793 (1975).

When estate of deceased debtor pays the debt, it is subrogated to claims of creditor and debtor to the proceeds of the policy. National Life Assurance Co. v. Massey-Ferguson Credit Corp., 136 Ga. App. 311, 220 S.E.2d 793 (1975).

Contents of contract of group insurance. — Contract of group insurance consists of both the master policy and the certificate of insurance. The insured is bound by provisions, including exclusions, in the master policy even though no reference is made to such provisions in the certificate because the certificate usually

contains a disclaimer that it is not the whole contract, and it is within the power of the insured to obtain a copy of the master policy to learn all the provisions in the contract. Investor's Nat'l Life Ins. Co. v. Norsworthy, 160 Ga. App. 340, 287 S.E.2d 66 (1981).

Certificate of credit insurance is evidence of coverage under the master policy. Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 168 S.E.2d 171 (1969).

Certificate holder is bound by the provisions of the master policy. Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 168 S.E.2d 171 (1969).

Master policy and certificate must be construed together. — In construing a contract of group insurance, the master group policy and the certificate of insurance must be construed together for it takes both to make the contract. Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 168 S.E.2d 171 (1969).

Insurance, including group insurance, is a matter of contract, and the language used is to be construed by giving the usual and ordinary meaning to the contract in arriving at the intention of the parties; if there is no ambiguity, the contract must be construed to mean what the contract says. Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 168 S.E.2d 171 (1969).

Unauthorized issuance of certificates exceeding company's liability. — When a provision appears in the master group policy that all agreements of the company must be signed by its president or secretary and that no other person can waive or alter the policy provisions, issuance by an agent of certificates in excess of the company's liability under the specific terms of the policy cannot increase the liability of the company beyond that provided in the policy. Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 168 S.E.2d 171 (1969).

Action by insured on policy. — Absent notice of the terms of the master policy, an insured is entitled to maintain an action on the policy the insured offered to purchase and which offer the insurer has accepted. Investor's Nat'l Life Ins. Co. v. Norsworthy, 160 Ga. App. 340, 287 S.E.2d 66 (1981).

Insured mortgagor has a legal interest in a group credit disability insurance policy. Walker v. Omaha Mut. Indem. Co., 835 F.2d 857 (11th Cir. 1988).

Subsection (c) requires delivery of policy or certificate to debtor. — Subsection (c) of O.C.G.A. § 33-31-7 requires delivery of the credit life, accident, or sickness policy or certificate to the debtor, regardless of who pays the premium. Robinson v. Volunteer State Life Ins. Co., 175 Ga. App. 292, 333 S.E.2d 171 (1985).

Acceptance or rejection of applications within given time period. — Subsection (d) of O.C.G.A. § 33-31-7 has not been construed to place upon insurance companies who receive applications any duty to accept or reject within 30 days of the date of indebtedness or even within some "reasonable time." Had the legislature intended to create such a duty, the legislature could easily have done so. All Am. Assurance Co. v. Brown, 177 Ga. App. 402, 339 S.E.2d 611 (1985), overruled on other grounds, Centennial Ins. Co. v. Sandner, Inc., 259 Ga. 317, 380 S.E.2d 704 (1989).

Cited in Pioneer Homeowners Life Ins. Co. v. Hogan, 110 Ga. App. 887, 140 S.E.2d 212 (1965); Cullers v. Home Credit Co., 130 Ga. App. 441, 203 S.E.2d 544 (1973); Poe v. Founders Life Assurance Co., 145 Ga. App. 757, 245 S.E.2d 166 (1978).

33-31-8. Filing of forms with Commissioner; approval or disapproval.

All forms, including policies, certificates of insurance, notices of proposed insurance, applications for insurance, binders, endorsements, and riders, together with the schedule of premiums therefor and the applicable maximum identifiable charges to debtors shall be filed with the Commissioner. The procedure for filing and approval of forms shall

be in accordance with Code Section 33-24-9. The Commissioner shall disapprove any form filed or withdraw any previous approval of such form if the benefits provided in such form are not reasonable in relation to the premium charges or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation of the policy.

History. — Code 1933, § 56-3307, enacted by Ga. L. 1960, p. 289, § 1.

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Premium charges other than those approved by Commissioner unauthorized. — Any premium charge made to the debtor other than as filed with and approved by the Insurance Commissioner and consistent with the premium rate charged by the insurer is unauthorized. 1965-66 Op. Att'y Gen. No. 66-184.

33-31-9. Premiums; refunds and credits.

(a) Any insurer, subject to the power of the Commissioner to disapprove the form as provided in Code Section 33-31-8, may revise its schedules of premium rates from time to time and shall file such revised schedules with the Commissioner. Premiums charged by an insurer shall be deemed to be reasonable and in compliance with this chapter and this title if the rate utilized in the calculation of the premium has been approved by the Commissioner. No insurer shall charge premiums for credit life insurance or credit accident and sickness insurance which exceed the premium rate then on file with the Commissioner, except that for the second and subsequent years of insurance provided for the debtors of a creditor it may charge a premium in excess of such maximum if such increase is approved by the Commissioner because of unfavorable claims experience. Nothing in this chapter shall be deemed to prohibit an insurer from decreasing the premium rate on the insurance provided for the debtors of a creditor for the second and subsequent years of insurance.

(b) The amount collected by the creditor from the debtor for any credit life insurance or any credit accident and sickness insurance shall be consistent with the premium rate charged by the insurer. Nothing in this chapter shall be construed to legalize any charge illegal under any statute or rule of law governing credit transactions.

(c) Each individual policy, notice of proposed insurance, or group certificate of credit life insurance and credit accident and sickness insurance shall provide that, in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of premium due shall be calculated as of the date the indebtedness terminated and be paid or credited promptly to the person entitled

to such refund; provided, however, that the Commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing a refund shall be filed with and approved by the Commissioner. It shall be the obligation of the insured to notify the insurer of the early payoff of the indebtedness which is covered by the insurance.

(c.1) Each individual policy, notice of proposed insurance, or group certificate of credit life insurance and credit accident and sickness insurance issued shall provide a notice on the face of such policy, notice, or certificate in at least 10 point type that it is the obligation of the insured to notify the insurer of any early payoff of the indebtedness which is covered by the insurance.

(d) If a creditor requires a debtor to make a payment in connection with credit life insurance or credit accident and sickness insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account.

History. — Code 1933, § 56-3308, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1996, p. 6, § 33; Ga. L. 1996, p. 912, § 5; Ga. L. 2005, p. 612, § 1/SB 167; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 386, § 107/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "now" following "legalize any charge" in the second sentence of subsection (b); and deleted "after May 2, 2005," following "sickness insurance issued" in subsection (c.1).

Editor's notes. — Ga. L. 2005, p. 612, § 2/SB 167, not codified by the General Assembly, provides that: "This Act is declaratory of existing law and is only intended to clarify such law. The passage of this Act shall not create any implication that any change in existing law is effected."

Law reviews. — For survey article on insurance law, see 59 Mercer L. Rev. 195 (2007). For survey article on trial practice and procedure, see 59 Mercer L. Rev. 423 (2007). For survey article on trial practice and procedure, see 60 Mercer L. Rev. 397 (2008).

JUDICIAL DECISIONS

Purpose of section. — This section recognizes and seeks to protect the interest of an insured debtor in credit life insurance. Betts v. Brown, 218 Ga. 782, 136 S.E.2d 365 (1964).

Determining method of refund pursuant to rules of Industrial Loan Commissioner. — When the method of determining the insurance refund is not specified by statute, it would properly be a subject for clarification under the rule-making power of the Industrial Loan Commissioner, which rules, if consistent with law, have the force and effect of law. Brown v. Quality Fin. Co., 112 Ga. App. 369, 145 S.E.2d 99 (1965).

Notice. — Insured's suit seeking a refund of unearned credit life insurance and credit disability policy premiums under O.C.G.A. § 33-31-9(c) was not barred by the insured's failure to give the insurer pre-suit notice of the insured's early payoff of the insured's truck loan; because O.C.G.A. § 33-31-9(c) did not specify a particular time for giving notice, the insured's filing of the complaint constituted sufficient notice. Baker v. Am. Heritage Life Ins. Co., No. 4:05-CV-128(CDL), 2006 U.S. Dist. LEXIS 62586 (M.D. Ga. Sept. 1, 2006).

Credit life insurer's failure to refund unearned premiums unless an insured

provided written notice to the insurer constituted a breach of the legal duty the insurer owed to the insurer's insureds to refund unearned premiums under O.C.G.A. § 33-31-5. The notice requirement in the policy was not a condition precedent or express stipulation of forfeiture, and failure to return unearned premiums was a breach of the insurer's obligation of good faith and fair dealing. Res. Life Ins. Co. v. Buckner, 304 Ga. App. 719, 698 S.E.2d 19 (2010).

Notice requirement met. — Because an insurer expressly acknowledged that, by filing suit, the insured satisfied any contractual notice requirement obligating the insurer to return any unearned premium, and a 2005 amendment to O.C.G.A. § 33-31-9 did not affect this result, the appeals court rejected the insurer's claim that the insured's claim in contract was barred due to the insured's failure to submit proof of early loan payoff, as required by both the expressed and implied terms of the insurance contract. J.M.I.C. Life Ins. Co. v. Toole, 280 Ga. App. 372, 634 S.E.2d 123 (2006).

Sufficiency of notice. — Insureds' failure to provide pre-suit notice of an early loan payoff and an insurer's failure to refund unearned premiums on credit policies because there were no express or implied term in the insurance certificates requiring pre-suit notice and the filing of the lawsuit sufficiently complied with notice required under O.C.G.A. § 33-31-9(c). Bishop's Prop. & Invs., LLC v. Protective Life Ins. Co., No. 4:05-CV-126(CDL), 2006 U.S. Dist. LEXIS 62593 (M.D. Ga. Sept. 1, 2006).

Torts related to contract. — Appellate court rejected an insurer's assertion that the insurer's insured's individual tort claims failed because a tort was the unlawful violation of a private legal right other than a mere breach of contract, express or implied, as the duties the insured alleged that the insurer violated did not arise merely from contract but were also imposed by O.C.G.A. § 33-31-9. J.M.I.C. Life Ins. Co. v. Toole, 280 Ga. App. 372, 634 S.E.2d 123 (2006).

Cited in Smith v. General Fin. Corp., 143 Ga. App. 390, 238 S.E.2d 694 (1977); SunTrust Bank v. Hightower, 291 Ga. App. 62, 660 S.E.2d 745 (2008).

OPINIONS OF THE ATTORNEY GENERAL

Premium charges other than those approved by Commissioner unauthorized. — Any premium charge made to the debtor other than as filed with and approved by the Insurance Commissioner and consistent with the premium rate charged by the insurer is unauthorized. 1965-66 Op. Att'y Gen. No. 66-184.

33-31-10. Filing and settlement of claims generally; manner of payment of claims.

(a) All claims shall be promptly reported to the insurer or its designated claim representative and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.

(b) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions or, upon direction of the claimant, to one specified.

(c) No plan or arrangement shall be used whereby any person, firm, or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting

claims, provided that a group policyholder, by arrangement with the group insurer, may draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

History. — Code 1933, § 56-3310, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

JUDICIAL DECISIONS

Payment of indebtedness to lender with proceeds of credit life insurance is, in legal effect, payment by the insured. Betts v. Brown, 219 Ga. 782, 136 S.E.2d 365 (1964).

Cited in GMAC v. Bearden, 114 Ga. App. 392, 151 S.E.2d 517 (1966).

RESEARCH REFERENCES

ALR. — 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.

33-31-11. Right of debtor to furnish insurance.

When credit life insurance or credit accident and sickness insurance is required as additional security for any indebtedness, the debtor, upon written request to the creditor, shall have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

History. — Code 1933, § 56-3311, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Effect of payment with insurance proceeds. — Since this section gives the debtor the option of procuring the debtor's own insurance coverage, the effect of payment with the proceeds of insurance should be the same regardless of which of the authorized methods of insurance the debtor chooses to employ. Betts v. Brown, 219 Ga. 782, 136 S.E.2d 365 (1964).

33-31-12. Promulgation of rules and regulations; enforcement of provisions; penalties for violations.

(a) The Commissioner after notice and hearing may issue such rules and regulations as he deems appropriate for the supervision of this chapter, including regulation of maximum premiums or maximum charges to debtors for all credit life or credit accident and sickness insurance. Whenever the Commissioner finds that there has been a

violation of this chapter or of any rules or regulations issued pursuant to this chapter, after written notice of the violation and hearing given to the insurer or other person authorized or licensed by the Commissioner he shall set forth the details of his findings together with an order for compliance by a specified date. The order shall be binding on the insurer and other person authorized or licensed by the Commissioner on the date specified, unless previously withdrawn by the Commissioner.

(b) In addition to any other penalty provided by law, any person who violates an order of the Commissioner after it has become final and while the order is in effect, upon proof of the violation to the satisfaction of the court, shall forfeit and pay to this state a sum not to exceed $250.00, which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed $1,000.00. The Commissioner, in his discretion, may revoke or suspend the license or certificate of authority of the person guilty of such violation. The order for suspension or revocation shall be subject to judicial review as provided in Chapter 2 of this title.

History. — Code 1933, § 56-3312, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

CHAPTER 32

PROPERTY INSURANCE

Sec.
33-32-1. Standard fire policy.
33-32-2. Coverage of personal property changing in specifics.
33-32-3. Privilege of rebuilding or reinstating property sustaining loss or damage.
33-32-4. Refund of premium payments where insured sustaining total loss of property receives less than maximum amount payable under policy.
33-32-5. Amount of insurance in certain fire policies deemed conclusive as to value of property covered.
33-32-6. Tobacco crop insurance coverage.

Cross references. — Quarterly reports by fire insurance companies regarding losses sustained by them, and release by fire insurance companies of fire loss information upon official request, §§ 25-2-32, 25-2-33. Definition of property insurance, § 33-7-6. Fair access to property insurance, T. 33, C. 33. Insurance of state property, § 50-16-8 et seq.

Administrative rules and regulations. — Property insurance regulations, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Insurance Department, Subject 120-2-19.

Law reviews. — For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979).

RESEARCH REFERENCES

Am. Jur. Proof of Facts. — Recovery Under Property Insurance for Loss Due to Surface Water, Sewer Backup, and Flood, 48 POF3d 419.

Loss by Storm Damage Under Property Insurance, 49 POF3d 501.

ALR. — Prorating provisions as applying to mortgagee, 1 A.L.R. 498; 72 A.L.R. 278.

Gasoline in automobile as violation of provision in fire insurance policy on building, 3 A.L.R. 798.

Construction of hail insurance policy, 4 A.L.R. 1298; 7 A.L.R. 373; 35 A.L.R. 267; 129 A.L.R. 1068.

Insurance: invalid or ineffective encumbrance as breach of condition against encumbrances, 13 A.L.R. 556.

Insurance: appointment of receiver, bankruptcy or insolvency proceedings, or assignment for benefit of creditors as change in interest, title, or possession within fire policy, 17 A.L.R. 382.

Insurance: effect of provision declaring loss, in case of mortgagee's interest, subject to all the terms and conditions of the policy, 19 A.L.R. 1449; 56 A.L.R. 850.

Provision in insurance policy as to means of extinguishing fire, 23 A.L.R. 27.

Effect on insurance of mere failure to disclose encumbrance on property, 28 A.L.R. 801.

Amount in case of partial loss of property insured under a proportional provision of statute or policy which provides in terms for full payment of amount of insurance in case of a total loss, 32 A.L.R. 651.

Validity and construction of contract indemnifying against loss due to confiscation of property by public authorities, 36 A.L.R. 1499.

What amounts to a sale within forfeiture provision of insurance policy forbidding property to be sold or conveyed without assent of insurer, 38 A.L.R. 316.

Burglary, larceny, theft, or robbery within policy of insurance, 41 A.L.R. 846; 44 A.L.R. 471.

Purchase of property by mortgagee or holder of mortgage securities as breach of

condition against sale or change of title in insurance policy with mortgage clause, 45 A.L.R. 597.

Validity of "three-fourths value" clause in fire insurance policy, 45 A.L.R. 1022.

Validity and effect of provision in insurance policy for forfeiture upon foreclosure, or commencement of foreclosure, or other proceeding to enforce a mortgage, 50 A.L.R. 1117; 57 A.L.R. 1044.

Rights as between mortgagor and insurance company where policy avoided as to mortgagor, but not as to mortgagee, 52 A.L.R. 278.

Reacquisition or extinguishment of title or interest as affecting provision in fire insurance policy against change of title, interest, or possession, or against encumbrance, 52 A.L.R. 843.

Divisibility of fire insurance policy covering stock and fixtures or furniture, 53 A.L.R. 1123.

Tourists' property insurance policy, 55 A.L.R. 803.

Loss due to inherent defect as within policy insuring property against loss or damage, 55 A.L.R. 941.

Fumigating premises as violation of fire insurance policy, 57 A.L.R. 948.

Vendee or vendor under executory contract as having exclusive ownership or interest, within the meaning of condition in insurance policy requiring interest of insured to be that of "unconditional and sole ownership," or the like, 60 A.L.R. 11.

Right of owner to sue on fire or marine policy taken out by warehouseman, bailee or carrier, 61 A.L.R. 720.

Liability of property insurer as affected by explosion, 65 A.L.R. 934.

Right of insured or beneficiary to reformation of fire insurance policy as affected by delay in discovering faults in policy as drafted, 76 A.L.R. 1218.

Change of conditions increasing hazard between time of filing of application and inception of risk under fire insurance policy, 76 A.L.R. 1295.

Meaning of term "sound value" employed in insurance policy or statute, 78 A.L.R. 904.

Fire insurance: insolvency of, or appointment of receiver for, insurer as affecting subsequent losses, 79 A.L.R. 1267.

Liability of mortgagee under mortgage clause for insurance premiums, 83 A.L.R. 105.

Insurance by agent on his own property, 83 A.L.R. 1509.

Failure of attempted appraisal under policy of insurance as affecting rights and remedies of parties, 94 A.L.R. 499.

Union or standard mortgage clause as relieving mortgagee of mortgagor's breach of conditions at inception of policy or before mortgage clause attached, 97 A.L.R. 1165.

Amount recoverable from one liable for damage to building as affected by building regulations applicable to restoration or repair of damaged buildings, 107 A.L.R. 1122.

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.

Right of creditors, or of trustee in bankruptcy, of grantor in conveyance fraudulent as against creditors, in respect of proceeds of insurance upon property, 114 A.L.R. 1374.

Rights, duties, and liabilities of life tenant (legal or equitable) and remaindermen in respect of property insurance or proceeds thereof, 126 A.L.R. 336.

Mortgage as breach of condition in insurance policy as to sole and unconditional ownership or as to change of title or interest, or similar terms, 126 A.L.R. 473.

Duty of mortgagee, or one holding title as security, to protect the interests of third persons in respect to insurance, 130 A.L.R. 598.

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.

What amounts to a leasehold interest within insurance policy, 130 A.L.R. 818.

Conditional sale as affecting provision in insurance policy against change of title, interest, or possession, 133 A.L.R. 785.

Fire insurance policy as covering loss resulting from article being accidentally thrown into or otherwise coming in contact with fire friendly in its origin, 133 A.L.R. 797.

Waiver or estoppel regarding sole and

unconditional ownership clause, where both insurer and insured are aware of the uncertainty as to the title, 140 A.L.R. 1235.

Right of insurer, in absence of subrogation clause, to be subrogated to claim of mortgagee (or conditional vendor) to whom it paid loss, under loss-payable or mortgagee clause, after policy had been canceled as against insured or had become unenforceable by him, 146 A.L.R. 442.

Breach of condition of fire insurance policy by less than all of the persons named as insured as affecting the others, 148 A.L.R. 487.

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.

Who is member of insured's "family" or "household" within coverage of property insurance policy, 1 A.L.R.2d 561.

Manufacture or sale of intoxicating liquor as increase of hazard or change in use avoiding fire insurance policy, 2 A.L.R.2d 1160.

Damage within coverage of water damage insurance, 4 A.L.R.2d 532.

Waiver of, or estoppel to assert, provision of policy respecting location of personal property covered thereby, 4 A.L.R.2d 868.

Amount of insurer's liability as affected by insured's executory contract to sell the property, 8 A.L.R.2d 1408.

What constitutes "upset" or "overturning" within provisions of property damage policy covering losses so caused, 8 A.L.R.2d 1433.

Right to proceeds, or to apportionment thereof, where fire insurance policy is issued jointly to lessor and lessee covering destruction of or damage to building, 8 A.L.R.2d 1445.

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.

Recovery under fire insurance policy for damage to party wall, 13 A.L.R.2d 619.

Rent loss insurance, 17 A.L.R.2d 1226.

Judgment for insurer who paid property damage as bar to another action against same tortfeasor by owner or another subrogated insurer for additional property damage arising from same tort, and vice versa, 22 A.L.R.2d 1455.

Keeping or placing of gasoline, kerosene, or similar inflammable substances on premises as increase of hazard avoiding fire insurance policy, 26 A.L.R.2d 809.

Casual or temporary repairs, and the like, as constituting increase of hazard so as to avoid fire or other property damage insurance, 28 A.L.R.2d 757.

Transfer or pledge of fire insurance policy as collateral security for debt as within policy provisions prohibiting or restricting assignment of policy, 31 A.L.R.2d 1199.

Insurance: waiver of, or estoppel to assert, iron safe clause, 33 A.L.R.2d 615.

Applicability of "increase of hazard" clause in fire insurance policy to conditions occurring accidentally, 34 A.L.R.2d 717.

Applicability of valued policy statute to partial fire loss, 36 A.L.R.2d 619.

Robbery insurance: risks and losses covered, 37 A.L.R.2d 1081.

What constitutes "household goods," or the like, within coverage thereof in fire insurance policy, 41 A.L.R.2d 720.

Construction and effect of clause in burglary policy requiring alarm system, 42 A.L.R.2d 733.

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.

Vacancy or unoccupancy within fire insurance policy which covers several buildings only some of which are or become vacant or unoccupied, 51 A.L.R.2d 1366.

Lessee's or lessor's right to recover on fire insurance policy for destroyed or damaged property which the other has replaced or repaired, 53 A.L.R.2d 1383.

Applicability of fraud and false swearing clause of fire insurance policy to testimony given at trial, 64 A.L.R.2d 962.

What constitutes "direct loss resulting from actual physical contact of vehicle with property" within purview of extended coverage provision of fire policy, 64 A.L.R.2d 1189.

Rights of vendor and purchaser, as between themselves, in insurance proceeds, 64 A.L.R.2d 1402.

Right to proceeds of insurance, as between holder of title to real estate and one having option to purchase it, 65 A.L.R.2d 989.

What constitutes "farm produce" or "farm product" within coverage of fire insurance policy, 71 A.L.R.2d 1266.

Damage from sonic boom as within property insurance policy, 74 A.L.R.2d 754.

Fluctuations in cost of making repairs between time of loss and time of payment as affecting property insurer's liability, 74 A.L.R.2d 1272.

Construction of terms "in transit," "transportation," and the like, within coverage or exclusion of insurance policy, 80 A.L.R.2d 445.

Scope and purview of clause excluding business property from the coverage of policy insuring unscheduled personal property, 80 A.L.R.2d 1289.

Construction and application of provision in fire policy specifically excepting loss by explosion unless fire ensues, 82 A.L.R.2d 1125.

Construction of property insurance provision excluding liability for destruction caused by order of civil authority, 84 A.L.R.2d 683.

Rights and remedies of property insurer as against third-person tortfeasor who has settled with insured, 92 A.L.R.2d 102.

Improvements and betterments insurance, 97 A.L.R.2d 1243.

Rights in proceeds of insurance on property held jointly with right of survivorship, where one of joint owners dies pending payment of proceeds, 4 A.L.R.3d 427.

Necessity and sufficiency of insurer's demand, under fire insurance policy, for examination of insured or his books or papers, or for proofs of loss, certificates, or sworn statements, 4 A.L.R.3d 631.

Insured's failure to inform insurer of pending condemnation proceedings as concealment or fraud within provision of fire policy, 9 A.L.R.3d 1411.

Provisions of burglary or theft policy as to effect of disappearance of property, 12 A.L.R.3d 865.

Construction of insurance coverage as to loss of or injury to trees, lawns, and shrubbery, 14 A.L.R.3d 1056.

Overvaluation in proof of loss of property insured as fraud avoiding fire insurance policy, 16 A.L.R.3d 774.

What constitutes a "private" structure or a private structure not used for mercantile purposes within the meaning of property insurance policies, 19 A.L.R.3d 902.

Change in purposes for which premises are occupied or used as increase of hazard voiding insurance coverage, 19 A.L.R.3d 1336.

Provisions of burglary or theft policy requiring losses evidenced by "physical damage to premises," 22 A.L.R.3d 1305.

Fraud, false swearing, or other misconduct of insured as affecting right of innocent mortgagee or loss payee to recover on property insurance, 24 A.L.R.3d 435.

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.

What constitutes "vacancy" or "unoccupancy" within fire insurance policy on building other than dwelling, 36 A.L.R.3d 505.

What are "appurtenant" private structures within provision of property insurance policy expressly extending coverage to such structures, 43 A.L.R.3d 1362.

Property insurance: construction and effect of provision excluding loss caused by earth movement or earthquake, 44 A.L.R.3d 1316.

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.

Right of mortgagee to notice by insurer of expiration of fire insurance policy, 60 A.L.R.3d 164.

What constitutes "money" within coverage or exclusion of theft or other crime policy, 68 A.L.R.3d 1179.

What constitutes "ensuing loss" caused by water damage within coverage provision of property insurance policy, 78 A.L.R.3d 950.

Loss through payment of extortion demand at place other than insured's prem-

ises as within coverage of theft policy insuring against losses incurred on premises, 85 A.L.R.3d 1103.

Personal injuries inflicted by animal as within homeowner's or personal liability policy, 96 A.L.R.3d 891.

Depreciation as factor in determining actual cash value for partial loss under insurance policy, 8 A.L.R.4th 533.

Right of innocent insured to recover under fire policy covering property intentionally burned by another insured, 11 A.L.R.4th 1228.

Liability insurance coverage as extending to liability for punitive or exemplary damages, 16 A.L.R.4th 11.

Right of mortgagee, who acquires title to mortgaged premises in satisfaction of mortgage, to recover, under fire insurance policy covering him as "mortgagee," for loss or injury to property thereafter damaged or destroyed by fire, 19 A.L.R.4th 778.

Property damage resulting from inadequate or improper design or construction of dwelling as within coverage or "all risks" homeowner's insurance policy, 41 A.L.R.4th 1095.

Duty of mortgagee of real property with respect to obtaining or maintenance of fire or other casualty insurance protecting mortgagor, 42 A.L.R.4th 188.

Fire insurance: insurable interest of one expecting to inherit property or take by will, 52 A.L.R.4th 1273.

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 property insurance provision permitting recovery of replacement cost of property, 1 A.L.R.5th 817.

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, anticipated profits, good will, 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.

Business interruption insurance, 37 A.L.R.5th 41.

Applicability of valued-policy statutes to flood, wind, and hurricane damage, 62 A.L.R. 6th 227.

33-32-1. Standard fire policy.

(a) No policy of fire insurance covering property located in this state shall be made, issued, or delivered unless it conforms as to all provisions and the sequence of the standard or uniform form prescribed by the Commissioner, except that, with regard to multiple line coverage providing other kinds of insurance combined with fire insurance, this Code section shall not apply if the policy contains, with respect to the fire portion of the policy, language at least as favorable to the insured as the applicable portions of the standard fire policy and such multiple line policy has been approved by the Commissioner.

(b) The Commissioner shall file and maintain on file in his office a true copy of the standard fire policy designated as such and bearing the Commissioner's authenticating certificate and signature and the date of filing. The standard fire insurance policy shall not be required for casualty insurance, marine and transportation insurance, or insurance on growing crops. Insurers issuing the standard fire insurance policy are authorized to affix to or include in such policy a written statement that the policy does not cover loss or damage caused by nuclear reaction

or nuclear radiation or radioactive contamination, whether directly or indirectly resulting from an insured peril under the policy; provided, however, that nothing contained in this Code section shall be construed to prohibit the attachment to any such policy of an endorsement or endorsements specifically assuming loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination.

History. — Code 1933, § 56-3201, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1982, p. 3, § 33.

Law reviews. — For annual survey on insurance, see 65 Mercer L. Rev. 135 (2013).

JUDICIAL DECISIONS

Obligations on coinsured. — Clear mandate of subsection (a) of O.C.G.A. § 33-32-1 requires that the language of Fireman's Fund's insurance policy be as favorable to the insured as the language in the standard fire policy; the use of "the insured" in the fraud provision standard fire policy must be construed to provide several obligations as to each coinsured, therefore, the minimum coverage allowed in Georgia creates several obligations as to each coinsured and Fireman's Fund's insurance contract must be reformed to conform with the minimum coverage provided in the standard fire policy. Fireman's Fund Ins. Co. v. Dean, 212 Ga. App. 262, 441 S.E.2d 436 (1994).

One year time limit to file suit contained in policy enforceable. — In an insurer's declaratory judgment action involving the insurer's obligations under a parent's property insurance policy, the insurer was properly granted summary judgment as to a child's claim since that claim was filed past the one year time limit set forth in the policy, which was a policy renewed in 2004. The child's counterclaim was filed 18 months after the declaratory judgment suit was filed and no waiver of the one year time limit was established. Morrill v. Cotton States Mut. Ins. Co., 293 Ga. App. 259, 666 S.E.2d 582 (2008).

At least as favorable. — Parties' intent was that the policy's statute of limitations provision be amended to conform to the Standard Fire Policy two-year statute of limitations provision and the conformed policy language clearly complied with O.C.G.A. § 33-32-1(a)'s requirement that the policy be at least as favorable to the insured as the standard fire policy. Jenkins v. Allstate Prop. & Cas. Ins. Co., No. 11-11811, 2011 U.S. App. LEXIS 24655 (11th Cir. Dec. 13, 2011) (Unpublished).

Georgia insurance commissioner exceeded legal authority in promulgating rule. — Multiple-line insurance policy providing first-party insurance coverage for theft-related property damage had to be reformed to conform with the two-year limitation period provided for in Georgia's Standard Fire Policy, Ga. Comp. R. & Regs. 120-2-19-.01, because the Georgia Insurance Commissioner exceeded the commissioner's legal authority under O.C.G.A. § 33-32-1(a) when the commissioner promulgated Ga. Comp. R. & Regs. 120-2-20-.02. White v. State Farm Fire & Casualty Co., 291 Ga. 306, 728 S.E.2d 685 (2012).

No error due to umpire's failure to itemize damaged property. — Trial court properly found no irregularity, palpable mistake of law, or fraud with regard to the appraisal awards in the homeowners' favor giving the homeowners less than the maximum amount of coverage set forth in the homeowners' policy following a fire at the residence because there existed no support for the contention that the umpire was required to itemize the homeowners' damaged personal property as the language of O.C.G.A. § 33-32-1, with regard to the standard fire policy, concerning what the umpire must do simply did not explicitly place such a duty on the umpire as the statute did on the insureds. Bell v. Liberty Mut. Fire Ins. Co., 319 Ga. App. 302, 734 S.E.2d 894 (2012).

Judicial notice. — Court of Appeals will take judicial notice of uniform mandatory form of fire insurance policies as prescribed by the Commissioner of Insurance. Farm Bureau Mut. Ins. Co. v. Bennett, 114 Ga. App. 623, 152 S.E.2d 609 (1966).

Cited in Andrews v. Georgia Mut. Ins. Co., 110 Ga. App. 92, 137 S.E.2d 746 (1964); Darnell v. Fireman's Fund Ins. Co., 115 Ga. App. 367, 154 S.E.2d 741 (1967); U.S. Fid. & Guar. Co. v. Barnes, 120 Ga. App. 593, 171 S.E.2d 632 (1969); Townley v. Patterson, 139 Ga. App. 249, 228 S.E.2d 164 (1976); Brookins v. State Farm Fire & Cas. Co., 529 F. Supp. 386 (S.D. Ga. 1982).

OPINIONS OF THE ATTORNEY GENERAL

Properly licensed foreign insurer may insure nuclear energy installations. — 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 the company's domicile. 1958-59 Op. Att'y Gen. p. 199.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 79 et seq.

Am. Jur. Proof of Facts. — Fire Insurer's Bad Faith in Responding to Claim by Insured, 49 POF2d 1.

Arson Defense to Coverage Under Property Insurance, 34 POF3d 291.

C.J.S. — 44 C.J.S., Insurance, § 486 et seq.

ALR. — Insurance: provision against change in interest, title, or possession as affected by a deed or other instrument which was merely colorable or has not been delivered, 7 A.L.R. 1608.

Insurance: what amounts to gross negligence, or recklessness which will relieve fire insurer from liability, 10 A.L.R. 728.

Liability of property insurer as affected by explosion, 13 A.L.R. 883; 65 A.L.R. 934.

Insurance against damage to automobile by fire, 14 A.L.R. 199; 35 A.L.R. 1471.

Rule precluding recovery for fire due to voluntary or wrongful act of insured as applicable to conduct not intended to cause fire, 37 A.L.R. 437.

Sufficiency of bookkeeping to satisfy conditions of insurance policy, 39 A.L.R. 1443; 62 A.L.R. 630; 125 A.L.R. 350.

Conditions causing damage by sprinkler system as constituting a fire within insurance policy, 49 A.L.R. 406.

Reacquisition or extinguishment of title or interest as affecting provision in fire insurance policy against change of title, interest, or possession, or against encumbrance, 52 A.L.R. 843.

Liability of mortgagee under mortgage clause for insurance premiums, 56 A.L.R. 679; 83 A.L.R. 105.

Insurance: effect of provision declaring loss in case of mortgagee's interest subject to the terms and conditions of the policy, 56 A.L.R. 850.

Provision of fire insurance policy terminating insurance upon fall of building except as result of fire, 56 A.L.R. 1068.

Belated compliance with requirement of insurance policy as to books and inventory, 56 A.L.R. 1086.

Claim under contract of property insurance as assignable after loss, 56 A.L.R. 1391.

Fumigating premises as violation of fire insurance policy, 57 A.L.R. 948.

Right of owner to sue on fire or marine policy taken out by warehouseman, bailee, or carrier, 61 A.L.R. 720.

Procuring of insurance by holder of mortgage or deed of trust as violation of provision in mortgagor's policy against additional insurance, 66 A.L.R. 1173.

Prorating provision as applying to mortgagee, 72 A.L.R. 278.

Union or standard mortgage clause as relieving mortgagee of mortgagor's breach of conditions at inception of policy or before mortgage clause attached, 97 A.L.R. 1165.

Liability of one on whose property accidental fire originates for damages from spread thereof, 111 A.L.R. 1140; 17 A.L.R.5th 547.

Requirement of "iron safe clause" as regards character or condition of receptacle and as to closing and locking it, 114 A.L.R. 584.

Independent contract theory or creditor-beneficiary theory as regards status of mortgagee under mortgage clause in policy fire insurance, 124 A.L.R. 1034.

Provision in fire insurance policy against other insurance as applied to property owned jointly or by cotenants, 143 A.L.R. 425.

Sale of land with reservation of insured building as violation of provisions of insurance policy, 173 A.L.R. 1207.

What constitute additions to or extension of buildings, within purview of insurance policies upon buildings and such additions, 19 A.L.R.2d 606.

Keeping or placing of gasoline, kerosene, or similar inflammable substances on premises as increase of hazard avoiding fire insurance policy, 26 A.L.R.2d 809.

Casual or temporary repairs, and the like, as constituting increase of hazard so as to avoid fire or other property damage insurance, 28 A.L.R.2d 757.

Coverage of clause of fire policy insuring against explosion, 28 A.L.R.2d 995.

Insurance: waiver of, or estoppel to assert, iron safe clause, 33 A.L.R.2d 615.

Applicability of "increase of hazard" clause in fire insurance policy to conditions occurring accidentally, 34 A.L.R.2d 717.

Insured's discontinued breach of warranty relating to use or keeping of prohibited articles as barring recovery on fire policy, 44 A.L.R.2d 1048.

Vacancy or unoccupancy within fire insurance policy which covers several buildings only some of which are or become vacant or unoccupied, 51 A.L.R.2d 1366.

Applicability of fraud and false swearing clause of fire insurance policy to testimony given at trial, 64 A.L.R.2d 962.

Fire policy on contents or the like as covering property of insured's customers or bailors, 67 A.L.R.2d 1241.

Damage to insured articles by fire-fighting efforts as within courage of fire insurance policy, 76 A.L.R.2d 1137.

Insurer's liability as affected by refusal of public authorities to permit reconstruction or repair after fire, 90 A.L.R.2d 790.

Time period for bringing action on standard form fire insurance policy provided for by statute, as running from time of fire (when loss occurs) or from time loss is payable, 95 A.L.R.2d 1023.

Fire insurance: failure to disclose prior fires affecting insured's property as ground of avoidance, 100 A.L.R.2d 1358.

Insured's failure to inform insurer of pending condemnation proceedings as concealment or fraud within provision of fire policy, 9 A.L.R.3d 1411.

Loss by heat, smoke, or soot without external ignition as within standard fire insurance policy, 17 A.L.R.3d 1155.

Determination of amount payable on loss to growing crop under policy insuring against loss or injury, 20 A.L.R.3d 924.

Fire insurance on corporate property as affected by its intentional destruction by a corporate officer, employee, or stockholder, 37 A.L.R.3d 1385.

Property insurance: construction and effect of provision excluding loss caused by earth movement or earthquake, 44 A.L.R.3d 1316.

What constitutes "vacant or unoccupied" dwelling within exclusionary provision of fire insurance policy, 47 A.L.R.3d 398.

Insured's right to recover from insurer prejudgment interest on amount of fire loss, 5 A.L.R.4th 126.

What constitutes "other insurance" within meaning of insurance policy provisions prohibiting insured from obtaining other insurance on same property, 7 A.L.R.4th 494.

Fire insurance: failure to disclose prior fires affecting insured's property as ground for avoidance of policy, 4 A.L.R.5th 117.

Coverage under all-risk insurance, 30 A.L.R.5th 170.

Property damage insurance: what constitutes "contamination" within policy clause excluding coverage, 90 A.L.R.6th 635.

Am. Jur. Trials. — Handling Fire Claims Out of Court, 57 Am. Jur. Trials 155.

Actions on Fire Insurance Policies, 10 Am. Jur. Trials 301.

33-32-2. Coverage of personal property changing in specifics.

A policy of insurance may be made to cover personal property changing in its specifics.

History. — Ga. L. 1895, p. 51, § 1; Civil Code 1895, § 2110; Civil Code 1910, § 2545; Code 1933, § 56-701; Code 1933, § 56-3202, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Section constitutional. — This Code section does not violate U.S. Const., amend. 14, or Ga. Const. 1976, Art. I, Sec. II, Para. VII (see Ga. Const. 1983, Art. I, Sec. I, Para. II). Aetna Ins. Co. v. Brigham, 120 Ga. 925, 48 S.E. 348 (1904).

This Code section does not apply to fire insurance contract made in another state covering property located in Georgia. Coffin v. London & Edinburgh Ins. Co., 27 F.2d 616 (N.D. Ga. 1928).

Limitation to three-fourths of loss. — Under this Code section, limitation of insurance recoverable to three-fourths of the loss is void. Coffin v. London & Edinburgh Ins. Co., 27 F.2d 616 (N.D. Ga. 1928).

RESEARCH REFERENCES

ALR. — Sufficiency of inventory to satisfy condition of insurance policy as affected by inclusion of, or failure to include, prop not insured, 92 A.L.R. 372.

Provisional or monthly reporting insurance, 13 A.L.R.2d 713.

Fire policy on contents or the like as covering property of insured's customers or bailors, 67 A.L.R.2d 1241.

Scope and purview of clause excluding business property from the coverage of policy insuring unscheduled personal property, 80 A.L.R.2d 1289.

Construction and effect of provisional or monthly reporting inventory insurance, 81 A.L.R.4th 9.

33-32-3. Privilege of rebuilding or reinstating property sustaining loss or damage.

The privilege of rebuilding or reinstating property sustaining loss or damage shall not exist unless it is reserved in the policy.

History. — Orig. Code 1863, § 2766; Code 1868, § 2774; Code 1873, § 2816; Code 1882, § 2816; Civil Code 1895, § 2112; Civil Code 1910, § 2547; Code 1933, § 56-704; Code 1933, § 56-3204, enacted by Ga. L. 1960, p. 289, § 1.

JUDICIAL DECISIONS

Measure of damages. — In an action on a policy of insurance against windstorm damage to recover for injury to the roof of a building, which policy provided that the property was insured to the extent of the actual cash value with proper deductions for depreciation of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality, and that it should be optional with the company to repair, rebuild, or replace the property lost or damaged with other of like kind and quality,

the measure of damages was the reasonable cost of repair without any deduction for the difference in value between new and old materials. North River Ins. Co. v. Godley, 55 Ga. App. 52, 189 S.E. 577 (1936).

RESEARCH REFERENCES

ALR. — Insurer's liability as affected by refusal of public authorities to permit reconstruction or repair after fire, 90 A.L.R.2d 790.

Necessity and manner of property insurer's giving notice of exercising option to repair insured's property, 98 A.L.R.2d 1319.

33-32-4. Refund of premium payments where insured sustaining total loss of property receives less than maximum amount payable under policy.

In the event of a total loss of property, if an insurer shall pay to the insured an amount less than the maximum amount authorized to be paid under an insurance policy covering the property, the insurer shall refund to the insured the difference between the amount of premiums actually paid for the insurance policy and the amount of premiums which would have been charged for a property insurance policy having a maximum amount payable equal to the amount actually paid by the insurer to the insured.

History. — Ga. L. 1895, p. 51, § 1; Civil Code 1895, § 2110; Civil Code 1910, § 2545; Code 1933, § 56-701; Code 1933, § 56-3205, enacted by Ga. L. 1960, p. 289, § 1.

RESEARCH REFERENCES

ALR. — Divisibility of fire insurance policy as regards subjects of insurance as affected by the fact that premium is payable at a named rate per one hundred dollars of insurance, 129 A.L.R. 651.

Rights, in respect of premiums paid but unearned or premiums earned but unpaid, between property insurer and lessor, under policy taken out by lessee, 143 A.L.R. 1463.

Validity, construction, and effect of insurance policy provision requiring insured to maintain coverage to specified value of property (coinsurance clause), 43 A.L.R.3d 566.

33-32-5. Amount of insurance in certain fire policies deemed conclusive as to value of property covered.

(a) Whenever any policy of insurance is issued to a natural person or persons or to any legal entity wholly owned by a natural person or persons insuring a specifically described one or two family residential building or structure located in this state against loss by fire and the building or structure is wholly destroyed by fire without fraudulent or criminal fault on the part of the insured or one acting in his or her behalf, the amount of insurance set forth in the policy relative to the building or structure shall be taken conclusively to be the value of the

property, except to the extent of any depreciation in value occurring between the date of the policy or its renewal and the loss, provided that, if loss occurs within 30 days of the original effective date of the policy, the insured shall be entitled to the actual loss sustained not exceeding the sum insured. Nothing in this Code section shall be construed as prohibiting the use of coinsurance or as preventing the insurer from repairing or replacing damaged property at its own expense without contribution on the part of the insured.

(b) Subsection (a) of this Code section shall not apply where:

(1) The building or structure is not wholly destroyed by fire;

(2) Insurance policies are issued or renewed by more than one company insuring the same building or structure against fire and the existence of the additional insurance is not disclosed by the insured to all insurers issuing policies;

(3) Two or more buildings or structures are insured under a blanket form for a single amount of insurance; or

(4) The completed value of a building or structure is insured under a builders' risk policy.

History. — Code 1933, § 56-3206, enacted by Ga. L. 1971, p. 657, § 1; Ga. L. 2016, p. 237, § 1/SB 137.

Law reviews. — 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).

JUDICIAL DECISIONS

Insured not limited to attempted sale price before fire. — Although insured attempted to sell the property before the fire, insured was not limited to that sale price as the amount of the insurable interest, but could recover the entire policy amount. Forbus v. Allstate Ins. Co., 603 F. Supp. 113 (N.D. Ga. 1984).

Rider guaranteeing replacement cost coverage. — O.C.G.A. § 33-32-5 did not apply to an insurance rider providing for payment of the full replacement cost of destroyed property and requiring replacement or repair as a condition precedent. Marchman v. Grange Mut. Ins. Co., 232 Ga. App. 481, 500 S.E.2d 659 (1998).

Home not wholly destroyed. — Trial court properly determined that the insureds were not entitled to the maximum amount of coverage set forth in the insureds' homeowner's policy under O.C.G.A. § 33-32-5, because the umpire determined that the insureds' home was not wholly destroyed during the fire. Bell v. Liberty Mut. Fire Ins. Co., 319 Ga. App. 302, 734 S.E.2d 894 (2012).

"Builders' risk" policies. — Policy containing provisions indicating that the insured dwelling was under construction was a "builders' risk" policy and, therefore, when the dwelling burned before completion, subsection (a) of O.C.G.A. § 33-32-6 did not override the provision for payment of the amount necessary to rebuild the structure, not the full amount of the policy. Georgia Farm Bureau Mut. Ins. Co. v. Garzone, 240 Ga. App. 304, 523 S.E.2d 386 (1999).

Cited in Allstate Ins. Co. v. Baugh, 173 Ga. App. 615, 327 S.E.2d 576 (1985); Southern Ins. Underwriters, Inc. v. Ray, 188 Ga. App. 469, 373 S.E.2d 236 (1988); Georgia Farm Bureau Mut. Ins. Co. v. Brown, 192 Ga. App. 504, 385 S.E.2d 87 (1989); Nationwide Mut. Fire Ins. Co. v.

Wiley, 220 Ga. App. 442, 469 S.E.2d 302 (1996).

RESEARCH REFERENCES

ALR. — Divisibility of fire insurance policy covering building and contents, 47 A.L.R. 650.

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.

Divisibility of fire insurance policy as regards subjects of insurance as affected by the fact that premium is payable at a named rate per one hundred dollars of insurance, 129 A.L.R. 651.

Applicability of "increase of hazard" clause in fire insurance policy to conditions occurring accidentally, 34 A.L.R.2d 717.

Test or criterion of "actual cash value" under insurance policy insuring to extent of actual cash value at time of loss, 61 A.L.R.2d 711.

Insurer's liability as affected by refusal of public authorities to permit reconstruction or repair after fire, 90 A.L.R.2d 790.

33-32-6. Tobacco crop insurance coverage.

Any insurer issuing a policy providing crop insurance coverage, other than federal crop insurance pursuant to 7 U.S.C. Section 1501, et seq., for tobacco crops grown in this state against loss or damage due to wind, hail, or both shall make available such coverage for a term extending until such time as the tobacco crop is harvested, either as a part of or as an optional endorsement to such policy of crop insurance.

History. — Code 1981, § 33-32-6, enacted by Ga. L. 1999, p. 647, § 1; Ga. L. 2000, p. 136, § 33; Ga. L. 2019, p. 386, § 108/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "on or after April 28, 1999," following "Any insurer issuing" near the beginning of this Code section.

CHAPTER 33

FAIR ACCESS TO INSURANCE REQUIREMENTS

Sec.
33-33-1. Establishment of Fair Access to Insurance Requirements Plan and underwriting association.
33-33-2. Requirements of plan and articles of association.
33-33-3. Requirement of participation in plan by property insurers.
33-33-4. Powers of Commissioner generally.
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33-33-11. Termination date; outstanding obligations unimpaired [Repealed].

Law reviews. — For article discussing the development of group marketing of insurance, with emphasis on recent attempts in the area of property and liability insurance, see 20 J. of Pub. L. 479 (1971).

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.

33-33-1. Establishment of Fair Access to Insurance Requirements Plan and underwriting association.

All insurers licensed to write and writing property insurance in this state on a direct basis are authorized, subject to approval and regulation by the Commissioner, to establish and maintain a Fair Access to Insurance Requirements (FAIR) Plan and to establish and maintain an underwriting association and to formulate and from time to time amend the plan and articles of association and rules and regulations in connection therewith and to assess and share on a fair and equitable basis all expenses, income, and losses incident to the Fair Access to Insurance Requirements Plan and underwriting association in a manner consistent with this chapter.

History. — Ga. L. 1970, p. 282, § 1; Ga. L. 1975, p. 22, § 1; Ga. L. 1995, p. 629, § 1.

33-33-2. Requirements of plan and articles of association.

The Fair Access to Insurance Requirements Plan and articles of association shall make provision for an underwriting association hav-

ing authority on behalf of its members to cause to be issued property insurance policies, to reinsure in whole or in part any such policies, and to cede any such reinsurance. The plan and articles of association shall provide, among other things, for the perils to be covered; geographical area of coverage; compensation and commissions; assessments of members; the sharing of expenses, income, and losses on an equitable basis; cumulative weighted voting for the board of directors of the association; the administration of the plan and association; and any other matter necessary or convenient for the purpose of assuring fair access to insurance requirements.

History. — Ga. L. 1970, p. 282, § 3; Ga. L. 1975, p. 22, § 3; Ga. L. 1995, p. 629, § 1.

33-33-3. Requirement of participation in plan by property insurers.

(a) Each insurer authorized to write and writing property insurance in this state shall be required to become and remain a member of the plan and the underwriting association and to comply with the requirements of the plan and the underwriting association as a condition of its authority to transact property insurance business.

(b) Each insurer shall participate in the writings, expenses, profits, and losses of the association in the following manner:

(1) For habitational risks, the same proportion as its habitational premiums written bear to the aggregate habitational premiums written by all insurers in the program; and

(2) For commercial risks, the same proportion as its commercial premiums written bear to the aggregate commercial premiums written by all insurers in the program.

History. — Ga. L. 1970, p. 282, § 2; Ga. L. 1975, p. 22, § 2; Ga. L. 1995, p. 629, § 1.

33-33-4. Powers of Commissioner generally.

(a) The directors of the association shall submit to the Commissioner, for review, a proposed Fair Access to Insurance Requirements Plan and articles of association consistent with this chapter.

(b) The Fair Access to Insurance Requirements Plan and articles of association shall be subject to approval by the Commissioner and shall take effect ten days after having been approved by the Commissioner. If the Commissioner disapproves all or any part of the proposed plan and articles, the directors of the association shall within 30 days submit for

review an appropriately revised plan and articles; and, if the directors fail to do so, the Commissioner shall thereafter promulgate such plan and articles consistent with this chapter.

(c) The directors of the association may, on their own initiative or at the request of the Commissioner, amend the plan and articles, subject to approval by the Commissioner.

History. — Ga. L. 1970, p. 284, § 4; Ga. L. 1975, p. 22, § 4; Ga. L. 1995, p. 629, § 1.

33-33-5. Modification by insurers of rates.

In conformity with Chapter 9 of this title, insurers may make reasonable rate modifications for fire and extended coverage and such other classes of basic property insurance.

History. — Ga. L. 1970, p. 282, § 11; Ga. L. 1975, p. 22, § 11; Code 1981, § 33-33-8; Code 1981, § 33-33-5, as redesignated by Ga. L. 1995, p. 629, § 1.

Editor's notes. — Ga. L. 1995, p. 629, § 1, repealed former Code Section 33-33-5, relating to establishment of the Riot Reinsurance Reimbursement Fund, and redesignated former Code Section 33-33-8 as Code Section 33-33-5, effective April 18, 1995. Former Code Section 33-33-5 was based on Ga. L. 1970, p. 282, § 7; Ga. L. 1975, p. 22, § 7; Ga. L. 1993, p. 1402, § 18.

33-33-6. Liability for inspections and statements.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, insurers, any inspection bureau, placement facility, or underwriting association, or their directors, agents, or employees, or the Commissioner or his or her authorized representatives for any inspections undertaken or statements made by any of them concerning the property to be insured; and any reports and communications in connection therewith shall not be considered public documents.

History. — Ga. L. 1970, p. 282, § 6; Ga. L. 1975, p. 22, § 6; Code 1981, § 33-33-9 [repealed]; Code 1981, § 33-33-6, as redesignated by Ga. L. 1995, p. 629, § 1.

Editor's notes. — Ga. L. 1995, p. 629, § 1, repealed former Code Section 33-33-6, relating to deposit of assessments received from insurers in fund, and redesignated former Code Section 33-33-9 as Code Section 33-33-6, effective April 18, 1995. Former Code Section 33-33-6 was based on Ga. L. 1970, p. 282, § 9; Ga. L. 1975, p. 22, § 9.

JUDICIAL DECISIONS

Application to uninsurable property. — This Code section deals with property of prospective insureds which, because of the property's geographical location in high risk urban areas, is considered uninsurable. Pennsylvania Millers Mut. Ins. Co. v. Thomas Milling Co., 137 Ga. App. 430, 224 S.E.2d 55 (1976).

Application to high risk property. — Privileged inspections, statements, records, and communications contemplated by this Code section are limited to high risk property within the meaning of the Urban Property Protection and Reinsurance Act of 1968, 12 U.S.C. § 1749bbb et seq., and are sui generis. Pennsylvania Millers Mut. Ins. Co. v. Thomas Milling Co., 137 Ga. App. 430, 224 S.E.2d 55 (1976).

33-33-7. Appeals from actions or decisions.

Any person aggrieved by any action or decision of the administrators of the plan, the underwriting association, or of any insurer as a result of its participation in the plan may appeal to the Commissioner within 30 days from the date of the action or the decision. The Commissioner, after a hearing held upon proper notice, shall issue an order approving the action or decision or disapproving the action or decision with respect to the matter which is the subject of appeal. All final orders and decisions of the Commissioner shall be subject to judicial review as provided in Chapter 2 of this title.

History. — Ga. L. 1970, p. 282, § 5; Ga. L. 1975, p. 22, § 5; Code 1981, § 33-33-10; Code 1981, § 33-33-7, as redesignated by Ga. L. 1995, p. 629, § 1; Ga. L. 2019, p. 386, § 109/SB 133.

The 2019 amendment, effective July 1, 2019, added "as provided in Chapter 2 of this title" at the end of the last sentence of this Code section.

Editor's notes. — Ga. L. 1995, p. 629, § 1, repealed former Code Section 33-33-7, relating to effect of failure of insurer to pay assessments and redesignated former Code Section 33-33-10 as Code Section 33-33-7, effective April 18, 1995. Former Code Section 33-33-7 was based on Ga. L. 1970, p. 282, § 8; Ga. L. 1975, p. 22, § 8.

33-33-8. Temporary insurance coverage for local public entity filing appeal of adverse underwriting decision.

(a) For the purposes of this Code section, the term "local public entity" means a county, municipality, or local board of education.

(b) In the event the insurance coverage of a local public entity filing an appeal of an adverse underwriting decision of the association established pursuant to this chapter is scheduled to cancel or expire while such appeal is pending, the Commissioner shall direct the association to provide coverage authorized under this chapter on a temporary basis to the local public entity as provided in this Code section.

(c) It shall be the duty of the local public entity to notify the Commissioner in writing at the same time the appeal is filed of the date its existing insurance coverage is to cancel or expire. Failure of the local public entity to notify the Commissioner as provided in this subsection shall render the local public entity ineligible for the temporary coverage authorized by this Code section. Upon receiving such notice, the Commissioner shall direct the association to provide coverage autho-

rized under this chapter to the local public entity, shall specify the date such coverage is to be effective, and shall specify the date of termination of such coverage, which shall not be set prior to the date of the Commissioner's final order disposing of the issues on appeal. The premium for the temporary coverage provided by this Code section shall be paid in full by the local public entity at the time the coverage is issued by such method and in such manner as directed by the Commissioner.

(d) Upon receipt of the notice from the public entity specified in subsection (c) of this Code section, the Commissioner shall notify such entity of the emergency property protection measures, if any, which will be required during the period of temporary coverage. Such measures may include the following:

(1) Protection of physically damaged property from further damage;

(2) Prevention or limitation of access to the premises;

(3) Disconnection of utilities;

(4) Installation of locks, alarms, or security lighting;

(5) Inspections of the premises; or

(6) Provision of security guards.

(e) After ordering the temporary coverage required under subsection (b) of this Code section, the Commissioner shall cause notice of such action and any emergency protection measures pertaining to such coverage to be published in the legal organ of the county in which the property is located.

History. — Code 1981, § 33-33-10.1, enacted by Ga. L. 1993, p. 320, § 1; Code 1981, § 33-33-8, as redesignated by Ga. L. 1995, p. 629, § 1; Ga. L. 2019, p. 386, § 110/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "existing" following "In the event the" near the beginning of subsection (b).

Editor's notes. — Ga. L. 1995, p. 629, § 1, redesignated former Code Section 33-33-8 as present Code Section 33-33-5.

33-33-9 and 33-33-10.

Redesignated as Code Sections 33-33-6 and 33-33-7 by Ga. L. 1995, p. 629, § 1, effective April 18, 1995.

Editor's notes. — Ga. L. 1995, p. 629, § 1, redesignated former Code Sections 33-33-9 and 33-33-10 as present Code Sections 33-33-6 and 33-33-7, respectively.

33-33-11. Termination date; outstanding obligations unimpaired.

Repealed by Ga. L. 1995, p. 629, § 1, effective April 18, 1995.

Editor's notes. — This Code section was based on Ga. L. 1970, p. 282, § 10; Ga. L. 1975, p. 22, § 10; Ga. L. 1982, p. 875, §§ 1, 2; Ga. L. 1986, p. 508, § 1; Ga. L. 1990, p. 1283, § 1.

CHAPTER 34

MOTOR VEHICLE ACCIDENT REPARATIONS

Sec.
33-34-1. Short title.
33-34-2. Definitions.
33-34-3. Requirements for issuance of policies.
33-34-3.1. Filing of rates and forms; optional coverage.
33-34-4. Owner required to provide coverage.
33-34-5. Vehicle not to be licensed until proof of insurance furnished [Repealed].
33-34-5.1. Self-insurers.
33-34-6. Selection of motor vehicle repair facility.
33-34-7. Continuation of coverage upon death of named insured or termination of marital relationship.
33-34-8. Rules and regulations.
33-34-9. Proceeds of insurance policy; limited access by insurers to records.

Cross references. — Uninsured motorist coverage under motor vehicle liability policies, § 33-7-11. Rate regulation and premium reductions, T. 33, C. 9. Motor carriers indemnity insurance or self-insurance, § 40-1-112. Motor vehicle liability insurance coverage, notice, and proof requirements, §§ 40-5-70 et seq., 40-6-10, 40-6-11. Motor vehicle accident financial responsibility, T. 40, C. 9. Motor carriers definitions and exemptions, § 46-1-1.

Editor's notes. — Ga. L. 1987, p. 542, § 2, effective April 2, 1987, repealed former Code Section 33-34-11, as enacted by Ga. L. 1974, p. 113, § 13, relating to promulgation of rules and regulations by the Commissioner.

Former Code Section 33-34-17 (Ga. L. 1989, p. 1805, § 1), relating to inapplicability of provisions to nondomiciliaries, was repealed by Ga. L. 1990, p. 2048, § 15. For similar provisions, see § 40-5-73.

Ga. L. 1990, p. 2048, §§ 6-12, provided for the repeal of former Code Sections 33-34-10.1, 33-34-10.2, 33-34-11, 33-34-12, 33-34-12.1, 33-34-12.2, and 33-34-12.3, effective January 1, 1991. For similar provisions, see Code Sections 40-5-70 through 40-5-72, 40-6-10, 40-6-12, and 40-6-13.

Ga. L. 1990, p. 2048, § 13, provided for the repeal of former Code Section 33-34-13 (Ga. L. 1987, p. 542, § 2; Ga. L. 1989, p. 1719, § 1; Ga. L. 1990, p. 2048, § 13), relating to rules and regulations, effective January 1, 1991.

Ga. L. 1990, p. 2048, § 14, provided for the repeal of former Code Section 33-34-14 (Ga. L. 1983, p. 726, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1987, p. 553, § 1), relating to liability insurance for motorcycles, effective January 1, 1991. For similar provisions effective after January 1, 1991, see § 40-6-11.

Ga. L. 1991, p. 1608, § 1.12, effective October 1, 1991, repealed the Code sections formerly codified at this chapter, and enacted the current chapter. The former chapter consisted of Code Sections 33-34-1 through 33-34-10, 33-34-10.1, 33-34-10.2, 33-34-11, 33-34-12, 33-34-12.1, 33-34-12.2, 33-34-12.3, 33-34-13 through 33-34-16, 33-34-16.1, 33-34-16.2, and 33-34-17, and was based on Ga. L. 1974, p. 113, §§ 1-14; Ga. L. 1975, p. 3, §§ 1-6; Ga. L. 1976, p. 642, § 1; Ga. L. 1976, p. 1078, § 1; Ga. L. 1976, p. 1513, § 1; Ga. L. 1976, p. 1523, § 1; Ga. L. 1977, p. 807, §§ 1; Ga. L. 1977, p. 1520, §§ 5; Ga. L. 1978, p. 1369, § 1; Ga. L. 1978, p. 2075, § 1; Ga. L. 1979, p. 594, § 1; Ga. L. 1980, p. 1428, § 2; Ga. L. 1981, p. 1329, §§ 1, 2; Ga. L. 1981, Ex. Sess. p. 8, Ga. L. 1982, p. 3, § 33; Ga. L. 1982, p. 1234, §§ 1, 2; Ga. L. 1983, p. 3, § 24; Ga. L. 1983, p. 726, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1984, p. 516, § 1; Ga. L. 1984, p. 697, § 1; Ga. L. 1984, p. 1221, §§ 1, 2; Ga. L. 1984, p.

1333, §§ 1-3; Ga. L. 1985, p. 149, § 33; Ga. L. 1985, p. 891, § 1; Ga. L. 1985, p. 935, § 1; Ga. L. 1987, p. 542, §§ 1-3; Ga. L. 1987, p. 553, § 1; Ga. L. 1987, p. 1116, § 1; Ga. L. 1987, p. 1433, §§ 1, 2; Ga. L. 1988, p. 13, § 33; Ga. L. 1988, p. 1555, § 1; Ga. L. 1988, p. 1890, §§ 1, 2; Ga. L. 1989, p. 14, § 33; Ga. L. 1989, p. 405, § 1; Ga. L. 1989, p. 510, §§ 1-3; Ga. L. 1989, p. 841, §§ 1, 2; Ga. L. 1989, p. 1719, § 1; Ga. L. 1989, p. 1805, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1990, p. 194, §§ 1, 2; Ga. L. 1990, p. 1236, § 1; Ga. L. 1990, p. 1477, §§ 1, 2, 6; Ga. L. 1991, p. 94, § 33; Ga. L. 1991, p. 1608, § 1.12; Ga. L. 1991, p. 1830, § 2; and Ga. L. 1992, p. 2464, § 2.

Ga. L. 1991, p. 1608, §§ 3.1, 3.2, not codified by the General Assembly, provides: "Section 3.1. Except as provided in Section 3.3 of this Act, this Act 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. Except for an otherwise permissible cancellation of a policy of motor vehicle insurance, coverages payable without regard to fault in motor vehicle insurance policies in existence on October 1, 1991, shall remain in effect until changed by specific request of the policyholder and reflected by endorsement to the policy or until the renewal date of the policy; provided, however, the insurer shall be required to send written notice to the policyholder of any changes in coverage to be effective upon renewal of the policy as a result of this Act not less than 60 days prior to the renewal date of the policy. Written notice to the policyholder shall be accomplished in such form and manner as prescribed by the Commissioner of Insurance."

"Section 3.2. (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."

Ga. L. 1991, p. 1608, § 3.1, became effective on April 17, 1991, for the purposes of promulgation of rules and regulations by the Commissioner of Insurance. Ga. L. 1991, p. 1608, § 3.2, became effective on April 17, 1991.

Administrative rules and regulations. — Georgia Automobile Insurance Plan, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-14.

Law reviews. — For article advocating compulsory automobile insurance, see 19

Ga. B.J. 207 (1956). For article arguing against compulsory automobile insurance, see 19 Ga. B.J. 209 (1956). For article advocating moderate reform of auto accident compensation system prior to Georgia's adoption of the Georgia Motor Vehicle Accident Reparations Act, see 5 Ga. St. B.J. 321 (1969). For article analyzing the trend in this country toward no-fault liability, see 25 Emory L.J. 163 (1976). For article surveying recent legislative and judicial developments regarding Georgia's insurance laws, see 31 Mercer L. Rev. 117 (1979). For article surveying judicial and legislative developments in Georgia's tort laws, see 31 Mercer L. Rev. 229 (1979). For article surveying developments in Georgia constitutional law from mid-1980 through mid-1981, see 33 Mercer L. Rev. 51 (1981). For survey article on insurance, see 34 Mercer L. Rev. 177 (1982). 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 insurance law, see 42 Mercer L. Rev. 259 (1990).

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

For comment, "Treatment of Guest Passengers: Georgia Maintains Its Minority Rule," see 31 Mercer L. Rev. 1061 (1980).

JUDICIAL DECISIONS

Repeal of former § 33-34-6. — Repeal of former O.C.G.A. § 33-34-6 bars plaintiff's recovery of penalties and punitive damages pursuant to that statute. American Ass'n of Cab Cos. v. Egeh, 205 Ga. App. 228, 421 S.E.2d 741, cert. denied, 205 Ga. App. 899, 421 S.E.2d 741 (1992).

Effect of repeal of former law. — Insured's ability to seek punitive damages and penalties under repealed O.C.G.A. § 33-34-6 of former No-Fault Act did not survive repeal of the act; the mere mention within the insurance contract of an act authorizing penalties is not sufficient to secure the right to collect penalties by contract since the right to collect penalties must be specifically included in the terms of the contract. Terry v. State Farm Mut. Auto. Ins. Co., 205 Ga. App. 224, 422 S.E.2d 212, cert. denied, 205 Ga. App. 901, 422 S.E.2d 212 (1992); Steptoe v. Auto-Owners Ins. Co., 210 Ga. App. 756, 437 S.E.2d 626 (1993).

Effect of repeal. — Plaintiff may seek recovery of attorney fees, punitive damages and a 25 percent penalty under former O.C.G.A. § 33-34-6 despite the section's repeal in 1991. State Farm Mut. Auto. Ins. Co. v. Sills, 208 Ga. App. 184, 430 S.E.2d 32 (1993).

Exclusion in an automobile policy for intentional injury or property damage was enforceable when 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).

Bad faith penalties under former O.C.G.A. § 33-34-6 are not awardable if an insurer has a reasonable and probable cause for refusing to pay a claim. The advice of an independent medical examiner that treatment furnished a claimant was not in fact necessary, unless patently wrong based on facts timely brought to the insurer's attention, provided a reasonable basis for an insurer's denial of a claim for payment for such treatment. Haezebrouck v. State Farm Mut. Auto. Ins. Co., 216 Ga. App. 809, 455 S.E.2d 842 (1995).

RESEARCH REFERENCES

Am. Jur. 2d. — 7 Am. Jur. 2d, Automobile Insurance, § 20 et seq. 7A Am. Jur. 2d, Automobile Insurance, § 342 et seq.

Am. Jur. Proof of Facts. — "Commercial" Use of an Automobile, 1 POF2d 285.

Insurer's Wrongful Refusal to Settle Within Policy Limits, 6 POF2d 247.

Resident of Household of Named Insured, 13 POF2d 681.

Automobile Insurer's Waiver of Policy Restriction, 27 POF2d 683.

Use of Motor Vehicle by Person Claiming Insurance Coverage, 34 POF2d 585.

Automobile Insurer's Bad Faith in Re-

sponding to First-Party Claim, 3 POF3d 751.

Ineffective Cancellation of Automobile Insurance Policy — Deficient Communication of Cancellation Notice, 10 POF3d 483.

Ineffective Cancellation of Automobile Insurance Policy — Deficient Form or Content of Cancellation Notice, 11 POF3d 131.

Ineffective Cancellation of Automobile Insurance Policy — Deficient Repayment or Render of Unearned Premium, 11 POF3d 227.

"Permissive" Use of Automobile — Grant of Permission to Insured's Permittee, 16 POF3d 433.

"Permissive" Use of Automobile — Delegation of Permission to Second Permittee, 17 POF3d 409.

"Permissive" Use of Automobile — Use Within Scope of Permission Granted, 18 POF3d 433.

Identification of Hit-And-Run Vehicle and Driver, 60 POF3d 91.

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.

Admissibility of evidence as to insurance on issue of negligence in operation or care of automobile, 28 A.L.R. 516.

Constitutionality of compulsory liability insurance legislation as a condition of use of automobile not operated for hire, 39 A.L.R. 1028; 69 A.L.R. 397.

Automobile insurance: pleading and proof as to value, 64 A.L.R. 172.

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.

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.

Automobile liability or indemnity insurance: "omnibus" coverage clause, 126 A.L.R. 544.

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 policy when used for pleasure and business, as including business of insured's employer, 146 A.L.R. 1189.

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.

Risks within "loading and unloading" clause of automobile liability policy, 160 A.L.R. 1259; 95 A.L.R.2d 1122.

Cancellation of compulsory automobile insurance, 171 A.L.R. 550; 34 A.L.R.2d 1297.

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.

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 limits of Financial Responsibility Act, 29 A.L.R.2d 817.

Construction and effect of exclusionary clause in automobile liability policy mak-

ing policy inapplicable while vehicle is used as a "public or livery conveyance," 30 A.L.R.2d 273.

Failure to give notice, or other lack of cooperation by insured, as defense to action against compulsory liability insurer by injured member of the public, 31 A.L.R.2d 645.

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.

Collision insurance: insured's release of tortfeasor before settlement by insurer as releasing insurer from liability, 38 A.L.R.2d 1095.

Risks within "loading and unloading" clause of motor vehicle liability insurance policy, 6 A.L.R.4th 686.

Cancellation of compulsory or "financial responsibility" automobile insurance, 44 A.L.R.4th 13.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

No-fault insurance coverage for injury or death of insured occurring during carjacking or attempted carjacking, 42 A.L.R.5th 727.

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.

33-34-1. Short title.

This chapter shall be known and may be cited as the "Georgia Motor Vehicle Accident Reparations Act."

History. — Code 1981, § 33-34-1, enacted by Ga. L. 1991, p. 1608, § 1.12.

JUDICIAL DECISIONS

Repeal of the No-Fault Act, effective October 1, 1991, did not affect the defendant's right to have the verdict reduced by the amount of the basic no-fault benefits received by the plaintiff. Walker v. Willis, 210 Ga. App. 139, 435 S.E.2d 621 (1993).

Post-accident repeal of former § 33-34-9, providing that the plaintiff could not recover against a tortfeasor damages for which minimum, mandatory no-fault compensation was available, was not retroactively applicable so as to deprive an automobile accident defendant of limitation on liability. Glover v. Colbert, 210 Ga. App. 666, 437 S.E.2d 363 (1993).

Repeal of former O.C.G.A. § 33-34-3 which provided a right of subrogation to recover no-fault benefits paid in certain circumstances did not extinguish those subrogation rights with respect to cases in which the collision occurred prior to repeal of the statute even though the subrogation suit was not brought until after the repeal. Fire & Cas. Ins. Co. v. GEIC, 213 Ga. App. 532, 445 S.E.2d 338 (1994).

ADVISORY OPINIONS OF THE STATE BAR

Contingency fees. — Benefits paid under PIP coverage are assured; thus, the taking of a contingency fee for the filling out of routine, undisputed PIP claim forms is unreasonable and a violation of the Rules of the State Bar of Georgia. An attorney may charge a reasonable fee for the attorney's time spent in processing a PIP claim. Adv. Op. No. 84-37 (January 20, 1984).

In those unusual circumstances when the payment of PIP benefits is not as-

sured, the State Disciplinary Board does not prohibit contingency fees in general. However, the attorney should examine the factors set out in DR 2-106(B) to determine whether a contingent fee arrangement would be reasonable. Adv. Op. No. 84-37 (January 20, 1984).

RESEARCH REFERENCES

ALR. — Automobile liability insurance policy as covering, in the absence of specific exclusion, personal injury to or death of, or loss sustained by, named or additional insured, 15 A.L.R.3d 711.

Validity, construction, and application of "named driver exclusion" in automobile insurance policy, 33 A.L.R.5th 121.

Conflict of laws in determination of coverage under automobile liability insurance policy, 110 A.L.R.5th 465.

Am. Jur. Trials. — Litigating the No-Fault Serious Injury Threshold, 59 Am. Jur. Trials 347.

Representing Automobile Accident Victims, 58 Am. Jur. Trials 283.

33-34-2. Definitions.

As used in this chapter, the term:

(1) "Medical payments coverage" includes any coverage in which the insurer agrees to reimburse the insured and others for reasonable and necessary medical expenses and funeral expenses incurred as a result of bodily injury or death caused by a motor vehicle accident, without regard to the insured's liability for the accident. Coverage shall be available to the named insured, resident spouse, and any resident relative while occupying the covered motor vehicle, and to any other person legally occupying a covered motor vehicle. Expenses must be incurred for services rendered within three years from the date of the accident; provided, however, that nothing shall prevent an insurer from allowing a longer period of time. Any rule or regulation promulgated which expands or conflicts with this definition shall be null and void.

(2) "Motor vehicle" means a vehicle having more than three load-bearing wheels of a kind required to be registered under the laws of this state relating to motor vehicles designed primarily for operation upon the public streets, roads, and highways and driven by power other than muscular power. The term includes a trailer drawn by or attached to such a vehicle and also includes without limitation a low-speed vehicle.

(3) "Owner" means the natural person, corporation, firm, partnership, cooperative, association, group, trust, estate, organization, or other entity in whose name the motor vehicle has been registered. If no registration is in effect at the time of an accident involving the motor vehicle, the term means the natural person, corporation, firm, partnership, cooperative, association, group, trust, estate, organization, or other entity who holds the legal title to the motor vehicle or, in the event the motor vehicle is subject to a security agreement or

lease with an option to purchase with the debtor or the lessee having the right to possession, the term means the debtor or the lessee.

(4) "Self-insurer" means any owner who has on file with the Commissioner an approved plan of self-insurance which provides for coverages, benefits, and efficient claims handling procedures substantially equivalent to those afforded by a policy of automobile liability insurance that complies with all of the requirements of this chapter.

History. — Code 1981, § 33-34-2, enacted by Ga. L. 1991, p. 1608, § 1.12; Ga. L. 1997, p. 683, § 4; Ga. L. 2002, p. 512, § 1; Ga. L. 2019, p. 386, § 111/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" near the beginning of paragraph (4).

Law reviews. — For article, "No-Fault Automobile Insurance In Georgia: Is Revision in Order?", see 27 Ga. St. B.J. 68 (1990).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former O.C.G.A. § 33-34-2, and Ga. L. 1975, p. 1207, §§ 1, 2, are included in the annotations for this Code section.

Farm tractor was "motor vehicle" based on uninsured motorist statute. — Farm tractor towing a mobile home on a county road was a "motor vehicle" for purposes of the uninsured motorist statute, O.C.G.A. § 33-7-11. Hinton v. Interstate Guar. Ins. Co., 267 Ga. 516, 480 S.E.2d 842 (1997).

Ownership upon delivery even without compliance with recording and insurance statutes. — When a seller had delivered possession of the automobile to the buyer and the transaction was complete as between them even though compliance had not yet been made with recording and insurance statutes, the buyer was the "owner" of the automobile, and the buyer alone, and not the seller or the seller's insurer, was liable to a third party for injuries sustained in an accident while the buyer was driving the automobile. American Mut. Fire Ins. Co. v. Cotton States Mut. Ins. Co., 149 Ga. App. 280, 253 S.E.2d 825 (1979) (decided under former Ga. L. 1975, p. 1202, §§ 1, 2).

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).

"Self-insured" who complies with self-insurance law is not financially irresponsible but rather is meeting the state's required minimum, and the self-insurer does not become financially irresponsible just because it chooses the state-permitted option not to insure above the minimum. Nationwide Gen. Ins. Co. v. Parnham, 182 Ga. App. 823, 357 S.E.2d 139 (1987) (decided under former O.C.G.A. § 33-34-2).

Exclusion in a car rental agreement excluding liability coverage for violations of a use restriction pertaining to driving under the influence was invalid to the extent of the mandatory minimum liability coverage. Ryan v. Boyd, 911 F. Supp. 524 (M.D. Ga. 1996).

Declaratory judgment as to whether rental company was self-insurer was improper. — In a widow's wrongful death action against rental truck companies, the widow's declaratory judgment claim under O.C.G.A. § 9-4-2 seeking a determination that the companies did not qualify as self-insurers under O.C.G.A. §§ 33-34-2(4) and 33-34-5.1 and, thus, could be liable for damages under

O.C.G.A. § 33-34-3, should have been dismissed because the widow had no direct relationship with the companies, the widow had only a hypothetical and generalized economic interest, and the widow was not in a position of uncertainty. U-Haul Co. of Arizona v. Rutland, 348 Ga. App. 738, 824 S.E.2d 644 (2019).

No-fault benefits denied for homicide following vehicular abduction. — When the insured automobile was not used to murder the victim nor was the focus of the crime, but was simply used to transport the victim to another state, the use of the vehicle was too remote and attenuated to establish the required causal nexus, such that the spouse was not entitled to a survivor's no-fault benefits. USAA Property & Cas. Ins. Co. v. Wilbur, 207 Ga. App. 57, 427 S.E.2d 49 (1993).

Cited in Georgia Farm Bureau Mut. Ins. Co. v. Martin, 264 Ga. 347, 444 S.E.2d 739 (1994); Hewell v. Walton County, 292 Ga. App. 510, 664 S.E.2d 875 (2008).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions under Ga. L. 1974, p. 113, § 2, are included in the annotations for this Code section.

Legislative intent regarding certification of self-insurers. — Manifest legislative intent, as it appears in the definition of "self-insurer" and as a whole, is for the Department of Public Safety to certify as self-insurers only those owners who undertake to provide reparations on the same terms and conditions as an insurer. 1974 Op. Att'y Gen. No. 74-86 (decided under Ga. L. 1974, p. 113, § 2; but see 1975 Op. Att'y Gen. 75-42).

Self-insurers deemed regulated entities. — Self-insurance funds for automobile liability are regulated entities for purposes of O.C.G.A. § 21-5-30.1. 1994 Op. Att'y Gen. No. 94-20.

RESEARCH REFERENCES

ALR. — Motorcycle as within contract, statute, or ordinance in relation to motor cars, motor-driven cars, etc., 70 A.L.R. 1253.

Insurance against injuring property or person of third person as liability of indemnity insurance, 83 A.L.R. 677; 117 A.L.R. 239.

Trailers as affecting automobile insurance, 31 A.L.R.2d 298; 65 A.L.R.3d 804.

Meaning of "operate" or "being operated" within clause of automobile liability policy limiting its coverage, 51 A.L.R.2d 924.

Automobile insurance: when is a person "occupying" an automobile within meaning of medical payments provision, 42 A.L.R.3d 501.

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.

Who is "named insured" within meaning of automobile insurance coverage, 91 A.L.R.3d 1280.

What constitutes "private passenger automobile" in insurance policy provisions defining risks covered or excepted, 11 A.L.R.4th 475.

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.

33-34-3. Requirements for issuance of policies.

(a)(1) All policies of motor vehicle liability insurance issued in this state must be in accordance with the requirements of this chapter.

Such policies shall contain at least the minimum coverages required under this chapter and shall be issued for a minimum term of six months.

(2) All insurers authorized to transact or transacting insurance in this state or controlling or controlled by or under common control by or with an insurer authorized to transact or transacting insurance in this state which issue policies or contracts providing motor vehicle liability insurance coverage or any other similar coverage in any state or Canadian province shall include in the policies or contracts of insurance a provision which provides at least the minimum liability coverage required under Code Section 33-34-4 with respect to motorists insured under the policies or contracts who are involved in motor vehicle accidents in this state and, notwithstanding any provisions of the policies or contracts to the contrary, all such policies or contracts of insurance shall be deemed to satisfy the minimum requirements of this chapter if a motorist insured under the policies or contracts of insurance is involved in a motor vehicle accident in this state.

(3) Nothing contained in this Code section shall be deemed to prohibit a nonadmitted insurer not otherwise required by paragraph (2) of this subsection to provide the minimum liability coverage required by Code Section 33-34-4 from providing such coverage for its insured motorists who are involved in motor vehicle accidents in this state and, to the extent that such coverage is provided, such policies or contracts shall be deemed to provide the minimum liability coverage required by this chapter.

(4)(A) No insurer shall issue a policy of motor vehicle liability insurance without requiring advance payment for the first 30 days of coverage. Insurers may rely on the insured's statements in the policy application for the purpose of calculating the initial payment required by this paragraph. This paragraph shall not apply to any renewal or continuation of a policy, to any replacement of a policy where there is no lapse of coverage, or to any personal automobile policy issued in connection with an employer sponsored payroll deduction plan. This paragraph shall apply only to personal automobile or family-type automobile liability insurance policies.

(B) If an insurer, agent, or premium finance company collects such advance payment in the form of a check or money order which is not honored upon initial presentation, such insurer, agent, or premium finance company shall be deemed to have complied with subparagraph (A) of this paragraph and may, thereafter, cancel for nonpayment of premium as provided in Code Section 33-24-44.

(b) Nothing in Code Section 33-34-4 shall be construed to prohibit the issuance of policies providing coverage more extensive than the minimum liability coverage required by that Code section.

(c) Policies purporting to satisfy the requirements of Code Section 33-34-4 shall contain a provision which states that, notwithstanding any of the other terms and conditions of the policy, the coverage afforded shall be at least as extensive as the minimum liability coverage required.

(d) Each policy of liability insurance issued in this state providing coverage to motor vehicles owned by a person, firm, or corporation engaged in the business of selling at retail new and used motor vehicles shall provide that, when an accident involves the operation of a motor vehicle by a person who is neither the owner of the vehicle involved in the accident nor an employee of the owner and the operator of the motor vehicle is an insured under a complying policy other than the complying policy insuring the motor vehicle involved in the accident, primary coverage as to all coverages provided in the policy under which the operator is an insured shall be afforded by the liability policy insuring the said operator and any liability policy under which the owner is an insured shall afford excess coverages. If the liability policy under which the owner is an insured and which affords excess coverage contains a provision which eliminates such excess coverage based on the existence of coverage provided in the operator's liability policy, such provision of the owner's liability policy shall be void.

(e) Each policy of motor vehicle liability insurance issued in this state shall provide that the requirement for giving notice of a claim, if not satisfied by the insured within 30 days of the date of the accident, may be satisfied by an injured third party who, as the result of such accident, has a claim against the insured; provided, however, that notice of a claim given by an injured third party to an insurer under this subsection shall be accomplished by mail. Each policy of motor vehicle liability insurance issued or renewed in this state shall be deemed to include and construed as including the provision regarding the notice requirements provided in this subsection.

History. — Code 1981, § 33-34-3, enacted by Ga. L. 1991, p. 1608, § 1.12; Ga. L. 1995, p. 1011, § 8; Ga. L. 2004, p. 430, § 1; Ga. L. 2019, p. 386, § 112/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (e), in the first sentence, deleted "on or after October 1, 1991," following "issued in this state" near the beginning, and inserted "that" following "provided, however," near the end, and deleted "on and after October 1, 1991," following "renewed in this state" in the middle of the second sentence.

Cross references. — Restrictions on right of insurance companies to cancel certification showing proof of financial responsibility for the future, § 40-9-82. Assigned risk plans, self-insurance, and "spot" insurance regarding motor vehicles, § 40-9-100 et seq.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, substituted "employer sponsored" for "employer-sponsored" in the third sentence of subparagraph (a)(4)(A).

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former O.C.G.A. § 33-34-3, and Ga. L. 1974, p. 113, § 5, are included in the annotations for this Code section.

Constitutionality. — Subsection (e) of former Ga. L. 1978, p. 2075, § 1 (see subsection (d) of O.C.G.A. § 33-34-3) was not unconstitutional as being violative of Ga. Const. 1976, Art. III, Sec. VII, Para. IV (see Ga. Const. 1983, Art. III, Sec. V, Para. III). Auto-Owners Ins. Co. v. Safeco Ins. Co. of Am., 245 Ga. 558, 266 S.E.2d 175 (1980) (decided under former Ga. L. 1978, p. 2075, § 1).

Provision that motor vehicle insurance policies issued by insurers authorized to transact business in the state are deemed to provide the minimum coverage required by Georgia law when the insured is involved in an accident in Georgia is shielded from attack under the Commerce Clause by the McCarran-Ferguson Act, 15 U.S.C. § 1011, and the provision does not retroactively impair obligations under the contract or violate equal protection in violation of the Georgia Constitution. Bankers Ins. Co. v. Taylor, 267 Ga. 134, 475 S.E.2d 619 (1996).

Applicability of subsection (e). — Language of subsection (e) of former § 33-34-3 (see now subsection (d) of O.C.G.A. § 33-34-3) did not explicitly or expressly limit the statute's application to situations involving loaners or test-driver vehicles. Standard Guar. Ins. Co. v. Grange Mut. Cas. Co., 182 Ga. App. 842, 357 S.E.2d 295 (1987) (decided under former O.C.G.A. § 33-34-3).

No coverage meant no application of § 33-34-3. — Because the declarations page of an automobile insurance policy unequivocally showed that no liability coverage was purchased for the covered vehicle, O.C.G.A. § 33-34-3 did not apply. Simalton v. AIU Ins. Co., 284 Ga. App. 152, 643 S.E.2d 553 (2007).

Nonowner driving with permission of insured. — Passage of compulsory motor vehicle liability insurance limited application of the "rule of election" by which one who was not the named insured of the policy was covered by the policy only if he or she so elected, so specific election of coverage was no longer required; thus, an insurer could not use a nonowner driver's failure to affirmatively seek coverage under the owner's policy to avoid the policy's contractual obligation and the insurer's liability was not limited to the statutory minimum coverage for compulsory insurance. Georgia Farm Bureau Mut. Ins. Co. v. Martin, 264 Ga. 347, 444 S.E.2d 739 (1994) (decided under former Ga. L. 1978, p. 2075, § 1).

Dealer's insurance is excess when customer has own insurance protection. — O.C.G.A. § 33-34-3 provides, in effect, that every "policy of liability insurance" issued in Georgia providing "coverage" to vehicles owned by automobile dealers shall provide that when an accident involves a loaner (a temporary substitute vehicle furnished by a dealer) driven by a customer and the customer-driver has his or her own insurance protection other than under the dealer's policy, primary coverage as to "all coverages" provided by the driver's policy shall be afforded by that policy, and the dealer's insurance shall be excess. Auto-Owners Ins. Co. v. Safeco Ins. Co. of Am., 245 Ga. 558, 266 S.E.2d 175 (1980).

Insurance coverage on dealer "loaner" vehicle. — Nothing required an insurer to provide excess insurance on a loaner car above the statutory minimum limits but the law required excess coverage in an amount not less than the limits; summary judgment reducing coverage below the limits was error. Hendrix v. Universal Underwriters Ins. Co., 263 Ga. App. 589, 588 S.E.2d 761 (2003).

Statute shifted primary coverage from the dealer's insurer in derogation of the general rule that automobile insurance followed the car; the test-driver's private automobile insurance afforded primary coverage and the dealer-owner's automobile policy afforded excess coverage. Motors Ins. Co. v. Auto-Owners Ins. Co., 251 Ga. App. 661, 555 S.E.2d 37 (2001).

Rental cars. — Operator's insurance was primary and the owner's insurance afforded excess coverage, if any, in the

case of a rental car, even though the operator's policy contained an "excess insurance" clause which stated that any liability insurance provided by the company for a vehicle not owned by the insured should be in excess of any other collectible insurance. Jones v. Wortham, 201 Ga. App. 668, 411 S.E.2d 716, cert. denied, 201 Ga. App. 904, 411 S.E.2d 716 (1991) (decided under former O.C.G.A. § 33-34-3).

Typically, when the owner and the driver are both covered by insurance and one of the policies contains an "excess insurance" clause pertaining to nonownership coverage, the owner's policy is primary and the other policy affords the excess coverage. Jones v. Wortham, 201 Ga. App. 668, 411 S.E.2d 716, cert. denied, 201 Ga. App. 904, 411 S.E.2d 716 (1991) (decided under former O.C.G.A. § 33-34-3).

Declaratory judgment as to whether rental company was self-insurer was improper. — In a widow's wrongful death action against rental truck companies, the widow's declaratory judgment claim under O.C.G.A. § 9-4-2 seeking a determination that the companies did not qualify as self-insurers under O.C.G.A. §§ 33-34-2(4) and 33-34-5.1 and, thus, could be liable for damages under O.C.G.A. § 33-34-3, should have been dismissed because the widow had no direct relationship with the companies, the widow had only a hypothetical and generalized economic interest, and the widow was not in a position of uncertainty. U-Haul Co. of Arizona v. Rutland, 348 Ga. App. 738, 824 S.E.2d 644 (2019).

Coverage for non-designated health-care providers. — Nothing in former O.C.G.A. § 33-34-1 et seq. authorized the self-insurer to condition its statutory obligation to pay no-fault benefits upon the insured's submission of claims for services that had been rendered only by certain designated health-care providers or to exclude no-fault coverage for services that had been rendered by non-designated health-care providers. Oluyole Pius Olukoya v. American Ass'n of Cab Cos., 202 Ga. App. 251, 414 S.E.2d 275 (1991), cert. denied, 202 Ga. App. 907, 414 S.E.2d 275 (1992) (decided under former O.C.G.A. § 33-34-3).

Settlement for the limits as stated in the policy satisfies the exhaustion requirement of O.C.G.A. § 33-24-41.1, even though under the "deemer" statute the tortfeasor's policy is deemed to provide greater coverage. Daniels v. Johnson, 270 Ga. 289, 509 S.E.2d 41 (1998).

When the insured settles a claim with the tortfeasor's liability insurer for the limits stated in the policy, the underinsured motorist carrier may plead and prove the availability of additional available coverage under O.C.G.A. § 33-34-3, and thus have its liability reduced by the amount the plaintiff waived. Daniels v. Johnson, 270 Ga. 289, 509 S.E.2d 41 (1998) (decided under former O.C.G.A. § 33-34-3).

Statutory minimum coverage requirement for an insured's out-of-state policy was not affected by the insured's alleged status as a Georgia resident. Atlanta Cas. Co. v. Gagnon, 174 Ga. App. 452, 330 S.E.2d 390 (1985) (decided under former O.C.G.A. § 33-34-3).

Personal injury protection coverage when policy transaction out-of-state. — When an insured's vehicle was registered in Georgia, but the insured's policy of insurance was solicited, negotiated, issued, and delivered out-of-state, the insurer was required to provide only $5,000 minimum personal injury protection coverage as specified in subparagraph (a)(2) of former O.C.G.A. § 33-34-3. Atlanta Cas. Co. v. Gagnon, 174 Ga. App. 452, 330 S.E.2d 390 (1985) (decided under former O.C.G.A. § 33-34-3).

Out of state accidents involving vehicles in Georgia for over 30 days. — Paragraph (a)(2) of O.C.G.A. § 33-34-3 extends coverage only where the insured is involved in an accident in Georgia, and not to accidents occurring out of state in vehicles which may have been in Georgia for more than 30 days. Spicer v. Old Republic Ins. Co., 204 Ga. App. 67, 418 S.E.2d 422 (1992).

Coverage for damage to vehicle loaned by automobile dealer not required. — Public policy does not require that an insurer provide primary coverage for damage to a vehicle loaned to insured by an automobile dealer when the insurance policy provides only for liability cov-

erage and not for collision coverage. Barfield v. Allstate Ins. Co., 172 Ga. App. 882, 324 S.E.2d 731 (1985) (decided under former O.C.G.A. § 33-34-3).

Insurance clause exempting company from liability if insured avoiding arrest. — Clause in an automobile liability policy exempting insurance company from liability if the automobile is involved in an accident occurring while an insured is attempting to avoid apprehension or arrest is void as against public policy, but only to the extent of insurance required by the compulsory insurance law at the time of the collision. Cotton States Mut. Ins. Co. v. Neese, 254 Ga. 335, 329 S.E.2d 136 (1985).

Pedestrian motorist. — O.C.G.A. § 33-34-3 does not refer only to those individuals actually riding in motor vehicles at the time the accident involving a motor vehicle occurs so that the estate of an insured who had stopped to make a telephone call and was killed by a truck upon the insured's return to the insured's vehicle was properly a motorist. Green v. State Farm Ins. Cos., 206 Ga. App. 478, 426 S.E.2d 3 (1992).

Subrogation rights of no-fault insurer under former law. — Under former no-fault statutes, the no-fault insurer of a motorist injured in an automobile accident did not waive the insurer's subrogation rights against the tortfeasor by failing to intervene in the insured's tort action. Southern Gen. Ins. Co. v. National Union Fire Ins. Co., 218 Ga. App. 400, 461 S.E.2d 574 (1995).

Secondary insurer not liable. — Car dealer's insurance was secondary under O.C.G.A. § 33-34-3(d), and no underinsured motorist (UM) benefits were paid to an injured party driving a car belonging to a car dealership, after stacking the UM coverages, when the injured party's own policy's UM benefits were sufficient to cover the liability limit set by the tortfeasor's policy. Crouch v. Federated Mut. Ins. Co., 257 Ga. App. 604, 571 S.E.2d 574 (2002).

Cited in Green v. State Farm Ins. Cos., 206 Ga. App. 478, 426 S.E.2d 3 (1992); Canal Indem. Company/Strickland Gen. Agency, Inc. v. Allstate Ins. Co., 207 Ga. App. 69, 427 S.E.2d 66 (1993); Mathews v. Continental Cas. Co., 228 Ga. App. 666, 492 S.E.2d 535 (1997).

RESEARCH REFERENCES

ALR. — Automobile insurance: pleading and proof as to value, 64 A.L.R. 172.

Liability or indemnity insurance as regards accident as "accident insurance," 77 A.L.R. 1416.

Liability insurance: insurer's assumption of, or continuation in, defense of action brought against the assured waiver, or estoppel, as regards defense of noncoverage, or other defense existing at time of accident, 81 A.L.R. 1326; 38 A.L.R.2d 1148.

Liability insurance: limitation of time within which to sue insurer, 83 A.L.R. 748.

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.

Liability of insurer based upon its act of withdrawal after assumption of defense, 167 A.L.R. 243.

Waiver by insurance company of right to subrogation, 16 A.L.R.2d 1269.

Right to subrogation, as against primary insurer, of liability insurer providing secondary insurance, 31 A.L.R.2d 1324.

Rights and remedies of insurer paying loss as against insured who has released or settled with third person responsible for loss, 51 A.L.R.2d 697.

Apportionment of liability between automobile liability insurers where one of the policies has an "excess insurance" clause and the other a "proportionate" or "pro rata" clause, 76 A.L.R.2d 502.

Liability insurer's rights and duties as to defense and settlement as affected by its having issued policies covering parties who have conflicting interests, 18 A.L.R.3d 482.

Subrogation rights of insurer under medical payments provision of automobile insurance policy, 19 A.L.R.3d 1054.

Validity and effect of "loan receipt"

agreement between injured party and one tortfeasor, for loan repayable to extent of injured party's recovery from a cotort-feasor, 62 A.L.R.3d 1111.

When does statute of limitations begin to run upon an action by subrogated insurer against third-party tortfeasor, 91 A.L.R.3d 844.

Druggist's civil liability for injuries sustained as result of negligence in incorrectly filling drug prescriptions, 3 A.L.R.4th 270.

Liability insurer's postloss conduct as waiver of, or estoppel to assert, "no-action" clause, 68 A.L.R.4th 389.

Application of automobile insurance "entitlement" exclusion to family member, 25 A.L.R.5th 60.

33-34-3.1. Filing of rates and forms; optional coverage.

(a) All insurers writing private passenger automobile insurance in this state shall file rates and forms for medical payments coverage for a limit of at least $2,000.00 but may file rates for higher or lower limits. The requirement for filing forms and rates under this subsection shall not be construed as a requirement for the offering or quoting of medical payment coverages to insureds or as authority for the Commissioner to require the offering or quoting of such coverage.

(b) Insurers may offer other optional coverage including combinations of sublimits and interests restricted to named insureds and resident relatives. Insurers may make collision, comprehensive, and loss of use coverages available as separate individual coverages and subject to differing levels of deductibles at the request of the policyholder.

(c) Any rule or regulation promulgated which expands or conflicts with this Code section shall be null and void.

History. — Code 1981, § 33-34-3.1, enacted by Ga. L. 1997, p. 683, § 5; Ga. L. 1998, p. 1064, § 11.

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

JUDICIAL DECISIONS

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 the 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).

33-34-4. Owner required to provide coverage.

No owner of a motor vehicle required to be registered in this state or any other person, other than a self-insurer as defined in this chapter, shall operate or authorize any other person to operate the motor vehicle unless the owner has motor vehicle liability insurance equivalent to that required as evidence of security for bodily injury and property

damage liability under Chapter 9 of Title 40, the "Motor Vehicle Safety Responsibility Act."

History. — Code 1981, § 33-34-4, enacted by Ga. L. 1991, p. 1608, § 1.12.

Cross references. — Requirements of motor vehicle liability policies, § 33-7-11. Minimum amounts of liability insurance coverage required under motor vehicle safety responsibility laws, § 40-9-37.

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).

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under Ga. L. 1974, p. 113, § 3; Ga. L. 1975, p. 1202, § 3; and former O.C.G.A. § 33-34-4 are included in the annotations for this Code section.

Constitutionality. — Mandatory requirement of insurance coverage is not unconstitutional as violative of due process or First Amendment rights, or as an unlawful exercise of policy power by the state. Williams v. Kennedy, 240 Ga. 163, 240 S.E.2d 51 (1977) (decided under former Ga. L. 1975, p. 1202, § 3).

Onus to procure insurance is put on the owner, and others are prohibited from operating the vehicle until that is done. Integon Indem. Corp. v. Canal Ins. Co., 256 Ga. 692, 353 S.E.2d 186 (1987) (decided under former O.C.G.A. § 33-34-4).

Willful injury. — Because any driver may be involved in an accident and such an accident may be determined to be the fault of such driver, the intentional act of driving without insurance coupled with negligent driving inflicts both a physical and economic injury, and the economic injury is a willful one. In re Whipple, 138 Bankr. 137 (Bankr. S.D. Ga. 1991) (decided under former O.C.G.A. § 33-34-4).

Language referring to minimum coverage. — Payment received by the plaintiff from the plaintiff's own insurer, under optional coverage or additional personal injury protection authorized by this section, is in no way controlled by the language referring to a minimum insurance coverage in this section. City Council v. Lee, 153 Ga. App. 94, 264 S.E.2d 683 (1980) (decided under former O.C.G.A. § 33-34-4).

Policy limiting coverage to vehicles owned by the insured or temporary substitutes used while the insured's vehicle was being repaired met the requirements of former O.C.G.A. § 33-34-4. Integon Indem. Corp. v. Canal Ins. Co., 256 Ga. 692, 353 S.E.2d 186 (1987) (decided under former O.C.G.A. § 33-34-4).

Exclusion limiting liability coverage for bodily injury to the named insured or any family member to the liability limits required by law did not violate public policy. Georgia Farm Bureau Mut. Ins. Co. v. Burch, 222 Ga. App. 749, 476 S.E.2d 62 (1996); Cotton States Mut. Ins. Co. v. Coleman, 242 Ga. App. 531, 530 S.E.2d 229 (2000).

"Business use" exclusion void. — Automobile policy exclusion for the insured using a vehicle "while employed or otherwise engaged in any business" was void as against public policy to the extent of the mandatory monetary requirements in effect at the time of the collision. Federated Mut. Ins. Co. v. Dunton, 213 Ga. App. 148, 444 S.E.2d 123 (1994).

Vehicle operated without employer's permission. — Trial court was correct in granting summary judgment in favor of the insurer when, at the time of the injury, the employee was not merely operating the vehicle for the employee's own personal use without the employer's express or implied permission, the employee was operating the vehicle in contravention of the employer's express direction that the vehicle was only to be used for business and not for personal purposes. Lunceford v. Integral Ins. Co., 204 Ga. App. 730, 420 S.E.2d 389 (1992).

Named driver exclusion valid. — No language in O.C.G.A. § 33-34-4 prohib-

ited named driver exclusion disallowing coverage for insured's spouse, nor was the contested provision violative of public policy, such that the trial court's conclusion that the provision was unenforceable was erroneous. Progressive Preferred Ins. Co. v. Browner, 209 Ga. App. 544, 433 S.E.2d 401 (1993).

Coverage for damage to vehicle loaned by automobile dealer not required. — Public policy does not require that an insurer provide primary coverage for damage to a vehicle loaned to an insured by an automobile dealer when the insurance policy provides only for liability coverage and not for collision coverage. Barfield v. Allstate Ins. Co., 172 Ga. App. 882, 324 S.E.2d 731 (1985) (decided under former O.C.G.A. § 33-34-4).

Recoverable accrued income. — Employee is entitled to recover the amount of the accrued income that the employee can prove with reasonable certainty would have been paid if not for the employee's injury. Vlahos v. Sentry Ins. Co., 262 Ga. 737, 426 S.E.2d 350 (1993).

"Radius of use" exclusion in a business automobile policy was not void as violative of public policy since it applied to a comprehensive coverage claim for loss by theft, not to the liability coverage. Empire Fire & Marine Ins. Co. v. Dobbins, 205 Ga. App. 700, 423 S.E.2d 396, cert. denied, 205 Ga. App. 900, 423 S.E.2d 396 (1992).

Rental cars. — Language in an automobile rental agreement stating that the lessor "furnishes no insurance whatsoever to the renter" did not exempt the lessor from providing liability insurance for injury to third parties. Jones v. Wortham, 201 Ga. App. 668, 411 S.E.2d 716, cert. denied, 201 Ga. App. 904, 411 S.E.2d 716 (1991).

O.C.G.A. § 40-9-102, which provides that lessees from U-drive-it agencies furnish their own insurance, does not completely exempt the agencies from the agencies' duty to procure liability insurance as owners of vehicles pursuant to the insurance law. Jones v. Wortham, 201 Ga. App. 668, 411 S.E.2d 716, cert. denied, 201 Ga. App. 904, 411 S.E.2d 716 (1991).

Even though a car rental agreement stated that coverage limits were those imposed by the state financial responsibility law where the accident occurs, the rental company could not claim entitlement to such limits when the company failed to comply with requirements that the company's limitations of coverage be specified in the company's self-insurance plan filed with the commissioner of insurance. Ryan v. Boyd, 911 F. Supp. 524 (M.D. Ga. 1996).

Although rental car companies, such as the vehicle owner, were required to insure cars the companies owned, the companies enjoyed special treatment on cars rented to the public in that the renter's liability insurance coverage was primary and the rental company's liability insurance coverage was secondary; thus, the insurer's coverage on the vehicle its insured, the company employee, rented was primary insurance in a case where the company employee was involved in a collision with the injured victim, the insurer settled with the injured victim, and the insurer argued the vehicle owner's insurance coverage was primary as the insurer did not show the insurer and vehicle owner had contracted to change the priority of coverage. Zurich Am. Ins. Co. v. General Car & Truck Leasing Sys., 258 Ga. App. 733, 574 S.E.2d 914 (2002).

Priority of payment of no-fault benefits. — This section does not specify the order in which the no-fault benefits it requires shall be paid. In the absence of any direction by the General Assembly, the parties are free to contract regarding the priority of payment of required no-fault benefits. Ryan v. State Farm Mut. Auto. Ins. Co., 261 Ga. 869, 413 S.E.2d 705 (1992).

Insurance clause exempting company from liability if insured avoiding arrest. — Clause in an automobile liability policy exempting insurance company from liability if the automobile is involved in an accident occurring while insured is attempting to avoid apprehension or arrest is void as against public policy, but only to the extent of insurance required by the compulsory insurance law at the time of the collision. Cotton States Mut. Ins. Co. v. Neese, 254 Ga. 335, 329 S.E.2d 136 (1985).

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).

Charging terms of statute to jury. — It was not error for the trial court to charge the jury on the provisions of coverage requirements under the Motor Vehicle Accident Reparations Act rather than terms of the insurance plan since the plan referenced the statute and conformed to the dictates thereof. American Ass'n of Cab Cos. v. Egeh, 205 Ga. App. 228, 421 S.E.2d 741, cert. denied, 205 Ga. App. 899, 421 S.E.2d 741 (1992).

Summary adjudication proper. — Where there was an absence of evidence supporting the plaintiffs' claim that the defendant did not comply with O.C.G.A § 33-34-5, summary adjudication was proper as a matter of law. Sagnibene v. Budget Rent-A-Car Sys., 209 Ga. App. 44, 432 S.E.2d 639 (1993).

Cited in Homick v. American Cas. Co., 209 Ga. App. 156, 433 S.E.2d 318 (1993); Guinn Transp., Inc. v. Canal Ins. Co., 234 Ga. App. 235, 507 S.E.2d 144 (1998); Scott v. Joe Thomson Auto Rental & Leasing, Inc., 257 Ga. App. 453, 571 S.E.2d 475 (2002); Auto-Owners Ins. Co. v. Hale Haven Props., 346 Ga. App. 39, 815 S.E.2d 574 (2018).

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions under Ga. L. 1975, p. 1202, § 3, are included in the annotations for this Code section.

Law enforcement officers may stop and check drivers for proof of insurance, and may utilize the failure to produce such proof to trigger a requirement that such proof be provided within a reasonable time to avoid a citation for no insurance; but no citations may be issued for failure to produce proof of insurance on the spot. 1980 Op. Att'y Gen. No. U80-18 (decided under Ga. L. 1975, p. 1202, § 3).

RESEARCH REFERENCES

ALR. — Constitutionality of compulsory liability insurance legislation as a condition of use of automobile not operated for hire, 69 A.L.R. 397.

Validity and construction of provision of automobile policy against encumbrances, 16 A.L.R.2d 736.

Conflict of laws as to right of injured person to maintain direct action against tortfeasor's automobile liability insurer, 16 A.L.R.2d 881.

Trailers as affecting automobile insurance, 31 A.L.R.2d 298; 65 A.L.R.3d 804.

What constitutes "private passenger automobile" in insurance policy provisions defining risks covered or excepted, 11 A.L.R.4th 475.

Combining or "stacking" medical payment provisions of automobile liability policy or policies issued by one or more insurers to different insureds, 25 A.L.R.4th 66.

Cancellation of compulsory or "financial responsibility" automobile insurance, 44 A.L.R.4th 13.

Validity, construction, and application of "named driver exclusion" in automobile insurance policy, 33 A.L.R.5th 121.

33-34-5. Vehicle not to be licensed until proof of insurance furnished.

Reserved. Repealed by Ga. L. 2003, p. 261, § 7, effective May 28, 2003.

Editor's notes. — This Code section was based on Code 1981, § 33-34-5, enacted by Ga. L. 1991, p. 1608, § 1.12; Ga. L. 2003, p. 140, § 33.

For present comparable provisions, see O.C.G.A. § 40-2-26.

33-34-5.1. Self-insurers.

(a)(1) Except as otherwise provided in paragraphs (2) and (3) of this subsection, any person in whose name one or more vehicles are registered in this state may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such person, issue such a certificate when he or she is satisfied that such person has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter.

(2) Except as otherwise provided in paragraph (3) of this subsection with regard to taxicabs, any person who operates one or more vehicles for hire which transport passengers and in whose name a certificate of title has been issued pursuant to Chapter 3 of Title 40 on one or more such vehicles may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such person, issue such a certificate when he or she is satisfied that such person has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter.

(3)(A) As used in this paragraph, the term "taxicab" means a motor vehicle used to transport passengers for a fare and which is fitted with a taximeter to compute such fare.

(B) Any person who operates 25 or more taxicabs and in whose name such vehicles are registered may qualify as a self-insurer by obtaining a certificate of self-insurance from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such person, issue such a certificate when he or she is satisfied that such person has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter. A person who operates fewer than 25 taxicabs and in whose name such vehicles are registered shall not be allowed to qualify as a self-insurer with regard to such vehicles.

(C) To qualify for a certificate of self-insurance under subparagraph (B) of this paragraph, a person shall maintain with the

Commissioner a cash deposit of at least $100,000.00 and shall also possess and thereafter maintain an additional amount of at least $300,000.00 which shall be invested in the types of assets described in subparagraphs (A) through (H) of paragraph (3) of Code Section 33-11-5 and Code Sections 33-11-10, 33-11-14.1, 33-11-20, 33-11-21, and 33-11-25, which relate to various types of authorized investments for insurers.

(D) Each year, a person operating as a self-insurer pursuant to this paragraph shall submit to the Commissioner, on forms prescribed by the Commissioner, reports of the business affairs and operations of the self-insurer in the same manner as required of insurers pursuant to Code Section 33-3-21. A person operating as a self-insurer pursuant to this paragraph shall also submit to the Commissioner an annual financial statement audited by an independent certified public accountant. The value of any asset listed in any report required by this subparagraph shall be limited to the equity interest of the person operating as a self-insurer pursuant to this paragraph.

(E) Any person operating as a self-insurer pursuant to this paragraph shall be subject to examination and proceedings in the same manner applicable to insurers transacting motor vehicle insurance in this state as provided in Chapter 2 of this title and shall maintain reserves for losses in the same manner as insurers transacting motor vehicle insurance as provided in Chapter 10 of this title.

(F) Until December 31, 2003, the provisions of subparagraph (C) of this paragraph shall not apply to taxicab self-insurers which were located in counties with populations of 400,000 or less according to the United States decennial census of 1990 or any future such census and were licensed by the Commissioner on December 31, 1998.

(b)(1) In addition to the persons described in subsection (a) of this Code section, a religious organization that meets the requirements of this subsection may qualify as a self-insurer for motor vehicle liability insurance for all motor vehicles registered in this state that are owned or leased by members of such religious organization that obtains a certificate from the Commissioner. The Commissioner may, in his or her discretion, upon the application of such religious organization, issue a certificate when he or she is satisfied that such religious organization meets the qualifications of this subsection and has and will continue to have the ability to provide coverages, benefits, and claims-handling procedures substantially equivalent to those afforded by a policy of vehicle insurance in compliance with this chapter.

(2) In addition to any other rules or regulations established by the Commissioner, a religious organization seeking to obtain a certificate under the provisions of this subsection shall meet the following qualifications:

(A) The religious organization shall be a recognized sect or division of a recognized religious group having established tenets or teachings and shall have remained in existence continuously since December 31, 1950, and whose members hold a common belief in mutual financial assistance in time of need;

(B) The religious organization shall be a recognized sect or division of a religious group which has been a recognized religious group for purposes of exemption from federal social security and medicare taxes since December 31, 1970; and

(C) The religious organization has filed with the Commissioner the required minimum security. The required minimum security shall in no event be less than the following amounts:

Number of Vehicles	Required Security
1-50	$150,000.00
51-100	$200,000.00
101-150	$300,000.00
151-200	$350,000.00
201-250	$400,000.00
251-350	$500,000.00
351 or more	$600,000.00

(3) The only forms of acceptable required minimum security shall be rendered in one or more of the following:

(A) United States currency placed as collateral with the Commissioner;

(B) Irrevocable letters of credit valid for a period of at least 24 months and renewable every 12 months and issued by a financial institution chartered by an agency of this state or the federal government; or

(C) Bonds or other negotiable obligations issued by this state, or a subdivision or instrumentality of this state, if not in default as to principal or interest.

(4) A certificate issued pursuant to this subsection shall be valid for a period of 12 months and may be renewed upon the religious organization's filing of an appropriate application, including a report of all claims incurred during the preceding calendar year, the number of covered motor vehicles, and proof that the organization continues to meet the requirements of this subsection. If, based upon the

number of claims incurred by the organization during the preceding calendar year or the number of covered motor vehicles, the Commissioner determines that the required minimum security under this subsection is inadequate, the Commissioner may require additional minimum security or reports, or both.

(c) Upon a determination that any self-insurer, including a religious organization granted a certificate pursuant to subsection (b) of this Code section, has failed to pay on any valid claim within 30 days of its submission or has failed to satisfy any judgment within 30 days after such judgment shall become final, the Commissioner shall revoke such insurer's certificate. The Commissioner may on reasonable grounds cancel a certificate of self-insurance, including a certificate granted pursuant to subsection (b) of this Code section, and is authorized to promulgate rules and regulations prescribing such grounds for the cancellation of such certificates.

History. — Ga. L. 1951, p. 565, § 16; Ga. L. 1956, p. 543, § 20; Ga. L. 1963, p. 593, § 10; Code 1933, § 68C-602, enacted by Ga. L. 1977, p. 1014, § 1; Code 1981, § 40-9-101; Ga. L. 1985, p. 989, § 1; Ga. L. 1988, p. 1488, § 1; Ga. L. 1994, p. 1931, § 2; Ga. L. 1995, p. 1060, § 1; Ga. L. 1995, p. 1348, § 9; Ga. L. 1996, p. 1079, § 2; Ga. L. 1997, p. 1042, § 2; Ga. L. 1998, p. 1205, § 1; Ga. L. 1999, p. 560, § 1A; Ga. L. 2000, p. 1246, § 15; Code 1981, § 33-34-5.1, as redesignated by Ga. L. 2000, p. 1246, § 16; Ga. L. 2010, p. 100, § 1/HB 656; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2019, p. 386, § 113/SB 133.

The 2019 amendment, effective July 1, 2019, in subparagraph (a)(3)(C), substituted "To" for "Except as otherwise provided in subparagraph (D) of this paragraph, on or after July 1, 1994, to" at the beginning, inserted "of paragraph (3)" in the middle; deleted former subparagraph (a)(3)(D), which read: "Any person operating as a self-insurer pursuant to a certificate of self-insurance issued prior to July 1, 1994, shall be allowed a transition period in which to meet the requirements of subparagraph (C) of this paragraph; provided, however, that, except as provided in subparagraph (G) of this paragraph, on and after December 31, 1995, all self-insurers under this paragraph shall comply fully with the requirements of subparagraph (C) of this paragraph. The Commissioner shall promulgate rules and regulations relative to the transition period for compliance provided in this subparagraph."; redesignated former subparagraphs (a)(3)(E) through (a)(3)(G) as present subparagraphs (a)(3)(D) through (a)(3)(F), respectively; and substituted "Each year," for "Beginning July 1, 1994, and each year thereafter," at the beginning of subparagraph (a)(3)(D).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, "claims-handling" was hyphenated in paragraphs (a)(1) and (a)(2).

Pursuant to Code Section 28-9-5, in 1996, "that, except" was substituted for "that except" in the first sentence of subparagraph (a)(3)(D) and "(C)" was substituted for "(c)" in subparagraph (a)(3)(G).

Editor's notes. — Ga. L. 2000, p. 1246, §§ 15 and 16, effective July 1, 2000, amended and then redesignated as this Code section the former provisions of Code Section 40-9-101.

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

Equivalent of insurance policy. — 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).

Co-owner is not co-insurer. — Despite the fact that the driver was also the co-owner of the cab, the driver did not necessarily occupy the status of a co-self-insurer and the driver could occupy the status of an insured under the other co-owner's plan of self-insurance. Oluyole Pius Olukoya v. American Ass'n of Cab Cos., 202 Ga. App. 251, 414 S.E.2d 275 (1991), cert. denied, 202 Ga. App. 907, 414 S.E.2d 275 (1992).

Only one co-owner as self-insurer. — Nothing in paragraph (a)(2) of O.C.G.A. § 33-34-5.1 prohibits only one of the joint owners of a vehicle from seeking to secure a certificate of self-insurance solely in one's name or compels all of the joint owners collectively to seek to secure a certificate of self-insurance in all the owners' names. Oluyole Pius Olukoya v. American Ass'n of Cab Cos., 202 Ga. App. 251, 414 S.E.2d 275 (1991), cert. denied, 202 Ga. App. 907, 414 S.E.2d 275 (1992).

Nothing in paragraph (a)(2) of O.C.G.A. § 33-34-5.1 prohibits the commissioner from issuing a certificate of self-insurance to only one of the joint owners of a vehicle or compels the commissioner to issue a certificate of self-insurance to all of the joint owners collectively. Oluyole Pius Olukoya v. American Ass'n of Cab Cos., 202 Ga. App. 251, 414 S.E.2d 275 (1991), cert. denied, 202 Ga. App. 907, 414 S.E.2d 275 (1992).

Option to insure only for minimum. — Self-insured who complies with the self-insurance law and O.C.G.A. § 33-34-5.1 is not financially irresponsible but rather is meeting the state's required minimum, and the self-insurer does not become financially irresponsible just because the self-insurer chooses the state-permitted option not to insure above the minimum. Nationwide Gen. Ins. Co. v. Parnham, 182 Ga. App. 823, 357 S.E.2d 139 (1987).

Defendant met requirements for self-insurer. — When the plaintiff's cab was registered in the names of both the plaintiff and the defendant, the defendant met the requirements for a self-insurer under the law in effect at the relevant time. 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).

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 the owners' 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).

Exclusion in a car rental agreement excluding liability coverage for violations of a use restriction pertaining to driving under the influence was invalid to the extent of the mandatory minimum liability coverage. Ryan v. Boyd, 911 F. Supp. 524 (M.D. Ga. 1996).

Exclusions from a policy of self-insurance contained in a car rental agreement were not required to be listed in the car rental agency's self-insurance plan filed with the insurance commissioner under O.C.G.A. § 33-34-5.1(a)(1). Hix v. Hertz Corp., 307 Ga. App. 369, 705 S.E.2d 219 (2010).

Declaratory judgment as to whether rental company was self-insurer was improper. — In a widow's wrongful death action against rental truck companies, the widow's declaratory judgment claim under O.C.G.A. § 9-4-2 seeking a determination that the companies did not qualify as self-insurers under O.C.G.A. §§ 33-34-2(4) and 33-34-5.1 and, thus, could be liable for damages under O.C.G.A. § 33-34-3, should have been dismissed because the widow had no direct relationship with the companies, the widow had only a hypothetical and generalized economic interest, and the widow

was not in a position of uncertainty. U-Haul Co. of Arizona v. Rutland, 348 Ga. App. 738, 824 S.E.2d 644 (2019).

Cited in Atlanta Metro Taxicab Group, Inc. v. Bekele, 154 Ga. App. 831, 269 S.E.2d 902 (1980); Commercial Union Ins. Co. v. Insurance Co. of N. Am., 155 Ga. App. 786, 273 S.E.2d 24 (1980); Eubanks v. Rhodes, Inc., 169 Ga. App. 731, 315 S.E.2d 9 (1984); Brantley v. Edwards, 197 Ga. App. 713, 399 S.E.2d 215 (1990).

RESEARCH REFERENCES

ALR. — Automobile liability insurance, 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.

Applicability of uninsured motorist statutes to self-insurers, 27 A.L.R.4th 1266.

33-34-6. Selection of motor vehicle repair facility.

(a) Subject to the provisions of subsection (b) of this Code section, no insurer shall represent to a person making a claim under a motor vehicle insurance policy that the use of or the failure to use a particular repair facility or particular repair facilities may result in the nonpayment of a claim.

(b) No insurer shall require a person making a claim under a motor vehicle insurance policy to use a particular repair facility or particular repair facilities in order to settle a claim if the person making the claim can obtain the repair work on the motor vehicle at the same cost from another source.

History. — Code 1981, § 33-34-6, enacted by Ga. L. 1991, p. 1608, § 1.12; Ga. L. 1992, p. 2464, § 2; Ga. L. 1999, p. 834, § 2.

Law reviews. — For annual survey of insurance law, see 56 Mercer L. Rev. 253 (2004).

JUDICIAL DECISIONS

No private cause of action. — Dismissal of an auto repair shop's claim against an insurance company for violation of the Georgia Motor Vehicle Accident Reparations Act, O.C.G.A. § 33-34-1 et seq., was appropriate because there was no private cause of action under O.C.G.A. § 33-34-6. State Farm Mut. Auto. Ins. Co. v. Hernandez Auto Painting & Body Works, 312 Ga. App. 756, 719 S.E.2d 597 (2011).

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 grounds for denial of claim: risks, causes, and extent of loss, injury, disability, or death, 123 A.L.R.5th 259.

33-34-7. Continuation of coverage upon death of named insured or termination of marital relationship.

Upon the death of or termination of the marital relationship of a named insured under a personal lines policy of insurance covering a private passenger motor vehicle, a spouse of said named insured who was covered under said policy of insurance immediately prior to the death or termination of the marital relationship shall upon notice to the insurer or agent of the insurer continue to be covered under said policy for a period of 90 days following such death or termination of marital relationship or until the expiration of the policy term, whichever is shorter. Every personal lines policy of insurance covering a private passenger motor vehicle shall contain a provision providing the coverage required by this Code section; and in the absence of such a provision in such a policy the policy shall be deemed to contain such a provision.

History. — Code 1981, § 33-34-7, enacted by Ga. L. 1991, p. 1608, § 1.12.

Law reviews. — For annual survey on insurance, see 61 Mercer L. Rev. 179 (2009).

JUDICIAL DECISIONS

Cited in Green v. State Farm Ins. Cos., 206 Ga. App. 478, 426 S.E.2d 3 (1992).

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 grounds for denial of claim: risks, causes, and extent of loss, injury, disability, or death, 123 A.L.R.5th 259.

33-34-8. Rules and regulations.

The Commissioner shall provide by rule or regulation procedures for the expeditious and efficient settlement of first-party property damage claims under personal private passenger motor vehicle policies. Such procedures may include, but shall not be limited to:

(1) Loss of use reimbursements;

(2) Cost of repairs;

(3) Determination of fair market value on total losses;

(4) Use of aftermarket parts;

(5) Time limitations for payments of claims for property damage by insureds; and

(6) Establishment of a panel for arbitration of disputed property damage claims where such claims involve total losses.

History. — Code 1981, § 33-34-8, enacted by Ga. L. 1991, p. 1608, § 1.12.

JUDICIAL DECISIONS

Conditional payment of benefit. — Insurance company's conditional payment of Georgia's basic no-fault benefits in an effort to settle litigation did not constitute an admission that Georgia no-fault insurance provisions applied, or an admission of liability or bad faith. Johnson v. Occidental Fire & Cas. Co., 954 F.2d 1581 (11th Cir. 1992).

33-34-9. Proceeds of insurance policy; limited access by insurers to records.

(a) Notwithstanding any other provision of law, in any claim involving a total loss of a vehicle which is subject to more than one lien, the proceeds of an insurance policy shall be applied to pay in full the debt owed to the senior lienholder before any proceeds of an insurance policy shall be applied to any other lien on the vehicle.

(b) For the purpose of implementing this Code section, at the discretion of the state revenue commissioner, an insurer may be granted access via electronic means to individual motor vehicle records. Any such access shall be in accordance with Code Section 40-3-23, and the Department of Revenue shall establish the application and approval process before allowing any such access. The information provided to an insurer pursuant to this Code section shall be limited to the verification of the vehicle owner's name, vehicle information, and any recorded security interests or liens as shown on the records of the Department of Revenue.

History. — Code 1981, § 33-34-9, enacted by Ga. L. 2002, p. 848, § 1; Ga. L. 2005, p. 334, § 13-2/HB 501.

Cross references. — Payment of proceeds of insurance policy where multiple liens on vehicle, § 40-3-61.

OPINIONS OF THE ATTORNEY GENERAL

Access to information in Registration and Title Information System. — The Department of Revenue is authorized to provide access to the information contained in the Georgia Registration and Title Information System only for the purposes mandated by the Driver's Privacy Protection Act of 1994, 18 U.S.C. § 2721 et seq., or to those state agencies designated in O.C.G.A. §§ 33-34-9, 40-2-130(c), and 40-3-23(d). 2008 Op. Att'y Gen. No. 2008-2.

CHAPTER 34A

VEHICLE PROTECTION PRODUCT WARRANTIES

Sec.
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RESEARCH REFERENCES

Am. Jur. 2d. — 67A Am. Jur. 2d, Sales, § 625 et seq.

C.J.S. — 21 C.J.S., Credit Reporting Agencies; Consumer Protection, § 60. 46 C.J.S., Insurance, §§ 1397, 1398.

33-34A-1. Short title.

This chapter shall be known and may be cited as the "Georgia Vehicle Protection Product Act."

History. — Code 1981, § 33-34A-1, enacted by Ga. L. 2003, p. 644, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "chapter" was substituted for "Act".

33-34A-2. Definitions.

As used in this chapter, the term:

(1) "Administrator" means a third party other than the warrantor who is designated by the warrantor to be responsible for the administration of vehicle protection product warranties.

(2) "Department" means the Department of Insurance.

(3) "Service contract" means a contract or agreement as defined under Code Section 33-7-6.

(4) "Incidental costs" means expenses specified in the warranty incurred by the warranty holder related to the failure of the vehicle protection product to perform as provided in the warranty. Incidental costs may include, without limitation, insurance policy deductibles, rental vehicle charges, the difference between the actual value of the stolen vehicle at the time of theft and the cost of a replacement vehicle, sales taxes, registration fees, transaction fees, and mechanical inspection fees.

(5) "Vehicle protection product" means a vehicle protection device, system, or service that:

(A) Is installed on or applied to a vehicle;

(B) Is designed to prevent loss or damage to a vehicle from a specific cause; and

(C) Includes a written warranty.

For purposes of this chapter, the term "vehicle protection product" shall include, without limitation, alarm systems, body part marking products, steering locks, window etch products, pedal and ignition locks, fuel and ignition kill switches, and electronic, radio, and satellite tracking devices.

(6) "Vehicle protection product warranty" or "warranty" means, for the purposes of this chapter, a written agreement by a warrantor that provides that if the vehicle protection product fails to prevent loss or damage to a vehicle from a specific cause, then the warranty holder shall be paid specified incidental costs by the warrantor as a result of the failure of the vehicle protection product to perform pursuant to the terms of the warranty.

(7) "Vehicle protection product warrantor" or "warrantor" for the purposes of this chapter means a person who is contractually obligated to the warranty holder under the terms of the vehicle protection product warranty agreement. "Warrantor" does not include an authorized insurer.

(8) "Warranty holder" for the purposes of this chapter means the person who purchases a vehicle protection product or who is a permitted transferee.

(9) "Warranty reimbursement insurance policy" means a policy of insurance that is issued to the vehicle protection product warrantor to provide reimbursement to the warrantor or to pay on behalf of the warrantor all covered contractual obligations incurred by the war-

rantor under the terms and conditions of the insured vehicle protection product warranties sold by the warrantor.

History. — Code 1981, § 33-34A-2, enacted by Ga. L. 2003, p. 644, § 1; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 386, § 114/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in paragraph (2); deleted former paragraph (3), which read: "'Commissioner' means the Commissioner of Insurance."; and redesignated former paragraphs (4) through (10) as present paragraphs (3) through (9), respectively.

33-34A-3. Compliance with chapter; vehicle manufacturers not required to comply.

(a) No vehicle protection product may be sold or offered for sale in this state unless the seller, warrantor, and administrator, if any, comply with the provisions of this chapter.

(b) Vehicle protection product warrantors and related vehicle protection product sellers and warranty administrators complying with this chapter are not required to comply with and are not subject to any other provision of this title.

(c) Service contract providers who do not sell vehicle protection products are not subject to the requirements of this chapter and sales of vehicle protection products are exempt from the requirements of Code Section 33-7-6.

(d) Warranties, indemnity agreements, and guarantees that are not provided as a part of a vehicle protection product are not subject to the provisions of this chapter.

(e) Vehicle manufacturers shall not be subject to any of the provisions of this chapter.

History. — Code 1981, § 33-34A-3, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-4. Representation as warrantor; filing of registration records; fees; renewal of registration.

(a) A person may not operate as a warrantor or represent to the public that the person is a warrantor unless the person is registered with the department on a form prescribed by the Commissioner.

(b) Warrantor registration records shall be filed annually and shall be updated within 30 days of any change. The registration records shall contain the following information:

(1) The warrantor's name, any fictitious names under which the warrantor does business in this state, principal office address, and telephone number;

(2) The name and address of the warrantor's agent for service of process in this state if other than the warrantor;

(3) The names of the warrantor's executive officer or officers directly responsible for the warrantor's vehicle protection product business;

(4) The name, address, and telephone number of any administrators designated by the warrantor to be responsible for the administration of vehicle protection product warranties in this state;

(5) A copy of the warranty reimbursement insurance policy or policies or other financial information required by Code Section 33-34-5; and

(6) A copy of each warranty the warrantor proposes to use in this state.

(c) The Commissioner may charge each registrant a reasonable fee to offset the cost of processing the registration and maintaining the records in an amount not to exceed $750.00 annually. The information in paragraphs (1) and (2) of subsection (b) of this Code section shall be made available to the public.

(d) If a registrant fails to register by the renewal deadline, the Commissioner shall give him or her written notice of the failure and the registrant will have 30 days to complete the renewal of his or her registration before he or she is suspended from being registered in this state.

(e) An administrator or person who sells or solicits a sale of a vehicle protection product but who is not a warrantor shall not be required to register as a warrantor or be licensed under the insurance laws of this state to sell vehicle protection products.

History. — Code 1981, § 33-34A-4, enacted by Ga. L. 2003, p. 644, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2003, "this state" was substituted for "the state" in paragraph (b)(1) and "in this state" was substituted for "the state" in paragraph (b)(2).

33-34A-5. Required warranty reimbursement insurance policy.

No vehicle protection product shall be sold or offered for sale in this state unless the vehicle protection product warrantor is insured under warranty insurance policy meeting the following conditions in order to ensure adequate performance under the warranty:

(1) The warranty reimbursement insurance policy is issued by an insurer authorized to do business in this state and provides that the insurer will pay to, or on behalf of, the warrantor 100 percent of all sums that the warrantor is legally obligated to pay according to the

warrantor's contractual obligations under the warrantor's vehicle protection product warranty;

(2) A true and correct copy of the warranty reimbursement insurance policy has been filed with the Commissioner by the warrantor; and

(3) The policy contains the provision required in Code Section 33-34A-6.

No other financial security requirements or financial standards for warrantors shall be required.

History. — Code 1981, § 33-34A-5, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-6. Conditions for warranty reimbursement insurance policies.

No warranty reimbursement insurance policy shall be issued, sold, or offered for sale in this state unless the policy meets the following conditions:

(1) The policy states that the issuer of the policy will reimburse or pay on behalf of the vehicle protection product warrantor all covered sums which the warrantor is legally obligated to pay or will provide that all service that the warrantor is legally obligated to perform according to the warrantor's contractual obligations under the provisions of the insured warranties sold by the warrantor;

(2) The policy states that in the event payment due under the terms of the warranty is not provided by the warrantor within 60 days after proof of loss has been filed according to the terms of the warranty by the warranty holder, the warranty holder may file directly with the warranty reimbursement insurance company for reimbursement;

(3) The policy provides that a warranty reimbursement insurance company that insures a warranty shall be deemed to have received payment of the premium if the warranty holder paid for the vehicle protection product and insurer's liability under the policy shall not be reduced or relieved by a failure of the warrantor, for any reason, to report the issuance of a warranty to the insurer; and

(4) The policy has the following provisions regarding cancellation of the policy:

(A) The issuer of a reimbursement insurance policy shall not cancel such policy until a notice of cancellation in writing has been mailed or delivered to the Commissioner and each insured warrantor;

(B) The cancellation of a reimbursement insurance policy shall not reduce the issuer's responsibility for vehicle protection products sold prior to the date of cancellation; and

(C) In the event an insurer cancels a policy that a warrantor has filed with the Commissioner, the warrantor shall do either of the following:

(i) File a copy of a new policy with the Commissioner, before the termination of the prior policy, provided that there is no lapse in coverage following the termination of the prior policy; or

(ii) Discontinue acting as a warrantor as of the termination date of the policy until a new policy becomes effective and is accepted by the Commissioner.

History. — Code 1981, § 33-34A-6, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-7. Required statements in warranty; required information to be provided to purchaser.

(a) Every vehicle protection product warranty shall be written in clear, understandable language and shall be printed or typed in an easy-to-read point size and font and shall not be sold or offered for sale in the state unless the warranty:

(1) Conspicuously states that the obligations of the warrantor to the warranty holder are guaranteed under a warranty reimbursement insurance policy;

(2) Conspicuously states that in the event a warranty holder must make a claim against a party other than the warranty reimbursement insurance policy issuer, the warranty holder is entitled to make a direct claim against the insurer upon the failure of the warrantor to pay any claim or meet any obligation under the terms of the warranty within 60 days after proof of loss has been filed with the warrantor;

(3) Conspicuously states the name and address of the issuer of the warranty reimbursement insurance policy. This information need not be preprinted on the warranty form but may be stamped on the warranty;

(4) Identifies the warrantor, the seller, and the warranty holder;

(5) Sets forth the total purchase price and the terms under which it is to be paid; however, the purchase price is not required to be preprinted on the vehicle protection product warranty and may be negotiated with the consumer at the time of sale;

(6) Sets forth the procedure for making a claim, including a telephone number;

(7) Conspicuously states the existence of a deductible amount, if any;

(8) Specifies the payments or performance to be provided under the warranty including payments for incidental costs, the manner of calculation or determination of payments or performance, and any limitations, exceptions, or exclusions;

(9) Sets forth the conditions on which substitution will be allowed;

(10) Conspicuously sets forth all of the obligations and duties of the warranty holder such as the duty to protect against any further damage to the vehicle, the obligation to notify the warrantor in advance of any repair, or other similar requirements, if any;

(11) Sets forth any terms, restrictions, or conditions governing transferability of the warranty, if any; and

(12) Contains a disclosure that reads substantially as follows: "This agreement is a product warranty and is not insurance."

(b) At the time of sale, the seller or warrantor shall provide to the purchaser:

(1) A copy of the vehicle protection product warranty; or

(2) A receipt or other written evidence of the purchase of the vehicle protection product and a copy of the warranty within 30 days of the date of purchase.

History. — Code 1981, § 33-34A-7, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-8. Cancellation of vehicle protection product; written notice of cancellation.

(a) No vehicle protection product may be sold or offered for sale in this state unless the vehicle protection product warranty clearly states the terms and conditions governing the cancellation of the sale and warranty, if any.

(b) The warrantor may only cancel the warranty if the warranty holder does any of the following:

(1) Fails to pay for the vehicle protection product;

(2) Makes a material misrepresentation to the seller or warrantor;

(3) Commits fraud; or

(4) Substantially breaches the warranty holder's duties under the warranty.

(c) A warrantor canceling a warranty shall mail written notice of cancellation to the warranty holder at the last address of the warranty holder in the warrantor's records at least 30 days prior to the effective date of the cancellation. The notice shall state the effective date of the cancellation and the reason for the cancellation.

History. — Code 1981, § 33-34A-8, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-9. Prohibited words in product contract; false or misleading statements prohibited; requiring as condition for loan prohibited.

(a) Unless licensed as an insurance company, a vehicle protection product warrantor shall not use in its name, contracts, or literature the words "insurance," "casualty," "surety," "mutual," or any other word that is descriptive of the insurance, casualty, or surety business or that is deceptively similar to the name or description of any insurance or surety corporation or any other vehicle protection product warrantor. A warrantor may use the term "guaranty" or a similar word in the warrantor's name.

(b) A vehicle protection product warrantor shall not make, permit, or cause any false or misleading statements, either oral or written, in connection with the sale, offer to sell, or advertisement of a vehicle protection product.

(c) A vehicle protection product warrantor shall not permit or cause the omission of any material statement in connection with the sale, offer to sell, or advertisement of a vehicle protection product, which under the circumstances should have been made in order to make the statements that were made not misleading.

(d) A vehicle protection product warrantor shall not make, permit, or cause any false or misleading statements, either oral or written, about the performance required or payments that may be available under the vehicle protection product warranty.

(e) A vehicle protection product warrantor shall not make, permit, or cause any statement or practice that has the effect of creating or maintaining a fraud.

(f) A bank, savings and loan association, insurance company, or other lending institution shall not require the purchase of a vehicle protection product as a condition of a loan.

(g) A vehicle protection product seller or warrantor may not require as a condition of sale or financing that a retail purchaser of a motor vehicle purchase a vehicle protection product that is not installed on the motor vehicle at the time of sale.

History. — Code 1981, § 33-34A-9, enacted by Ga. L. 2003, p. 644, § 1.

Cross references. — Georgia Fair Lending Act, § 7-6A-1 et seq.

33-34A-10. Required records; period of retention; examination by Commissioner.

(a) All vehicle protection product warrantors shall keep accurate accounts, books, and records concerning transactions regulated under this chapter.

(b) A vehicle protection product warrantor's accounts, books, and records shall include:

(1) Copies of all vehicle protection product warranties;

(2) The name and address of each warranty holder; and

(3) The dates, amounts, and descriptions of all receipts, claims, and expenditures.

(c) A vehicle protection product warrantor shall retain all required accounts, books, and records pertaining to each warranty holder for at least two years after the specified period of coverage has expired. A warrantor discontinuing business in the state shall maintain its records until it furnishes the Commissioner satisfactory proof that is has discharged all obligations to warranty holders in this state.

(d) Vehicle protection product warrantors shall make all accounts, books, and records concerning transactions regulated under this chapter available to the Commissioner for the purpose of examination.

History. — Code 1981, § 33-34A-10, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-11. Examinations by Commissioner; enforcement; opportunity for a hearing; burden on Commissioner to show justification; penalty for violations.

(a) The Commissioner may conduct examinations of warrantors, administrators, or other persons to enforce this chapter and protect warranty holders in this state. Upon request of the Commissioner, a warrantor shall make available to the Commissioner all accounts, books, and records concerning vehicle protection products sold by the warrantor that are necessary to enable the Commissioner to reasonably determine compliance or noncompliance with this chapter.

(b) The Commissioner may take action that is necessary or appropriate to enforce the provisions of this chapter and the Commissioner's rules and orders and to protect warranty holders in this state. If a warrantor engages in a pattern or practice of conduct that violates this chapter and that the Commissioner reasonably believes threatens to

render the warrantor insolvent or cause irreparable loss or injury to the property or business of any person or company located in this state, the Commissioner may:

(1) Issue an order directed to that warrantor to cease and desist from engaging in further acts, practices, or transactions that are causing the conduct;

(2) Issue an order prohibiting that warrantor from selling or offering for sale service contracts in violation of this chapter;

(3) Issue an order imposing a civil penalty on that warrantor; or

(4) Issue any combination of paragraphs (1) through (3) of this subsection, as applicable.

(c) Prior to the effective date of any order issued pursuant to this Code section, the Commissioner must provide written notice of the order to the warrantor and the opportunity for a hearing to be held within ten business days after receipt of the notice, except that prior notice and hearing shall not be required if the Commissioner reasonably believes that the warrantor has become, or is about to become, insolvent.

(d) A person aggrieved by an order issued under this Code section may request a hearing before the Commissioner. The hearing request shall be filed with the Commissioner within 20 days after the date the Commissioner's order is effective, and the Commissioner must hold such a hearing within 15 days after receipt of the hearing request.

(e) At the hearing, the burden shall be on the Commissioner to show why the order issued pursuant to this Code section is justified. The provisions of Chapter 13 of Title 50, the "Georgia Administrative Procedure Act," shall apply to a hearing request under this Code section.

(f) The Commissioner may bring an action in any court of competent jurisdiction for an injunction or other appropriate relief to enjoin threatened or existing violations of this chapter or of the Commissioner's orders or rules. An action filed under this Code section also may seek restitution on behalf of persons aggrieved by a violation of this chapter or orders or rule of the Commissioner.

(g) A person who is found to have violated this chapter or orders or rules of the Commissioner may be ordered to pay to the Commissioner a civil penalty in an amount, determined by the Commissioner, of not more than $500.00 per violation and not more than $10,000.00 in the aggregate for all violations of a similar nature. For purposes of this Code section, violations shall be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice,

irrespective of the number of times the conduct, action, or practice that is determined to be a violation of this chapter occurred.

History. — Code 1981, § 33-34A-11, enacted by Ga. L. 2003, p. 644, § 1.

33-34A-12. Adoption of rules and regulations.

The Commissioner shall adopt rules and regulations which include disclosures for the benefit of the warranty 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 protection product warranty agreements.

History. — Code 1981, § 33-34A-12, enacted by Ga. L. 2003, p. 644, § 1; Ga. L. 2019, p. 386, § 115/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "shall adopt rules and regulations which include" for "may adopt such administrative rules consistent with the provisions of this chapter as are necessary to implement them. Such rules and regulations shall include" near the beginning of this Code section.

33-34A-13. Applicability.

Repealed by Ga. L. 2019, p. 386, § 116/SB 133, effective July 1, 2019.

Editor's notes. — Ga. L. 2020, p. 493, § 33/SB 429, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted the reservation of this Code section.

CHAPTER 35

PREPAID LEGAL SERVICES PLANS

Sec.

33-35-1. Purposes of chapter; legislative findings of fact.
33-35-2. Definitions.
33-35-3. Benefits excluded from chapter application.
33-35-4. Licenses required for sponsors of prepaid legal services plans; license fee; endorsement of change of address on license; requirements as to applications for licenses generally.
33-35-5. Procedure for issuance or denial of licenses generally; standards for issuance or renewal of licenses generally.
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33-35-12. Standards for advertising and solicitation.
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33-35-16. Annual filing of information by sponsors.
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33-35-19. Venue of actions against sponsors.
33-35-20. Promulgation of rules and regulations by Commissioner [Repealed].
33-35-21. Applicability of chapter generally.
33-35-22. Applicability of chapter to other insurers.
33-35-23. Applicability of Chapter 6 of title.

Cross references. — Attorneys generally, T. 15, C. 19.

Administrative rules and regulations. — Prepaid legal services plan, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Insurance Department, Subject 120-2-29.

Law reviews. — For article discussing legal services insurance, etc., see 6 Ga. L. Rev. 247 (1972). For article, "Prepaid Legal Services — Survival for the Practitioner," see 11 Ga. St. B.J. 16 (1974). For articles advocating the support and sponsorship of prepaid legal services programs in Georgia and exhibiting plans offered in other states, see 13 Ga. St. B.J. 7 (1976).

RESEARCH REFERENCES

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

Prepaid legal services plans, 93 A.L.R.3d 199.

33-35-1. Purposes of chapter; legislative findings of fact.

(a) The purposes of this chapter are to provide for the registration of prepaid legal services plans, to promote access to quality legal services at the lowest possible price, and to regulate the development and operation of prepaid legal services plans; and it is the intention of the General Assembly that this chapter be interpreted as liberally as necessary to accomplish these purposes.

(b) The General Assembly finds that insurers authorized to transact casualty, life, or accident and sickness insurance in this state are authorized to write policies for prepaid legal services. The General Assembly further finds that there exists no other specific framework within the insurance laws of this state designed to regulate prepaid legal services. Because of the interest of the state in the controlled development of new methods for providing legal services, exertion of the state's power is necessary for the protection of its citizens.

History. — Code 1933, § 56-3501, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 2019, p. 386, § 117/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "there exists no other" for "there presently exists no" near the middle of the second sentence of subsection (b).

33-35-2. Definitions.

As used in this chapter, the term:

(1) "Advertising" means any communication, other than a solicitation, as defined in paragraph (5) of this Code section, to the public or any segment of the public by means of radio, television, newspaper, magazine, periodical, brochure, pamphlet, circular, or any other means, the apparent purpose or reasonable effect of which would be to convey information purporting to relate to or describe legal rights, legal services, attorneys, or prepaid legal services plans.

(2) "Insurer" means an insurer authorized to transact casualty, life, or accident and sickness insurance in this state.

(3) "Legal services" means any services normally provided by an attorney as well as the payment of court costs and related expenses incurred in the exercise of any right, but not including the payment of fines, penalties, judgments, or assessments.

(4) "Prepaid legal services plan" or "plan" means any arrangement whereby responsibility is undertaken to provide, arrange for, pay for, or reimburse any part of the cost of any legal services for a consideration consisting in part of prepaid or periodic charges or dues.

(5) "Solicitation" means any written or oral communication in person or by means of telephone, radio, television, newspaper, magazine, periodical, brochure, circular, or otherwise of any offer of coverage in a prepaid legal services plan, any invitation or request to enroll in a prepaid legal services plan, any attempt to obtain consideration for the coverage of a prepaid legal services plan, or any other device, the apparent purpose or reasonable effect of which would be to induce the recipient of such communication to enroll in or pay any consideration for the coverage provided by a prepaid legal services plan.

(6) "Sponsor" means any person, group, or fraternal or benevolent organization, including but not limited to insurers; corporations; partnerships; trusts; labor, craft, or other unions; or other entities which establish or operate prepaid legal services plans.

(7) "Subscriber" means any person who has been enrolled in a prepaid legal services plan and is entitled to receive the benefits provided in the plan.

(8) "Subscription contract" means any contract signed by an authorized representative of a prepaid legal services plan and an individual or an authorized representative of his group or employer or labor union or other entity with which he is affiliated under which the individual becomes a subscriber to the plan.

History. — Code 1933, § 56-3503, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 2; Ga. L. 1990, p. 8, § 33; Ga. L. 2019, p. 386, § 118/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "or any corporation organized pursuant to Chapter 18 or 19 of this title" following "state" at the end of paragraph (2).

33-35-3. Benefits excluded from chapter application.

This chapter shall not apply to the benefits available under automobile club membership contracts and automobile liability insurance policies which supply limited legal services or reimbursement for legal services in automobile related matters under certificates of authority issued by the Commissioner, to any legal aid or other legal services program for the indigent, or to any employer-employee legal services plan which is excluded from this chapter by the federal Employee Retirement Income Security Act of 1974.

History. — Code 1933, § 56-3503, enacted by Ga. L. 1975, p. 1268, § 1.

U.S. Code. — The federal Employee Retirement Income Security Act of 1974 is codified, principally, as 29 U.S.C. § 1001 et seq.

33-35-4. Licenses required for sponsors of prepaid legal services plans; license fee; endorsement of change of address on license; requirements as to applications for licenses generally.

(a) No person other than an insurer, as defined in paragraph (2) of Code Section 33-35-2, shall act as a sponsor or enter into any contract with an individual person or persons whereby such person or persons become subscribers to a prepaid legal services plan without first having obtained a license from the Commissioner to act as sponsor of prepaid legal services in this state.

(b) The annual license fee shall be as provided in Code Section 33-8-1. The fee for the license shall be paid to the Commissioner for the use of the state on or before March 1 of each year.

(c) Before any licensee changes his address, he shall return his license to the Commissioner who shall endorse the license, indicating the change.

(d) The person to whom the license or the renewal of such license may be issued shall file sworn answers, subject to the penalties of perjury, 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 of the firm, partnership, or corporation who may materially influence the applicant's conduct meets the standards of this chapter.

History. — Code 1933, § 56-3504, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1992, p. 2725, § 28.

JUDICIAL DECISIONS

Cited in National Gen. Ins. Co. v. Meeks, 145 Ga. App. 830, 244 S.E.2d 920 (1978).

33-35-5. Procedure for issuance or denial of licenses generally; standards for issuance or renewal of licenses generally.

(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 90 days after he has received such application 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 as a sponsor of prepaid legal services plans in this state;

(2) Has a good business reputation and has had experience, training, or education so as to be qualified to act as a sponsor of prepaid legal services plans; and

(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.

History. — Code 1933, § 56-3505, enacted by Ga. L. 1975, p. 1268, § 1.

33-35-6. Minimum capital, surplus, and bond requirements.

No license or renewal license under this chapter shall be issued to a sponsor other than an insurer as defined in paragraph (2) of Code Section 33-35-2, unless such sponsor:

(1) Shall possess as minimum capital and thereafter maintain a minimum balance of at least $5,000.00 in its capital accounts as shown in its annual report to the Commissioner; provided, however, that the Commissioner shall in his discretion require such higher amounts of capital as he deems necessary for the protection of the public;

(2) Shall deposit with the Commissioner securities acceptable to the Commissioner in the amount of $25,000.00 or shall file with the Commissioner a bond to be approved by the Commissioner and made payable to the Commissioner or his successors in office, which bond is executed by such 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 sponsor will conduct his business in accordance with this chapter and the laws of this state and that the sponsor will properly account for all moneys collected in connection therewith. 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; and

(3) Shall maintain such minimum surplus as the Commissioner may require, which shall be at least 25 percent of its anticipated income over a two-year period calculated on the basis of estimates of premium writings for two-year and five-year periods which shall be filed with the Commissioner as a part of the sponsors' rate filing required under Code Section 33-35-11.

History. — Code 1933, § 56-3512, enacted by Ga. L. 1975, p. 1268, § 1.

33-35-7. Grounds and procedure for revocation, suspension, or refusal to renew licenses; imposition of probation or fine; review.

(a) The Commissioner may revoke, suspend, or refuse to renew the license of any sponsor when and if, after investigation, the Commissioner finds that:

(1) Any license issued to the sponsor was obtained by fraud;

(2) There was any misrepresentation in the application for the license;

(3) The sponsor has otherwise shown itself untrustworthy or incompetent to act as a sponsor;

(4) The sponsor has violated any of the provisions of this chapter or of the rules and regulations of the Commissioner;

(5) The sponsor has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any moneys entrusted to the sponsor in its fiduciary capacity belonging to an insurer or insured; or

(6) The sponsor 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.

(b) Before the Commissioner shall revoke, suspend, or refuse to renew the license of any sponsor, he shall give to that person an opportunity to be heard fully and to introduce evidence in his behalf.

(c) In lieu of revoking, suspending, or refusing to renew the license for any of the causes enumerated in subsection (a) of this Code section, after hearing as provided in this subsection the Commissioner may place the sponsor on probation for a period of time not to exceed one year or may fine the sponsor not more than $2,000.00 for each offense, or do both, when, in the Commissioner's judgment he or she finds that the public interest would not be harmed by the continued operation of the sponsor. The amount of any penalty shall be paid by such sponsor to the Commissioner for the use of the state.

(d) At any hearing provided by this Code section, 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.

(e) Any action of the Commissioner taken pursuant to this Code section shall be subject to such review as may be provided in Chapter 2 of this title.

History. — Code 1933, § 56-3506, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 2019, p. 386, § 119/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (c), in the first sentence, substituted "$2,000.00" for "$1,000.00" and substituted "in the Commissioner's judgment he or she finds" for "in his judgment he finds".

33-35-8. Execution, contents, and filing of subscription contracts generally.

(a) Any sponsor of any prepaid legal services plan or authorized representative of any prepaid legal services plan may enter into a subscription contract with any person, with any person's employer, or with any other person or group acting in his or its behalf under which a minimum of 80 percent of all individuals lawfully represented by such person or group become subscribers to the prepaid legal services plan; provided, however, that: (1) no subscription contract shall be written for a period longer than one year; and (2) in the case of subscription contracts issued to groups, no member of the group shall be bound by the subscription contract unless he indicates in writing to the group no earlier than ten days after the date on which he has received effective notice of the terms and benefits of the plan and of the intention of his group to contract for the plan that he does wish to become a subscriber and to be bound by the subscription contract. The notice received by the member shall contain without limitation the provisions itemized in subsection (b) of this Code section.

(b) Every subscription contract shall be in writing and shall contain the following provisions:

(1) A brief statement of the plan's financial structure, including a statement of the amount of any premiums, charges, or dues to be charged or currently being charged and the manner in which such amount is to be paid;

(2) A statement of the amount of benefits, reimbursement, or indemnity to be furnished to each subscriber and the period during which it will be furnished and, if there are exceptions, reductions, exclusions, limitations, or restrictions of such reimbursement or indemnity, a detailed statement of such exceptions, reductions, exclusions, limitations, or restrictions;

(3) A statement of the terms and conditions upon which the subscription contract may be canceled or otherwise terminated by the sponsor or by the subscriber or by his employer or by his group; provided, however, that any cancellation or termination by the sponsor shall not become effective unless accomplished in accordance with Code Section 33-24-44;

(4) A statement describing the applicability or nonapplicability of the benefits of the plan to the family dependents of the subscriber;

(5) A statement of the period of grace which will be allowed the subscriber or his employer or group for making any payment due under the subscription contract, which period shall not be less than ten days;

(6) A statement describing a procedure for settling disputes between or among the sponsor, participating or staff attorneys, and the subscribers;

(7) A statement that the subscription contract includes the endorsements on the contract and attached papers, if any, and contains the entire contract; and

(8) A statement that no statements by the subscriber or his employer or group in the application for the contract shall void the subscription contract or be used in any legal proceeding under the contract, unless such application or an exact copy of the application is included in or attached to such subscription contract.

(c) If a prepaid legal services plan is sponsored by an insurer or is underwritten by an insurer pursuant to subsection (a) of Code Section 33-35-10, the subscription contract of the plan shall contain a provision which shall provide that nothing contained in the subscription contract shall interfere in any way with the right of any individual subscriber to retain any attorney of his free choice at the expense of the plan.

(d) Every subscriber shall be furnished a copy of his subscription contract, and every employer or other group shall be furnished a copy of the subscription contract signed by it.

(e) The sponsor shall be required to file every subscription contract and a copy of its underwriting rules with the Commissioner; also a copy of such subscription contract and underwriting rules shall be sent to the State Bar of Georgia by the sponsor. The filings with the Commissioner shall be deemed approved 90 days after the date the filing is received by the Commissioner, unless prior to the expiration of said 90 day period the Commissioner notifies the sponsor of the prepaid legal services plan in writing of the Commissioner's disapproval. The Commissioner shall require that all subscription contracts shall be fair and reasonable and shall not approve any subscription contracts or underwriting rules that

are unfair or inequitable or contrary to the public policy of this state or would, because the provisions are unclear or deceptively worded, encourage misrepresentation.

History. — Code 1933, § 56-3507, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1982, p. 3, § 33.

33-35-9. Sale of subscription contracts.

(a) Nothing contained in this Code section shall be deemed to prohibit an insurer authorized to transact casualty, life, or accident and sickness insurance in this state from selling or offering for sale in this state individually underwritten and individually issued policies of prepaid legal services insurance on policy forms which have been approved by the Commissioner pursuant to Chapter 9 of this title.

(b) This Code section shall not apply to any subscription contracts negotiated and issued in accordance with Section 302C of the Labor Management Relations Act of 1947 (87 Stat. 314, 29 U.S.C.A. Section 186(c)(8)).

(c) This Code section shall not apply in the event that prior to April 1, 1976, legal services plans' coverages are mandated by any applicable state or federal laws or court decisions.

History. — Code 1933, § 56-3522, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 3; Ga. L. 2019, p. 386, § 120/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "Nothing" for "No subscription contracts for prepaid legal services may be sold or offered for sale in this state prior to April 1, 1976, provided that nothing" at the beginning of subsection (a).

33-35-10. Powers of sponsors to contract for provision of legal and administrative services.

(a)(1) The sponsor of any prepaid legal services plan or authorized representative of the plan may contract with any company licensed to transact casualty, life, or accident and sickness insurance in this state under which contracts the company agrees for a consideration consisting of a specified premium to assume the monetary obligations of the plan to provide or pay for the legal services covered by the subscription contracts issued under such plan upon the failure of the plan itself to meet such obligations within a specified period. The duration of the contract shall not be longer than three years and each contract shall be filed with and subject to the approval of the Commissioner for the fairness of its terms and premiums. The contracts shall be deemed to be approved 90 days after the date of filing with the Commissioner, unless prior to the expiration of such 90

day period the Commissioner notifies the sponsor of the prepaid legal services plan in writing of the Commissioner's disapproval.

(2) Any sponsor entering into such contracts shall fairly disclose to all subscribers affected by them the nature and extent of the extra protection provided by them. Any plan having lawful access to any other source of funds besides the premiums collected, which may be used to meet the obligations of the plan under its subscription contracts, shall make similar fair disclosure to affected subscribers.

(3) Any sponsor which seeks to limit its liability under its subscription contracts to the total of funds collected in premiums from subscribers shall state such limitation clearly and prominently in all subscription contracts.

(b) Any sponsor of any prepaid legal services plan or authorized representative of the plan may contract with any person to provide administrative services necessary to the administration of the plan and the subscription contracts issued under such plan. The duration of the contracts shall not be longer than three years, and each contract shall be filed with and subject to the approval of the Commissioner as to the fairness of its terms. The contracts shall be deemed to be approved 90 days after the date of filing with the Commissioner, unless prior to the expiration of the 90 day period the Commissioner notifies the sponsor of the prepaid legal services plan in writing of the Commissioner's disapproval.

History. — Code 1933, § 56-3508, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 4; Ga. L. 1990, p. 8, § 33; Ga. L. 2019, p. 386, § 121/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "or any corporation organized pursuant to Chapter 18 or 19 of this title," following "in this state" in the middle of the first sentence of paragraph (a)(1).

33-35-11. Submission to Commissioner of underwriting rules and rates, premiums, or fees; approval or disapproval.

(a) No sponsor of any prepaid legal services plan or authorized representative of the plan shall enter into any contract with subscribers unless and until the sponsor has filed with the Commissioner a copy of its underwriting rules and a full schedule of the rates, premiums, or membership fees to be charged to the subscribers. These filings shall be deemed to be approved by the Commissioner 90 days after the date of filing with the Commissioner, unless prior to the expiration of the 90 day period the Commissioner notifies the sponsor of the prepaid legal services plan in writing of the Commissioner's disapproval.

(b) In considering whether or not to approve a given rate schedule, the Commissioner shall consider the following factors:

(1) Whether the rates are adequate to ensure that all the benefits contracted for will be supplied;

(2) Whether the rates are excessive;

(3) Whether the rates are unfairly discriminatory; and

(4) Whether the rates are otherwise contrary to the laws or public policies of this state.

(c) Insurers authorized to transact casualty, life, or accident and sickness insurance in this state shall be required to comply with the requirements of this Code section if they sell or offer for sale policies of prepaid legal services insurance in this state or if they underwrite prepaid legal services plans of sponsors licensed to operate prepaid legal services plans in this state; provided, however, that nothing contained in this Code section shall be deemed to relieve any insurer authorized to transact casualty, life, or accident and sickness insurance in this state from complying with the requirements of this title and the laws of this state.

History. — Code 1933, § 56-3509, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 5; Ga. L. 1990, p. 8, § 33; Ga. L. 1992, p. 6, § 33; Ga. L. 2019, p. 386, § 122/SB 133.

The 2019 amendment, effective July 1, 2019, in subsection (c), deleted "or any corporation organized pursuant to Chapter 18 or 19 of this title" following "in this state" near the beginning and near the end.

33-35-12. Standards for advertising and solicitation.

All advertising and solicitation concerning prepaid legal services plans shall be conducted in a simple, dignified manner. Every item of advertising or solicitation shall conform with the following standards:

(1) The form and content of any advertisement or solicitation shall be accurate and shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence within the segment of the public to which it is directed or within a segment of the public to which such advertisement may be reasonably calculated to reach;

(2) All advertisements and solicitations shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implications or by familiarity with insurance terminology, shall not be used;

(3) Advertising and solicitation which include references to the legal rights or remedies of citizens shall be legally accurate;

(4) Advertising and solicitation which include references to the particular characteristics of one or more sponsors or prepaid legal services plans or which compare one or more sponsors or prepaid legal services plans shall be truthful and not misleading; and

(5) No advertising or solicitation shall contain the name, address, telephone number, or any other identifying information about any attorney; and no such advertising or solicitation shall extol the alleged virtues or qualifications or point out the alleged shortcomings of any attorney, whether named or not; provided, however, that communications directed solely to existing subscribers of prepaid legal services plans which restrict their benefits to services rendered by attorneys preselected by the plan may include the names, addresses, and telephone numbers of participating attorneys.

History. — Code 1933, § 56-3510, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1990, p. 8, § 33.

Cross references. — Solicitation on behalf of attorneys generally, § 15-19-55.

33-35-13. Investment of funds of plans.

A sponsor shall invest the funds of a prepaid legal services plan only in such investments as are authorized by the laws of this state for the investment of assets of insurance companies and subject to the limitations placed on the investments.

History. — Code 1933, § 56-3520, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 6; Ga. L. 2019, p. 386, § 123/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "or in such investments as are authorized by the laws of this state for the investment of assets of corporations authorized to transact business in this state pursuant to Chapter 18 or 19 of this title as the case may be" following "investments" at the end of this Code section.

33-35-14. Administration of deposits of plans.

Any deposits of a sponsor of a prepaid legal services plan deposited with the Commissioner pursuant to this chapter shall be administered by the Commissioner in accordance with Chapter 12 of this title as though deposited by a domestic casualty, life, or accident and sickness insurer authorized to transact insurance in this state.

History. — Code 1933, § 56-3521, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 7; Ga. L. 2019, p. 386, § 124/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "or as deposited by a corporation authorized to transact business in this state pursuant to Chapter 18 or 19 of this title" following "state" at the end of this Code section.

33-35-15. Maintenance of books and records by sponsors; examination by Commissioner; reports of examinations; payment of expenses of examinations.

(a) The Commissioner shall require every sponsor of a prepaid legal services plan to retain at the address shown on its license the plan related books, records, accounts, and vouchers for a term of three years beginning immediately after the completion of the transaction and shall require that they be kept in such manner that the Commissioner or his authorized representatives may readily verify its annual statements and determine whether the plan and the sponsor are in compliance with the law.

(b) The Commissioner or his designee shall at least every three years visit each sponsor of a prepaid legal services plan and examine into such of its affairs as relate to the business of operating the plan. The Commissioner shall have free access to all plan related books, records, accounts, and vouchers of the plan and may summon and examine under oath officers, trustees, agents, and employees of the plan and any other persons regarding the affairs and condition of the plan; provided, however, that no written or oral information need be supplied under this or any other subsection of this chapter in violation of the attorney-client privilege as it is construed by the courts of this state.

(c) Every sponsor of a plan being examined and its officers, employees, and representatives shall produce and make freely accessible to the Commissioner the accounts, records, documents, and files in its possession or control relating to the subject of the examination. The officers, employees, and representatives shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(d)(1) The Commissioner shall 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.

(2) 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 paragraph (3) of this subsection, shall be admissible in evidence in any proceeding brought by the Commissioner against the sponsor of the plan examined or any officer or agent of such sponsor and shall be prima-facie evidence of the facts stated in the report.

(3) The Commissioner shall furnish a copy of the proposed report to the sponsor of the plan examined not less than 20 days prior to filing the report. If the plan so requests in writing within the 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 file the report until after the hearing and such modifications have been made in the report as the Commissioner may deem proper.

(4) 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 plan examined from unwarranted injury.

(5) After the report has been filed, the Commissioner may publish the report or the results of the report in one or more newspapers published in this state if he should deem it to be in the public interest.

(e) The sponsor of the plan so examined shall pay at the direction of the Commissioner 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 sponsor 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 sponsor 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 sponsor examined to the Commissioner; and the payment shall be deposited with the Office of the State Treasurer.

History. — Code 1933, § 56-3514, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 1993, p. 1402, § 18; Ga. L. 2010, p. 863, § 2/SB 296.

33-35-16. Annual filing of information by sponsors.

Every sponsor of a prepaid legal services plan shall annually on or before March 1 file in the office of the Commissioner the following items:

(1) A statement verified by at least two of its principal officers or trustees showing the financial condition of the plan on December 31 of the preceding year, which statement shall be in such form and shall contain such matters as the Commissioner shall prescribe. A copy of such statement shall also be sent to each subscriber to the plan on or before March 31 unless such sponsor is an insurer as defined in Code Section 33-35-2 whose annual report of its affairs and operations has been filed with the Commissioner in accordance with Code Section 33-3-21;

(2) A statistical summary listing the numbers and types of claims paid and the average dollar amount of each type of claim;

(3) A list of the groups currently subscribing to the plan;

(4) A statement of the name, organizational form, and principal place of business of the plan and the name, organizational form, and principal place of business of the sponsor of the plan;

(5) Copies of all advertising or solicitation material which the plan is using; and

(6) Such other pertinent and relevant information as the Commissioner may reasonably require for the proper administration of this chapter; provided, however, that all information furnished under this paragraph shall be kept confidential by the Commissioner and shall not be made public by the Commissioner or any other person without the prior written consent of the sponsor or insurer to which it pertains, unless the Commissioner, after giving the sponsor or insurer who would be affected by the information notice and opportunity to be heard, determines that the interests of the subscribers, policyholders, or the public will be served by the publication of the information, in which event he may publish all or any part thereof in such manner as he may deem appropriate except to the extent that it may be produced in any judicial or administrative proceeding and may be admissible in evidence therein.

History. — Code 1933, § 56-3513, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1985, p. 1087, § 5.

33-35-17. Conduct of hearings and proceedings.

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 shall have all the powers granted to him in Chapter 2 of this title.

History. — Code 1933, § 56-3515, enacted by Ga. L. 1975, p. 1268, § 1.

33-35-18. Issuance of injunctions against transaction of business by plans; appointment of receivers; institution of criminal proceedings.

If the Commissioner finds that any prepaid legal services plan or its sponsor: (1) has failed to comply with any provision of this chapter; (2) is fraudulently operated; (3) is in such condition as to render further plan operations hazardous to the public interest or the interest of subscribers; (4) is financially unable to meet its obligations and claims as they come due; or (5) has violated any other law, he may apply to the Superior Court of Fulton County for an injunction. The court may immediately issue a temporary injunction restraining the transaction of any business by the plan; and it may after a full hearing make the

injunction permanent and appoint one or more receivers to take possession of the books, papers, moneys, and other assets of the plan to settle its affairs and distribute its funds to those entitled to such funds, subject to such rules and orders as the court may prescribe. If it appears that a crime has been committed in connection with the sale, advertisement, administration, or management of any prepaid legal services plan, the Attorney General of this state may pursue the appropriate criminal action.

History. — Code 1933, § 56-3516, enacted by Ga. L. 1975, p. 1268, § 1.

33-35-19. Venue of actions against sponsors.

The venue provisions applicable to insurers under Chapter 4 of this title shall apply to sponsors as defined in paragraph (6) of Code Section 33-35-2.

History. — Code 1933, § 56-3517, enacted by Ga. L. 1975, p. 1268, § 1.

33-35-20. Promulgation of rules and regulations by Commissioner.

Reserved. Repealed by Ga. L. 2019, p. 386, § 125/SB 133, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1933, § 56-3518, enacted by Ga. L. 1975, p. 1268, § 1.

33-35-21. Applicability of chapter generally.

This chapter shall apply to all persons, groups, or fraternal or benevolent organizations, including but not limited to insurers; corporations; partnerships; trusts; labor, craft, or other unions; or any other entities who propose to operate or are operating or participating in the operation of a prepaid legal services plan as such plan is defined in paragraph (4) of Code Section 33-35-2.

History. — Code 1933, § 56-3502, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1990, p. 8, § 33.

33-35-22. Applicability of chapter to other insurers.

All insurers authorized to transact casualty, life, or accident and sickness insurance in this state which is authorized to issue policies of prepaid legal services insurance in this state shall be required to meet

all the requirements of this chapter unless specifically excepted from the requirements by this chapter, provided that nothing contained in this chapter shall be deemed to relieve the obligations of an insurer authorized to transact casualty, life, or accident and sickness insurance in this state from complying with any other applicable requirements of this title and any other applicable laws of this state.

History. — Code 1933, § 56-3519, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 1983, p. 748, § 8; Ga. L. 2019, p. 386, § 126/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "or any corporation organized pursuant to Chapter 18 or 19 of this title" following "in this state" near the beginning and near the end of this Code section.

33-35-23. Applicability of Chapter 6 of title.

Chapter 6 of this title, applicable to insurers, shall apply to sponsors as defined in paragraph (6) of Code Section 33-35-2; and, for the purpose of determining whether a violation of Chapter 6 of this title has occurred, a subscriber, as defined in paragraph (7) of Code Section 33-35-2, shall be deemed to be an insured or a policyholder as used in Chapter 6 of this title, whichever is applicable.

History. — Code 1933, § 56-3511, enacted by Ga. L. 1975, p. 1268, § 1; Ga. L. 2005, p. 60, § 33/HB 95.

CHAPTER 36

GEORGIA INSURERS INSOLVENCY POOL

Sec.
33-36-1. Short title.
33-36-2. Creation; accounts; responsibility; supervision and regulation.
33-36-3. Definitions.
33-36-4. Insurers Solvency Board.
33-36-5. Insurers required to become members of pool.
33-36-6. Plan to govern members; rules; requirements for plan; assignment of claims or judgments against insolvent insurers; claimants of assets of insolvent insurers; jurisdiction; venue.
33-36-7. Levy of assessments against insurers; reimbursement of expenses; refunds of assessments.
33-36-7.1. Surcharge on premiums to recoup assessments; disclosure to insureds; excess surcharges, exception where the expense of collection would exceed the amount of the surcharge.
33-36-8. Issuance by Commissioner of notice of judicial determination of insolvency of insurer; requirement of notification of insureds by agents of insurer; publication of notice.
33-36-9. Coverage afforded by insolvent insurers to become obligation of pool; investigation and settlement of claims by pool.
33-36-10. Recovery under chapter of covered claims recoverable under insolvency funds of other states.
33-36-11. Limitation for filing claims; claims filed after final date set by court; default judgments.
33-36-12. Powers and duties of Commissioner as to collection of assessments; judicial review.
33-36-13. Allowance of claims by receivers, liquidators, or statutory successors; appointment of pool as insurer's agent.
33-36-14. Exhaustion of rights by claimants against insolvent insurers prior to recovery; recovery of payment to claimants in excess of amounts authorized; reduction of liability of insured; recovery of amounts paid on behalf of certain persons.
33-36-14.1. Recommendations and report by the board of trustees.
33-36-15. Examination of pool.
33-36-16. Exemption from taxation of pool.
33-36-16.1. Immunity from liability for performance of powers and duties under this chapter.
33-36-17. Termination of operation of pool as to particular kinds of insurance; proceeds upon termination of operation of pool; expiration of pool.
33-36-18. Appeal to Commissioner; judicial review.
33-36-19. Advertisements, announcements, or statements using insolvency pool for purpose of sales.
33-36-20. Liability of pool to claimants and electing insureds in emergency circumstances; definitions; exceptions.

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

Self-regulation. — One indirect effect of Ga. L. 1970, p. 700 (see O.C.G.A. § 33-36-1 et seq.) is to induce a degree of self-regulation by the insurance industry; another, more direct consequence of Ga. L. 1970, p. 700 is to provide an industry-financed buffer between an individual policyholder and the policyholder's insurer in the event the latter does become insolvent. 1972 Op. Att'y Gen. No. 72-158.

Contracts covering losses incurred by automobile dealers under warranty agreements are of the type of insurance covered by O.C.G.A. § 33-36-1 et seq. 1981 Op. Att'y Gen. No. 81-95.

RESEARCH REFERENCES

ALR. — Right of policyholder having matured claim to priority over other policyholders in the distribution of assets of insolvent insurance company, 1 A.L.R. 598.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like, 17 A.L.R.4th 16.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency, 30 A.L.R.4th 1110.

33-36-1. Short title.

This chapter shall be known and may be cited as the "Georgia Insurers Insolvency Pool Act."

History. — Ga. L. 1970, p. 700, § 1.

JUDICIAL DECISIONS

Cited in Conex Freight Sys. v. Ga. Ins. Insolvency Pool, 254 Ga. App. 92, 561 S.E.2d 221 (2002); Lumpkin County v. Ga. Insurers Insolvency Pool, 292 Ga. 76, 734 S.E.2d 880 (2012); Pandora Franchising, LLC v. Kingdom Retail Group, LLLP, 299 Ga. 723, 791 S.E.2d 786 (2016); Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

33-36-2. Creation; accounts; responsibility; supervision and regulation.

There is created a Georgia Insurers Insolvency Pool which shall consist of three accounts: (1) workers' compensation account; (2) automobile account; and (3) all other covered insurance account. The pool shall be responsible for the investigation, adjustment, compromise, settlement, and payment of covered claims; for the investigation, handling, and denial of noncovered claims; and for the management and investment of funds administered by the pool. The members of the pool shall be responsible for the payment of assessments levied pursuant to subsection (b) of Code Section 33-36-7; for adherence to the rules of the plan approved pursuant to Code Section 33-36-6; and for other obligations imposed by this chapter. The pool shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

History. — Ga. L. 1970, p. 700, § 2; Ga. L. 1985, p. 1485, § 1; Ga. L. 1987, p. 3, § 33; Ga. L. 2005, p. 563, § 11/HB 407.

Editor's notes. — Ga. L. 1985, p. 1485, § 9, not codified by the General Assembly, provided that that Act would be applicable to all insolvencies occurring on or after July 1, 1985.

Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

JUDICIAL DECISIONS

Purpose and practice of insolvency pool. — Georgia Insurers Insolvency Pool was created as a non-profit industry financed buffer between an individual policyholder and an insurer in the event an insurer becomes insolvent; it is not an alternative source of recovery of non-coverage claims against the insolvent insurer. Reimbursement Consultants, Inc. v. Georgia Insurers Insolvency Pool, 207 Ga. App. 230, 427 S.E.2d 519 (1993).

When an insurer becomes insolvent, the Georgia Insurers Insolvency Pool is required to fulfill the insurer's obligations to the insured. United States v. Rutland, Inc., 849 F. Supp. 806 (S.D. Ga. 1994), aff'd, 46 F.3d 71 (11th Cir. 1995).

Construction of exhaustion provision. — Georgia Court of Appeals held that the plain language of O.C.G.A. § 33-36-14(a) did not require that the amount of offset must be for the same claim or for amounts paid by a solvent carrier that were also at issue under an insolvent carrier's policy underlying a claim against Georgia's Insurers Insolvency Pool. Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

Cited in Georgia Insurers Insolvency Pool v. Elbert County, 258 Ga. 317, 368 S.E.2d 500 (1988); Norman Enters. Interior Design, Inc. v. DeKalb County, 245 Ga. App. 538, 538 S.E.2d 130 (2000); Lumpkin County v. Ga. Insurers Insolvency Pool, 292 Ga. 76, 734 S.E.2d 880 (2012).

33-36-3. Definitions.

As used in this chapter, the term:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Affiliate of the insolvent insurer" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(3) "Control" 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 with 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 that control does not exist in fact and any person disputing his or her status as an affiliate of an insurer authorized to do business in Georgia or an insolvent insurer may file a disclaimer in accordance with subsection (i) of Code Section 33-13-4.

(4)(A) "Covered claim" means an unpaid claim which:

(i) Arises out of a property or casualty insurance policy issued by an insurer which becomes an insolvent insurer which was authorized to do an insurance business in this state either at the time the policy was issued or when the insured event occurred; and

(ii) Is within any of the classes of claims under subparagraph (B) of this paragraph.

(B) A claim shall not be paid unless it arises out of an insurable event under a property or casualty insurance policy and it is:

(i) An unearned premium claim of a policyholder who at the time of the insolvency was a resident of this state;

(ii) An unearned premium claim of a policyholder under a policy affording coverage for property permanently situated in this state;

(iii) The claim of a policyholder or insured who at the time of the insured event was a resident of this state;

(iv) The claim of a person having an insurable interest in or related to property which was permanently situated in this state; or

(v) A claim under a liability or workers' compensation insurance policy when either the insured or third-party claimant was a resident of this state at the time of the insured event.

(C) A covered claim shall not include any claim in an amount of less than $50.00; provided, however, that any claim of $50.00 or more shall be paid in full.

(D) A covered claim shall not include that portion of any first-party claim which is in excess of the applicable limits provided in the policy or $300,000.00, whichever is less.

(E) A covered claim shall not include that portion of any third-party claim, other than a workers' compensation claim, which

is in excess of the applicable limits provided in the policy or $300,000.00, whichever is less.

(F) A covered claim shall not include any obligation to insurers, reinsurers, insurance pools, underwriting associations, health maintenance organizations, hospital plan corporations, or professional health service corporations as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, or professional health service corporation may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the pool obligation limitations set forth in this Code section.

(G) A covered claim shall not include any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, however, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; or any third-party claim relating to a policy of an insured whose net worth exceeds $25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, however, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and further provided that this exclusion shall not apply to third-party claims against the insured where the insured has applied for or consented to the appointment of a receiver, trustee, or liquidator for all or a substantial part of its assets, filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law or, if an order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

(H) A covered claim shall not include any first-party claims by an insured which is an affiliate of the insolvent insurer.

(I) A covered claim shall not include any claim or judgment for punitive damages and attorney's fees associated therewith against any insolvent insurer, its insured, or the insurers insolvency pool.

(J) A covered claim shall not include any workers' compensation benefits payable under subsection (e) or (f) of Code Section

34-9-221 or paragraph (2), (3), or (4) of subsection (b) of Code Section 34-9-108 after the effective date of the court order of rehabilitation or liquidation.

(K) A covered claim shall include a claim for unearned premium only if such claim derives from the payment of a stated premium and shall not include those which derive from an unstated premium such as calculated from audit, dividend, deposit, or retrospect plans. Further, a covered claim shall not include:

(i) That portion of a claim for unearned premium which is in excess of $20,000.00; or

(ii) A claim for unearned premium resulting from a policy which was not in force on the date of the final order of liquidation.

(L) A covered claim shall not include any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent.

(M) A covered claim shall not include any fee or other amount sought by or on behalf of an attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the pool. However, in such a case, the pool shall not offset amounts from any recovery paid to a claimant in such an action which the claimant has agreed are to be paid to the attorney in a contingency fee arrangement.

(N) A covered claim shall not include any claims for interest.

(5) "Insolvent insurer" means an insurer which was licensed to issue property or casualty insurance policies in this state at any time subsequent to July 1, 1970, and against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(6) "Insolvency pool" or "pool" means the Georgia Insurers Insolvency Pool established pursuant to Code Section 33-36-2.

(7) "Insured" means any named insured, any additional insured, any vendor, any lessor, or any other party identified as an insured under the policy as long as insurable interests remain relevant.

(8) "Insurer" or "company" means any corporation or organization that has held or currently holds a license to engage in the writing of

property or casualty insurance policies in this state, including the exchanging of reciprocal or interinsurance contracts among individuals, partnerships, and corporations, except farmer assessment mutual insurers, county assessment mutual insurers, and municipal assessment mutual insurers.

(9) "Net direct written premiums" means direct gross premiums written on property or casualty insurance policies, less return premiums on the policies and dividends paid or credited to policyholders on such direct business. Premiums written by any authorized insurer on policies issued to self-insurers, whether or not designated as reinsurance contracts, shall be deemed net direct written premiums.

(10) "Person" means any individual or legal entity, including governmental entities.

(11) "Property and casualty insurance policies" or "policy" means any contract, including endorsements to such contract and without regard to the nature or form of the contract or endorsement, which provides coverages as enumerated in Code Sections 33-7-3 and 33-7-6, except:

(A) Life insurance and annuities (being that class of insurance referred to in Code Section 33-7-4);

(B) Accident, health, and disability insurance except where written as part of an automobile insurance contract (being that class of insurance referred to in Code Section 33-7-2);

(C) Title insurance (being that class of insurance referred to in Code Section 33-7-8);

(D) Credit life insurance (being that class of insurance referred to in paragraph (2) of Code Section 33-31-1);

(E) Credit insurance, vendors' single interest insurance, or collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(F) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

(G) Fidelity or surety bonds or any other bonding obligations;

(H) Insurance of warranties or service contracts including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

(I) Ocean marine insurance;

(J) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk; or

(K) Any insurance provided by or guaranteed by government.

History. — Ga. L. 1970, p. 700, § 3; Ga. L. 1973, p. 497, §§ 1, 3; Ga. L. 1985, p. 1485, §§ 2-4; Ga. L. 1988, p. 13, § 33; Ga. L. 1989, p. 74, §§ 3, 4; Ga. L. 1996, p. 912, § 6; Ga. L. 2005, p. 563, § 12/HB 407; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 386, § 127/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "preceding" for "proceeding" near the end of paragraph (2); substituted "against which" for "against whom" in the middle of paragraph (5); and deleted "since July 1, 1970" following "in this state" in the middle of paragraph (8).

Editor's notes. — Ga. L. 1985, p. 1485, § 9, not codified by the General Assembly, provided that that Act would be applicable to all insolvencies occurring on or after July 1, 1985.

Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563/HB 407, became effective July 1, 2005.

JUDICIAL DECISIONS

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

County deemed "person." — County is a "legal entity" within the meaning of O.C.G.A. § 33-1-2 and is, therefore, a "person" within the meaning of that Code section and O.C.G.A. § 33-36-3. As a "person," if its stipulated net worth is more than $1 (now $3) million, its claim is not covered by O.C.G.A. § 33-36-1 et seq. Georgia Insurers Insolvency Pool v. Elbert County, 258 Ga. 317, 368 S.E.2d 500 (1988).

Dollar limitation does not apply to a company with a net worth in excess of one million dollars, when that company asserts a claim for return of unearned premiums as the assignee and attorney-in-fact for individual policy holders who would be entitled to the premiums but for the assignments. United Budget Co. v. Georgia Insurers Insolvency Pool, 253 Ga. 435, 321 S.E.2d 333 (1984).

Application of dollar limitation. — Third-party claim against an insured employer for indemnification arising out of a suit against the third party by the employer's employee was an obligation owed by the employer's insolvent insurer to the employer rather than to the third party, for purposes of the dollar limitation; the third-party claimant had assets over $3 million and the employer did not. Georgia Insurers Insolvency Pool v. Southeast Atl. Cargo Operators, Inc., 211 Ga. App. 660, 440 S.E.2d 254 (1994).

Even if the Georgia Insurer's Insolvency Pool (GIIP) had a valid defense, i.e., the claimant was a person with a net worth in excess of $3 million, absolving it from liability, the insured could not assert the defense to substantively bar the claimant's tort action against it and, if the claimant recovered against the insured, the insured's obligation to pay the claimant's judgment was not dependent on the

GIIP's obligation to reimburse the insured. United States v. Rutland, Inc., 849 F. Supp. 806 (S.D. Ga. 1994), aff'd, 46 F.3d 71 (11th Cir. 1995).

Defense set forth in O.C.G.A. § 33-36-3, which is available to the Georgia Insurers Insolvency Pool (GIIP), could not be asserted by the insured whose insurer has been declared insolvent and whose defense was being maintained by the GIIP, when the GIIP has not been made a party to the action. Norman Enters. Interior Design, Inc. v. DeKalb County, 245 Ga. App. 538, 538 S.E.2d 130 (2000).

"Covered claims." — When an award of attorney fees was assessed against an employer and the employer's insurer, who had become insolvent, and the award was therefore not a "covered claim" under O.C.G.A. § 33-36-3, the employer's responsibility to pay the award was, nevertheless, not thereby extinguished. Claxton Mfg. Co. v. Hodges, 201 Ga. App. 371, 411 S.E.2d 109 (1991).

Georgia Insurers Insolvency Pool Act, O.C.G.A. § 33-36-1 et seq., did not bar assignee's subrogation claim against an insolvent Florida corporation based on negligent construction of power lines that killed a worker in Georgia because it was not a "covered claim" under O.C.G.A. § 33-36-3(4); district court erred in barring the claim under the Florida Insurance Guaranty Association Act, Fla. Stat. § 631.54, because Florida law was not applicable under Georgia's ex loci delicti choice of law rule. Federated Rural Elec. Ins. Exch. v. R. D. Moody & Assocs., 468 F.3d 1322 (11th Cir. 2006).

Application of net worth exemption to county. — Trial court did not err in excluding a county from Georgia Insurers Insolvency Pool because it met the net worth exemption provided for in the Georgia Insurers Insolvency Pool Act (Act), O.C.G.A. § 33-36-3(4)(G), and, therefore, did not qualify for coverage under the Act. Lumpkin County v. Ga. Insurers Insolvency Pool, 292 Ga. 76, 734 S.E.2d 880 (2012).

Assignee entitled to benefits. — That the insured's right to recover from the insolvent insurance company was assigned to another party did not relieve the pool from the statutory duty to pay the claim since an assignee of an insured who would be entitled to payment of a claim by the pool "stands in the shoes" of the insured and is entitled to the same benefits to which the insured would be entitled but for the assignment. J. Transport, Inc. v. Georgia Insurers Insolvency Pool, 209 Ga. App. 748, 434 S.E.2d 552 (1993).

Cited in Crider v. Georgia Life & Health Ins. Guar. Ass'n, 188 Ga. App. 407, 373 S.E.2d 30 (1988); Garel v. Georgia Insurers' Insolvency Pool, 191 Ga. App. 572, 382 S.E.2d 400 (1989).

OPINIONS OF THE ATTORNEY GENERAL

"Covered claims." — O.C.G.A. § 33-36-3 excludes from the definition of "covered claims" unearned premiums on an insurance policy resulting from a completed audit. 1994 Op. Att'y Gen. No. 94-3.

33-36-4. Insurers Solvency Board.

(a) There shall be a board of trustees of the Georgia Insurers Insolvency Pool which shall be known as the Insurers Solvency Board and which shall consist of seven members. At all times, the board shall contain at least one member from a domestic insurer. The members of the board shall not be considered employees of the department. The members of the board shall be selected by the Commissioner. Each board member so selected shall represent a company licensed to do business in Georgia. Any member may be removed from office by the Commissioner when, in his or her judgment, the public interest may so require. Each member appointed shall serve for a term of three years

and until his or her successor has been appointed and qualified and, in case of a vacancy for any reason in the office of any such member, the Commissioner shall appoint a member to fill the unexpired term of such vacant office.

(b) In approving selections to the board, the Commissioner shall consider among other things whether all member insurers are fairly represented.

(c) The actual expenses of the members of the board incurred in attending meetings shall be paid out of the assets of the insolvency pool, but members of the board shall not otherwise be compensated by the pool for their services. For the purpose of considering questions before it, the board shall have access to all the books, records, reports, and papers in the department, including all confidential communications; and the members of the board shall treat such communications as confidential.

History. — Ga. L. 1970, p. 700, § 15; Ga. L. 1985, p. 1485, §§ 5, 6; Ga. L. 2005, p. 563, § 13/HB 407.

Editor's notes. — Ga. L. 1985, p. 1485, § 9, not codified by the General Assembly, provided that that Act would be applicable to all insolvencies occurring on or after July 1, 1985.

Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-5. Insurers required to become members of pool.

Every insurer authorized to write property or casualty insurance policies in this state shall be a member of the insolvency pool and shall be liable for assessments pursuant to Code Section 33-36-7 and shall also be responsible for the other obligations imposed pursuant to this chapter.

History. — Ga. L. 1970, p. 700, § 4.

JUDICIAL DECISIONS

Purpose and practice of insolvency pool. — When an insurer becomes insolvent, the Georgia Insurers Insolvency Pool is required to fulfill the insurer's obligations to the insured. United States v. Rutland, Inc., 849 F. Supp. 806 (S.D. Ga. 1994), aff'd, 46 F.3d 71 (11th Cir. 1995).

Cited in Freeman v. Criterion Ins. Co., 693 F.2d 1021 (11th Cir. 1982); Norman Enters. Interior Design, Inc. v. DeKalb County, 245 Ga. App. 538, 538 S.E.2d 130 (2000).

RESEARCH REFERENCES

ALR. — Sufficiency of notice of claim against local government unit as regards identity, name, address, and residence of claimant, 53 A.L.R.5th 617.

33-36-6. Plan to govern members; rules; requirements for plan; assignment of claims or judgments against insolvent insurers; claimants of assets of insolvent insurers; jurisdiction; venue.

(a) The Georgia Insurers Insolvency Pool is a nonprofit legal entity with the right to bring and defend actions and such right to bring and defend actions includes the power and right to intervene as a party before any court in this state that has jurisdiction over an insolvent insurer as defined in this chapter. The pool shall adopt, and the Commissioner shall approve, a reasonable plan which is not inconsistent with this chapter and which is fair to insurers and equitable to their policyholders, pursuant to which all admitted insurers shall become members of the pool. All members of the pool shall adhere to the rules of the plan. The plan may be amended by an affirmative vote of a majority of the Insurers Solvency Board.

(b) If, for any reason, the pool fails to adopt a suitable plan, or if, at any time, the pool fails to adopt necessary amendments to the plan, the Commissioner shall adopt and promulgate, after a hearing, such reasonable rules as are necessary to effectuate this chapter. The rules shall continue in force until modified by the Commissioner or superseded by a plan of operation adopted by the pool and approved by the Commissioner.

(c) The plan as provided for in subsection (a) of this Code section shall:

(1) Establish the procedures whereby all the powers and duties of the pool under this chapter will be performed;

(2) Establish procedures for handling assets of the pool;

(3) Mandate that procedures be established for the disposition of liquidating dividends or other moneys received from the estate of the insolvent insurer;

(4) Mandate that procedures be established to designate the amount and method of reimbursing members of the board of trustees under Code Section 33-36-4;

(5) Establish procedures by which claims may be filed with the pool and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the pool or its agent and a list of claims shall be

periodically submitted to the pool or insolvency fund or its equivalent in another state by the receiver or liquidator;

(6) Establish regular places and times for meetings of the board of trustees;

(7) Mandate that procedures be established for records to be kept of all financial transactions of the pool, its agents, and the board of trustees;

(8) Establish the procedures whereby selections for the board of trustees will be submitted to the Commissioner; and

(9) Contain additional provisions necessary or proper for the execution of the powers and duties of the pool.

(d) In accordance with the plan, the pool may designate insurers to act on behalf of the pool to carry out the purposes of this chapter, but a member may decline such designation. The Commissioner may disapprove such designation. The plan may provide a procedure under which pending claims or judgments against the insolvent insurer or its insureds are assigned to the member companies designated to act for the pool. The assignee-insurer is authorized to appear and defend a claim in a court of competent jurisdiction or otherwise and to investigate, adjust, compromise, and settle a covered claim or to investigate, handle, and deny a noncovered claim, and to do so on behalf of and in the name of the pool. If an assignee-insurer pays the covered claim, it shall be reimbursed by the pool or be entitled to set off said payment against future assessments. The unreimbursed claim of such an insurer against the pool shall be an admitted asset of the insurer. Insureds entitled to protection of this chapter shall cooperate with the pool and the assignee-insurer.

(e) The pool as a legal entity and any of its individual members shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer and except as otherwise provided in this chapter. The pool shall be subrogated to the rights of any insured or claimant, to the extent of a covered claim, to participate in the distribution of assets of the insolvent insurer to the extent that the pool has made payment. Any claimant or insured entitled to the benefits of this chapter shall be deemed to have assigned to the pool, to the extent of any payment received, his or her rights against the estate of the insolvent insurer. After determination of insolvency of any insurer, the pool shall be a party in interest in all proceedings involving policies insured or assumed by the pool with the same rights to receive notice and defend, appeal, and review as the insolvent insurer would have had if solvent. All moneys recovered under this Code section or any other Code section shall be added to the assessments collected under Code Section 33-36-7.

(f) Except for actions by member insurers aggrieved by final actions or decisions of the pool pursuant to Code Section 33-36-18, all actions relating to or arising out of this chapter against the pool must be brought in the courts in this state. Such courts shall have exclusive jurisdiction over all actions relating to or arising out of this chapter against the pool.

(g) Exclusive venue in any action by or against the pool is in the Superior Court of DeKalb County. The pool may, at the option of the pool, waive such venue as to specific actions.

History. — Ga. L. 1970, p. 700, § 7; Ga. L. 1989, p. 74, § 5; Ga. L. 2005, p. 563, § 14/HB 407; Ga. L. 2019, p. 386, § 128/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "a suitable plan, or if, at any time, the pool" for "a suitable plan within six months following July 1, 1970, or if at any time after July 1, 1970, the pool" in the first sentence of subsection (b).

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

JUDICIAL DECISIONS

Construction of exhaustion provision. — Georgia Court of Appeals held that the plain language of O.C.G.A. § 33-36-14(a) did not require that amount of offset must be for the same claim or for amounts paid by a solvent carrier that were also at issue under an insolvent carrier's policy underlying a claim against Georgia's Insurers Insolvency Pool. Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

33-36-7. Levy of assessments against insurers; reimbursement of expenses; refunds of assessments.

(a) For the purposes of administration and assessment under this Code section, the pool shall be divided into three separate accounts: (1) workers' compensation insurance account; (2) automobile insurance account; and (3) all other covered insurance account. Separate assessment shall be made for each account. No assessment shall be levied for any account as long as the assets held in such account are sufficient to cover all estimated payments for liquidation in process under the account.

(b) To the extent necessary to secure the funds for the respective accounts of the pool for the payment of covered claims and also to pay the reasonable costs to administer the pool, the Commissioner, upon certification of the pool, shall levy assessments in the proportion that each insurer's net direct written premiums in this state in the classes

protected by the account bear to the total of the net direct written premiums received in this state by all such insurers for the preceding calendar year for the kinds of insurance included within such account. Assessments shall be remitted to and administered by the pool in the manner specified by the approved plan. Each insurer so assessed shall have at least 30 days' written notice as to the date the assessment is due and payable. Every assessment shall be made as a uniform percentage applicable to the net direct written premiums of each insurer in the kinds of insurance included within the account in which the assessment is made. The assessments levied against any insurer shall not exceed in any one year more than 2 percent of that insurer's net direct written premiums in this state for the kinds of insurance included within such account during the calendar year next preceding the date of such assessments. If sufficient funds from the assessments, together with funds previously raised, are not available in any one year in the respective account to make all the payments or reimbursements then owing to insurers designated to act for the pool, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available.

(c) The pool may exempt any insurer from an assessment if an assessment by the pool would result in the insurer's financial statement reflecting an amount of capital or surplus less than the sum of the minimum amount required by any jurisdiction in which the insurer is authorized to transact insurance.

(d) Any necessary and proper expenses incurred by an insurer in the investigation, adjustment, compromise, settlement, denial, or handling of claims assigned to it shall, upon proper verification under the rules of the pool, entitle the insurer to reimbursement. Any insurer whose employee serves on the staff of the pool may set off from its assessment any necessary and proper expenses incurred by the insurer resulting from said service of its employee.

(e) An insurer which ceases to engage in the business of writing property or casualty insurance policies in this state shall have no right to a refund of any assessment previously remitted to the pool.

History. — Ga. L. 1970, p. 700, § 8; Ga. L. 1985, p. 1485, § 7; Ga. L. 2005, p. 563, § 15/HB 407.

Editor's notes. — Ga. L. 1985, p. 1485, § 9, not codified by the General Assembly, provided that that Act would be applicable to all insolvencies occurring on or after July 1, 1985.

Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-7.1. Surcharge on premiums to recoup assessments; disclosure to insureds; excess surcharges, exception where the expense of collection would exceed the amount of the surcharge.

(a) The plan adopted pursuant to Code Section 33-36-6 shall contain provisions whereby each member insurer is required to recoup over the year following the year of the assessment a sum calculated to recoup the assessments paid by the member insurer under this chapter by way of a surcharge on premiums charged for insurance policies to which this chapter applies. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

(b) The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. Member insurers who collect surcharges in excess of assessments paid pursuant to Code Section 33-36-7 for an insolvent insurer shall remit the excess to the pool as an additional assessment within 30 days after the pool has determined the amount of the excess recoupment and given notice to the member of that amount. The excess shall be applied to reduce future assessment charges in the appropriate category.

(c) The plan of operation may permit a member insurer to omit collection of the surcharge from its insureds when the expense of collecting the surcharge would exceed the amount of the surcharge. However, nothing in this Code section shall relieve the member insurer of its obligation to recoup the amount of surcharge otherwise collectable.

History. — Code 1981, § 33-36-7.1, enacted by Ga. L. 2005, p. 563, § 16/HB 407; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 386, § 129/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "this chapter" for "this article" near the end of the first sentence of subsection (a).

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-8. Issuance by Commissioner of notice of judicial determination of insolvency of insurer; requirement of notification of insureds by agents of insurer; publication of notice.

Upon the determination of a court of competent jurisdiction of the state of domicile of an insurer that the insurer is insolvent, the

Commissioner of this state shall promptly give notice of the insurer's insolvency by first-class mail to all persons known or reasonably expected to have or be interested in claims against the insurer at such person's last known address, all insureds of the insolvent insurer known to the Commissioner at such insured's last known address, and all insurers subject to this chapter. The Commissioner may also require each agent of the insolvent insurer to give prompt written notice by first-class mail at the insured's last known address to each insured of the insolvent insurer for whom he was agent of record. Notice shall also be given by publication in a newspaper of general circulation published in the county where the insurer had its principal office not less than once per week for four weeks and by publication elsewhere in this state as the court may direct.

History. — Ga. L. 1970, p. 700, § 5; Ga. L. 1982, p. 3, § 33; Ga. L. 1990, p. 8, § 33.

33-36-9. Coverage afforded by insolvent insurers to become obligation of pool; investigation and settlement of claims by pool.

In the event an insurer is ordered to be liquidated, the coverage afforded by property and casualty insurance policies issued by such insurer shall, with respect to covered claims, become the obligation of the pool for a period of 30 days from the date of such determination or until policy expiration date if less than said 30 days or until the policy has been replaced by the insurer within said 30 days. The pool shall be deemed the insurer only to the extent of its obligation on the covered claims and to such extent, subject to the limitations provided in this chapter, shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including, but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The pool shall not be deemed the insolvent insurer for any purpose relating to the issue of whether the pool is amenable to the personal jurisdiction of the courts of any state. The pool is authorized to investigate, adjust, compromise, and settle covered claims or to investigate, handle, and deny noncovered claims. The pool shall have the authority, upon approval of the Commissioner, to borrow funds necessary to effect the purposes of this chapter. The pool shall have the authority to establish procedures for requesting financial information from insureds on a confidential basis for purposes of applying Code sections concerning their net worth, subject to such information being shared with any other association similar to the pool and the liquidator for the insolvent company on the same confidential basis. If the insured refuses to provide the requested financial information and an auditor's certification of the same where requested and available, the pool may deem the net worth of the

insured, in the instance of a first-party claim, to be in excess of $10 million at the relevant time or, in the event of a third-party claim, to be in excess of $25 million at the relevant time. In any lawsuit contesting the applicability of subparagraph (G) of paragraph (4) of Code Section 33-36-3 or subsection (d) of Code Section 33-36-14 where the insured has declined to provide financial information under the procedure provided pursuant to this Code section, the insured shall bear the burden of proof concerning its net worth at the relevant time. If the insured fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the pool its full costs, expenses, and reasonable attorney's fees in contesting the claim.

History. — Ga. L. 1970, p. 700, § 6; Ga. L. 1973, p. 497, § 3; Ga. L. 1982, p. 3, § 33; Ga. L. 2005, p. 563, § 17/HB 407; Ga. L. 2013, p. 141, § 33/HB 79.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

JUDICIAL DECISIONS

Purpose and practice of insolvency pool. — When an insurer becomes insolvent, the Georgia Insurers Insolvency Pool is required to fulfill the insurer's obligations to the insured. United States v. Rutland, Inc., 849 F. Supp. 806 (S.D. Ga. 1994), aff'd, 46 F.3d 71 (11th Cir. 1995).

Insurer's Insolvency Pool is liable only for contractual obligations of an insolvent insurer and not an insurer's statutory obligations such as attorney's fees and punitive damages under O.C.G.A. § 33-34-6. Colwell v. Voyager Cas. Ins. Co., 184 Ga. App. 842, 363 S.E.2d 310 (1987).

Construction of exhaustion provision. — Georgia Court of Appeals held that the plain language of O.C.G.A. § 33-36-14(a) did not require that the amount of offset must be for the same claim or for amounts paid by a solvent carrier that were also at issue under an insolvent carrier's policy underlying a claim against Georgia's Insurers Insolvency Pool. Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

Application of net worth exemption to county. — Trial court did not err in excluding a county from Georgia Insurers Insolvency Pool because it met the net worth exemption provided for in the Georgia Insurers Insolvency Pool Act (Act), O.C.G.A. § 33-36-1 et seq., and, therefore, did not qualify for coverage under the Act. Lumpkin County v. Ga. Insurers Insolvency Pool, 292 Ga. 76, 734 S.E.2d 880 (2012).

Cited in Norman Enters. Interior Design, Inc. v. DeKalb County, 245 Ga. App. 538, 538 S.E.2d 130 (2000); Royal Indem. Co. v. Ga. Insurers Insolvency Pool, 284 Ga. App. 787, 644 S.E.2d 279 (2007).

OPINIONS OF THE ATTORNEY GENERAL

Claims of Georgia residents for unearned premiums on insurance contracts with an insolvent property insurer are obligations of the Georgia Insurers' Insolvency Pool. 1982 Op. Att'y Gen. No. 82-80.

With regard to a claim by an auto dealer against the Georgia Insurers' Insolvency Pool for unearned premium on extended auto warranty insurance contract issued by an insolvent insurer, when the dealer had only one policy and did not have a separate policy for each warranty sold, the dealer would be entitled to an unearned premium refund based upon total or aggregate premium paid for the dealer's single policy. 1982 Op. Att'y Gen. No. 82-80.

33-36-10. Recovery under chapter of covered claims recoverable under insolvency funds of other states.

(a) It is not the purpose of this chapter to provide or permit duplicate recoveries of covered claims under this chapter and an insolvency fund or its equivalent of any other state. In the construction and application of this chapter with respect to a covered claim which may be recoverable under this chapter and under an insolvency fund or its equivalent in another state, the sole recovery: (1) with respect to a workers' compensation claim, shall be under the insolvency fund or its equivalent of the state of residence of the claimant; (2) with respect to a first-party claim of an insured for damage to or destruction of property with a permanent location, shall be under the insolvency fund or its equivalent of the state where the property is permanently situated; and (3) with respect to any other covered claim, shall be under the insolvency fund or its equivalent of the state of residence of the insured.

(b) Any recovery obtained from the pool pursuant to this chapter shall be reduced by those amounts recovered in any other state from a similar or equivalent insolvency fund in such state when the recovery was obtained by the same claimant for the same claim filed against the pool in this state.

History. — Ga. L. 1970, p. 700, § 16; Ga. L. 1989, p. 74, § 6.

JUDICIAL DECISIONS

Choice of law. — Georgia Insurers Insolvency Pool Act, O.C.G.A. § 33-36-1 et seq., did not bar the assignee's subrogation claim against an insolvent Florida insurer based on the negligent construction of power lines that killed a worker in Georgia because it was not a "covered claim" under O.C.G.A. § 33-36-3(4); also, O.C.G.A. § 33-36-10 did not mandate application of the Florida Insurance Guaranty Association Act, Fla. Stat. § 631.50-.70, because O.C.G.A. § 33-36-10 was intended to prevent duplicative recoveries when more than one state's insolvent insurer scheme applied, rather than to referee the more general question of which state's statutory scheme controlled in a conflict of law situation. Federated Rural Elec. Ins. Exch. v. R. D. Moody & Assocs., 468 F.3d 1322 (11th Cir. 2006).

33-36-11. Limitation for filing claims; claims filed after final date set by court; default judgments.

(a) Notwithstanding any other provisions of this chapter, except as provided for in Code Section 33-36-20, a covered claim shall not include a claim filed with the pool after the earlier of (1) 18 months after the date of the order of liquidation, or (2) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer and shall not include any claim filed with the pool or a liquidator for protection afforded under the insured's policy for incurred but not reported losses.

(b) The pool may not be found in default. No default judgments may be entered against the pool, the insolvent insurer, or the insured of the insolvent insurer after the instigation of an insolvency proceeding prior to an order of liquidation, nor during the pendency of insolvency proceedings, nor during a 120 day stay following an order of liquidation.

(c) In no instance may a finding of default or the entry of a default judgment against an insurer be applicable or enforceable against the pool or the insured of the insolvent insurer.

History. — Ga. L. 1970, p. 700, § 9; Ga. L. 1989, p. 74, § 7; Ga. L. 1992, p. 6, § 33; Ga. L. 2005, p. 563, § 18/HB 407; Ga. L. 2010, p. 1085, § 1/HB 1364; Ga. L. 2013, p. 141, § 33/HB 79.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-12. Powers and duties of Commissioner as to collection of assessments; judicial review.

The Commissioner shall bring an action for and recover, on behalf of the pool, any assessment not paid when due. He may, after notice and hearing, revoke the certificate of authority to transact business in this state of an insurer who is a member of the pool which fails to pay an assessment when due as provided in this chapter and after demand having been made or which otherwise fails to comply with the plan as approved pursuant to Code Section 33-36-6. Any action taken by the Commissioner shall be subject to judicial review as provided in Code Sections 33-2-26 through 33-2-28.

History. — Ga. L. 1970, p. 700, § 12.

33-36-13. Allowance of claims by receivers, liquidators, or statutory successors; appointment of pool as insurer's agent.

With respect to insolvent insurers incorporated in this state, the receiver, liquidator, or statutory successor shall allow as a proper claim on the assets of the insolvent insurer amounts paid under this chapter by or on behalf of the pool or paid by an insolvency fund or its equivalent in another state on or with respect to covered claims, notwithstanding provisions to the contrary in any statute of this state relating to the rights and duties of such receiver, liquidator, or statutory successor. As a condition of an insurer doing business in this state, all property and casualty insurance policies issued or renewed shall be deemed to provide that the insurer appoints the pool as its agent with respect to investigation, adjustment, compromise, and settlement of covered claims and to reimburse the pool for any payment made under the terms of this chapter, and that such appointment and obligation shall be binding on any receiver, liquidator, or statutory successor appointed to liquidate or wind up its affairs.

History. — Ga. L. 1970, p. 700, § 10; Ga. L. 2005, p. 563, § 19/HB 407.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24,/HB 407 to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-14. Exhaustion of rights by claimants against insolvent insurers prior to recovery; recovery of payment to claimants in excess of amounts authorized; reduction of liability of insured; recovery of amounts paid on behalf of certain persons.

(a) Except as provided for in Code Section 33-36-20, any person having a claim against a policy or an insured under a policy issued by an insolvent insurer, which claim is a covered claim and is also a claim within the coverage of any policy issued by a solvent insurer, shall be required to exhaust first his or her rights under such policy issued by the solvent insurer. The policy of the solvent insurer shall be treated as primary coverage and the policy of the insolvent insurer shall be treated as secondary coverage and his or her rights to recover such claim under this chapter shall be reduced by any amounts received from the solvent insurers.

(b) Any amount paid a claimant in excess of the amount authorized by this chapter may be recovered by an action brought by or on behalf of the pool.

(c) To the extent that the pool's obligation is reduced by the application of this Code section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

(d) Except as provided for in Code Section 33-36-20, the pool shall have the right to recover from the following persons all amounts paid by the pool on behalf of such person, whether for indemnity or defense or otherwise:

(1) Any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds $25 million, provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and

(2) Any person who is an affiliate of the insolvent insurer.

History. — Ga. L. 1970, p. 700, § 11; Ga. L. 1982, p. 3, § 33; Ga. L. 1989, p. 74, § 8; Ga. L. 2005, p. 563, § 20/HB 407; Ga. L. 2010, p. 1085, § 2/HB 1364; Ga. L. 2012, p. 1350, § 9/HB 1067.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

Law reviews. — For annual survey of law on workers' compensation, see 62 Mercer L. Rev. 383 (2010). For annual survey on worker's compensation, see 71 Mercer L. Rev. 345 (2019).

JUDICIAL DECISIONS

Construction of exhaustion provision. — Georgia Court of Appeals held that the plain language of O.C.G.A. § 33-36-14(a) did not require that the amount of offset must be for the same claim or for amounts paid by a solvent carrier that were also at issue under an insolvent carrier's policy underlying a claim against Georgia's Insurers Insolvency Pool. Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

Trial court erred by limiting offset rights of the Georgia's Insurers Insolvency Pool (Pool) under O.C.G.A. § 33-36-14(a) to amounts received by the insured specific to lost wages and medical expenses because the language of O.C.G.A. § 33-36-14(a) did not require that a policy issued by an insolvent carrier under which a claim against the Pool arises had to be for the same type of coverage as provided by the solvent insurer's policy. Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

Insolvency not bar to action against defendants. — When the defendants' li-

ability carrier becomes insolvent, a plaintiff's apparently good faith settlement with the plaintiff's own uninsured motorist carrier for less than the policy limits does not provide the defendants with a personal defense so as to bar the plaintiff's pursuit of a tort action against them. Plaintiff's compliance or noncompliance with subsection (a) of O.C.G.A. § 33-36-14 is only a relevant inquiry if and when the plaintiff obtains a judgment against the defendants. Lee v. Fulton Concrete Co., 195 Ga. App. 348, 393 S.E.2d 449 (1990) (applying statutory language prior to 1989 amendment).

In an action against defendants whose liability carrier became insolvent, matters of the existence or nonexistence of uninsured motorist coverage and compliance or noncompliance with O.C.G.A. § 33-36-14 did not constitute defenses available to the defendants, and any decision as to who might be ultimately liable for any decision against the defendants was not ripe for adjudication. Reid v. United States Fid. & Guar. Co., 223 Ga. App. 204, 477 S.E.2d 369 (1996), aff'd, 268 Ga. 432, 491 S.E.2d 50 (1997).

When the defendant's liability insurance carrier was declared insolvent after suit was filed, the issue whether the plaintiffs' failure to serve their uninsured motorist insurer evinced a failure to "exhaust" their rights under their own policy was not ripe since judgment had not yet been rendered against the tortfeasor. Grigsby v. White, 228 Ga. App. 682, 492 S.E.2d 603 (1997).

Failure to obtain uninsured motorist benefits prior to the date the tortfeasor's liability insurer became insolvent did not bar the insured's claim to Georgia Insurer's Insolvency funds since, because the two-year personal injury statute of limitations had expired when the tortfeasor's insurer became insolvent, the insured had no benefit rights to exhaust under the insured's uninsured motorist coverage. G & MSS Trucking, Inc. v. Rich, 224 Ga. App. 130, 479 S.E.2d 761 (1996).

No coverage by solvent insurer. — Passenger's uninsured motorist (UM) insurer was not required to provide the $15,000 bodily injury coverage afforded by the insolvent insurer for a permissive driver under O.C.G.A. § 33-36-14(a) because the UM insurer's benefits were not available to the passenger as the owner's UM coverage was not available to stack with the UM insurer's coverage as the owner's insurer was the liability insurer with respect to the single car accident; therefore, the passenger's claim was not a claim within the coverage of a policy issued by the UM insurer as required by § 33-36-14. Jefferson Ins. Co. v. Thomas, 278 Ga. App. 89, 628 S.E.2d 171 (2006).

Medical expenses paid by an insured's own carrier reduced the liability of the Georgia Insurers Insolvency Pool; the fact such carrier might have a subrogation claim against the tortfeasor did not give the insured the right to collect the amount from the pool. G & MSS Trucking, Inc. v. Rich, 224 Ga. App. 130, 479 S.E.2d 761 (1996).

Court lacked subject matter jurisdiction under earlier provisions in subsection (a). — Because: (1) resolution of the issues raised in a petition filed by the Georgia Insurers Insolvency Pool were dependent upon a determination by the State Board of Workers' Compensation of the amount, if any, an injured employee was entitled to recover in the pending, unresolved claim for workers' compensation; and (2) after a notice to controvert was filed, the Board never held a hearing or issued any findings with regard to liability for the claim, the trial court lacked subject matter jurisdiction to determine the applicability of earlier provisions of O.C.G.A. § 33-36-14(a) to the Pool's claim against an insurer, after another carrier became insolvent, and hence, grant the Pool summary judgment in its declaratory judgment action. Royal Indem. Co. v. Ga. Insurers Insolvency Pool, 284 Ga. App. 787, 644 S.E.2d 279 (2007), cert. denied, No. S07C1207, 2007 Ga. LEXIS 639 (Ga. 2007).

33-36-14.1. Recommendations and report by the board of trustees.

(a) To aid in the detection and prevention of insurer insolvencies:

(1) The board of trustees may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies;

(2) The board of trustees may, upon majority vote, make recommendations to the Commissioner on matters generally related to improving or enhancing regulation for solvency; and

(3) The board of trustees may, at the conclusion of any domestic insurer insolvency in which the pool was obligated to pay covered claims, prepare a report on the history and causes of such insolvency based on the information available to the pool and submit such report to the Commissioner.

(b) Reports and recommendations made pursuant to this Code section shall not be considered public documents.

History. — Code 1981, § 33-36-14.1, enacted by Ga. L. 2005, p. 563, § 21/HB 407.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-15. Examination of pool.

The pool shall be deemed a company or insurer within the scope of Code Section 33-2-11 relating to examinations. Notwithstanding the provisions of Code Section 33-2-11 or this Code section, whether such examinations shall be conducted and the frequency of any such examinations shall be at the sole discretion of the Commissioner.

History. — Ga. L. 1970, p. 700, § 13; Ga. L. 2005, p. 563, § 22/HB 407.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that the amendment to this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-16. Exemption from taxation of pool.

The pool shall be exempt from all license fees, income, franchise, privilege, occupation, or other taxes levied or assessed by the state, any municipality, county, or other political subdivision of the state, except state, county, or municipal taxes upon the real or personal property of the pool, which shall be assessed and taxed in the same manner as real property and personal property of other nonexempt persons.

History. — Ga. L. 1970, p. 700, § 14.

33-36-16.1. Immunity from liability for performance of powers and duties under this chapter.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, the pool or its agents or employees, the board of trustees, or any person serving as a representative of any member of the board of trustees for any action taken or any failure to act by them in the performance of their powers and duties under this chapter.

History. — Code 1981, § 33-36-16.1, enacted by Ga. L. 2005, p. 563, § 23/HB 407.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, a comma was inserted following "arise against" near the beginning of this Code section.

Editor's notes. — Ga. L. 2005, p. 563, § 24/HB 407, not codified by the General Assembly, provides that this Code section shall apply to insolvencies which occur on or after July 1, 2005.

Ga. L. 2006, p. 887, § 1/HB 1444, not codified by the General Assembly, amended Ga. L. 2005, p. 563, § 24/HB 407, to read: "The provisions of Section 12 of this Act shall apply to insolvencies that occur on or after the effective date of this Act. All other provisions shall apply as of the effective date of this Act." Ga. L. 2005, p. 563, became effective July 1, 2005.

33-36-17. Termination of operation of pool as to particular kinds of insurance; proceeds upon termination of operation of pool; expiration of pool.

(a) The Commissioner shall by order terminate the operation of the insolvency pool as to any kind of insurance afforded by property or casualty insurance policies with respect to which he has found, after hearing, that there is in effect a statutory or voluntary plan which:

(1) Is a permanent plan which is adequately funded or for which adequate funding is provided; and

(2) Extends, or will extend to the Georgia policyholders and residents, protection and benefits with respect to insolvent insurers not substantially less favorable and effective to such policyholders

and residents than the protection and benefits provided with respect to that kind of insurance under this chapter.

(b) The Commissioner shall by the same order authorize discontinuance of future payments by insurers to the insolvency pool with respect to the same kinds of insurance, provided that assessments and payments shall continue as necessary to liquidate covered claims of insurers adjudged insolvent prior to the order and the related expenses not covered by the other plan.

(c) In the event the operation of any account of the insolvency pool shall be so terminated as to all kinds of insurance otherwise within its scope, the pool as soon as possible after the termination shall distribute the balance of moneys and assets remaining in the account (after discharge of the functions of the pool with respect to prior insurer insolvencies not covered by such other plan, together with related expenses) to the insurers which are then writing in this state policies of the kinds of insurance covered by such account, and which had made payments into such account, pro rata upon the basis of the aggregate of the payments made by the respective insurers to the account during the period of five years preceding the date of the order. Upon completion of such distribution with respect to all of the accounts specified in Code Section 33-36-7, this chapter shall be deemed to have expired.

History. — Ga. L. 1970, p. 700, § 17; Ga. L. 1982, p. 3, § 33.

33-36-18. Appeal to Commissioner; judicial review.

Any action of the Insurers Solvency Board may be appealed to the Commissioner by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction.

History. — Code 1981, § 33-36-18, enacted by Ga. L. 1985, p. 1485, § 8.

Editor's notes. — Ga. L. 1985, p. 1485, § 9, not codified by the General Assembly, provided that that Act would be applicable to all insolvencies occurring on or after July 1, 1985.

33-36-19. Advertisements, announcements, or statements using insolvency pool for purpose of sales.

(a) No person, including an insurer or agent or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public in any newspaper, magazine, or other publication; in the form of a notice, circular, pamphlet, letter, or poster; over any radio station or television station; or in any other way

any advertisement, announcement, or statement which uses the existence of the pool for the purposes of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter. This Code section shall not apply to the pool or any other entity which does not sell or solicit insurance.

(b) Any person who violates subsection (a) of this Code section may, after notice and hearing and upon order of the Commissioner, be subject to one or both of the following:

(1) A monetary penalty of not more than $1,000.00 for each act or violation, but not to exceed an aggregate penalty of $10,000.00; or

(2) Suspension or revocation of his license or certificate of authority.

History. — Code 1981, § 33-36-19, enacted by Ga. L. 1989, p. 74, § 9.

33-36-20. Liability of pool to claimants and electing insureds in emergency circumstances; definitions; exceptions.

(a) It is the policy of this state to protect insureds and their claimants from liability as a result of the insolvency of insurers. In furtherance of this policy, it is the intent of the legislature, notwithstanding any provision of law to the contrary, that the Georgia Insurers Insolvency Pool shall be liable to claimants and electing insureds in emergency circumstances.

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

(1) "Electing insured" means any insured under a workers' compensation insurance policy that is impacted by an emergency circumstance. Such term shall include but not be limited to governmental insureds and other insureds under a workers' compensation insurance policy impacted by an emergency circumstance whose net worth exceeds $25 million as of December 31 of the year preceding the filing of a claim.

(2) "Emergency circumstance" means a circumstance in which an association or industrial insured captive insurance company, including such a captive company that subsequently was authorized to transact business pursuant to Chapter 3 of this title, that is issuing, or which has issued, workers' compensation insurance contracts and has been declared insolvent.

(3) "Emergency claimant" means any third-party claimant, under a workers' compensation insurance policy, who is impacted by an emergency circumstance and whose employer has, by a court of competent jurisdiction, been declared bankrupt or insolvent.

(c) Any electing insured whose net worth is less than $25 million as of December 31 of the year preceding the filing of a claim may be shielded from liability by the pool and have any workers' compensation claims filed against such electing insured covered by the pool, provided said electing insured pays $10,000.00 per claim to the insolvency pool prior to October 1, 2010. Any electing insured whose net worth exceeds $25 million as of December 31 of the year preceding the filing of a claim may be shielded from liability by the pool and have any workers' compensation claims filed against such electing insured covered by the pool, provided said electing insured pays $50,000.00 per claim to the insolvency pool prior to October 1, 2010. Claims of all emergency claimants shall be covered by the insolvency pool.

(d) Claimants shall retain the right to pursue claims against any insured that is not an electing insured.

History. — Code 1981, § 33-36-20, enacted by Ga. L. 2010, p. 1085, § 3/HB 1364.

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Employee's failure to prove insolvency. — Employee seeking workers' compensation from the Georgia Insurers Insolvency Pool failed to prove that the employer was insolvent as required for recovery under O.C.G.A. § 33-36-20(b)(2) and (3) based on the owner's non-credible testimony that the owner had sold the company and that the buyer had defaulted on the buyer's loans from the owner. Reece v. Ga. Insurers Insolvency Pool, 324 Ga. App. 437, 750 S.E.2d 746 (2013).

CHAPTER 37

INSURERS REHABILITATION AND LIQUIDATION

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Cross references. — Dissolution of secretary of state corporations generally, § 14-4-160 et seq.

Editor's notes. — Ga. L. 1991, p. 1424, effective July 1, 1991, repealed the chapter formerly codified at this chapter and enacted the current chapter. The former chapter consisted of Code Sections 33-37-1 through 33-37-50 and was based on Ga. L. 1960, p. 289, § 1; Ga. L. 1976, p. 1076,

§§ 1, 2; Ga. L. 1981, Ex. Sess. p. 8; Ga. L. 1982, p. 3, § 331; Ga. L. 1985, p. 1087, § 6; Ga. L. 1986, p. 10, § 33; and Ga. L. 1990, p. 8, § 33.

Law reviews. — For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999).

For note on 1991 revision of this chapter, see 8 Ga. St. U.L. Rev. 89 (1992).

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Cited in Preferred Ins. Co. v. Bentley, 223 Ga. 735, 157 S.E.2d 737 (1967); Preferred Ins. Co. v. Bentley, 225 Ga. 160, 166 S.E.2d 340 (1969).

ARTICLE 1

GENERAL PROVISIONS

33-37-1. Construction and purpose of chapter.

(a) This chapter shall be known and may be cited as the "Insurers Rehabilitation and Liquidation Act."

(b) This chapter shall not be interpreted to limit the powers granted the Commissioner by other provisions of law.

(c) This chapter shall be liberally construed to effect the purpose stated in subsection (d) of this Code section.

(d) The purpose of this chapter is the protection of the interests of insureds, claimants, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(1) Early detection of any potentially dangerous condition in an insurer and prompt application of appropriate corrective measures;

(2) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(3) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(4) Equitable apportionment of any unavoidable loss;

(5) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

(6) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business; and

(7) Providing for a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to this

chapter as part of the regulation of the business of insurance, insurance industry, and insurers in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

History. — Code 1981, § 33-37-1, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "interference" was substituted for "interferance" in subsection (d).

Law reviews. — For note, "Misrepresentations and Nondisclosures in the Insurance Application," see 13 Ga. L. Rev. 876 (1979).

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Trial court required to grant stay based on order of New York court. — Because a New York Order of Rehabilitation enjoined any actions, lawsuits, or proceedings against an insurance company, pursuant to O.C.G.A. § 33-37-23(a), the trial court was required to grant a stay as to proceedings against the insurance company in order to give full faith and credit to the injunction ordered by the New York court. Aon Risk Servs. v. Commercial & Military Sys. Co., 270 Ga. App. 510, 607 S.E.2d 157 (2004).

Claims in common with the insolvent trust fund versus personal claims. — Trial court erred in dismissing the plaintiffs' breach of contract, misrepresentation, and other claims against a workers compensation trust fund because while the court properly concluded that the Georgia Insurance Commissioner, as an appointed receiver, had the exclusive authority to prosecute legal claims that were common to the insolvent trust fund, the court erred in finding that plaintiffs did not have standing to prosecute claims that were personal in nature and not common to the trust fund. Superior Roofing Co. of Ga., Inc. v. Am. Prof'l Risk Servs., 323 Ga. App. 416, 744 S.E.2d 400 (2013).

Cited in Georgia Insurers Insolvency Pool v. Dubose, 349 Ga. App. 238, 825 S.E.2d 606 (2019).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 127, 190, 226 et seq., 249 et seq.

ALR. — Validity, construction, and application of Uniform Insurers Liquidation Act, 44 A.L.R.5th 683.

33-37-2. Applicability.

The proceedings authorized by this chapter may be applied to:

(1) All insurers who are doing or have done an insurance business in this state and against whom claims may arise from such business;

(2) All insurers who purport to do an insurance business in this state;

(3) All insurers who have insureds resident in this state;

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(5) All nonprofit service plans and all fraternal benefit societies;

(6) All title insurance companies; and

(7) All prepaid health care delivery plans, health care plans, and health maintenance organizations.

History. — Code 1981, § 33-37-2, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 386, § 130/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "claims may arise from such business" for "claims arising from that business may exist now or in the future" at the end of paragraph (1).

Cross references. — Domestic stock and mutual insurers, T. 33, C. 14. Reciprocal insurers, T. 33, C. 17.

33-37-3. Definitions.

As used in this chapter, the term:

(1) "'Ancillary state" means any state other than a domiciliary state.

(2) "Creditor" means a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(3) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving such insurer and any summary proceeding under Code Section 33-37-9. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(4) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(A) The issuance or delivery of contracts of insurance to persons resident in this state;

(B) The solicitation of applications for such contracts or other negotiations preliminary to the execution of such contracts;

(C) The collection of premiums, membership fees, assessments, or other consideration for such contracts;

(D) The transaction of matters subsequent to execution of such contracts and arising out of them; or

(E) Operating under a license or certificate of authority, as an insurer, issued by the Department of Insurance.

(5) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(6) "Fair consideration" means:

(A) When in exchange for property or obligation as a fair equivalent therefor and in good faith, property is conveyed, services are rendered, an obligation is incurred, or an antecedent debt is satisfied; or

(B) When property or obligation is received in good faith to secure a present advance or antecedent, debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(7) "Federal home loan bank" means a federal home loan bank established under the federal Home Loan Bank Act, 12 U.S.C. Section 1421, et seq.

(8) "Foreign country" means any other jurisdiction not in any state.

(9) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, general assets includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors in more than a single state shall be treated as general assets.

(10) "Guaranty association" means the Georgia Insurers Insolvency Pool created by Chapter 36 of this title, the Georgia Life and Health Insurance Guaranty Association created by Chapter 38 of this title, and any other similar entity now or hereafter created by the General Assembly for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(11) "Insolvency" or "insolvent" means:

(A) For an insurer issuing only assessable fire insurance policies:

(i) The inability to pay any obligation within 30 days after it becomes payable; or

(ii) If an assessment is made within 30 days after an obligation becomes payable, the inability to pay such obligation 30 days following the date specified in the first assessment notice issued after the date of loss; and

(B) For any other insurer, the inability to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(i) Any capital and surplus required by law for its organization; or

(ii) The total par or stated value of its authorized and issued capital stock.

For purposes of this paragraph, "liabilities" shall include, but not be limited to, reserves required by statute or by regulations or specific requirements imposed by the Commissioner upon a subject company at the time of admission or subsequent thereto.

(12) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do an insurance business and is or has been subject to liquidation, rehabilitation, reorganization, supervision, the authority of, or conservation by any state insurance regulatory official. For purposes of this chapter, any other persons included under Code Section 33-37-2 shall be deemed to be insurers.

(13) "Insurer-member" means an insurer who is a member of a federal home loan bank.

(14) "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

(15) "Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

(16) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(17) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(18) "State" means any state, district, or territory of the United States.

(19) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property, an interest therein, the possession thereof or of fixing a lien upon property or upon an interest therein, whether absolutely or conditionally, voluntarily, or by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

History. — Code 1981, § 33-37-3, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2015, p. 377, § 2-1/HB 552; Ga. L. 2016, p. 816, § 1/HB 883; Ga. L. 2019, p. 386, § 131/SB 133.

The 2019 amendment, effective July 1, 2019, deleted former paragraph (2), which read: "'Commissioner' means the Commissioner of Insurance."; redesignated former paragraphs (3) through (7.1) as present paragraphs (2) through (7), respectively; substituted "Department of Insurance" for "Insurance Department" in subparagraph (4)(E); added "and" at the end of division (11)(A)(ii); substituted a period for "; and" at the end of division (11)(B)(ii); deleted former subparagraph (11)(C), which read: "As to any insurer licensed to do business in this state as of July 1, 1991, which does not meet the standard established under subparagraph (B) of this paragraph, for a period not to exceed three years from July 1, 1991, the inability to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the Commissioner under provisions of this title."; and redesignated former paragraphs (12.1) through (18) as present paragraphs (13) through (19), respectively.

Cross references. — Venue of actions against insurance companies generally, § 33-4-1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, a quotation mark was added at the beginning of paragraph (19).

Law reviews. — 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

Reciprocal state. — Arizona is a reciprocal state as Arizona has adopted and substantially put into effect the equivalent of certain key provisions found in O.C.G.A. § 33-37-1 et seq. Smith v. Farm & Home Life Ins. Co., 269 Ga. 709, 506 S.E.2d 104 (1998).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 267 et seq.

33-37-4. Jurisdiction; exclusiveness of remedy; venue; change of venue.

(a) No delinquency proceeding shall be commenced under this chapter by anyone other than the Commissioner, and no court shall have jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

(b) No court of this state shall have jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this chapter.

(c) In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to Code Section

9-11-4 or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(1) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(2) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract;

(3) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer;

(4) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(5) If the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

(d) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

(e) Any action authorized in this Code section shall be brought in the Superior Court of Fulton County.

History. — Code 1981, § 33-37-4, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, a comma was inserted following "incidental to" in subsection (b).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 334 et seq., 348 et seq.

33-37-5. Grounds for restraining orders and injunctions; rights regarding collateral pledged by insurer-member; process and timeline; options for renewal or restructuring of loan.

(a) Any receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(1) The transaction of further business;

(2) The transfer of property;

(3) Interference with the receiver or with a proceeding under this chapter;

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

(6) The institution or further prosecution of any actions or proceedings;

(7) The obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders;

(8) The levying of execution against the insurer, its assets, or its policyholders;

(9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(10) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(11) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of any proceeding under this chapter.

(b) The receiver may apply to any court outside of the state for the relief described in subsection (a) of this Code section.

(c)(1) After the seventh day following the filing of a delinquency proceeding, a federal home loan bank shall not be stayed or prohibited from exercising its rights regarding collateral pledged by an insurer-member.

(2) If a federal home loan bank exercises its rights regarding collateral pledged by an insurer-member who is subject to a delinquency proceeding, the federal home loan bank shall repurchase any

outstanding capital stock that is in excess of that amount of federal home loan bank stock that the insurer-member is required to hold as a minimum investment to the extent the federal home loan bank in good faith determines the repurchase to be permissible under applicable laws, regulations, regulatory obligations, and the federal home loan bank's capital plan and consistent with the federal home loan bank's current capital stock practices applicable to its entire membership.

(d) Following the appointment of a receiver for an insurer-member, the federal home loan bank shall, within ten business days after a request from the receiver, provide a process and establish a timeline for all of the following:

(1) The release of collateral that exceeds the amount required to support secured obligations remaining after any repayment of loans as determined in accordance with the applicable agreements between the federal home loan bank and the insurer-member;

(2) The release of any of the insurer-member's collateral remaining in the federal home loan bank's possession following repayment of all outstanding secured obligations of the insurer-member in full;

(3) The payment of fees owed by the insurer-member and the operation of deposits and other accounts of the insurer-member with the federal home loan bank; and

(4) The possible redemption or repurchase of federal home loan bank stock or excess stock of any class that an insurer-member is required to own.

(e) Upon request from a receiver, the federal home loan bank shall provide any available options for an insurer-member subject to a delinquency proceeding to renew or restructure a loan to defer associated prepayment fees, subject to market conditions, the terms of any loans outstanding to the insurer-member, the applicable policies of the federal home loan bank, and the federal home loan bank's compliance with federal laws and regulations.

History. — Code 1981, § 33-37-5, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2015, p. 377, § 2-2/HB 552.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, a comma was inserted following "assets" in paragraph (a)(8).

33-37-6. Cooperation with Commissioner mandated; penalties for failure to cooperate.

(a) Any officer, manager, director, trustee, owner, employee, or agent of any insurer or any other persons with authority over or in charge of any segment of the insurer's affairs shall cooperate with the Commis-

sioner in any proceeding under this chapter or any investigation preliminary to the proceeding. The term "person" as used in this Code section shall include any person who exercises control directly or indirectly over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(1) To reply promptly in writing to any inquiry from the Commissioner requesting such a reply; and

(2) To make available to the Commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody, or control.

(b) No person shall obstruct or interfere with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This Code section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings or other orders.

(d) Any person included within subsection (a) of this Code section who fails to cooperate with the Commissioner, or any person who obstructs or interferes with the Commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the Commissioner issued validly under this chapter may:

(1) Be sentenced to pay a fine not exceeding $10,000.00 or to undergo imprisonment for a term of not more than one year, or both; or

(2) After a hearing, be subject to the imposition by the Commissioner of a civil penalty not to exceed $10,000.00 and shall be subject further to the revocation or suspension of any insurance licenses issued by the Commissioner.

History. — Code 1981, § 33-37-6, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 19 et seq.

C.J.S. — 44 C.J.S., Insurance, § 154 et seq.

33-37-7. Effect of enactment of chapter on pending proceedings.

Reserved. Repealed by Ga. L. 2019, p. 386, § 132/SB 133, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1981, § 33-37-7, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-8. Prohibition against release from proceedings or continuing business.

No insurer that is subject to any delinquency proceedings, whether formal or informal, administrative or judicial, shall:

(1) Be released from such proceeding, unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;

(2) Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(3) Be returned to the control of its shareholders or private management; or

(4) Have any of its assets returned to the control of its shareholders or private management

until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

History. — Code 1981, § 33-37-8, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

ALR. — 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.

33-37-8.1. Immunity of receivers and employees; indemnification; attorney's fees; approval of settlement.

(a) For the purposes of this Code section, the persons entitled to protection under this Code section are:

(1) All receivers responsible for the conduct of a delinquency proceeding under this chapter, including present and former receivers; and

(2) Their employees, meaning all present and former special deputies and assistant special deputies appointed by the Commissioner and all persons whom the Commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency

proceeding under this chapter. Attorneys, accountants, auditors, and other professional persons or firms who are retained by the receiver as independent contractors and their employees shall not be considered employees of the receiver for purposes of this Code section.

(b) The receiver and his or her employees shall have official immunity and shall be immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property, personal injury, or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of their duties or employment, provided that nothing in this subsection shall be construed to hold the receiver or any employee immune from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the receiver or any employee.

(c) If any legal action is commenced against the receiver or any employee, whether against him or her personally or in his or her official capacity, alleging property damage, property loss, personal injury, or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of their duties or employment, the receiver and any employee shall be indemnified from the assets of the insurer for all expenses, attorneys' fees, judgments, settlements, decrees, or amounts due and owing or paid in satisfaction of or incurred in the defense of such legal action unless it is determined upon a final adjudication on the merits that the alleged act, error, or omission of the receiver or employee giving rise to the claim did not arise out of or by reason of his or her duties or employment or was caused by intentional or willful and wanton misconduct.

(d)(1) Attorneys' fees and any and all related expenses incurred in defending a legal action for which immunity or indemnity is available under this Code section shall be paid from the assets of the insurer, as they are incurred, in advance of the final disposition of such action upon receipt of an undertaking by or on behalf of the receiver or employee to repay the attorneys' fees and expenses if it shall ultimately be determined upon a final adjudication on the merits that the receiver or employee is not entitled to immunity or indemnity under this Code section.

(2) Any indemnification for expense payments, judgments, settlements, decrees, attorneys' fees, surety bond premiums, or other amounts paid or to be paid from the insurer's assets pursuant to this Code section shall be an administrative expense of the insurer.

(3) In the event of any actual or threatened litigation against a receiver or any employee for which immunity or indemnity may be

available under this Code section, a reasonable amount of funds which in the judgment of the Commissioner may be needed to provide immunity or indemnity shall be segregated and reserved from the assets of the insurer as security for the payment of indemnity until such time as all applicable statutes of limitation shall have run, and all actual or threatened actions against the receiver or any employee shall have been completely and finally resolved, and all obligations of the insurer and the Commissioner under this Code section shall have been satisfied.

(4) In lieu of the segregation and reserving of funds, the Commissioner may, in his or her discretion, obtain a surety bond or make other arrangements which will enable the Commissioner to fully secure the payment of all obligations under this Code section.

(e) If any legal action against an employee for which indemnity may be available under this Code section is settled prior to final adjudication on the merits, the insurer must pay the settlement amount on behalf of the employee or indemnify the employee for the settlement amount unless the Commissioner determines:

(1) That the claim did not arise out of or by reason of the employee's duties or employment; or

(2) That the claim was caused by the intentional or willful and wanton misconduct of the employee.

(f) In any legal action in which the receiver is a defendant, that portion of any settlement relating to the alleged act, error, or omission of the receiver shall be subject to the approval of the court before which the delinquency proceeding is pending. The court shall not approve that portion of the settlement if it determines:

(1) That the claim did not arise out of or by reason of the receiver's duties or employment; or

(2) That the claim was caused by the intentional or willful and wanton misconduct of the receiver.

(g) Nothing contained or implied in this Code section shall operate or be construed or applied to deprive the receiver or any employee of any immunity, indemnity, benefits of law, rights, or any defense otherwise available.

History. — Code 1981, § 33-37-8.1, enacted by Ga. L. 1996, p. 928, § 2; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2019, p. 386, § 133/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "subsection" for "provision" near the end of subsection (b); and substituted "Reserved." for the former provisions of subsection (h), which read: "(h)(1) Subsection (b) of this Code section shall apply to any suit based in whole or in

part on any alleged act, error, or omission which takes place on or after April 15, 1996.

"(2) No legal action shall lie against the receiver or any employee based in whole or in part on any alleged act, error, or omission which took place prior to April 15, 1996, unless a suit is filed and valid service of process is obtained within 12 months after April 15, 1996.

"(3) Subsections (c), (d), (e), and (f) of this Code section shall apply to any suit which is pending on or filed after April 15, 1996, without regard to when the alleged act, error, or omission took place."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former subsection (h) which was designated as reserved.

Law reviews. — For review of 1996 risk-based capital legislation, see 13 Ga. St. U.L. Rev. 212 (1996).

JUDICIAL DECISIONS

Official immunity did not apply. — In granting writs of certiorari in cases involving the liquidation of an insurance company to review the court of appeals' decision, because the official immunity provision of O.C.G.A. § 33-37-8.1 did not apply to state officers or employees sued in their official capacities, the court of appeals erred in remanding that case for the trial court to consider evidence of intentional or willful and wanton misconduct by the liquidator and the liquidator's deputies rather than simply holding that official immunity was irrelevant. State of Ga. v. International Indemnity Co., 305 Ga. 126, 823 S.E.2d 806 (2019).

In granting writs of certiorari in cases involving the liquidation of an insurance company to review the court of appeals' decision, the official immunity provision of O.C.G.A. § 33-37-8.1 had no application to the claims of the sole shareholder of the insurance company against the independent contractor hired by the receiver to assist in the liquidation as the independent contractor, as a private corporation, was plainly not covered by that provision. State of Ga. v. International Indemnity Co., 305 Ga. 126, 823 S.E.2d 806 (2019).

ARTICLE 2

PROCEDURE FOR DELINQUENCY PROCEEDING

33-37-9. Commencing formal delinquency proceeding; ex parte seizure order; hearing and review of order; notice.

(a) The Commissioner may file in the superior court of the county in which the insurer is domiciled or in the Superior Court of Fulton County a petition alleging, with respect to a domestic insurer:

(1) That there exists any grounds that would justify a court order for a formal delinquency proceeding against an insurer under this chapter;

(2) That the interests of policyholders, creditors, or the public will be endangered by delay; and

(3) The contents of an order deemed necessary by the Commissioner.

(b) Upon a filing under subsection (a) of this Code section, the court may issue forthwith, ex parte, and without a hearing the requested order which shall direct the Commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer and of the premises occupied by it for transaction of its business and until further order of the court, enjoin the insurer and its officers, managers, agents, and employees from disposition of its property and from the transaction of its business except with the written consent of the Commissioner.

(c) The court shall specify in the order what its duration shall be which shall be such time as the court deems necessary for the Commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the Commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this chapter shall ipso facto vacate the seizure order.

(d) Entry of a seizure order under this Code section shall not constitute an anticipatory breach of any contract of the insurer.

(e) An insurer subject to an ex parte order under this Code section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than 15 days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

(f) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

History. — Code 1981, § 33-37-9, enacted by Ga. L. 1991, p. 1424, § 7.

JUDICIAL DECISIONS

Editor's notes. — In light of the similarity of the statutory provisions, decisions under former Code 1933, § 56-2204 are included in the annotations for this Code section.

Ancillary receiver in Georgia shall liquidate special deposit claims which are proven and allowed in the ancillary proceedings, and in such proceedings the laws of Georgia shall apply.

Collins v. Dacus, 211 Ga. 779, 89 S.E.2d 198 (1955) (decided under former Code 1933, § 56-2204).

Claim duly and timely filed in this state with the ancillary receiver of an insurance company, based upon injury sustained prior to receivership of the insurer, on which judgment was obtained against the insurer after the receivership and without judgment against the insurer, is a proper claim for consideration by the ancillary receiver, who, under this section, is required to liquidate special deposit claims which are approved and allowed by the receiver in the ancillary proceedings in this state. Collins v. Dacus, 211 Ga. 779, 89 S.E.2d 198 (1955) (decided under former Code 1933, § 56-2204).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 86 et seq.

C.J.S. — 44 C.J.S., Insurance, § 65.

ALR. — 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.

33-37-10. Confidentiality of proceedings.

In all proceedings and judicial reviews thereof under Code Section 33-37-9, all records of the insurer, other documents, and all Department of Insurance files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the court, after hearing arguments from the parties in chambers, shall order otherwise or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the superior court shall be held by him in a confidential file.

History. — Code 1981, § 33-37-10, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 337, § 1-93/SB 132.

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

ARTICLE 3

PROCEDURE FOR REHABILITATION

33-37-11. Petition for rehabilitation; grounds.

The Commissioner may apply by petition to the Superior Court of Fulton County for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(1) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors, or the public;

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion

of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer;

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the Commissioner to be dishonest or untrustworthy in a way affecting the insurer's business;

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy;

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director, trustee, employee, or other person, has refused to be examined under oath by the Commissioner concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management;

(6) After demand by the Commissioner under Code Section 33-2-11 or under this chapter, the insurer has failed promptly to make available for examination any of its own property, books, accounts, documents, or other records or those of any subsidiary or related company within the control of the insurer or those of any person having executive authority in the insurer so far as they pertain to the insurer;

(7) Without first obtaining the written consent of the Commissioner, the insurer has transferred, or attempted to transfer, in a manner contrary to Chapter 13 of this title, substantially its entire property or business or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person;

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator, or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this chapter;

(9) Within the previous four years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any provision of this title, or any valid order of the Commissioner;

(10) The insurer has failed to pay within 60 days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the Commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full;

(11) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the Commissioner, has failed to give an adequate explanation immediately; or

(12) The board of directors or the holders of a majority of the shares entitled to vote or a majority of those individuals entitled to the control of the insurer request or consent to rehabilitation under this chapter.

History. — Code 1981, § 33-37-11, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 386, § 134/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "the insurer" for "insurers" near the end of paragraph (12).

JUDICIAL DECISIONS

Parties could not convert claims. — Parties who would otherwise be general creditors of an insurance company with Class 4 priority claims could not convert those parties' claims to Class 1 priority claims by agreeing with the rehabilitator to compromise those parties' claims against the company during the rehabilitation process. Oxendine v. Commissioner of Ins., 229 Ga. App. 604, 494 S.E.2d 545 (1998).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 83 et seq., 89 et seq.

C.J.S. — 44 C.J.S., Insurance, § 267 et seq.

33-37-12. Order to rehabilitate; Commissioner to be appointed as rehabilitator; effect of order.

(a) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the Commissioner and his successors in office the rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the superior court or recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place

of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(b) Any order issued under this Code section shall require accountings to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order, but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan under subsection (d) of Code Section 33-37-13 will be prepared by the rehabilitator and the timetable for doing so.

(c) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless such revocation or cancellation is done by the rehabilitator pursuant to Code Section 33-37-13.

History. — Code 1981, § 33-37-12, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, in subsection (c), "or" was substituted for "of" preceding "cancellation".

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

C.J.S. — 44 C.J.S., Insurance, §§ 226 et seq., 249 et seq.

33-37-13. Authority of rehabilitator; additional remedies; rehabilitation plan.

(a) The Commissioner as rehabilitator may appoint one or more special deputies who shall have all the powers and responsibilities of the rehabilitator granted under this Code section, and the Commissioner may employ such clerks and assistants as deemed necessary. The compensation of the special deputy, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the Commissioner with the approval of the court and shall be paid out of the funds or assets of the insurer. The persons appointed under this Code section shall serve at the pleasure of the Commissioner. The Commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by

the Commissioner or the court in rehabilitation proceedings conducted under this chapter.

(b) In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the Department of Insurance. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the Department of Insurance out of the first available money of the insurer.

(c) The rehabilitator may take such action as he deems necessary or appropriate to reform and revitalize the insurer. He shall have all the powers of the directors, officers, and managers whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(d) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(e) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this Code section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies for such period and to such an extent as may be necessary.

(f) The rehabilitator shall have the power under Code Sections 33-37-25 and 33-37-26 to avoid fraudulent transfers.

History. — Code 1981, § 33-37-13, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 337, § 1-93/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in two places in subsection (b).

JUDICIAL DECISIONS

Notice and discovery. — Insurers Rehabilitation and Liquidation Act, O.C.G.A. § 33-37-1 et seq., does not set forth any specific guidelines for giving notice of proposed action or give a creditor the right to take discovery before approval of such action, but leaves such matters to the discretion of the trial court. O'Neal v. Oxendine, 237 Ga. App. 171, 514 S.E.2d 908 (1999).

RESEARCH REFERENCES

Am. Jur. 2d. — 36 Am. Jur. 2d, Foreign Corporations, § 436. 43 Am. Jur. 2d, Insurance, § 89 et seq.

C.J.S. — 44 C.J.S., Insurance, § 179 et seq.

33-37-14. Effect of rehabilitation order on pending litigation; standing of guaranty association to participate in rehabilitation.

(a) Any court in this state before which any action or proceeding in which the insurer is a party, or is obligated to defend a party, is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for 90 days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he deems necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(b) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

(c) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

History. — Code 1981, § 33-37-14, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

ALR. — 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.

33-37-15. Petition for order of liquidation; defense; payment of costs and expenses; order terminating rehabilitation.

(a) Whenever the Commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public or would be futile the Commissioner may petition the superior court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under Code Section 33-37-16. The superior court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer or such costs and other expenses of defense as justice may require.

(b) The protection of the interests of insureds, claimants, and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of six months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under subsection (d) of Code Section 33-37-13, the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(c) The rehabilitator may at any time petition the superior court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the superior court finds that rehabilitation has been accomplished and that grounds for rehabilitation under Code Section 33-37-11 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The superior court may also make that finding and issue that order at any time upon its own motion.

History. — Code 1981, § 33-37-15, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-16. Grounds for order of liquidation.

The Commissioner may petition the superior court for an order directing him to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(1) Of any ground for an order of rehabilitation as specified in Code Section 33-37-11, whether or not there has been a prior order directing the rehabilitation of the insurer;

(2) That the insurer is insolvent; or

(3) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

History. — Code 1981, § 33-37-16, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

33-37-17. Commissioner appointed as liquidator; seizure and administration of assets; effect of filing order; petition for declaration of insolvency; financial reports; plan for continued performance pending appeal.

(a) An order to liquidate the business of a domestic insurer shall appoint the Commissioner and his successors in office liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the superior court and the recorder of deeds of the county in which its principal office or place or business is located, or, in the case of real estate, with the recorder of deeds of the county where the property is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(b) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in Code Sections 33-37-18 and 33-37-36.

(c) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(d) At the time of petitioning for an order of liquidation, or at any time thereafter, the Commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

(e) Any order issued under this Code section shall require financial reports to the court by the liquidator. Financial reports shall include at a minimum the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within one year of the liquidation order and at least annually thereafter.

(f)(1) Within five days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the Commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. In the event the defendant company's financial condition will not, in the judgment of the Commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants as the Commissioner finds to be fair and equitable considering the relative circumstances of such policyholders and claimants. The court shall examine the plan submitted by the Commissioner and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the Commissioner or any of his or her deputies, agents, clerks, assistants, or attorneys by any party based on preference in an appeal pendency plan approved by the court.

(2) The appeal pendency plan shall not supersede or affect the obligations of any insurance guaranty association.

(3) Any such plans shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, in the event that the liquidator pays claims from assets

of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, in the event an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses in connection therewith relating to obligations of the company, shall be repaid in full, together with interest at the judgment rate of interest or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty associations.

History. — Code 1981, § 33-37-17, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 386, § 135/SB 133.

The 2019 amendment, effective July 1, 2019, in paragraph (f)(1), substituted "Within" for "Within ten days of July 1, 1991, or, if later, within" at the beginning of the first sentence, and inserted "or her" in the last sentence.

OPINIONS OF THE ATTORNEY GENERAL

Editor's notes. — In light of the similarity of the statutory provisions, opinions under former Code 1933, § 56-1503, are included in the annotations for this Code section.

Disposing of accumulated, undisbursed funds held by Commissioner. — Proper method of disposing of accumulated and undisbursed receivership funds held by the Commissioner in cases where creditors or claimants of defunct domestic stock and mutual insurance companies cannot be located or where checks issued to the companies for the companies' 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 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 the court deems advisable. 1975 Op. Att'y Gen. No. 75-83 (decided under former Code 1933, § 56-1503).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

C.J.S. — 44 C.J.S., Insurance, § 267 et seq.

33-37-18. Termination of policy coverage.

(a) All policies, including bonds and other noncancelable business, other than life or accident and sickness insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(1) A period of 30 days from the date of entry of the liquidation orders;

(2) The expiration of the policy coverage;

(3) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(4) The date on which the liquidator effects a transfer of the policy obligation pursuant to paragraph (9) or (10) of subsection (a) of Code Section 33-37-20; or

(5) The date proposed by the liquidator and approved by the court to cancel coverage.

(b) An order of liquidation under Code Section 33-37-17 shall terminate coverages at the time specified in subsection (a) of this Code section for purposes of any other statute.

(c) Policies of life or accident and sickness insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

(d) Policies of life or accident and sickness insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (a) and (b) of this Code section.

History. — Code 1981, § 33-37-18, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 386, § 136/SB 133.

The 2019 amendment, effective July 1, 2019, inserted "or (10)" in paragraph (a)(4).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "of" was substituted for "or" near the beginning of subsection (b).

33-37-19. Petition for dissolution of corporate existence.

The Commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the Commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

History. — Code 1981, § 33-37-19, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 37 Am. Jur. 2d, Fraudulent Conveyances and Transfers, §§ 74, 75.

C.J.S. — 44 C.J.S., Insurance, § 208 et seq.

33-37-20. Powers of liquidator.

(a) The liquidator shall have the power:

(1) To appoint a special deputy or deputies to act for him under this chapter and to determine his reasonable compensation. The special deputy shall have all powers of the liquidator granted by this Code section. The special deputy shall serve at the pleasure of the liquidator;

(2) To employ employees and agents, actuaries, accountants, appraisers, consultants, and such other personnel as he may deem necessary to assist in the liquidation;

(3) To appoint, with the approval of the court, an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the Commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the Commissioner or the court in liquidation proceedings conducted under this chapter;

(4) To fix the reasonable compensation of employees and agents, actuaries, accountants, appraisers, and consultants with the approval of the court;

(5) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the Commissioner may advance the costs so incurred out of any appropriation for the maintenance of the Department of Insurance. Any amounts so advanced for expenses of administration shall be repaid to the Commissioner for the use of the Department of Insurance out of the first available moneys of the insurer;

(6) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to

compel any person to subscribe to his testimony after it has been correctly reduced to writing and, in connection therewith, to require the production of any books, papers, records, or other documents which he deems relevant to the inquiry;

(7) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer;

(8) To collect all debts and moneys due and claims belonging to the insurer, wherever located, and for this purpose:

(A) To institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts;

(B) To do such other acts as are necessary or expedient to collect, conserve, or protect its assets or property, including the power to sell, compound, compromise, or assign debts for purposes of collection upon such terms and conditions as he deems best; and

(C) To pursue any creditor's remedies available to enforce his claims;

(9) To conduct public and private sales of the property of the insurer;

(10) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Code Section 33-37-41;

(11) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon, or otherwise dispose of or deal with any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation;

(12) To borrow money on the security of the insurer's assets or without such security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution;

(13) To enter into such contracts as are necessary to carry out the order to liquidate and to affirm or disavow any contracts to which the insurer is a party;

(14) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings, in this state or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under Code Section 33-37-19, he shall have the power to apply to any court in this state or elsewhere for leave to substitute himself for the insurer as plaintiff;

(15) To prosecute any action which may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer or any other person;

(16) To remove any or all records and property of the insurer to the offices of the Commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations;

(17) To deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions;

(18) To invest all sums not currently needed, unless the court orders otherwise;

(19) To file any necessary documents for record in the office of the clerk of the superior court or any other recorder of deeds or record office in this state or elsewhere where property of the insurer is located;

(20) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations;

(21) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included within Code Sections 33-37-25 through 33-37-27;

(22) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee and to act as the receiver or trustee whenever the appointment is offered;

(23) To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states; and

(24) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this chapter.

(b)(1) If a company placed in liquidation issued liability policies on a claims made basis, which provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period in which to report claims. The extended reporting period shall be made available only to those insureds who are unable to secure substitute coverage at a cost not in excess of that charged by the liquidator. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or 18 months from the order of liquidation.

(2) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within 60 days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. Such offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within 90 days after the order of liquidation. No commissions, premium taxes, assessments, or other fees shall be due on the charge pertaining to the extended period to report claims.

(c) The enumeration, in this Code section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not specifically enumerated or otherwise provided, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(d) Notwithstanding the powers of the liquidator as stated in subsections (a) and (b) of this Code section, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

History. — Code 1981, § 33-37-20, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 337, § 1-93/SB 132.

The 2019 amendment, effective July 1, 2019, substituted "Department of Insurance" for "Insurance Department" in two places in paragraph (a)(5).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "excess of" was substituted for "excess if" in the second sentence of paragraph (b)(1), and "report" was substituted for "reports" at the end of paragraph (b)(2).

JUDICIAL DECISIONS

Claims in common with the insolvent trust fund versus personal claims. — Trial court erred in dismissing the plaintiffs' breach of contract, misrepresentation, and other claims against a workers compensation trust fund because while the court properly concluded that the Georgia Insurance Commissioner, as an appointed receiver, had the exclusive authority to prosecute legal claims that were common to the insolvent trust fund, the court erred in finding that the plaintiffs did not have standing to prosecute claims that were personal in nature and not common to the trust fund. Superior Roofing Co. of Ga., Inc. v. Am. Prof'l Risk Servs., 323 Ga. App. 416, 744 S.E.2d 400 (2013).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

ALR. — Basis for allowance of claims under policies of insolvent life insurance company, 106 A.L.R. 1513.

Limitations governing action to recover unearned premium retained by insurer upon cancellation of policy, 29 A.L.R.2d 938.

33-37-21. Notice of liquidation.

(a) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(1) By first-class mail and either by telegram or telephone to the commissioner of insurance of each jurisdiction in which the insurer is doing business;

(2) By first-class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(3) By first-class mail to all insurance agents of the insurer;

(4) By first-class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last known address as indicated by the records of the insurer; and

(5) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(b) Notice to potential claimants under subsection (a) of this Code section shall require claimants to file with the liquidator their claims together with proper proofs thereof under Code Section 33-37-35, on or before a date the liquidator shall specify in the notice. Although an earlier date may be set by the liquidator, the last day to file claims shall be no later than 18 months following the order of liquidation. The

liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(c)(1) Notice under subsection (a) of this Code section to agents of the insurer and to potential claimants who are policyholders shall include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(2) The liquidator shall promptly provide to the guaranty associations such information concerning the identities and addresses of such policyholders and their policy coverages as may be within the liquidator's possession or control and otherwise cooperate with guaranty associations to assist them in providing to such policyholders timely notice of the guaranty associations' coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

(d) If notice is given in accordance with this Code section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

History. — Code 1981, § 33-37-21, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 97, 98.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

33-37-22. Responsibility of agent to provide information; penalty for violation.

(a) Every person who receives notice in the form prescribed in Code Section 33-37-21 that an insurer which he represents as an agent is the subject of a liquidation order, shall within 30 days of such notice provide to the liquidator, in addition to the information he may be required to provide pursuant to Code Section 33-37-6, the information in the agent's records related to any policy issued by the insurer through the agent and, if the agent is a general agent, the information in the general agent's record related to any policy issued by the insurer through an agent under contract to him, including the name and address of such subagent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy or if the agent has had in his possession a copy of the declarations of the policy at any time

during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(b) Any agent failing to provide information to the liquidator as required in subsection (a) of this Code section may be subject to payment of a penalty of not more than $1,000.00 and may have his licenses suspended, said penalty to be imposed after a hearing held by the Commissioner.

History. — Code 1981, § 33-37-22, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 109 et seq.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

ALR. — Basis for allowance of claims under policies of insolvent life insurance company, 106 A.L.R. 1513.

33-37-23. Stay of collateral proceedings against insurer; authority of liquidator to intervene in, and defend, out-of-state action.

(a) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he may intervene in the action. The liquidator may defend any action in which he intervenes under this Code section at the expense of the estate of the insurer.

(b) The liquidator may, upon or after an order for liquidation, within two years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for

taking any action, filing any claim or pleading, or doing any act and where in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any such action or do any such act required of or permitted to the insurer within a period of 180 days subsequent to the entry of an order for liquidation or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(c) No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the petition is denied.

(d) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

History. — Code 1981, § 33-37-23, enacted by Ga. L. 1991, p. 1424, § 7.

JUDICIAL DECISIONS

Trial court required to grant stay based on order of New York court. — Because a New York Order of Rehabilitation enjoined any actions, lawsuits, or proceedings against an insurance company, pursuant to O.C.G.A. § 33-37-23(a), the trial court was required to grant a stay as to proceedings against the insurance company in order to give full faith and credit to the injunction ordered by the New York court. Aon Risk Servs. v. Commercial & Military Sys. Co., 270 Ga. App. 510, 607 S.E.2d 157 (2004).

Claims in common with the insolvent trust fund versus personal claims. — Trial court erred in dismissing the plaintiffs' breach of contract, misrepresentation, and other claims against a workers compensation trust fund because while the court properly concluded that the Georgia Insurance Commissioner, as an appointed receiver, had the exclusive authority to prosecute legal claims that were common to the insolvent trust fund, the court erred in finding that the plaintiffs did not have standing to prosecute claims that were personal in nature and not common to the trust fund. Superior Roofing Co. of Ga., Inc. v. Am. Prof'l Risk Servs., 323 Ga. App. 416, 744 S.E.2d 400 (2013).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

33-37-24. Time for filing list of assets; reducing assets to liquidity.

(a) As soon as practicable after the liquidation order but not later than 120 days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the superior court and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(b) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(c) A submission to the court for disbursement of assets in accordance with Code Section 33-37-33 fulfills the requirements of subsection (a) of this Code section.

History. — Code 1981, § 33-37-24, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 880 et seq.

33-37-25. Fraudulent transfers or obligations incurred; avoidance.

(a) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter which is fraudulent under this Code section may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and, in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a

simple contract could become superior to the rights of the transferee under subsection (c) of Code Section 33-37-27.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (a) of this Code section if:

(1) The transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and

(2) Any part of the transaction took place within one year prior to the date of filing of the petition through which the receivership was commenced.

(d) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (a) of this Code section shall be personally liable therefor and shall be bound to account to the liquidator.

History. — Code 1981, § 33-37-25, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "transaction" was substituted for "transactions" near the end of paragraph (c)(1).

RESEARCH REFERENCES

Am. Jur. 2d. — 44 Am. Jur. 2d, Insurance, §§ 774 et seq., 1037 et seq.

C.J.S. — 44 C.J.S., Insurance, § 208 et seq.

33-37-26. Transfer of property in good faith; recording copy of petition as notice of seizure of property.

(a) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred;

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending;

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith; and

(4) A person asserting the validity of a transfer under this Code section shall have the burden of proof. Except as elsewhere provided in this Code section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(c) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (a) of this Code section shall be personally liable therefor and shall be bound to account to the liquidator.

(d) Nothing in this chapter shall impair the negotiability of currency or negotiable instruments.

History. — Code 1981, § 33-37-26, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-26.1. Limitations on ability of receiver to void transfer of certain property in connection with federal home loan bank security agreement; transfer avoidance under certain circumstances.

The receiver for an insurer shall not void any transfer of, or any obligation to transfer, money or any other property arising under or in connection with any federal home loan bank security agreement; any pledge, security, collateral, or guarantee agreement; or any other similar arrangement or credit enhancement relating to a federal home loan bank security agreement made in the ordinary course of business and in compliance with the applicable federal home loan bank agreement. However, a transfer may be avoided under this Code section if the transfer was made with intent to hinder, delay, or defraud the insurer, the receiver for the insurer, or existing or future creditors. This Code section shall not affect a receiver's rights regarding advances to an insurer in delinquency proceedings pursuant to 12 C.F.R. Section 1266.4.

History. — Code 1981, § 33-37-26.1, enacted by Ga. L. 2015, p. 377, § 2-3/HB 552; Ga. L. 2019, p. 386, § 137/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "insurer" for "insurer-member" throughout this Code section.

33-37-27. Preferential transfers; liens; when transfer perfected; avoidance; transfer for new and contemporaneous consideration; payments to attorneys; personal liability of participants.

(a)(1) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor for or on account of an antecedent debt made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

(2) Any preference may be avoided by the liquidator if:

(A) The insurer was insolvent at the time of the transfer;

(B) The transfer was made within four months before the filing of the petition;

(C) The creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(D) The creditor receiving it was an officer, any employee, attorney, or other person who was in fact in a position of comparable influence on the insurer to an officer whether or not he held such position or any shareholder holding directly or indirectly more than 5 percent of any class of any equity security issued by the insurer or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(3) Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate in which event the lien or title shall pass to the liquidator.

(b)(1) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(2) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(3) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(4) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(5) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(c)(1) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree or upon attachment, garnishment, execution, or like process whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(2) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (b) of this Code section if such consequences would follow only from the lien or purchase itself or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (b) of this Code section through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(d) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (b) of this Code section to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within 21 days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(e) If any lien deemed voidable under paragraph (2) of subsection (a) of this Code section has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this chapter which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(f) The property affected by any lien deemed voidable under subsections (a) and (e) of this Code section shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be

executed as may be proper or adequate to evidence the title of the liquidator.

(g) The superior court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this Code section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator within such reasonable times as the court shall fix.

(h) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and voided by the liquidator or where the property is retained under subsection (g) of this Code section to the extent of the amount paid to the liquidator.

(i) If a creditor has been preferred and afterward in good faith gives the insurer further credit without security of any kind for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

(j) If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for liquidation under this chapter, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate, provided that where the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney for services rendered or to be rendered shall be governed by the provision of subparagraph (a)(2)(D) of this Code section.

(k)(1) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become

insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within four months before the date of filing of this successful petition for liquidation.

(2) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (a) of this Code section shall be personally liable therefor and shall be bound to account to the liquidator.

(3) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

History. — Code 1981, § 33-37-27, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 1992, p. 6, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "set off" was substituted for "setoff" in subsection (i), and a comma was inserted following "attorney" near the beginning of paragraph (k)(1).

RESEARCH REFERENCES

Am. Jur. Trials. — Litigation of Recovery from Insurers for Medical Provider Liens, 152 Am. Jur. Trials 265.

33-37-28. Disallowing preferred creditor's claims.

(a) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this chapter shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within 30 days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) of this Code section by reason of the avoidance, whether voluntary or involuntary, a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under Code Section 33-37-34 if filed within 30 days from the date of the avoidance, or within the further time allowed by the court under subsection (a) of this Code section.

History. — Code 1981, § 33-37-28, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 386, § 138/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "late filing" for "last filing" in the middle of subsection (b).

33-37-29. Mutual debts and credits.

(a) In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, such credits and debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) of this Code section.

(b) No setoff shall be allowed in favor of any person where:

(1) The obligation of the insurer to the person would not, at the date of the entry of any liquidation order or otherwise, as provided in Code Section 33-37-17, entitle him to share as a claimant in the assets of the insurer;

(2) The obligation of the insurer to the person was purchased by or transferred to the person with a view of its being used as a setoff; or

(3) The obligation of the person is to pay an assessment levied against the members of a mutual insurer or against the subscribers of a reciprocal insurer or is to pay a balance upon the subscription to the capital stock of a stock insurer.

History. — Code 1981, § 33-37-29, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "set off" was substituted for "setoff" in subsection (a).

33-37-30. Liquidator's report to court; assessment against members of insurer; procedure when assessment not paid.

(a) As soon as practicable but not more than two years from the date of an order of liquidation under Code Section 33-37-17 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The insurer's probable total liabilities;

(3) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(4) A recommendation as to whether or not an assessment should be made and in what amount.

(b)(1) Upon the basis of the report provided in subsection (a) of this Code section, including any supplements and amendments thereto, the superior court may levy one or more assessments against all members of the insurer who are subject to assessment.

(2) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the

probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(c) After levy of assessment under subsection (b) of this Code section, the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment therefor.

(d) The liquidator shall give notice of the order to show cause by publication and by first-class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least 20 days before the return date of the order to show cause.

(e)(1) If a member does not appear and serve duly verified objections upon the liquidator on or before the return date of the order to show cause under subsection (c) of this Code section, the court shall make an order adjudging the member liable for the amount of the assessment against him pursuant to subsection (c) of this Code section, together with costs, and the liquidator shall have a judgment against the member therefor.

(2) If on or before such return date the member appears and serves duly verified objections upon the liquidator, the Commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the Commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(f) The liquidator may enforce any order or collect any judgment under subsection (e) of this Code section by any lawful means.

History. — Code 1981, § 33-37-30, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, a period was substituted for the semicolon at the end of paragraph (b)(1), and commas were deleted following "collection of the assessment" in paragraph (b)(2) and following "pursuant to the order" in subsection (c).

33-37-31. Liability of reinsurers.

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings regardless of any provision in the reinsurance contract or other agreement. The reinsurance shall be payable under a contract or contracts reinsured by the assuming insurer on the basis of reported claims allowed by the liquidation court, without diminution because of the insolvency of the ceding insurer. Such payments shall be made directly to the ceding insurer or to its domiciliary liquidator except:

(1) Where the contract or other written agreement specifically provides for another payee of such reinsurance in the event of the insolvency of the ceding insurer; or

(2) Where the assuming insurer, with the consent of the direct insured or insureds, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligation of the ceding insurer to such payees.

History. — Code 1981, § 33-37-31, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2001, p. 872, § 1.

33-37-32. Premiums due during pendency of liquidation action; penalties for violation; notice; right to appeal.

(a)(1) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits or setoffs or both shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(2) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(b) Upon satisfactory evidence of a violation of this Code section, the Commissioner may pursue either one or both of the following courses of action:

(1) Suspend, revoke, or refuse to renew the licenses of such offending party or parties; or

(2) Impose a penalty of not more than $5,000.00 for each and every act in violation of this Code section by said party or parties.

(c) Before the Commissioner shall take any action as provided in subsection (b) of this Code section, written notice shall be provided to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least ten days thereafter, when a hearing on the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing, the Commissioner, if he shall find such

violation, shall impose such of the penalties under subsection (b) of this Code section as he deems advisable.

(d) When the Commissioner shall take action in any or all of the ways set out in subsection (b) of this Code section, the party aggrieved may appeal from said action to the superior court.

History. — Code 1981, § 33-37-32, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-33. Application for approval of proposal to disburse assets; notice.

(a) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshaled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this Code section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(b) Such proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in Classes 1 and 2 as provided in Code Section 33-37-41;

(2) Disbursement of the assets marshaled to date and subsequent disbursement of assets as they become available;

(3) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(4) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this Code section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in Code Section 33-37-41 in accordance with such priorities. No bond shall be required of any such association; and

(5) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments

under or to be made thereby for which such associations could assert a claim against the liquidator and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association then disbursements shall be in the amount of available assets.

(d) The liquidator's proposal shall, with respect to an insolvent insurer writing life or accident and sickness insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or accident and sickness insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating such associations.

(e) Notice of such application shall be given to the association in and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States mail to be dispatched by certified mail or first-class mail at least 30 days prior to submission of such application to the court. Action on the application may be taken by the court provided the above-required notice has been given and, provided, further, that the liquidator's proposal complies with paragraphs (1) and (2) of subsection (b) of this Code section.

History. — Code 1981, § 33-37-33, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2019, p. 386, § 139/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "United States mail to be dispatched by certified mail or first-class mail" for "United States certified mails, first-class postage prepaid" in the second sentence of subsection (e).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "marshaled" was substituted for "marshalled" in subsection (a) and paragraph (b)(2), and "provided, further," was substituted for "provided further" near the end of subsection (e).

33-37-34. Proof of claims; late filing.

(a) Proof of all claims shall be filed with the liquidator in the form required by Code Section 33-37-35 on or before the last day for filing specified in the notice required under Code Section 33-37-21, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(b) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(1) The existence of the claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(2) A transfer to a creditor was avoided under Code Sections 33-37-25 through 33-37-27 or was voluntarily surrendered under Code Section 33-37-28, and that the filing satisfies the conditions of Code Section 33-37-28; and

(3) The valuation under Code Section 33-37-40 of security held by a secured creditor shows a deficiency, which is filed within 30 days after the valuation.

(c) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

(d) The liquidator may consider any claim filed late which is not covered by subsection (b) of this Code section and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

History. — Code 1981, § 33-37-34, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, the comma was deleted following "33-37-40" in paragraph (b)(3).

33-37-35. Contents of proof of claim; effect of judgment or order within four months of, or after, filing petition for liquidation.

(a) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(1) The particulars of the claim including the consideration given for it;

(2) The identity and amount of the security on the claim;

(3) The payments made on the debt, if any;

(4) That the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

(5) Any right of priority of payment or other specific right asserted by the claimants;

(6) A copy of the written instrument which is the foundation of the claim; and

(7) The name and address of the claimant and the attorney who represents him, if any.

(b) No claim need be considered or allowed if it does not contain all the information in subsection (a) of this Code section which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(c) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (a) of this Code section and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(d) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(e) All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

History. — Code 1981, § 33-37-35, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-36. Third-party contingent claim; claims due in future; claims under employment contracts.

(a) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(b) A claim may be allowed, even if contingent, if it is filed in accordance with Code Section 33-37-34. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(c) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(d) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the

issuance of any order of rehabilitation or liquidation under Code Section 33-37-12 or 33-37-17.

History. — Code 1981, § 33-37-36, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-37. Third-party claim against insured.

(a) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(b) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within 60 days after mailing of the notice required by Code Section 33-37-21, whichever is later, he is an unexcused late filer.

(c) The liquidator shall make his recommendations to the court under Code Section 33-37-41 for the allowance of an insured's claim under subsection (b) of this Code section after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property based on the lesser of the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expense of defense or the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(d) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this Code section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured shall be evaluated as in

subsection (c) of this Code section. If any insured's claim is subsequently reduced under subsection (c) of this Code section, the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(e) No claim may be presented under this Code section if it is or may be covered by any guaranty association or foreign guaranty association.

History. — Code 1981, § 33-37-37, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-38. Procedure when claim denied.

(a) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his attorney by first-class mail at the address shown in the proof of claim. Within 60 days from the mailing of the notice, the claimant may file his objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or his attorney and to any other persons directly affected, not less than ten nor more than 30 days before the date of the hearing. The matter may be heard by the court or by a court appointed referee who shall submit findings of fact along with his recommendation.

History. — Code 1981, § 33-37-38, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-39. When third person subrogated to rights of creditor.

Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution; however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person," as used in this Code section, is not intended to apply to a guaranty association or foreign guaranty association.

History. — Code 1981, § 33-37-39, enacted by Ga. L. 1991, p. 1424, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, double quotation marks were substituted for single quotation marks enclosing "other person" in the last sentence of this Code section.

33-37-40. Determining value of security held by secured creditor.

(a) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(2) By agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(b) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

History. — Code 1981, § 33-37-40, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 83 et seq., 95 et seq.

ALR. — Validity, construction, and application of Uniform Insurers Liquidation Act, 44 A.L.R.5th 683.

33-37-41. Priority of distribution of claims.

For all claims in insolvencies, the priority of distribution of claims from the insurer's estate shall be in accordance with the order as set forth in this Code section. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) **Class 1.** The costs and expenses of administration during rehabilitation and liquidation, including, but not limited to, the following:

(A) The actual and necessary costs of preserving or recovering the assets of the insurer;

(B) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(C) Any necessary filing fees;

(D) The fees and mileage payable to witnesses;

(E) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation; and

(F) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses;

(2) **Class 2.** All claims under policies, including third-party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance or as gratuities. No payment by an employer to his or her employee shall be treated as a gratuity;

(3) **Class 3.** Claims of the federal government except those under Class 2;

(4) **Class 4.** Reasonable compensation to employees for services performed to the extent that such compensation does not exceed two months of monetary compensation and represents payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees;

(5) **Class 5.** Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors, including claims of ceding and assuming companies in their capacity as such;

(6) **Class 6.** Claims of any state or local government except those under Class 2. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims established under paragraph (9) of this Code section;

(7) **Class 7.** Claims filed late or any other claims other than claims under paragraphs (8) and (9) of this Code section;

(8) **Class 8.** Surplus or contribution notes or similar obligations and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law; and

(9) **Class 9.** The claims of shareholders or other owners in their capacity as shareholders.

History. — Code 1981, § 33-37-41, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 1997, p. 683, § 2; Ga. L. 1997, p. 1581, § 3; Ga. L. 2019, p. 386, § 140/SB 133.

The 2019 amendment, effective July 1, 2019, substituted "For all claims in insolvencies" for "For all pending and future claims in insolvencies existing on July 1, 1997, and for all claims in future insolvencies" at the beginning of the introductory paragraph, and inserted "or her" in the last sentence of paragraph (2).

Code Commission notes. — Pursuant to Code Section 28-9-3, in 1997, the amendment of this Code section by Ga. L. 1997, p. 683, § 2, was treated as impliedly repealed and superseded by Ga. L. 1997, p. 1581, § 3, due to irreconcilable conflict. See County of Butts v. Strahan, 151 Ga. 417 (1921); Keener v. McDougall, 232 Ga. 273 (1974).

Editor's notes. — Ga. L. 1997, p. 683, § 6, not codified by the General Assembly, provides that the 1997 amendment "shall apply to all claims filed in any proceeding to liquidate an insurer, which proceeding is pending on July 1, 1997, or which is commenced on or after July 1, 1997."

Ga. L. 1997, p. 1581, § 5, not codified by the General Assembly, provides that the 1997 amendment "shall apply to all claims filed in any proceeding to liquidate an insurer which proceeding is pending on July 1, 1997, or which is commenced on or after July 1, 1997".

JUDICIAL DECISIONS

Parties could not convert claims. — Parties who would otherwise be general creditors of an insurance company with Class 4 priority claims could not convert those parties' claims to Class 1 priority claims by agreeing with the rehabilitator to compromise the parties' claims against the company during the rehabilitation process. Oxendine v. Commissioner of Ins., 229 Ga. App. 604, 494 S.E.2d 545 (1998).

33-37-42. Authority of liquidator to compound, compromise, or negotiate claims; report to court.

(a) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court except where the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under Code Section 33-37-38. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each

claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(b) The court may approve, disapprove, or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of 60 days following submission by the liquidator shall be treated by the liquidator as allowed claims subject thereafter to later modification or to rulings made by the court pursuant to Code Section 33-37-38. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

History. — Code 1981, § 33-37-42, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

C.J.S. — 44 C.J.S., Insurance, § 267 et seq.

33-37-43. Payment of distributions.

Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third-party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

History. — Code 1981, § 33-37-43, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 83 et seq.

ALR. — Conflict of laws respecting duration of or time for enforcement of liability of policyholders in respect of assessments, 161 A.L.R. 989.

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.

33-37-44. Disposition of unclaimed funds subject to distribution.

(a) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, mem-

ber, or other person who is unknown or cannot be found shall be maintained by the Commissioner and shall be paid without interest except in accordance with Code Section 33-37-41 to the person entitled thereto or his legal representative upon proof satisfactory to the Commissioner of his right thereto. Any amount on deposit not claimed within six years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited in the general fund of the state.

(b) All funds withheld under Code Section 33-37-36 and not distributed shall upon discharge of the liquidator be maintained by the Commissioner and paid by him in accordance with Code Section 33-37-41. Any sums remaining which under Code Section 33-37-41 would revert to the undistributed assets of the insurer shall be transferred to the general fund of the state under subsection (a) of this Code section, unless the Commissioner in his discretion petitions the court to reopen the liquidation under Code Section 33-37-46.

History. — Code 1981, § 33-37-44, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

ALR. — Conflict of laws respecting duration of or time for enforcement of liability of policyholders in respect of assessments, 161 A.L.R. 989.

33-37-45. Liquidator's application for discharge.

(a) When all assets justifying the expense of collection and distribution have been collected and distributed under this chapter, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute as may be deemed appropriate.

(b) Any other person may apply to the court at any time for an order under subsection (a) of this Code section. If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

History. — Code 1981, § 33-37-45, enacted by Ga. L. 1991, p. 1424, § 7.

JUDICIAL DECISIONS

Cited in Heritage Ins. Co. of Am. v. Evans, 205 Ga. App. 98, 421 S.E.2d 534 (1992).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, §§ 78 et seq., 92 et seq.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

ALR. — Conflict of laws respecting duration of or time for enforcement of liability of policyholders in respect of assessments, 161 A.L.R. 989.

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.

33-37-46. Reopening liquidation proceedings.

After the liquidation proceeding has been terminated and the liquidator discharged, the Commissioner or other interested party may at any time petition the superior court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

History. — Code 1981, § 33-37-46, enacted by Ga. L. 1991, p. 1424, § 7.

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, § 93 et seq.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

33-37-47. Retention or destruction of records.

Whenever it shall appear to the Commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

History. — Code 1981, § 33-37-47, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 93 et seq.

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

33-37-48. Receivership audits.

The superior court may, as it deems desirable, cause audits to be made of the books of the Commissioner relating to any receivership established under this chapter, and a report of each audit shall be filed with the Commissioner and with the court. The books, records, and

other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

History. — Code 1981, § 33-37-48, enacted by Ga. L. 1991, p. 1424, § 7.

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 245 et seq.

ARTICLE 4

LIQUIDATION PROCEEDINGS

33-37-49. Commissioner appointed as conservator of alien or foreign insurer's property; grounds.

(a) If a domiciliary liquidator has not been appointed, the Commissioner may apply to the superior court by verified petition for an order directing him to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(1) Any of the grounds provided in Code Section 33-37-11;

(2) That any of its property has been sequestered by official action in its domiciliary state or in any other state;

(3) That enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; or

(4)(A) That its certificate of authority to do business in this state has been revoked or that none was ever issued; and

(B) That there are residents of this state with outstanding claims or outstanding policies.

(b) When an order is sought under subsection (a) of this Code section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(c) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of superior court of the county in which the principal business of the company is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with the clerk would have imparted.

(d) The conservator may at any time petition for and the court may grant an order under Code Section 33-37-50 to liquidate assets of a foreign or alien insurer under conservation or, if appropriate, for an order under Code Section 33-37-52 to be appointed ancillary receiver.

(e) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party but, if such motion is denied, all costs shall be assessed against such party.

History. — Code 1981, § 33-37-49, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-50. Commissioner appointed as liquidator of foreign or alien insurer's assets; grounds.

(a) If no domiciliary receiver has been appointed, the Commissioner may apply to the superior court by verified petition for an order directing him to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

(1) Any of the grounds provided in Code Section 33-37-11 or 33-37-16; or

(2) Any of the grounds specified in paragraphs (2) through (4) of subsection (a) of Code Section 33-37-49.

(b) When an order is sought under subsection (a) of this Code section, the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(c) If it shall appear to the court that the best interests of creditors, policyholders, and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the superior court of the county in which the principal business of the company is located or the county in which its principal office or place of business is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with the clerk would have imparted.

(d) If a domiciliary liquidator is appointed in another state while a liquidation is proceeding under this Code section, the liquidator under this Code section shall thereafter act as ancillary receiver under Code Section 33-37-52.

(e) On the same grounds as are specified in subsection (a) of this Code section, the Commissioner may petition any appropriate federal

district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction or any lesser part thereof that the Commissioner deems desirable for the protection of the policyholders and creditors in this state.

(f) The court may order the Commissioner, when he has liquidated the assets of a foreign or alien insurer under this Code section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under this chapter as are otherwise compatible with the provisions of this Code section.

History. — Code 1981, § 33-37-50, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2016, p. 816, § 2/HB 883.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "in" was inserted following "specified" in paragraph (a)(2), and "Commissioner" was substituted for "commissioner" twice in subsection (e) and in subsection (f).

RESEARCH REFERENCES

ALR. — 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.

33-37-51. Title to property of insurer domiciled in another state; rights of resident claimants.

(a) The domiciliary liquidator of an insurer domiciled in another state shall, except as to special deposits and security on secured claims under subsection (c) of Code Section 33-37-52, be vested by operation of law with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts, and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts, and other records of the insurer located in this state. He or she also shall have the right to recover all other assets of the insurer located in this state, subject to the provisions of Code Section 33-37-52.

(b) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

History. — Code 1981, § 33-37-51, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2016, p. 816, § 3/HB 883.

33-37-52. Commissioner as ancillary receiver for insurer not domiciled in this state.

(a) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the Commissioner may file a petition with the superior court requesting appointment as ancillary receiver in this state:

(1) If he or she finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver; or

(2) If the protection of creditors or policyholders in this state so requires.

(b) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the appropriate clerk of the superior court in this state imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with the clerk.

(c) When a domiciliary liquidator has been appointed in another state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state and shall pay the necessary expenses of the proceedings. He or she shall promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator or his or her designee, at the direction of the domiciliary liquidator. Subject to this Code section, the ancillary receiver and his or her deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(d) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in other states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties, and powers to those provided in subsection (c) of this Code section for ancillary receivers appointed in this state.

(e) If the Commissioner elects not to file a petition with the superior court requesting appointment as ancillary receiver in this state pursuant to subsection (a) of this Code section, the Commissioner may,

notwithstanding the provisions of Code Sections 33-3-8 through 33-3-10 and Code Sections 33-12-8 and 33-12-9, transfer title and possession of all special deposits under his or her control to the domiciliary liquidator or his or her designee, at the direction of the domiciliary liquidator. Prior to transferring title and possession of such special deposits, the Commissioner may require the domiciliary liquidator to agree, in writing, to handle such deposits and special deposit claims in accordance with the statutes pursuant to which the special deposits were required and to any other requirements deemed necessary by the Commissioner.

History. — Code 1981, § 33-37-52, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2016, p. 816, § 4/HB 883.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "Commissioner" was substituted for "commissioner" in the introductory paragraph of subsection (a), and a comma was inserted following "duties" in subsection (d).

33-37-53. Commissioner's cooperation with officials of domiciliary state of foreign or alien insurer.

The Commissioner in his sole discretion may institute proceedings under Code Sections 33-37-9 and 33-37-10 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

History. — Code 1981, § 33-37-53, enacted by Ga. L. 1991, p. 1424, § 7.

33-37-54. Rights of nonresident claimants in proceeding against domiciliary insurer.

(a) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in other states where an ancillary receiver has not been appointed must file claims in this state, and claimants residing in other states where an ancillary receiver has been appointed may file claims either with the ancillary receivers in their respective states or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in other states where an ancillary receiver has been appointed may be proved either in the liquidation proceeding in this state as provided in this chapter or in ancillary proceedings in the other states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in subsection (b) of Code Section 33-37-55 with respect to ancillary proceedings, the final allowance of claims by

the courts in ancillary proceedings in other states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under Code Section 33-37-41.

History. — Code 1981, § 33-37-54, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2016, p. 816, § 5/HB 883.

33-37-55. Rights of resident claimants in proceeding in another state against nondomiciliary insurer.

(a) In a liquidation proceeding in another state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state or in ancillary proceedings, if any, in this state. If a claimant elects to prove his or her claim in this state, he or she shall file such claim with the ancillary receiver in the manner provided in Code Sections 33-37-34 and 33-37-35. The ancillary receiver shall make his or her recommendation to the court as under Code Section 33-37-42. He or she shall also arrange a date for hearing if necessary under Code Section 33-37-38 and shall give notice to the liquidator in the domiciliary state, either by certified mail or statutory overnight delivery or by personal service at least 40 days prior to the date set for hearing. If the domiciliary liquidator, within 30 days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or statutory overnight delivery or by personal service, of his or her intention to contest the claim, he or she shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(c) If a claimant files a claim in this state with the ancillary receiver, the final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

History. — Code 1981, § 33-37-55, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 2000, p. 1589, § 3; Ga. L. 2016, p. 816, § 6/HB 883.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (b) is applicable with respect to notices delivered on or after July 1, 2000.

33-37-56. Stay of proceedings during pendency of liquidation proceeding.

During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

History. — Code 1981, § 33-37-56, enacted by Ga. L. 1991, p. 1424, § 7.

JUDICIAL DECISIONS

Constitutionality. — O.C.G.A. § 33-37-56 does not impermissibly conflict with the constitutional jurisdiction of the superior courts; the statute is an authorized exception to the superior courts' grant of general jurisdiction. Smith v. Farm & Home Life Ins. Co., 269 Ga. 709, 506 S.E.2d 104 (1998).

O.C.G.A. § 33-37-56 does not unconstitutionally attempt to exclude property located in the state from ad valorem taxation without specific authorization; the statute does not state that the property of an insolvent, non-domiciliary insurer is exempt from taxation and, instead, merely grants such insurers a stay in proceedings against the insurers to collect amounts owed. Smith v. Farm & Home Life Ins. Co., 269 Ga. 709, 506 S.E.2d 104 (1998).

33-37-57. Superiority of order of distribution issued by domiciliary state; priority of payment and claims; rights of secured creditors.

(a) In a liquidation proceeding in this state involving one or more other states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and other states. All claims of residents of other states shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with Code Section

33-37-40, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

History. — Code 1981, § 33-37-57, enacted by Ga. L. 1991, p. 1424, § 7; Ga. L. 1992, p. 6, § 33; Ga. L. 2016, p. 816, § 7/HB 883.

33-37-58. Failure of ancillary receiver to transfer assets.

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under paragraph (7) of Code Section 33-37-41.

History. — Code 1981, § 33-37-58, enacted by Ga. L. 1991, p. 1424, § 7.

CHAPTER 38

GEORGIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Sec.
33-38-1. Purpose.
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33-38-15. Assessments against member insurers.
33-38-16. Reports and recommendations as to solvency of companies; board may report information as to insolvency of member insurer; examinations of member insurers; reports of insurer insolvencies.
33-38-17. Assessment liability, association as creditor of insolvent or impaired insurer; distribution of insolvent insurer's ownership rights; reimbursement of association from disbursement of marshaled assets as available; recovery of distributions to affiliates.
33-38-18. Stay of court proceedings to which insolvent insurer is a party; setting aside of default judgments.
33-38-19. Notification as to effect of chapter.
33-38-20. Appeal to the Commissioner; judicial review.
33-38-21. References to the association in advertisements for insurance.
33-38-22. Premium tax liability offsets; refunds offset against taxes.

33-38-1. Purpose.

The purpose of this chapter is to protect the persons specified in subsection (b) of Code Section 33-38-2, subject to certain limitations, against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in subsection (a) of Code Section 33-38-2, due to the impairment or insolvency of the member insurer issuing such policies, plans, or contracts. To provide this protection: (1) an association of member insurers is created to enable the guaranty of payment of benefits and continuation of coverages as limited by this chapter; (2) members of the association are subject to assessment to provide funds to carry out the purpose of this chapter; and (3) the association is authorized to assist the Commis-

sioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

History. — Code 1933, § 56-2201, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 1/HB 1050.

The 2020 amendment, effective July 1, 2020, in the first sentence, substituted "life, health, and annuity policies, plans or contracts" for "life and health insurance policies and annuity contracts" near the beginning, and inserted "member", and ", plans," at the end; and, in the second sentence, inserted "member", substituted a colon for a comma, and substituted semicolons for commas twice.

Editor's notes. — Ga. L. 2020, p. 113, § 1/HB 1050, which amended this Code section, purported to amend Code Section 33-8-1 but actually amended Code Section 33-38-1.

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

Claim must be based upon failure to perform "contractual" obligation. — Claim against an insurance guaranty association for statutory damages under O.C.G.A. § 33-34-6, based upon an insolvent insurer's failure to perform the insurer's statutory obligation, was sought to be enforced pursuant to O.C.G.A. § 33-38-1 et seq., which authorizes only enforcement of claims based upon an insolvent insurer's failure to perform the insurer's contractual obligations. Since there had been no default as to the insolvent insurer's "contractual obligations" to the insureds, the insureds had no viable claim. Crider v. Georgia Life & Health Ins. Guar. Ass'n, 188 Ga. App. 407, 373 S.E.2d 30 (1988).

Cited in Ga. Life & Health Ins. Guar. Ass'n v. Gilman Paper Co. Deferred Comp. Sav. & Inv. Plan, 249 Ga. App. 767, 549 S.E.2d 751 (2001).

RESEARCH REFERENCES

C.J.S. — 44 C.J.S., Insurance, § 227 et seq.

33-38-2. Scope.

(a) This chapter shall provide coverage to the persons specified in subsection (b) of this Code section for policies or contracts of direct, nongroup life insurance; health insurance which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates and health care plans issued by health care corporations; annuities; for certificates under direct group policies and contracts and supplemental contracts to any of these; and for unallocated annuity contracts, in each case issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(b)(1) Coverage under this chapter shall be provided only:

(A) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subparagraph (B) of this paragraph; and

(B) To persons who are owners of or certificate holders or enrollees under such policies or contracts, other than unallocated annuity contracts and structured settlement annuities, to the persons who are the contract holders and who:

(i) Are residents; or

(ii) Are not residents, but the member insurers which issued such policies or contracts are domiciled in this state; the states in which such persons reside have associations similar to the association created by this chapter; and such persons are not eligible for coverage by an association in any other state due to the fact that the insurer, health maintenance organization, or health care corporation was not licensed in the state at the time specified in the state's guaranty association law.

(2) For unallocated annuity contracts specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to:

(A) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(B) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(3) For structured settlement annuities specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

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

(B) Is not a resident, but only under both of the following conditions:

(i)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this chapter; and

(ii) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This chapter shall not provide coverage to:

(A) A person who is a payee or beneficiary of a contract owner who is a resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state;

(B) A person covered under paragraph (2) of this subsection, if any coverage is provided by the association of another state to that person; or

(C) A person who acquires rights to receive payments through a structured settlement factoring transaction, as such term is defined in 26 U.S.C. Section 5891(c)(3)(A) as such term existed on January 23, 2002, regardless of whether the transaction occurred before or after such date.

(5) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(c) Except as otherwise provided in subsection (d) of this Code section, this chapter shall not provide coverage to:

(1) That portion or part of a policy or contract not guaranteed by a member insurer, or under which the risk is borne by the policy or contract owner;

(2) A policy or contract of reinsurance or any policy or contract or part thereof assumed by the impaired or insolvent insurer under a

contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(3) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) Averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any prepaid legal services plan, as defined in Code Section 33-35-2;

(5) Any policy, contract, or certificate issued by a fraternal benefit society, as defined in Code Section 33-15-1;

(6) Accident and sickness insurance as defined in Code Section 33-7-2 when written by a property and casualty insurer as part of an automobile insurance contract;

(7) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss insurance policy; or

(D) An administrative services only contract;

(8) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(9) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(10) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(11) Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;

(12) A portion of a policy or contract to the extent that the assessments required by Code Section 33-38-15 with respect to the policy or contract are preempted by federal or state law;

(13) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(14) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(15) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but

which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(16) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C & D, Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto; or

(17) Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction, as such term is defined in 26 U.S.C. Section 5891(c)(3)(A) as such term existed on January 23, 2002, regardless of whether the transaction occurred before or after such date.

(d) The exclusion from coverage referenced in paragraph (3) of subsection (c) of this Code section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care for any other health insurance benefit.

(e) The provisions of this Code section shall apply only to coverage the Georgia Life and Health Insurance Guaranty Association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency on or after July 1, 2020.

History. — Code 1933, § 56-2202, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1984, p. 1080, § 5; Ga. L. 1988, p. 1900, § 1; Ga. L. 1995, p. 1348, § 5; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2017, p. 164, § 51/HB 127; Ga. L. 2019, p. 386, § 141/SB 133; Ga. L. 2019, p. 1056, § 33/SB 52; Ga. L. 2020, p. 113, § 2/HB 1050.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, substituted "on or after July 1, 2012" for "after the effective date of this Code section" at the end of subsection (d). The second 2019 amendment, effective May 12, 2019, part of an Act to revise, modernize, and correct the Code, in paragraph (c)(4), deleted "a" preceding "health care plan" and preceding "prepaid legal services plan" and substituted "or health maintenance organization" for "and a health maintenance organization".

The 2020 amendment, effective July 1, 2020, in the first sentence of subsection (a), substituted "policies or contracts of direct, nongroup life insurance; health insurance which for the purposes of this chapter includes health maintenance or-

ganization subscriber contracts and certificates and health care plans issued by health care corporations; annuities;" for "direct, nongroup life, health, or annuity policies or contracts,", deleted "for" preceding "supplemental", and added a semicolon; inserted "including health care providers rendering services covered under health insurance policies or certificates," in subparagraph (b)(1)(A); inserted "or enrollees" in in subparagraph (b)(1)(B); in division (b)(1)(B)(ii), inserted "member", substituted "chapter" for "article", and inserted ", health maintenance organization, or health care corporation"; deleted "or" at the end of subparagraph (b)(4)(A); substituted "; or" for the period at the end of subparagraph (b)(4)(B); and added subparagraph (b)(4)(C); inserted "enrollee," in the last sentence of paragraph (b)(5); substituted "Except as otherwise provided in subsection (d) of this Code section, this" for "This" at the beginning of subsection (c); substituted "a member insurer" for "an insurer" in paragraph (c)(1); in paragraph (c)(4), deleted "policy, contract, certificate, health care plan referred to in Chapter 20 of this title," preceding "prepaid legal" and deleted ", or health maintenance organization, as defined in Code Section 33-21-1" following "Code Section 33-35-2"; in paragraph (c)(13), inserted "member" and "enrollee, certificate holder,"; inserted "member" in subparagraph (c)(13)(B); inserted "or contract" in subparagraphs (c)(13)(B) and (c)(13)(C); deleted "or" at the end of paragraph (c)(15); in paragraph (c)(16), inserted "Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid)," and substituted "; or" for the period at the end; added paragraph (c)(17); added subsection (d); redesignated former subsection (d) as present subsection (e); and, in subsection (e), substituted "Georgia Life and Health Insurance Guaranty Association" for "guaranty association" and substituted "July 1, 2020" for "July 1, 2012" at the end.

Law reviews. — For article, "Insurance," see 53 Mercer L. Rev. 281 (2001).

JUDICIAL DECISIONS

An unallocated annuity contract held by a non-resident trustee was excluded from coverage under O.C.G.A. § 33-38-2(b)(2). Ga. Life & Health Ins. Guar. Ass'n v. Gilman Paper Co. Deferred Comp. Sav. & Inv. Plan, 249 Ga. App. 767, 549 S.E.2d 751 (2001).

OPINIONS OF THE ATTORNEY GENERAL

Liability for claims when foreign life insurer in liquidation. — Georgia Life and Health Insurance Guaranty Association is liable for claims by insureds of a foreign life insurer now in liquidation in its domiciliary state, if the insurer was authorized to transact business in this state at the time it wrote the policies, although it does not have a certificate of authority in this state at the time the claims against the Guaranty Association are made. 1987 Op. Att'y Gen. No. 87-22. (See paragraph (b)(2), added by the 1988 amendment.)

Liability for obligations of insolvent foreign insurer. — When courts of a foreign state cancel the certificates, policies and other obligations of an insolvent insurer domiciled in that state, which obligations fall within the scope of this chapter, the Georgia Life and Health Insurance Guaranty Association must meet the obligations of that insurer as provided by law and may not cancel coverage to eligible Georgia residents other than as provided in the certificates, policies, or other obligations. 1989 Op. Att'y Gen. 89-42.

33-38-3. Construction.

This chapter shall be construed to effect the purpose set forth in Code Section 33-38-1.

History. — Code 1933, § 56-2218, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

JUDICIAL DECISIONS

Cited in Crider v. Georgia Life & Health Ins. Guar. Ass'n, 188 Ga. App. 407, 373 S.E.2d 30 (1988).

33-38-4. Definitions.

As used in this chapter, the term:

(1) "Account" means any of the two accounts created under Code Section 33-38-5.

(2) "Affiliate" means any person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(3) "Association" means the Georgia Life and Health Insurance Guaranty Association created under Code Section 33-38-5.

(4) "Authorized assessment," or "authorized" when used in the context of assessments, means a resolution by the board of directors of the association has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(5) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(6) "Called assessment," or "called" when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(7) "Contractual obligation" means any obligation under a covered policy, contract, or certificate under a group policy or contract, or portion thereof for which coverage is provided under Code Section 33-38-2.

(8) "Control" or "controlled" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise.

(9) "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Code Section 33-38-2.

(10) "Extra-contractual claims" shall include, for example, any claim not authorized by, or outside the scope of, the underlying policy or contract to include any claim based on bad faith, punitive or exemplary damages, treble damages, prejudgment or postjudgment interest, attorney's fees, or costs of litigation.

(11) "Health benefit plan" means any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or any other similar health contract. This term does not include:

(A) Accident only insurance;

(B) Credit insurance;

(C) Dental only insurance;

(D) Vision only insurance;

(E) Medicare supplement insurance;

(F) Benefits for long-term care, home health care, community based care, or any combination thereof;

(G) Disability income insurance;

(H) Coverage for on-site medical clinics; or

(I) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(12) "Health care corporation" means a corporation established in accordance with the provisions of Chapter 20 of Title 33 to administer one or more health care plans as defined in Code Section 33-20-3(4).

(13) "Impaired insurer" means a member insurer which is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(14) "Insolvent insurer" means a member insurer against which an order of liquidation containing a finding of insolvency has been entered by a court of competent jurisdiction.

(15) "Member insurer" means any insurer, health maintenance organization, or health care corporation which is licensed or which holds a certificate of authority to transact in this state any kind of insurance, health care plan, or health maintenance organization

business for which coverage is provided under Code Section 33-38-2 and includes any insurer, health care corporation, or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(A) A fraternal benefit society;

(B) A mandatory state pooling plan;

(C) A mutual assessment company or any entity that operates on an assessment basis;

(D) An insurance exchange;

(E) An organization that has a certificate or license limited to the issuance of charitable gift annuities under Code Sections 33-58-1 through 33-58-6; or

(F) Any entity similar to those described in subparagraphs (A) through (E) of this paragraph.

(16) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(17) "Owner" of a policy or contract, "policyholder," "policy owner," and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms "owner," "contract owner," "policyholder," and "policy owner" shall not include persons with a mere beneficial interest in a policy or contract.

(18) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(19) "Plan sponsor" means:

(A) The employer in the case of a benefit plan established or maintained by a single employer;

(B) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(C) In a case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(20) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts, less returned premiums, considerations and deposits thereon and less dividends and experience credits. The term "premiums" shall not include:

(A) Amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under this chapter except that assessable premium shall not be reduced on account of paragraph (3) of subsection (c) of Code Section 33-38-2, relating to interest limitations, and paragraph (12) of Code Section 33-38-7, relating to limitations with respect to one individual, one participant, and one policy or contract owner;

(B) Premiums in excess of $5 million on an unallocated annuity contract; or

(C) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of $5 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(21)(A) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

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

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

(iii) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in

which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(B) The principal place of business of a plan sponsor of a benefit plan described in subparagraph (C) of paragraph (19) of this Code section shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(22) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

(23) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

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

(25) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

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

(27) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

History. — Code 1933, § 56-2203, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1988, p. 1900, § 2; Ga. L. 1995, p. 1348, § 6; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2017, p. 164, § 52/HB 127; Ga. L. 2019, p. 386, § 142/SB 133; Ga. L. 2020, p. 113, § 3/HB 1050.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 1981" following "jurisdiction" at the end of paragraphs (11) and (12).

The 2020 amendment, effective July 1, 2020, substituted "'Covered contract' or 'covered policy'" for "'Covered policy'" in paragraph (9); added the definitions for "Health benefit plan" and "Health care corporation"; redesignated former paragraphs (11) through (25) as present paragraphs (13) through (27), respectively; in paragraph (15), inserted ", health maintenance organization, or health care corporation", inserted ", health care plan, or health maintenance organization business", and inserted ", health care corporation, or health maintenance organization"; deleted former subparagraphs (15)(A) through (15)(C), which read: "(A) A for profit hospital or medical service corporation;

"(B) A health care corporation;

"(C) A health maintenance organization;";

and redesignated former subparagraphs (15)(D) through (15)(I) as present subparagraphs (15)(A) through (15)(F), respectively; in paragraph (17), in the first sentence, substituted ", 'policyholder,' 'policy owner,' and" for "and 'policy owner'" and inserted "member", and inserted "'policyholder,' in the second sentence; inserted "policy or" in subparagraph (20(A); inserted "or contract" in subparagraph (20)(C); substituted "paragraph (19)" for "paragraph (17)" in subparagraph (21)(B); and inserted "member" in paragraph (23).

JUDICIAL DECISIONS

Cited in Crider v. Georgia Life & Health Ins. Guar. Ass'n, 188 Ga. App. 407, 373 S.E.2d 30 (1988); Ga. Life & Health Ins. Guar. Ass'n v. Gilman Paper Co. Deferred Comp. Sav. & Inv. Plan, 249 Ga. App. 767, 549 S.E.2d 751 (2001).

RESEARCH REFERENCES

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

33-38-5. Creation; required membership; functions and powers; supervision of association; accounts for administration and assessment.

(a) There is created a nonprofit, unincorporated association to be known as the Georgia Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance, a health maintenance organization business, or a health care corporation business in this state. The association shall perform its functions under the plan of operation established and approved under Code Section 33-38-8 and shall exercise its powers through a board of directors established under Code Section 33-38-6.

(b) The association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

(c) For purposes of administration and assessment, the association shall maintain two accounts: (1) the health insurance account; and (2) the life insurance and annuity account. The life insurance and annuity account shall contain three subaccounts: (A) the life insurance account; (B) the annuity account; and (C) the unallocated annuity account.

(d) For purposes of assessment, supplemental contracts shall be covered under the account in which the basic policy is covered.

History. — Code 1933, § 56-2204, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 3; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 4/HB 1050.

The 2020 amendment, effective July 1, 2020, inserted ", a health maintenance organization business, or a health care corporation business" in the second sentence of subsection (a).

RESEARCH REFERENCES

Am. Jur. 2d. — 2 Am. Jur. 2d, Administrative Law, § 19.

C.J.S. — 73 C.J.S., Public Administrative Law and Procedure, § 9.

33-38-6. Membership of the board of directors; vacancies; compensation and reimbursement of expenses.

(a) The board of directors of the association shall consist of not less than seven nor more than 11 member insurers serving terms as established in the plan of operation. The members of the board shall be selected by the Commissioner from a list provided to the Commissioner from the board. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner.

(b) In approving selections of members to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them in their capacity as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

History. — Code 1933, § 56-2205, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 5/HB 1050.

The 2020 amendment, effective July 1, 2020, in the first sentence of subsection (a), substituted "seven" for "five" and "11" for "nine".

RESEARCH REFERENCES

Am. Jur. 2d. — 2 Am. Jur. 2d, Administrative Law, § 52.

C.J.S. — 73 C.J.S., Public Administrative Law and Procedure, §§ 13, 14.

33-38-7. Powers and duties of the association generally.

(a) In addition to the powers and duties enumerated elsewhere in this chapter, the association shall have the following powers and duties:

(1) If a member insurer is an impaired insurer, the association, subject to any conditions, other than those conditions which impair the contractual obligations of the impaired insurer, imposed by the association and approved by the Commissioner, may, in its discretion:

(A) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the covered policies or contracts of the impaired insurer; and

(B) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subparagraph (A) of this paragraph and assure payment of the contractual obligations of the impaired insurer pending action under subparagraph (A) of this paragraph; and

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(A)(i)(I) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the covered policies or contracts of the insolvent insurer; or

(II) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties; or

(B) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(I) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts; and

(II) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to division (i) of this subparagraph, of the benefits provided;

(iii) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of division (iv) of this subparagraph, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer, health maintenance organization, or health care corporation had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(iv) In providing the substitute coverage required under division (iii) of this subparagraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Commissioner. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The association may reinsure any alternative or reissued policy or contract;

(v)(I) Alternative policies or contracts adopted by the association shall be subject to the approval of the Commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(II) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(III) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the Commissioner;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage, policy, or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association; and

(viii) When proceeding under this subparagraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with paragraph (3) of subsection (c) of Code Section 33-38-2;

(3) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter;

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

(5) The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state;

(6) In carrying out its duties under paragraph (2) of this Code section, the association may:

(A) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that

the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(B) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court;

(7) A deposit in this state, held pursuant to law or required by the Commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to Code Sections 33-3-8 through 33-3-10, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this paragraph. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in paragraph (2) of this Code section, the Commissioner shall have the powers and duties of the association under this chapter with respect to the insolvent insurers;

(9) Upon the Commissioner's request, the association may render assistance and advice to the Commissioner concerning rehabilitation,

payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer;

(10) The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise;

(11)(A) Any person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon such person. The association shall be subrogated to these rights against the assets of any impaired or insolvent insurer.

(B) The subrogation rights of the association under this paragraph shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(C) In addition to subparagraphs (A) and (B) of this paragraph, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts.

(D) If subparagraphs (A) through (C) of this paragraph are invalid or ineffective with respect to any person or claim for any

reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the association.

(E) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this paragraph, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the association;

(12) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

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

(B) With respect to one life, regardless of the number of policies or contracts:

(i) The amount of $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance;

(ii) For health insurance benefits, $300,000.00 for disability income insurance; $300,000.00 for long-term care insurance; $300,000.00 for health insurance other than disability income insurance as referenced above, long-term care insurance as referenced above or health benefit plans as referenced below, including any net cash surrender and net cash withdrawal values; and $500,000.00 for health benefit plans; and

(iii) The amount of $300,000.00 in the present value of annuity benefits, but not more than $250,000.00 in net cash surrender and net cash withdrawal values for an annuity;

(C) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $300,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(D) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of $300,000.00 in benefits with respect to any one life under subparagraphs (B) and (C) of this paragraph except with respect to benefits for health benefit plans under

division (ii) of this subparagraph, in which case the aggregate liability of the association shall not exceed $500,000.00 with respect to any one individual; or

(ii) With respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5 million in benefits, regardless of the number of policies and contracts held by the owner;

(E) With respect to either one contract owner provided coverage under subparagraph (b)(2)(B) of Code Section 33-38-2 or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts, $5 million in benefits, regardless of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than $5 million in benefits with respect to all these unallocated contracts;

(F) The limitations set forth in this paragraph are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights; and

(G) For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(13) In performing its obligations to provide coverage under this Code section, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract;

(14) In addition to the rights and powers elsewhere in this chapter, the association may:

(A) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(B) Sue or be sued, including the right to seek a declaratory judgment in any superior court of this state as to uncertainties with respect to the payment of benefits under this Code section. The association may also take any legal actions necessary or proper for recovery of any unpaid assessments under Code Section 33-38-15 and may settle claims or potential claims against it;

(C) Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(D) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this chapter;

(E) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(F) Take such legal action as may be necessary to avoid payment of improper claims; and

(G) Exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life insurer, health insurer, health maintenance organization or health care corporation; but in no case may the association issue policies or contracts other than those issued to perform its obligations under this chapter;

(15) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(16) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;

(17) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter;

(18) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter;

(19) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association;

(20) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making such election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date on which the order of liquidation was entered;

(21) The board of directors shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner;

(22) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement;

(23) Exclusive venue in any action by or against the association is in the Superior Court of DeKalb County. The association may, at its option, waive such venue as to specific actions. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter; and

(24) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under paragraph (1) or (2) of this Code section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(A) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(B) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(C) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(b) The provisions of this Code section shall apply only to coverage the Georgia Life and Health Insurance Guaranty Association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency on or after July 1, 2020.

History. — Code 1933, § 56-2206, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 4; Ga. L. 1993, p. 491, § 3; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2019, p. 386, § 143/SB 133; Ga. L. 2020, p. 113, § 6/HB 1050.

The 2019 amendment, effective July 1, 2019, substituted "this Code section" for "Code Section 33-38-7" near the beginning of paragraph (a)(13); and substituted "on or after July 1, 2012" for "after the effective date of this Code section" at the end of subsection (b).

The 2020 amendment, effective July 1, 2020, rewrote subsection (a) and, in subsection (b), substituted "Georgia Life and Health Insurance Guaranty Association" for "guaranty association" near the middle and substituted "July 1, 2020" for "July 1, 2012" at the end.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, a period was substituted for a semicolon at the end of subparagraph (8)(A) (now (11)(A)).

Law reviews. — For note on 1993 amendment of this Code section, see 100 Ga. St. U.L. Rev. 152 (1993).

JUDICIAL DECISIONS

Cited in Ga. Life & Health Ins. Guar. Ass'n v. Gilman Paper Co. Deferred Comp. Sav. & Inv. Plan, 249 Ga. App. 767, 549 S.E.2d 751 (2001).

RESEARCH REFERENCES

Am. Jur. 2d. — 2 Am. Jur. 2d, Administrative Law, § 60 et seq.

C.J.S. — 73 C.J.S., Public Administrative Law and Procedure, § 49 et seq.

33-38-8. Submission of plan of operation; contents; compliance with such plan.

(a) The association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner. If the association fails to submit a suitable plan of operation or, if at any time thereafter the association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the association and approved in writing by the Commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

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

(2) Establish the amount and method of reimbursing members of the board of directors under Code Section 33-38-6;

(3) Establish regular places and times for meetings of the board of directors;

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

(5) Establish any additional procedures for assessments under Code Section 33-38-15; and

(6) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

History. — Code 1933, § 56-2208, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2019, p. 386, § 144/SB 133.

The 2019 amendment, effective July 1, 2019, deleted "within 180 days following July 1, 1981," following "plan of operation" near the middle of the third sentence of subsection (a).

RESEARCH REFERENCES

Am. Jur. 2d. — 2 Am. Jur. 2d, Administrative Law, § 77 et seq.

C.J.S. — 73 C.J.S., Public Administrative Law and Procedure, § 87 et seq.

33-38-9. Delegation of powers and duties of the association.

The plan of operation described in Code Section 33-38-8 may provide that any or all powers and duties of the association, except those under subparagraph (a)(14)(C) of Code Section 33-38-7 and Code Section 33-38-15, shall be delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this Code section shall take effect only with the approval of both the board of directors and the Commissioner and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided for by this chapter.

History. — Code 1933, § 56-2208, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 7/HB 1050.

The 2020 amendment, effective July

1, 2020, substituted "subparagraph (a)(14)(C)" for "subparagraph (C) of paragraph (14)" in the first sentence.

33-38-10. Duties and powers of the Commissioner.

In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The Commissioner shall:

(A) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer; and

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

(2) The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation.

History. — Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 8/HB 1050.

The 2020 amendment, effective July 1, 2020, inserted "impaired" in the last sentence of subparagraph (1)(B) and substituted "transact business" for "transact insurance" in the middle of paragraph (2).

RESEARCH REFERENCES

Am. Jur. 2d. — 2 Am. Jur. 2d, Administrative Law, § 79 et seq.

C.J.S. — 73 C.J.S., Public Administrative Law and Procedure, § 49 et seq.

33-38-11. Records of meetings and negotiations of the association.

Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under Code Section 33-38-7. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except (a) upon the termination of the impairment or insolvency of the insurer, or (b) upon the order of a court of competent jurisdiction. Nothing in this Code section

shall limit the duty of the association to render a report of its activities under Code Section 33-38-12.

History. — Code 1933, § 56-2211, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

33-38-12. Examination of the association by the Commissioner; annual report.

The association shall be subject to examination and regulation by the Commissioner. Notwithstanding the foregoing, whether such examinations shall be conducted and the frequency of any such examination shall be at the sole discretion of the Commissioner. The board of directors shall submit to the Commissioner not later than May 1 of each year a financial report and a report of its activities for the preceding calendar year on forms approved by the Commissioner.

History. — Code 1933, § 56-2212, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

33-38-13. Exemption of the association from taxation.

The association shall be exempt from all taxation in this state based upon income or gross receipts and shall likewise be exempt from all state and local occupation license and business fees and occupation license and business taxes.

History. — Code 1933, § 56-2213, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

RESEARCH REFERENCES

Am. Jur. 2d. — 71 Am. Jur. 2d, State and Local Taxation, § 309.
C.J.S. — 84 C.J.S., Taxation, § 250.

33-38-14. Immunity from liability for actions or omissions in performance of powers and duties pursuant to this chapter.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the Commissioner or his or her representatives, for any action or omission by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participa-

tion in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

History. — Code 1933, § 56-2214, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

RESEARCH REFERENCES

C.J.S. — 73 C.J.S., Public Administrative Law and Procedure, § 15.

33-38-15. Assessments against member insurers.

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers separately for the health account and for each subaccount of the life insurance and annuity account at such time and for such amounts as the board finds necessary. Assessment shall be due not less than 30 days after prior written notice to the member insurers.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative costs and legal and other general expenses not related to a particular impaired or insolvent insurer, and examinations conducted under the authority of subsection (c) of Code Section 33-38-16; and

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Code Section 33-38-7 with regard to an impaired or insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the board of directors and may be made on a pro rata or non-pro rata basis. If a Class A assessment is made on a pro rata basis, the board may provide that it be credited against future Class B assessments. The amount of any Class B assessment except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts in subsection (c) of Code Section 33-38-5 pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances. The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a method included in the plan of operation and approved

by the Commissioner. Such method shall provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers.

(2) Class B assessments against member insurers for each account or subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account or subaccount for the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under subsection (b) of this Code section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(d) The association may abate or defer in whole or in part the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this Code section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e)(1) The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed 2 percent of such member insurer's premiums received in this state on the policies covered by the account during the calendar year preceding the assessment. If the maximum assessment in any account, together with the other assets of the association, does not provide in any one year in such account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(2) The total of all assessments upon a member insurer for each subaccount of the life insurance and annuity account shall not in any

one calendar year exceed 2 percent of such insurer's premiums received in this state on the policies covered by the subaccount during the calendar year preceding the assessment. If the maximum assessment for any subaccount of the life insurance and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then the board shall assess the other subaccounts of the life insurance and annuity account for the necessary additional amount up to the maximum assessment level provided in paragraph (1) of this subsection.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account or subaccount, the amount by which the assets of the account or subaccount exceed the amount the board finds is necessary to carry out the obligations of the association during the coming year with regard to that account or subaccount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account or subaccount to provide funds for the continuing expenses of the association and for future losses if the board determines that refunds are impractical.

(g) It shall be proper for any member insurer in determining its premium rates and policy owner dividends as to any kind of insurance health maintenance organization business or health care corporation business within the scope of this chapter to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The association shall issue to each member insurer paying an assessment under this chapter, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form, for such an amount and for such period of time, not to exceed five years from the date of assessment, as the Commissioner may approve.

(i)(1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within 60 days following the payment of an assessment under protest by a member insurer, the association shall notify the member

insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the Commissioner for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

(j) The association may request information of member insurers in order to aid in the exercise of its power under this Code section, and member insurers shall promptly comply with a request.

History. — Code 1933, § 56-2207, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 5; Ga. L. 1990, p. 1367, § 1; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 9/HB 1050.

The 2020 amendment, effective July 1, 2020, in paragraph (c)(1), deleted the former third sentence which read: "An assessment for costs and expenses other than for examinations which is made on a non-pro rata basis shall not exceed $300.00 per company in any one calendar year.", in the present third sentence, inserted "except for assessments related to long term care insurance," and substituted "between the accounts and among the" for "among the accounts or", and added the last two sentences; inserted "member" in paragraph (c)(2), paragraph (e)(1), subsection (f), and twice in subsection (h); inserted "health maintenance organization business or health care corporation business" in subsection (g); in paragraph (i)(5), substituted "insurer" for "company" in the first sentence and inserted "insurer" in the second sentence; and inserted a comma in subsection (j).

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, "preceding" was substituted for "preceeding" in the first sentence of paragraph (e)(2) to correct a misspelling.

33-38-16. Reports and recommendations as to solvency of companies; board may report information as to insolvency of member insurer; examinations of member insurers; reports of insurer insolvencies.

(a) The board of directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer, or to the solvency of any health maintenance organization,

insurer, or health care corporation seeking to do business in this state. Such reports and recommendations shall not be considered public documents.

(b) The board of directors may, upon majority vote, notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(c) The board of directors may, upon majority vote, request that the Commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within 30 days of the receipt of such request, the Commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners' examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the association, and the examination report shall be treated the same as other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the Commissioner from complying with subsection (a) of this Code section. The Commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the Commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(d) The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

(e) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the Commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the board of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer and may adopt by reference any report prepared by such other associations.

History. — Code 1933, § 56-2210, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 10/HB 1050.

The 2020 amendment, effective July 1, 2020, in the first sentence of subsection (a), substituted "health maintenance organization, insurer, or health care corporation" for "company" and deleted "an insurance" preceding "business in this state"; inserted a comma in the fourth sentence of subsection (c); and inserted "member" in subsection (d).

33-38-17. Assessment liability, association as creditor of insolvent or impaired insurer; distribution of insolvent insurer's ownership rights; reimbursement of association from disbursement of marshaled assets as available; recovery of distributions to affiliates.

(a) This chapter shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of the assets attributable to covered policies, reduced by any amounts to which the association is entitled as subrogee pursuant to paragraph (11) of Code Section 33-38-7. The assets of the impaired or insolvent insurer attributable to covered policies shall be used by the association to continue the covered policies and pay the contractual obligations of the impaired or insolvent insurer as required by this chapter. For purposes of this subsection, that portion of the total assets of an impaired or insolvent insurer that is attributable to covered policies or contracts shall be determined by using the same proportion as the reserves that should have been established for such policies or contracts bears to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(c) As a creditor of the impaired or insolvent insurer as established in subsection (b) of this Code section and consistent with Code Section 33-37-33, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(d)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination,

consideration shall be given to the welfare of the policyholders, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.

(2) No distribution to stockholders of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Code Section 33-38-7, with respect to such member insurer, has been fully recovered by the association.

(3) No insurer that is subject to any delinquency proceedings, whether formal or informal, administrative or judicial, shall have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

(e)(1) If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right on behalf of the member insurer to recover from any affiliate the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation, subject to the limitations of this Code section.

(2) No such distribution shall be recoverable if the member insurer shows that the distribution was lawful and reasonable when paid and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable to the extent of the distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared shall be liable to the extent of the distributions that would have been received if such distributions had been paid immediately. Whenever two persons are liable with respect to the same distribution, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed, in excess of all other available assets of the insolvent insurer, to pay the contractual obligations of the insolvent insurer.

(5) Whenever any person liable under paragraph (3) of this subsection is insolvent, all affiliates that 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 insolvent affiliate.

History. — Code 1933, § 56-2211, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 11/HB 1050.

The 2020 amendment, effective July 1, 2020, inserted "member" throughout this Code section; in the last sentence of subsection (b), inserted "or contracts" twice and inserted "or health benefit plans" at the end; substituted "insolvency of a member insurer" for "insolvency of an insurer" in the second sentence of subsection (c); in paragraph (d)(1), inserted "contract owners, certificate holders, enrollees and" and inserted ", contract owners, certificate holders, and enrollees"; and substituted "a member insurer" for "an insurer" near the beginning of paragraph (e)(1).

Editor's notes. — Ga. L. 2020, p. 113, § 11/HB 1050 purported to add the word "insurer" in paragraph (e)(3); however, that change was not given effect since the word "insurer" was already present.

33-38-18. Stay of court proceedings to which insolvent insurer is a party; setting aside of default judgments.

All proceedings in any court in this state in which the insolvent insurer is a party shall be stayed 180 days from the date of a final order of liquidation, rehabilitation, or conservation to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment entered under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such action on the merits.

History. — Code 1933, § 56-2215, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

33-38-19. Notification as to effect of chapter.

The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

History. — Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

33-38-20. Appeal to the Commissioner; judicial review.

Any action of the board of directors may be appealed to the Commissioner by any member insurer if such appeal is taken within 60 days of its receipt of notice of the action being appealed. Any final action or order of the Commissioner shall be subject to judicial review in a court

of competent jurisdiction in accordance with the laws of this state that may apply to the actions or orders of the Commissioner.

History. — Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786.

33-38-21. References to the association in advertisements for insurance.

(a) No person, including a member insurer or agent or affiliate of a member insurer, shall make, publish, disseminate, circulate, or place before the public or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication; in the form of a notice, circular, pamphlet, letter, or poster; over any radio station or television station; or in any other way, any advertisement, announcement, or statement which uses the existence of the association for the purposes of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this chapter. This Code section shall not apply to the association or any other entity which does not sell or solicit insurance or coverage provided by a health maintenance organization or a health care corporation.

(b) Any person who violates subsection (a) of this Code section may, after notice and hearing and upon order of the Commissioner, be subject to one or more of the following:

(1) A monetary penalty of not more than $1,000.00 for each act or violation, but not to exceed an aggregate penalty of $10,000.00; or

(2) Suspension or revocation of his or her license or certificate of authority.

History. — Code 1933, § 56-2216, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 12/HB 1050.

The 2020 amendment, effective July 1, 2020, in subsection (a), in the first sentence, substituted "a member insurer" for "an insurer" in two places and inserted "or other coverage", and added "or coverage provided by a health maintenance organization or a health care corporation" at the end of the last sentence.

33-38-22. Premium tax liability offsets; refunds offset against taxes.

(a) A member insurer may offset against its premium tax liability to this state an assessment described in Code Section 33-38-15 to the extent of 20 percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all

uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(b) A member insurer that is exempt from taxes referenced in subsection (a) of this Code section may recoup its assessments by a surcharge on its premiums in a sum reasonably calculated to recoup the assessments over a reasonable period of time, as approved by the Commissioner. Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax, the medical loss ratio, or agent commission. If a member insurer collects excess surcharges, the insurer shall remit the excess amount to the association, and the excess amount shall be applied to reduce future assessments in the appropriate account.

(c) Any sums which are acquired by refund, pursuant to subsection (f) of Code Section 33-38-15, from the association by member insurers and which have theretofore been offset against premium taxes as provided in subsection (a) of this Code section shall be paid by such member insurers to this state in such manner as the Commissioner may require. The association shall notify the Commissioner that such refunds have been made.

History. — Code 1981, § 33-38-22, enacted by Ga. L. 1988, p. 1900, § 6; Ga. L. 1989, p. 14, § 33; Ga. L. 2012, p. 701, § 1/HB 786; Ga. L. 2020, p. 113, § 13/HB 1050.

The 2020 amendment, effective July 1, 2020, added subsection (b), redesignated former subsection (b) as present subsection (c), and inserted "member" in the first sentence of subsection (c).

CHAPTER 39

COLLECTION, USE, AND DISCLOSURE OF INFORMATION GATHERED BY INSURANCE INSTITUTIONS

Sec.
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Sec.
33-39-13. Limitation of adverse underwriting decisions.
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33-39-22. Availability of remedy for disclosure of personal, privileged, or false information.
33-39-23. Obtaining of information under false pretenses as constituting misdemeanor.

RESEARCH REFERENCES

ALR. — Insured-insurer communications as privileged, 55 A.L.R.4th 336.

33-39-1. Purpose of chapter.

The purpose of this chapter is to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents, or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to such information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision.

History. — Code 1981, § 33-39-1, enacted by Ga. L. 1982, p. 615, § 1.

33-39-2. Applicability of obligations imposed by chapter; extension of rights granted by chapter; applicability of chapter to information from public records pertaining to title insurance.

(a) The obligations imposed by this chapter shall apply to those insurance institutions, agents, or insurance-support organizations which:

(1) In the case of life, health, or disability insurance:

(A) Collect, receive, or maintain information which pertains to natural persons who are residents of this state in connection with insurance transactions; or

(B) Engage in insurance transactions with applicants, individuals, or policyholders who are residents of this state; and

(2) In the case of property or casualty insurance:

(A) Collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state; or

(B) Engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state.

(b) The rights granted by this chapter shall extend to:

(1) In the case of life, health, or disability insurance, the following persons who are residents of this state:

(A) Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

(B) Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions; and

(2) In the case of property or casualty insurance, the following persons:

(A) Natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state; and

(B) Applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state.

(c) For purposes of this Code section, a person shall be considered a resident of this state if the person's last known mailing address, as shown in the records of the insurance institution, agent, or insurance-support organization, is located in this state.

(d) Notwithstanding subsections (a) and (b) of this Code section, this chapter shall not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this state.

History. — Code 1981, § 33-39-2, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1985, p. 149, § 33; Ga. L. 2019, p. 386, § 145/SB 133.

The 2019 amendment, effective July 1, 2019, deleted ", on or after January 1, 1984" following "which" at the end of subsection (a).

33-39-3. Definitions.

As used in this chapter:

(1) "Adverse underwriting decision" means:

(A) Any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:

(i) A declination of insurance coverage;

(ii) A termination of insurance coverage;

(iii) Failure of an agent to apply for insurance coverage with a specific insurance institution which the agent represents and which is requested by an applicant;

(iv) In the case of property or casualty insurance coverage:

(I) Placement by an insurance institution or agent of a risk with a residual market mechanism or an unauthorized insurer; or

(II) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished;

(v) In the case of a life, health, or disability insurance coverage, an offer to insure at higher than standard rates; or

(B) Notwithstanding subparagraph (A) of this paragraph, the following actions shall not be considered adverse underwriting decisions but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(i) The termination of an individual policy form on a class or state-wide basis;

(ii) A declination of insurance coverage solely because such coverage is not available on a class or state-wide basis;

(iii) The rescission of a policy; or

(iv) The accommodation of an insured by an agent who places insurance for such insured with any insurer, residual market mechanism, or unauthorized insurer which is satisfactory to such insured when such insured has been canceled, nonrenewed, declined, or otherwise unable to obtain coverage for any reason.

(2) "Affiliate" or "affiliated" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(3) "Agent" means any agent, broker, subagent, counselor, adjustor, solicitor, or service representative as defined in Code Sections 33-23-1 and 33-23-40.

(4) "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking insurance coverage that is not individually underwritten.

(5) "Consumer report" means any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation,

personal characteristics, or mode of living which is used or expected to be used in connection with an insurance transaction.

(6) "Consumer reporting agency" means any person who:

(A) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

(B) Obtains information primarily from sources other than insurance institutions; and

(C) Furnishes consumer reports to other persons.

(7) "Control" including the term "controlled by" or "under common control with," means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(8) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or agent of requested insurance coverage.

(9) "Individual" means any natural person who:

(A) In the case of property or casualty insurance, is a past, present, or proposed named insured or certificate holder;

(B) In the case of life, health, or disability insurance, is a past, present, or proposed principal insured or certificate holder;

(C) Is a past, present, or proposed policyowner;

(D) Is a past or present applicant;

(E) Is a past or present claimant; or

(F) Derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this chapter.

(10) "Institutional source" means any person or governmental entity that provides information about an individual to an agent, insurance institution, or insurance-support organization other than:

(A) An agent;

(B) The individual who is the subject of the information; or

(C) A natural person acting in a personal capacity rather than in a business or professional capacity.

(11) "Insurance institution" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fra-

ternal benefit society, or other person engaged in the business of insurance, including health care plans and health maintenance organizations as defined in Chapters 20 and 21 of this title. "Insurance institution" shall not include agents or insurance-support organizations.

(12) "Insurance-support organization" means:

(A) Any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or agent for insurance transactions, including:

(i) The furnishing of consumer reports or investigative consumer reports to an insurance institution or agent for use in connection with an insurance transaction; or

(ii) The collection of personal information from insurance institutions, agents, or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation, or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(B) Notwithstanding subparagraph (A) of this paragraph, the following persons shall not be considered "insurance-support organizations" for purposes of this chapter: agents, government institutions, insurance institutions, medical care institutions, and medical professionals.

(13) "Insurance transaction" means any transaction involving insurance primarily for personal, family, or household needs rather than business or professional needs which entails:

(A) The individual determination of an individual's eligibility for an insurance coverage, benefit, or payment; or

(B) The servicing of an insurance application, policy, contract, or certificate.

(14) "Investigative consumer report" means a consumer report or portion thereof in which information about a natural person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning such items of information.

(15) "Medical-care institution" means any facility or institution that is licensed to provide health care services to natural persons, including but not limited to: health maintenance organizations, home

health agencies, hospitals, medical clinics, public health agencies, rehabilitation agencies, and skilled nursing facilities.

(16) "Medical professional" means any person licensed or certified to provide health care services to natural persons, including but not limited to, a chiropractor, clinical dietitian, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, psychiatric social worker, or speech therapist.

(17) "Medical-record information" means personal information which:

(A) Relates to an individual's physical or mental condition, medical history, or medical treatment; and

(B) Is obtained from a medical professional or medical-care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(18) "Person" means any natural person, corporation, association, partnership, or other legal entity.

(19) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. "Personal information" does not include an individual's name, address, and age when no other underwriting information is gathered on that individual nor does it include any "privileged information."

(20) "Policyholder" means any person who:

(A) In the case of individual property or casualty insurance, is a present named insured;

(B) In the case of individual life, health, or disability insurance, is a present policyholder; or

(C) In the case of group insurance which is individually underwritten, is a present group certificate holder.

(21) "Pretext interview" means an interview whereby a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

(A) Pretends to be someone he or she is not;

(B) Pretends to represent a person he or she is not in fact representing;

(C) Misrepresents the true purpose of the interview; or

(D) Refuses to identify himself or herself upon request.

(22) "Privileged information" means any individually identifiable information that:

(A) Relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual; and

(B) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual;

provided, however, that information otherwise meeting the requirements of this paragraph shall nevertheless be considered "personal information" under this chapter if it is disclosed in violation of Code Section 33-39-14.

(23) "Residual market mechanism" means an association, organization, or other entity defined or described in Code Sections 33-9-7, 33-9-8, and 33-9-10.

(24) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(25) "Unauthorized insurer" means an insurance institution that has not been granted a certificate of authority by the Commissioner to transact the business of insurance in this state.

History. — Code 1981, § 33-39-3, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1985, p. 149, § 33; Ga. L. 1990, p. 8, § 33; Ga. L. 1995, p. 1070, § 1; Ga. L. 2019, p. 386, § 146/SB 133; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, deleted former paragraph (5), which read: "'Commissioner' means the Commissioner of Insurance of the State of Georgia."; redesignated former paragraphs (6) through (26) as present paragraphs (5) through (25), respectively; in paragraph (11), in the first sentence, deleted "medical service corporations, hospital service corporations," following "including", deleted a comma following "health care plans", and substituted "Chapters 20 and 21" for "Chapters 18, 19, 20, and 21"; and inserted "that" near the beginning of the proviso following subparagraph (22)(B).

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, inserted "of this title" at the end of the first sentence of paragraph (11).

33-39-4. Pretext interviews.

No insurance institution, agent, or insurance-support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction; provided, however, a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily

recognized privileged relationship with the person about whom the information relates for the purpose of investigating a claim where, based upon specific information available for review by the Commissioner, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with the claim.

History. — Code 1981, § 33-39-4, enacted by Ga. L. 1982, p. 615, § 1.

33-39-5. Transactions requiring notice of information practices; form and content of notice; abbreviated notice; satisfaction of obligations by another institution or agent.

(a) An insurance institution or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions as provided below:

(1) In the case of an application for insurance, a notice shall be provided no later than:

(A) At the time of the delivery of the insurance policy or certificate when personal information is collected only from the applicant or from public records; or

(B) At the time the collection of personal information is initiated when personal information is collected from a source other than the applicant or public records;

(2) In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:

(A) Nonpublic personal information is provided to nonaffiliated third parties only in accordance with this chapter; and

(B) The information collection or sharing practices of the insurance institution or agent relating to nonpublic personal information have not changed since the last notice of such information practices was given to the policyholder in accordance with this chapter;

(3) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for a policy reinstatement or change in insurance benefits is received by the insurance institution, except that no notice shall be required if personal information is collected only from the policyholder or from public records.

(b) The notice required by subsection (a) of this Code section shall be in writing and shall state:

(1) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information;

(3) The types of persons identified in paragraphs (2), (3), (4), (5), (6), (9), (11), (12), and (14) of Code Section 33-39-14 and the circumstances under which such disclosures may be made without prior authorization; provided, however, only those circumstances need be described which occur with such frequency as to indicate a general business practice;

(4) A description of the rights established under Code Sections 33-39-9 and 33-39-10 and the manner in which such rights may be exercised; and

(5) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(c) In lieu of the notice prescribed in subsection (b) of this Code section, the insurance institution or agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;

(3) A right of access and correction exists with respect to all personal information collected; and

(4) The notice prescribed in subsection (b) of this Code section will be furnished to the applicant or policyholder upon request.

(d) The obligations imposed by this Code section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

History. — Code 1981, § 33-39-5, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 2018, p. 242, § 1/SB 350.

The 2018 amendment, effective July 1, 2018, substituted the present provisions of subparagraph (a)(2)(A) for the former provisions, which read: "Personal information is collected only from the policyholder or from public records; or"; and substituted the present provisions of subparagraph (a)(2)(B) for the former provisions, which read: "A notice meeting the requirements of this Code section has been given within the previous 24 months;".

33-39-6. Specification of questions designed to obtain marketing or research information.

An insurance institution or agent shall clearly specify those questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction.

History. — Code 1981, § 33-39-6, enacted by Ga. L. 1982, p. 615, § 1.

33-39-7. Disclosure authorization forms authorizing disclosure of personal or privileged information.

Notwithstanding any other provision of law of this state, no insurance institution, agent, or insurance-support organization may utilize as its disclosure authorization form in connection with insurance transactions a form or statement which authorizes the disclosure of personal or privileged information about an individual to the insurance institution, agent, or insurance-support organization unless the form or statement:

(1) Is written in plain language;

(2) Is dated;

(3) Specifies the types of persons authorized to disclose information about the individual;

(4) Specifies the nature of the information authorized to be disclosed;

(5) Names the insurance institution or agent and identifies by generic reference representatives of the insurance institution to whom the individual is authorizing information to be disclosed;

(6) Specifies the purposes for which the information is collected;

(7) Specifies the length of time such authorization shall remain valid, which shall be no longer than:

(A) In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits:

(i) Thirty months from the date the authorization is signed if the application or request involves life, health, or disability insurance;

(ii) One year from the date the authorization is signed if the application or request involves property or casualty insurance; or

(B) In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:

(i) The term of coverage of the policy if the claim is for a health insurance benefit;

(ii) The duration of the claim if the claim is not for a health insurance benefit; and

(8) Advises the individual or person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

History. — Code 1981, § 33-39-7, enacted by Ga. L. 1982, p. 615, § 1.

33-39-8. Investigative consumer reports.

(a) No insurance institution, agent, or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement, or a change in insurance benefits unless the insurance institution or agent informs the individual:

(1) That he or she may request to be interviewed in connection with the preparation of the investigative consumer report; and

(2) That upon a request pursuant to Code Section 33-39-9, he or she is entitled to receive a copy of the investigative consumer report.

(b) If an investigative consumer report is to be prepared by an insurance institution or agent, the insurance institution or agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

(c) If an investigative consumer report is to be prepared by an insurance-support organization, the insurance institution or agent desiring such report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such interviews, if requested.

History. — Code 1981, § 33-39-8, enacted by Ga. L. 1982, p. 615, § 1.

33-39-9. Access to recorded personal information.

(a) If any individual, after proper identification, submits a written request to an insurance institution, agent, or insurance-support orga-

nization for access to recorded personal information about the individual which is reasonably described by the individual and reasonably locatable and retrievable by the insurance institution, agent, or insurance-support organization, the insurance institution, agent, or insurance-support organization shall within 30 business days from the date such request is received:

(1) Inform the individual of the nature and substance of such recorded personal information in writing, by telephone, or by other oral communication, whichever the insurance institution, agent, or insurance-support organization prefers;

(2) Permit the individual to see and copy, in person, such recorded personal information pertaining to him or her or to obtain a copy of such recorded personal information by mail, whichever the individual prefers, unless such recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

(3) Disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, agent, or insurance-support organization has disclosed such personal information within two years prior to such request and, if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations, or other persons to whom such information is normally disclosed; and

(4) Provide the individual with a summary of the procedures by which he or she may request correction, amendment, or deletion of recorded personal information.

(b) Any personal information provided pursuant to subsection (a) of this Code section shall identify the source of the information if such source is an institutional source.

(c) Medical-record information supplied by a medical-care institution or medical professional and requested under subsection (a) of this Code section, together with the identity of the medical professional or medical-care institution which provided such information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution, agent, or insurance-support organization prefers. If it elects to disclose the information to a medical professional designated by the individual, the insurance institution, agent, or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

(d) Except for personal information provided under Code Section 33-39-11, an insurance institution, agent, or insurance-support organi-

zation may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

(e) The obligations imposed by this Code section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection (a) of this Code section, an insurance institution, agent, or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

(f) The rights granted to individuals in this Code section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(g) For purposes of this Code section, the term "insurance-support organization" does not include "consumer reporting agency."

History. — Code 1981, § 33-39-9, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1990, p. 8, § 33; Ga. L. 1996, p. 6, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1985, "of this Code section" was substituted for "above" in subsection (b).

33-39-10. Requests to correct, amend, or delete recorded personal information.

(a) Within 30 business days from the date of receipt of a written request from an individual to correct, amend, or delete any recorded personal information about the individual within its possession, an insurance institution, agent, or insurance-support organization shall either:

(1) Correct, amend, or delete the portion of the recorded personal information in dispute; or

(2) Notify the individual of:

(A) Its refusal to make such correction, amendment, or deletion;

(B) The reasons for the refusal; and

(C) The individual's right to file a statement as provided in subsection (c) of this Code section.

(b) If the insurance institution, agent, or insurance-support organization corrects, amends, or deletes recorded personal information in

accordance with paragraph (1) of subsection (a) of this Code section, the insurance institution, agent, or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment, or fact of deletion to:

(1) Any person specifically designated by the individual who may have, within the preceding two years, received such recorded personal information;

(2) Any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received such recorded personal information from the insurance institution within the preceding seven years; provided, however, that the correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and

(3) Any insurance-support organization that furnished the personal information that has been corrected, amended, or deleted.

(c) Whenever an individual disagrees with an insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information, the individual shall be permitted to file with the insurance institution, agent, or insurance-support organization:

(1) A concise statement setting forth what the individual thinks is the correct, relevant, or fair information; and

(2) A concise statement of the reasons why the individual disagrees with the insurance institution's, agent's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information.

(d) In the event an individual files either statement as described in subsection (c) of this Code section, the insurance institution, agent, or support organization shall:

(1) File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it;

(2) In any subsequent disclosure by the insurance institution, agent, or support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the individual's statement along with the recorded personal information being disclosed; and

(3) Furnish the statement to the persons and in the manner specified in subsection (b) of this Code section.

(e) The rights granted to individuals in this Code section shall extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, agent, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(f) For purposes of this Code section, the term "insurance-support organization" does not include "consumer reporting agency."

History. — Code 1981, § 33-39-10, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33.

33-39-11. Procedure upon adverse underwriting decision; satisfaction of obligations by another institution or agent; adverse decisions upon oral requests or inquiries.

(a) In the event of an adverse underwriting decision the insurance institution or agent responsible for the decision shall:

(1) Either provide the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise such person that upon written request he or she may receive the specific reason or reasons in writing; and

(2) Provide the applicant, policyholder, or individual proposed for coverage with a summary of the rights established under subsection (b) of this Code section and Code Sections 33-39-9 and 33-39-10.

(b) Upon receipt of a written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder, or individual proposed for coverage, the insurance institution or agent shall furnish to such person within 21 business days from the date of receipt of such written request:

(1) The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to paragraph (1) of subsection (a) of this Code section.

(2) The specific items of personal and privileged information that support those reasons; provided, however:

(A) The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reason-

able suspicion, based upon specific information available for review by the Commissioner, that the applicant, policyholder, or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure; and

(B) Specific terms of medical-record information supplied by a medical-care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or agent prefers; and

(3) The names and addresses of the institutional sources that supplied the specific items of information pursuant to paragraph (2) of subsection (b) of this Code section; provided, however, that the identity of any medical professional or medical-care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or agent prefers.

(c) The obligations imposed by this Code section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

(d) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection (a) of this Code section may be given orally.

History. — Code 1981, § 33-39-11, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1990, p. 8, § 33.

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No monetary damages for violations. — Monetary damages for a violation of O.C.G.A. § 33-39-11 would not be authorized since O.C.G.A. § 33-39-21 limits its recovery to equitable relief. Garrett v. Life Ins. Co., 221 Ga. App. 315, 471 S.E.2d 262 (1996).

33-39-12. Requests for information regarding previous adverse underwriting decisions or previous coverage obtained through residual market mechanism.

No insurance institution, agent, or insurance-support organization may seek information in connection with an insurance transaction concerning:

(1) Any previous adverse underwriting decision experienced by an individual; or

(2) Any previous insurance coverage obtained by an individual through a residual market mechanism,

unless such inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

History. — Code 1981, § 33-39-12, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1992, p. 6, § 33.

33-39-13. Limitation of adverse underwriting decisions.

(a) No insurance institution or agent may base an adverse underwriting decision in whole or in part:

(1) On the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism; provided, however, an insurance institution or agent may base an adverse underwriting decision on further information obtained from an insurance institution or agent responsible for a previous adverse underwriting decision;

(2) On personal information received from an insurance-support organization whose primary source of information is insurance institutions; provided, however, an insurance institution or agent may base an adverse underwriting decision on further personal information obtained as the result of information received from such insurance-support organization.

(b) With respect to a personal or family type policy of motor vehicle insurance, no insurance institution or agent may base an adverse underwriting decision solely on the fact that the applicant has never purchased such a policy of motor vehicle insurance or has not owned or been covered by such a policy of motor vehicle insurance during any specified period immediately preceding the date of application.

History. — Code 1981, § 33-39-13, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 1989, p. 642, § 1.

33-39-14. Disclosure of personal or privileged information received in connection with insurance transactions.

An insurance institution, agent, or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

(1) With the written authorization of the individual, provided:

(A) If such authorization is submitted by another insurance institution, agent, or insurance-support organization, the authorization meets the requirement of Code Section 33-39-7; or

(B) If such authorization is submitted by a person other than an insurance institution, agent, or insurance-support organization, the authorization is:

(i) Dated;

(ii) Signed by the individual; and

(iii) Obtained one year or less prior to the date a disclosure is sought pursuant to this subsection; or

(2) To a person other than an insurance institution, agent, or insurance-support organization, provided such disclosure is reasonably necessary:

(A) To enable such person to perform a business, professional, or insurance function for the disclosing insurance institution, agent, or insurance-support organization and such person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(i) Would otherwise be permitted by this Code section if made by an insurance institution, agent, or insurance-support organization; or

(ii) Is reasonably necessary for such person to perform its function for the disclosing insurance institution, agent, or insurance-support organization; or

(B) To enable such person to provide information to the disclosing insurance institution, agent, or insurance-support organization for the purpose of:

(i) Determining an individual's eligibility for an insurance benefit or payment; or

(ii) Detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction; or

(3) To an insurance institution, agent, insurance-support organization, or self-insurer, provided the information disclosed is limited to that which is reasonably necessary:

(A) To detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or

(B) For either the disclosing or receiving insurance institution, agent, or insurance-support organization to perform its function in connection with an insurance transaction involving the individual;

(4) To a medical-care institution or medical professional for the purpose of:

(A) Verifying insurance coverage or benefits;

(B) Informing an individual of a medical problem of which the individual may not be aware; or

(C) Conducting an operations or services audit;

provided only such information is disclosed as is reasonably necessary to accomplish the foregoing purposes;

(5) To an insurance regulatory authority;

(6) To a law enforcement or other governmental authority:

(A) To protect the interests of the insurance institution, agent, or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

(B) If the insurance institution, agent, or insurance-support organization reasonably believes that illegal activities have been conducted by the individual;

(7) Otherwise permitted or required by law;

(8) In response to a facially valid administrative or judicial order, including a search warrant or subpoena;

(9) Made for the purpose of conducting actuarial or research studies, provided:

(A) No individual may be identified in any actuarial or research report;

(B) Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and

(C) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this Code section if made by an insurance institution, agent, or insurance-support organization;

(10) To a party or a representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurance institution, agent, or insurance-support organization, provided:

(A) Prior to the consummation of the sale, transfer, merger, or consolidation only such information is disclosed as is reasonably

necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation; and

(B) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this Code section if made by an insurance institution, agent, or insurance-support organization;

(11) To a person whose only use of such information will be in connection with the marketing of a product or service, provided:

(A) No medical-record information, privileged information, or personal information relating to an individual's character, personal habits, mode of living, or general reputation is disclosed, and no classification derived from such information is disclosed;

(B) The individual has been given an opportunity to indicate that he or she does not want personal information disclosed for marketing purposes and has given no indication that he or she does not want the information disclosed; and

(C) The person receiving such information agrees not to use it except in connection with the marketing of a product or service;

(12) To an affiliate whose only use of the information will be in connection with an audit of the insurance institution or agent or the marketing of an insurance product or service, provided the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons;

(13) By a consumer reporting agency, provided the disclosure is to a person other than an insurance institution or agent;

(14) To a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurance institution's or agent's operations or services, provided the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit;

(15) To a professional peer review organization for the purpose of reviewing the service or conduct of a medical-care institution or medical professional;

(16) To a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable;

(17) To a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction; or

(18) To a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or agent as having legal or beneficial interest in a policy of insurance, provided that:

(A) No medical-record information is disclosed unless the disclosure would otherwise be permitted by this Code section; and

(B) The information disclosed is limited to that which is reasonably necessary to permit such person to protect its interest in such policy.

History. — Code 1981, § 33-39-14, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33.

33-39-15. Investigations by Commissioner into affairs of insurance institutions, agents, or insurance-support organizations.

(a) The Commissioner shall have power to examine and investigate into the affairs of every insurance institution or agent doing business in this state to determine whether the insurance institution or agent has been or is engaged in any conduct in violation of this chapter.

(b) The Commissioner shall have the power to examine and investigate into the affairs of every insurance-support organization acting on behalf of an insurance institution or agent which either transacts business in this state or transacts business outside this state that has an effect on a person residing in this state in order to determine whether such insurance-support organization has been or is engaged in any conduct in violation of this chapter.

History. — Code 1981, § 33-39-15, enacted by Ga. L. 1982, p. 615, § 1.

33-39-16. Violations of chapter; service of statement of charges and notice of hearing; conduct of hearing.

(a) Whenever the Commissioner has reason to believe that an insurance institution, agent, or insurance-support organization has been or is engaged in conduct in this state which violates this chapter, or if the Commissioner believes that an insurance-support organization has been or is engaged in conduct outside this state which has an effect on a person residing in this state and which violates this chapter, the Commissioner shall issue and serve upon such insurance institution, agent, or insurance-support organization a statement of charges and notice of hearing to be held at a time and place fixed in the notice. The date for such hearing shall be not less than 30 days after the date of service.

(b) At the time and place fixed for such hearing the insurance institution, agent, or insurance-support organization charged shall have an opportunity to answer the charges against it and present evidence on its behalf. Upon good cause shown, the Commissioner shall permit any adversely affected person to intervene, appear, and be heard at such hearing by counsel or in person.

(c) At any hearing conducted pursuant to this Code section, the Commissioner may administer oaths, examine and cross-examine witnesses, and receive oral and documentary evidence. The Commissioner shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, and other documents which are relevant to the hearing. A stenographic record of the hearing shall be made upon the request of any party or at the discretion of the Commissioner. If no stenographic record is made and if judicial review is sought, the Commissioner shall prepare a statement of the evidence for use on review. Hearings conducted under this Code section shall be governed by the same rules of evidence and procedure as set forth in Chapter 2 of this title.

(d) Statements of charges, notices, orders, and other processes of the Commissioner under this chapter may be served by anyone duly authorized to act on behalf of the Commissioner. Service of process may be completed in the manner provided by law for service of process in civil actions or by registered mail or statutory overnight delivery. A copy of the statement of charges, notice, order, or other process shall be provided to the person or persons whose rights under this chapter have been allegedly violated. A verified return setting forth the manner of service, or return postcard receipt in the case of registered mail or statutory overnight delivery shall be sufficient proof of service.

History. — Code 1981, § 33-39-16, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 2000, p. 1589, § 4.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (d) is applicable with respect to notices delivered on or after July 1, 2000.

33-39-17. Commissioner as appointed to accept service on behalf of insurance-support organization transacting business outside state.

For the purpose of this chapter, an insurance-support organization transacting business outside this state which has an effect on a person residing in this state shall be deemed to have appointed the Commissioner to accept service of process on its behalf, provided the Commissioner causes a copy of such service to be mailed forthwith by registered mail or statutory overnight delivery to the insurance-support organization at its last known principal place of business. The return postcard

receipt for such mailing shall be sufficient proof that the same was properly mailed by the Commissioner.

History. — Code 1981, § 33-39-17, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 2000, p. 1589, § 4.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to this Code section is applicable with respect to notices delivered on or after July 1, 2000.

33-39-18. Service of findings and cease and desist orders of Commissioner; modification or setting aside of order or report.

(a) If, after a hearing pursuant to Code Section 33-39-16, the Commissioner determines that the insurance institution, agent, or insurance-support organization charged has engaged in conduct or practices in violation of this chapter, the Commissioner shall reduce his or her findings to writing and shall issue and cause to be served upon such insurance institution, agent, or insurance-support organization a copy of such findings and an order requiring such insurance institution, agent, or insurance-support organization to cease and desist from the conduct or practices constituting violation of this chapter.

(b) If, after a hearing pursuant to Code Section 33-39-16, the Commissioner determines that the insurance institution, agent, or insurance-support organization charged has not engaged in conduct or practices in violation of this chapter, the Commissioner shall prepare a written report which sets forth findings of fact and conclusions of law. Such report shall be served upon the insurance institution, agent, or insurance-support organization charged and upon the person or persons, if any, whose rights under this chapter were allegedly violated.

(c) Until the expiration of the time allowed under Code Section 33-39-20 for filing a petition for review or until such petition is actually filed, whichever occurs first, the Commissioner may modify or set aside any order or report issued under this Code section. After the expiration of the time allowed under Code Section 33-39-20 for filing a petition for review, if no such petition has been duly filed, the Commissioner may, after notice and opportunity for hearing, alter, modify, or set aside, in whole or in part, any order or report issued under this Code section whenever conditions of fact or law warrant such action or if the public interest so requires.

History. — Code 1981, § 33-39-18, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33.

33-39-19. Monetary penalty for knowing violations of chapter; monetary penalty for violation of cease and desist order.

(a) In any case where a hearing pursuant to Code Section 33-39-16 results in the finding of a knowing violation of this chapter, the Commissioner may, in addition to the issuance of a cease and desist order as prescribed in Code Section 33-39-18, order payment of a monetary penalty of not more than $500.00 for each violation but not to exceed $10,000.00 in the aggregate for multiple violations.

(b) Any person who violates a cease and desist order of the Commissioner under Code Section 33-39-18 may, after notice and hearing and upon order of the Commissioner, be subject to one or more of the following penalties, at the discretion of the Commissioner:

(1) A monetary fine of not more than $10,000.00 for each violation;

(2) A monetary fine of not more than $50,000.00 if the Commissioner finds that violations have occurred with such frequency as to constitute a general business practice; or

(3) Suspension or revocation of an insurance institution's or agent's license.

History. — Code 1981, § 33-39-19, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1984, p. 22, § 33.

33-39-20. Order or report of Commissioner.

(a) Any person subject to an order of the Commissioner under Code Section 33-39-18 or Code Section 33-39-19 or any person whose rights under this chapter were allegedly violated may obtain a review of any order or report of the Commissioner by filing in the Superior Court of Fulton County, within 30 days from the date of the service of such order or report, a written petition requesting that the order or report of the Commissioner be set aside. A copy of such petition shall be simultaneously served upon the Commissioner, who shall forthwith certify and file in such court a transcript of the entire record of the proceeding giving rise to the order or report which is the subject of the petition. Upon filing of the petition and transcript the court shall have jurisdiction to make and enter a decree modifying, affirming, or reversing any order or report of the Commissioner, in whole or in part. The findings of the Commissioner as to the facts supporting any order or report, if supported by any evidence, shall be conclusive.

(b) To the extent an order or report of the Commissioner is affirmed, the court shall issue its own order commanding obedience to the terms of the order or report of the Commissioner. If any party affected by an

order or report of the Commissioner shall apply to the court for leave to produce additional evidence and shall show to the satisfaction of the court that such additional evidence is material and that there are reasonable grounds for the failure to produce such evidence in prior proceedings, the court may order such additional evidence to be taken before the Commissioner in such manner and upon such terms and conditions as the court may deem proper. The Commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence so taken and shall file such modified or new findings along with any recommendation, if any, for the modification or revocation of a previous order or report. If supported by clear and convincing evidence, the modified or new findings shall be conclusive as to the matters contained therein.

(c) An order or report issued by the Commissioner under Code Section 33-39-18 or 33-39-19 shall become final:

(1) Upon the expiration of the time allowed for the filing of a petition for review, if no such petition has been duly filed except that the Commissioner may modify or set aside an order or report to the extent provided in subsection (c) of Code Section 33-39-18; or

(2) Upon a final decision of the superior court if it directs that the order or report of the Commissioner be affirmed or the petition for review dismissed.

(d) No order or report of the Commissioner under this chapter or order of the court to enforce the same shall in any way relieve or absolve any person affected by such order or report from any liability under any law of this state.

History. — Code 1981, § 33-39-20, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1983, p. 3, § 24.

33-39-21. Equitable relief; damages recoverable; costs and attorney's fees; statute of limitations; limitation on remedy or recovery.

(a) If any insurance institution, agent, or insurance-support organization fails to comply with Code Section 33-39-9, 33-39-10, or 33-39-11 with respect to the rights granted under those Code sections, any person whose rights are violated may apply to any superior court of this state, having jurisdiction over the defendant, for appropriate equitable relief.

(b) An insurance institution, agent, or insurance-support organization which discloses information in violation of Code Section 33-39-14 shall be liable for damages sustained by the individual about whom the information relates; provided, however, that no individual shall be

entitled to a monetary award which exceeds the actual damages sustained by the individual as a result of a violation of Code Section 33-39-14.

(c) In any action brought pursuant to this Code section, the court may award the cost of the action and reasonable attorney's fees to the prevailing party.

(d) An action under this Code section must be brought within two years from the date the alleged violation is or should have been discovered.

(e) Except as specifically provided in this Code section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of this chapter.

History. — Code 1981, § 33-39-21, enacted by Ga. L. 1982, p. 615, § 1; Ga. L. 1983, p. 3, § 24; Ga. L. 1984, p. 22, § 33.

Law reviews. — For article, "Statutes of Limitation: Counterproductive Complexities," see 37 Mercer L. Rev. 1 (1985).

JUDICIAL DECISIONS

No monetary damages for violations. — Monetary damages for a violation of O.C.G.A. § 33-39-11 would not be authorized since § 33-39-21 limits recovery to equitable relief. Garrett v. Life Ins. Co., 221 Ga. App. 315, 471 S.E.2d 262 (1996).

33-39-22. Availability of remedy for disclosure of personal, privileged, or false information.

No cause of action in the nature of defamation, invasion of privacy, or negligence shall arise against any person for disclosing personal or privileged information in accordance with this chapter, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurance institution, agent, or insurance-support organization; provided, however, this Code section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

History. — Code 1981, § 33-39-22, enacted by Ga. L. 1982, p. 615, § 1.

33-39-23. Obtaining of information under false pretenses as constituting misdemeanor.

Any person who knowingly and willfully obtains information about an individual from an insurance institution, agent, or insurance-support organization under false pretenses shall be guilty of a misdemeanor.

History. — Code 1981, § 33-39-23, enacted by Ga. L. 1982, p. 615, § 1.

CHAPTER 40

RISK RETENTION GROUPS

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33-40-16. Purchases by purchasing group.
33-40-17. Enforcement.
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33-40-20. Enforcement of federal order.
33-40-21. Rules [Repealed].

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

Am. Jur. 2d. — 44A Am. Jur. 2d, Insurance, § 1822 et seq.

ALR. — Primary insurer's insolvency as affecting excess insurer's liability, 85 A.L.R.4th 729.

33-40-1. Purpose.

The purpose of this chapter is to regulate the formation and operation of risk retention groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 (RRA 1986).

History. — Code 1981, § 33-40-1, enacted by Ga. L. 1987, p. 875, § 1.

33-40-2. Definitions.

As used in this chapter, the term:

(1) "Commissioner" means the Commissioner of Insurance of the State of Georgia or the commissioner, director, or superintendent of insurance in any other state.

(2) "Completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which

is not owned or controlled by any person who performs that work or any person who hires an independent contractor to perform that work and shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(3) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means the state in which the purchasing group is incorporated if it is a corporation or, if the purchasing group is an unincorporated entity, the state of its principal place of business.

(4) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to meet obligations to policyholders with respect to known claims and reasonably anticipated claims or is unlikely to be able to pay other obligations in the normal course of business.

(5) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

(6) "Liability" means:

(A) Legal liability for damages, including costs of defense; legal costs and fees; and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of any nonprofit or for profit business, trade, product, services, including professional services, premises, or operations or any activity of any state or local government or any agency or political subdivision thereof; and

(B) Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act, 45 U.S.C. Section 51, et seq.

(7) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial, or household responsibilities or activities, rather than from responsibilities or activities referred to in paragraph (6) of this Code section.

(8) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group, including, at a minimum, the following:

(A) The coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(B) Historical and expected loss experience of the proposed members and national experience of similar exposures;

(C) Pro forma financial statements and projections;

(D) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(E) Identification of management, underwriting procedures, managerial oversight methods, and investment policies; and

(F) Such other matters as may be prescribed by the Commissioner for casualty or liability insurance companies authorized by this title.

(9) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred.

(10) "Purchasing group" means any group which:

(A) Has as one of its purposes the purchase of liability insurance on a group basis;

(B) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in subparagraph (C) of this paragraph;

(C) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises, or operations; and

(D) Is domiciled in any state.

(11) "Risk retention group" means any corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands:

(A) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(B) Which is organized for the primary purpose of conducting the activity described under subparagraph (A) of this paragraph;

(C) Which:

(i) Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as such terms were defined in the federal Product Liability Risk Retention Act of 1981 as such act existed prior to October 27, 1986;

(D) Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

(E) Which has as its members only persons who have an ownership interest in the group and has as its owners only persons who are members who are provided insurance by the risk retention group or which has as its sole member and sole owner an organization which is owned by persons who are provided insurance by the risk retention group;

(F) Whose members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar, or common business trade, product, services, premises, or operations;

(G) Whose activities do not include the provision of insurance other than:

(i) Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) Reinsurance with respect to the liability of any other risk retention group which is engaged in businesses or activities so that such group or member meets the requirement described in subparagraph (F) of this paragraph for membership in the risk retention group which provides such reinsurance; and

(H) The name of which includes the phrase "risk retention group."

(12) "State" means any state of the United States or the District of Columbia.

History. — Code 1981, § 33-40-2, enacted by Ga. L. 1987, p. 875, § 1; Ga. L. 1988, p. 13, § 33; Ga. L. 1992, p. 6, § 33.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "Section" was inserted in subparagraph (6)(B).

33-40-3. Risk retention groups chartered in this state.

A risk retention group seeking to be chartered in this state must be chartered and licensed as a casualty or liability insurance company as provided in this title or as a risk retention group captive insurance company under Chapter 41 of this title and, except as provided elsewhere in this chapter or in Chapter 41, as applicable, must comply with all of the laws, rules, regulations, and requirements applicable to such insurers chartered and licensed in this state and with Code Section 33-40-4 to the extent such requirements are not a limitation on laws, rules, regulations, or requirements of this state. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Commissioner a plan of operation or a feasibility study and revisions of such plan or study if the group intends to offer any additional lines of casualty or liability insurance.

History. — Code 1981, § 33-40-3, enacted by Ga. L. 1987, p. 875, § 1; Ga. L. 1988, p. 966, § 1.

33-40-4. Risk retention groups not chartered in this state.

(a) Risk retention groups chartered in states other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as provided in this Code section.

(b) Before offering insurance in this state, a risk retention group shall submit to the Commissioner:

(1) A statement identifying the state or states in which the risk retention group is chartered and licensed as a casualty or liability insurance company, date of chartering, its principal place of business, and such other information, including information on its membership, as the Commissioner may require to verify that the risk retention group is qualified under this chapter;

(2) A copy of its plan of operations or a feasibility study and revisions of such plan or study submitted to its state of domicile; provided, however, that the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance which was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986, and which was offered before such date by any risk retention group which had been chartered and operating for not less than three years before such date;

(3) A statement of registration which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process; and

(4) A fee or fees as provided in Code Section 33-8-1, which shall accompany such statements and plans required under paragraphs (1), (2), and (3) of this subsection.

(c) Any risk retention group doing business in this state shall submit to the Commissioner:

(1) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist approved by the Commissioner;

(2) A copy of each examination of the risk retention group as certified by the Commissioner or public official conducting the examination;

(3) Upon request by the Commissioner, a copy of any audit performed with respect to the risk retention group;

(4) Such information as may be required to verify its continuing qualification as a risk retention group under this chapter; and

(5) A fee or fees as provided in Code Section 33-8-1, which shall accompany such copies required under paragraphs (1) and (2) of this subsection.

History. — Code 1981, § 33-40-4, enacted by Ga. L. 1987, p. 875, § 1; Ga. L. 1992, p. 2725, § 29.

33-40-5. Tax on premiums.

(a) All premiums paid for coverages within this state to risk retention groups shall be subject to taxation at the rate of 4 percent on all premiums paid or due and payable during the preceding quarter, less return premium. Risk retention groups shall be subject to interest, fines, and penalties for nonpayment or nonreporting as provided in Code Section 33-5-32 for surplus lines brokers.

(b) To the extent agents or brokers are utilized, they shall report and pay the taxes for the premiums for risks which they have placed with or on behalf of a risk retention group not chartered in this state.

(c) To the extent agents or brokers are not utilized or fail to pay the tax, each risk retention group shall pay the tax for risks insured within

the state. Further, each risk retention group shall report all premiums paid to it for risks insured within the state.

History. — Code 1981, § 33-40-5, enacted by Ga. L. 1987, p. 875, § 1.

33-40-6. Unfair trade practices.

Any risk retention group and its agents and representatives shall comply with Chapter 6 of this title and all rules and regulations promulgated pursuant to such chapter.

History. — Code 1981, § 33-40-6, enacted by Ga. L. 1987, p. 875, § 1.

33-40-7. Financial examination.

Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within 60 days after a request by the Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the Examiner Handbook of the National Association of Insurance Commissioners.

History. — Code 1981, § 33-40-7, enacted by Ga. L. 1987, p. 875, § 1.

33-40-8. Notice required in policy.

Any policy issued by a risk retention group shall contain in ten-point type on the front page and the declaration page the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

History. — Code 1981, § 33-40-8, enacted by Ga. L. 1987, p. 875, § 1.

33-40-9. Prohibited acts.

The following acts by a risk retention group are prohibited:

(1) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(2) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

History. — Code 1981, § 33-40-9, enacted by Ga. L. 1987, p. 875, § 1.

33-40-10. Insurance companies as members.

No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group comprised solely of insurance companies.

History. — Code 1981, § 33-40-10, enacted by Ga. L. 1987, p. 875, § 1.

33-40-11. Financially impaired nonresident groups.

A risk retention group not chartered in this state and doing business in this state must comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under Code Section 33-40-7.

History. — Code 1981, § 33-40-11, enacted by Ga. L. 1987, p. 875, § 1.

33-40-12. Georgia Insurers Insolvency Pool.

No risk retention group shall be permitted to join or contribute financially to the Georgia Insurers Insolvency Pool under Chapter 36 of this title nor shall any risk retention group or its insureds receive any benefit from the Georgia Insurers Insolvency Pool for claims arising out of the operations of such risk retention group.

History. — Code 1981, § 33-40-12, enacted by Ga. L. 1987, p. 875, § 1.

33-40-13. Countersigning policies.

Reserved. Repealed by Ga. L. 1999, p. 878, § 14, effective July 1, 1999.

Editor's notes. — This Code section was based on Code 1981, § 33-40-13, enacted by Ga. L. 1987, p. 875, § 1.

33-40-14. Federal purchasing groups.

Any purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state which prohibits providing or offering to provide to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group shall be subject to all other applicable laws of this state.

History. — Code 1981, § 33-40-14, enacted by Ga. L. 1987, p. 875, § 1.

33-40-15. Purchasing group requirements.

(a) A purchasing group which intends to do business in this state shall furnish to the Commissioner notice which shall:

(1) Identify the state in which the group is domiciled;

(2) Specify the lines and classifications of casualty or liability insurance which the purchasing group intends to purchase;

(3) Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company;

(4) Identify the principal place of business of the group; and

(5) Provide such other information as may be required by the Commissioner to verify that the purchasing group is qualified under Code Section 33-40-2.

(b) The purchasing group shall register with and designate the Commissioner as its agent solely for the purpose of receiving service of legal documents or process, except that such requirements shall not apply in the case of a purchasing group:

(1) Which was domiciled before April 2, 1986, and is domiciled on and after October 27, 1986, in any state of the United States;

(2) Which, before October 27, 1986, purchased insurance from an insurance carrier licensed in any state and since October 27, 1986, has purchased its insurance from an insurance carrier licensed in any state;

(3) Which was a purchasing group under the requirements of the Product Liability Retention Act of 1981 before October 27, 1986; and

(4) Which does not purchase insurance that was not authorized for purposes of an exemption under that act, as in effect before October 27, 1986.

(c) The notice and registration required by subsections (a) and (b) of this Code section shall be accompanied by a fee or fees as provided in Code Section 33-8-1.

History. — Code 1981, § 33-40-15, enacted by Ga. L. 1987, p. 875, § 1; Ga. L. 1992, p. 2725, § 30.

33-40-16. Purchases by purchasing group.

A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

History. — Code 1981, § 33-40-16, enacted by Ga. L. 1987, p. 875, § 1; Ga. L. 1992, p. 6, § 33.

33-40-17. Enforcement.

The Commissioner is authorized to make use of any of the powers established under this title to enforce the laws of this state so long as those powers are not specifically preempted by the federal Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986. This includes, but is not limited to, the Commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and impose penalties. With regard to any investigation, administrative proceedings, or litigation, the Commissioner can rely on the procedural law and regulations of this state. The injunctive authority of the Commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

History. — Code 1981, § 33-40-17, enacted by Ga. L. 1987, p. 875, § 1.

RESEARCH REFERENCES

ALR. — Construction and application of federal Product Liability Risk Retention Act of 1981, and amending Liability Risk Retention Act of 1996, 15 U.S.C.A. §§ 3901 et seq., 11 A.L.R. Fed. 3d 3.

33-40-18. Penalties.

Any risk retention group which violates any provision of this chapter will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license or the right to do business in this state.

History. — Code 1981, § 33-40-18, enacted by Ga. L. 1987, p. 875, § 1.

33-40-19. License requirement.

Any person acting or offering to act as an agent or broker for a risk retention group or purchasing group which solicits members, sells insurance coverage, purchases coverage for its members located within the state, or otherwise does business in this state shall, before commencing any such activity, obtain a license from the Commissioner.

History. — Code 1981, § 33-40-19, enacted by Ga. L. 1987, p. 875, § 1.

33-40-20. Enforcement of federal order.

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating, in any state, in all states, or in any territory or possession of the United States upon a finding that such a group is in a hazardous financial condition shall be enforceable in the courts of this state.

History. — Code 1981, § 33-40-20, enacted by Ga. L. 1987, p. 875, § 1.

33-40-21. Rules.

Reserved. Repealed by Ga. L. 2019, p. 533, § 1-1/HB 99, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1981, § 33-40-21, enacted by Ga. L. 1987, p. 875, § 1.

CHAPTER 41

CAPTIVE INSURANCE COMPANIES

Article 1

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33-41-100. Application.
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33-41-103. Incorporated protected cells; legal entity status; requirements for formation; naming; rights and authority.
33-41-104. Accounting and financial matters of incorporated protected cells.
33-41-105. Commingling of assets prohibited; separation of cells.
33-41-106. Application of Code Section 33-41-16 to sponsored captive insurance companies.

Code Commission notes. — Two 1988 Acts added a new Chapter 41 to this title. Pursuant to Code Section 28-9-5, the chapter enacted by Ga. L. 1988, p. 966 has retained the Chapter 41 designation, but the chapter enacted by Ga. L. 1988, p. 1541 has been redesignated as Chapter 42 and the Code sections have been renumbered accordingly.

Administrative rules and regulations. — Captive Insurance Companies, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-45.

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).

ARTICLE 1

GENERAL PROVISIONS

Editor's notes. — Ga. L. 2019, p. 533, § 2-1/HB 99, effective July 1, 2019, designated Code Sections 33-41-1 through 33-41-26 as Article 1.

33-41-1. Short title.

This chapter shall be known and may be cited as the "Georgia Captive Insurance Company Act."

History. — Code 1981, § 33-41-1, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-2. Definitions.

Terms not defined in this chapter shall have the same meaning ascribed to them in this title. As used in this chapter, unless the context otherwise requires, the term:

(1) "Affiliate" means any person in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.

(2) "Agency captive insurance company" means:

(A) Any domestic insurance company granted a certificate of authority pursuant to this chapter that is owned or controlled by an insurance agency, brokerage, managing general agent, or reinsurance intermediary, or an affiliate thereof, or under common ownership or control with such agency, brokerage, managing general agent, or reinsurance intermediary, and that only reinsures the risk of insurance or annuity contracts placed by or through such agency, brokerage, managing general agent, or reinsurance intermediary; or

(B) Any domestic insurance company granted a certificate of authority pursuant to this chapter that is owned or controlled by a marketer, producer, administrator, issuer, or provider of service contracts or warranties and that only reinsures the contractual liability arising out of such service contracts or warranties sold through such marketer, producer, administrator, issuer, or provider.

(3) "Association" means any membership organization whose members consist of a group of individuals, corporations, partner-

ships, or other entities or associations who engage in similar or related professional, trade, or business activities and who collectively own, control, or hold with power to vote all of the outstanding voting interests of an association captive insurance company or of a person that is the sole shareholder of an association captive insurance company.

(4) "Association captive insurance company"' means any domestic insurance company granted a certificate of authority pursuant to this chapter to insure or reinsure the similar or related risks of members and affiliates of members of its association.

(5) "Captive insurance company" means any pure captive insurance company, association captive insurance company, agency captive insurance company, industrial insured captive insurance company, sponsored captive insurance company, or risk retention group captive insurance company.

(6) "Controlled unaffiliated business" means:

(A) Any person:

(i) That is not in the corporate system of a parent and its affiliated companies;

(ii) That has an existing contractual relationship with a parent or one of its affiliated companies; and

(iii) Whose risks are managed by a captive insurance company in accordance with this chapter and approved by the Commissioner; or

(B) A reinsurance arrangement with other captive insurance companies that is approved by the Commissioner.

(7) "Dormant captive insurance company" means a captive insurance company that:

(A) Has ceased transacting the business of insurance, including the issuance of insurance policies; and

(B) Has no remaining liabilities associated with insurance business transactions, or insurance policies issued prior to the filing of its application for a certificate of dormancy pursuant to this chapter.

(8) "Formation documents" means articles of incorporation, if the captive insurance company or the prospective captive insurance company is a stock insurer, stock corporation, or a mutual insurer, or articles of organization, if the captive insurance company or the prospective captive insurance company is a limited liability company, and any amendments or restatements of the same. For purposes of

this term, an incorporated protected cell, as defined in Article 2 of this chapter, shall be included in the definition of "captive insurance company."

(9) "Industrial insured" means an insured:

(A) Who procures the insurance of any risk or risks through the use of the services of a full-time employee who acts as an insurance manager, risk manager, or insurance buyer or through the services of a person licensed as a property and casualty agent, broker, or counselor in such person's state of domicile;

(B) Whose aggregate annual premiums for insurance on all risks total at least $25,000.00; and

(C) Who either:

(i) Has at least 25 full-time employees;

(ii) Has gross assets in excess of $3 million; or

(iii) Has annual gross revenues in excess of $5 million.

(10) "Industrial insured captive insurance company" means any domestic insurance company granted a certificate of authority pursuant to this chapter to insure or reinsure the risks of industrial insureds and their affiliates and which has as its shareholders or members only industrial insureds that are insured or reinsured by the industrial insured captive insurance company or which has as its sole shareholder or sole member an entity whose only owners are industrial insureds that are insured or reinsured by the industrial insured captive insurance company.

(11) "Mutual insurer" means an incorporated insurer without capital stock or shares that is owned and governed by its policyholders.

(12) "Parent" means an entity which directly or indirectly owns, controls, or holds with power to vote more than 50 percent of the total outstanding voting:

(A) Securities of a pure captive insurance company organized as a stock corporation; or

(B) Membership interests of a pure captive insurance company organized as a limited liability company.

(13) "Pure captive insurance company" means any domestic insurance company granted a certificate of authority under this chapter to insure or reinsure the risks of its parent and affiliates of its parent, and controlled unaffiliated business.

(14) "Risk retention group captive insurance company" is any domestic insurance company granted a certificate of authority pur-

suant to this chapter and determined by the Commissioner to be established and maintained as a "risk retention group" as defined under the federal Liability Risk Retention Act of 1986, as amended.

(15) "Stock insurer" means an incorporated insurer with capital divided into shares and owned by its shareholders.

(16) "Transact," as used in this chapter, shall not include the organizational activities associated with the preliminary formation, incorporation, petitioning for a certificate of authority, and initial capitalization of a captive insurance company.

History. — Code 1981, § 33-41-2, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-1/HB 552; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 1/SB 173; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2019, p. 533, § 2-2/HB 99.

The 2019 amendment, effective July 1, 2019, inserted "sponsored captive insurance company," near the end of paragraph (5); deleted "pure" preceding "captive" in the middle of division (6)(A)(iii); deleted "pooling" following "reinsurance" near the beginning of subparagraph (6)(B); added paragraph (7); redesignated former paragraphs (7) through (15) as present paragraphs (8) through (16), respectively; in paragraph (8), inserted ", stock corporation," near the middle of the first sentence, and added the second sentence; and, in paragraph (14), deleted "which has been" preceding "granted a certificate" near the middle of the first sentence, and deleted the former second sentence, which read: "A risk retention group may be chartered and licensed pursuant to this chapter or pursuant to Chapter 40 of this title."

33-41-3. Permissible business; limitations.

(a) Subject to the provisions of subsection (c) of this Code section and the other provisions of this chapter, a captive insurance company, where permitted by its formation documents, may engage in the business of any of the following kinds of insurance or reinsurance:

(1) Casualty, as described in Code Section 33-7-3 but excluding accident and sickness insurance as defined in Code Section 33-7-2, except for a pure captive insurance company, which may engage in the business of accident and sickness insurance as defined in Code Section 33-7-2;

(2) Marine and transportation, as described in Code Section 33-7-5;

(3) Property, as described in Code Section 33-7-6; and

(4) Surety, as described in Code Section 33-7-7.

(b) Insurance policies and bonds issued by a captive insurance company for workers' compensation insurance and motor vehicle accident insurance shall be in conformity with all minimum requirements for coverages and coverage amounts established by this state for such types of insurance. Such insurance policies and bonds issued by a captive insurance company shall constitute satisfactory proof that the

motor vehicle owners or employers, as applicable, insured under such policies or bonds have satisfied the requirements for motor vehicle accident insurance prescribed by Code Section 33-34-4 and for workers' compensation insurance prescribed by Code Section 34-9-121.

(c) Except as otherwise provided in this Code section:

(1) A captive insurance company shall not insure any risks resulting from:

(A) Any personal, familial, or household responsibilities; or

(B) Activities other than risks resulting from responsibilities arising out of any business, whether profit or nonprofit; trade; product; services, including professional or fiduciary services; or commercial premises or commercial operations;

(2) A captive insurance company may only cede reinsurance as provided in Code Section 33-41-14;

(3) A pure captive insurance company may only insure or reinsure the risks of its parent, affiliates of its parent, and controlled unaffiliated business;

(4) An association captive insurance company may only insure or reinsure the risks of the members of its association and their affiliates;

(5) An industrial insured captive insurance company may only insure or reinsure the risks of the industrial insureds, and their affiliates, that are its shareholders or shareholders of its sole shareholder;

(6) A risk retention group captive insurance company may only insure or reinsure the risks of its group members; and

(7) An agency captive insurance company may only reinsure:

(A) The risk of insurance or annuity contracts placed by or through the agency, brokerage, managing general agent, or reinsurance intermediary by which it is owned or controlled; or

(B) The contractual liability arising out of service contracts or warranties sold through a marketer, producer, administrator, issuer, or provider of service contracts or warranties by which it is owned or controlled.

(d) A captive insurance company may, with prior written approval from the Commissioner, reinsure the risks insured or reinsured either directly or indirectly by:

(1) Any other captive insurance company; or

(2) Any foreign or alien insurance company which satisfies the ownership or membership requirements of a captive insurance company under this chapter; provided, however, that the risks insured or reinsured from the foreign or alien insurance company are solely those of its owners or members or their affiliates.

History. — Code 1981, § 33-41-3, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 1989, p. 14, § 33; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 2/SB 173; Ga. L. 2019, p. 533, § 2-3/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "or reinsure" following "insure" in paragraph (c)(1).

JUDICIAL DECISIONS

Captive Insurance Company Act. — To the extent uninsured motorist provisions are inconsistent with the Georgia Captive Insurance Company Act, O.C.G.A. § 33-41-1 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).

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).

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).

33-41-4. Prerequisites to transacting insurance.

No captive insurance company may transact any insurance in this state unless:

(1) It first obtains from the Commissioner a certificate of authority authorizing it to transact insurance in this state;

(2) It maintains its principal place of business in this state;

(3) Any organization providing the principal administrative or management services to such captive insurance company shall be approved by the Commissioner;

(4) Its board of directors or board of managers holds at least one meeting each year in this state; and

(5) It appoints a registered agent to accept service of process in this state, provided that, whenever such registered agent cannot with reasonable diligence be found at the registered office of the captive insurance company, the Commissioner shall be an agent of such captive insurance company upon whom any process, notice, or demand may be served.

History. — Code 1981, § 33-41-4, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-2/HB 552; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 3/SB 173; Ga. L. 2019, p. 533, § 2-4/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "and" at the end of paragraph (3), substituted "; and" for the period at the end of paragraph (4), and added paragraph (5).

33-41-5. Incorporation.

(a) For purposes of this Code section, an incorporated protected cell, as defined in Article 2 of this chapter, shall be included in the definition of "captive insurance company."

(a.1)(1) A pure captive insurance company or an agency captive insurance company may be incorporated as a stock insurer or organized as a manager-managed limited liability company.

(2) An association captive insurance company, an industrial insured captive insurance company, a sponsored captive insurance company, or a risk retention group captive insurance company may be incorporated as a stock insurer, incorporated as a mutual insurer, or organized as a manager-managed limited liability company.

(b)(1) Captive insurance companies formed as corporations pursuant to this chapter shall be subject to the provisions of Chapter 2 of Title 14, other applicable statutes, and the applicable provisions of this chapter. Such captive insurance companies are also subject to regulations promulgated hereunder, which the Commissioner has the authority to establish regarding the formation, organization, operations, merger, and dissolution of captive insurance companies formed as corporations. In the event of any conflict between statutes or regulations of this state that are applicable to such captive insurance companies, the provisions of this chapter or regulations promulgated hereunder shall control.

(2) Captive insurance companies formed as limited liability companies pursuant to this chapter shall be subject to the provisions of

Chapter 11 of Title 14, other applicable statutes, and the applicable provisions of this chapter. Such captive insurance companies are also subject to regulations promulgated hereunder, which the Commissioner has the authority to establish regarding the formation, organization, operations, merger, and dissolution of captive insurance companies formed as limited liability companies. In the event of any conflict between statutes or regulations of this state that are applicable to such captive insurance companies, the provisions of this chapter or regulations promulgated hereunder shall control.

(3) Captive insurance companies shall be exempt from all applicable publishing and probate court certification requirements set forth in Title 14 or this title.

(4) The provisions of Chapter 14 of this title shall not apply to captive insurance companies except as specifically set forth herein or by the Commissioner through regulation.

(c)(1)(A) To form a captive insurance company in this state, formation documents and a fee of $100.00 shall be submitted to the Commissioner, who shall pay such fee into the state treasury. The Commissioner shall examine the formation documents to determine whether such documents will enable the captive insurance company to comply with the applicable insurance laws of this state; and, if the Commissioner finds that the formation documents, if approved, will enable the captive insurance company to do so, the Commissioner shall issue under his or her hand and official seal a certificate approving the formation documents and shall transmit a copy of such documents and the certificate of approval to the Secretary of State for recording.

(B) The articles of incorporation of a captive insurance company must be signed by the incorporator and shall contain the following:

(i) The name of the captive insurance company;

(ii) The number of shares the captive insurance company is authorized to issue, which must be greater than zero;

(iii) The street address and county of the initial registered office and the name of the initial registered agent at that office;

(iv) The name and address of each incorporator, of which there must be at least one;

(v) The street address of the captive insurance company's principal office;

(vi) The number of directors, which number shall not be less than three, who shall conduct the affairs of the captive insurance company; and

(vii) Such other provisions not inconsistent with law deemed appropriate by the incorporator.

(C) The articles of organization of a captive insurance company must be signed by the organizer and must contain the following:

(i) The name of the captive insurance company;

(ii) The street address and county of the initial registered office and the name of the initial registered agent at that office;

(iii) The name and address of each organizer, of which there must be at least one;

(iv) The street address of the captive insurance company's principal office;

(v) The number of managers, which number shall not be less than three, who shall conduct the affairs of the captive insurance company; and

(vi) Such other provisions not inconsistent with law deemed appropriate by the organizer.

(2) All corporate powers and privileges to captive 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 for any reason the Secretary of State is disqualified or unable to issue or grant said powers, the duties required by this chapter, or regulations promulgated hereunder, to be performed by the Secretary of State shall be performed by the Commissioner.

(3) When the certificate of the Commissioner as to his or her approval of the formation documents have been received in the office of the Secretary of State, the Secretary of State shall issue to the captive insurance company under the seal of this state a certificate of incorporation or organization. The captive insurance company 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 chapter.

(d)(1) A captive insurance company may amend its formation documents for any lawful purpose in accordance with the provisions of Chapter 2 of Title 14 if it is a corporation or Chapter 11 of Title 14 if it is a limited liability company.

(2) The captive insurance company shall submit to the Commissioner any proposed amendment to its formation documents and a fee of $50.00, which the Commissioner shall transmit into the state treasury.

(3) The Commissioner shall examine the proposed amendment to its formation documents to determine whether such documents will enable the captive insurance company to comply with the applicable insurance laws of this state; and, if the Commissioner finds that such documents, if approved, will enable the captive insurance company to do so, the Commissioner shall issue under his or her hand and official seal a certificate approving amended formation documents and shall transmit a copy of such documents and the certificate of approval to the Secretary of State for recording.

(e)(1) A captive insurance company may merge with or into one or more business entities in accordance with the provisions of Chapter 2 of Title 14 if it is a corporation or Chapter 11 of Title 14 if it is a limited liability company, but shall submit to the Commissioner all required merger documents set forth therein.

(2) The Commissioner shall examine all required merger documents to determine whether such documents will enable the captive insurance company to comply with the applicable insurance laws of this state; and, if the Commissioner finds that such documents, if approved, will enable the captive insurance company to do so, the Commissioner shall issue under his or her hand and official seal a certificate approving the merger documents and shall transmit a copy of such documents and the certificate of approval to the Secretary of State for recording.

(f)(1) A captive insurance company that was formed as a stock corporation may elect to convert to a manager-managed limited liability company pursuant to Title 14, but shall submit to the Commissioner all required conversion documents set forth therein and a fee of $100.00, which the Commissioner shall transmit to the state treasury.

(2) The Commissioner shall examine the required conversion documents to determine whether such documents will enable the captive insurance company to comply with the applicable laws of this state; and, if the Commissioner finds that such documents, if approved, will enable the captive insurance company to do so, the Commissioner shall issue under his or her hand and official seal a certificate approving the conversion documents and shall transmit a copy of such documents and the certificate of approval to the Secretary of State for recording.

(g)(1) A captive insurance company may dissolve in accordance with the provisions of Chapter 2 of Title 14 if it is a corporation, or Chapter 11 of Title 14 if it is a limited liability company, but shall submit to the Commissioner all required dissolution documents set forth therein.

(2) The Commissioner shall examine the required dissolution documents to determine whether such documents will enable the captive insurance company to dissolve in compliance with the applicable insurance laws of this state; and, if the Commissioner finds that such documents, if approved, will enable the captive insurance company to do so, the Commissioner shall issue under his or her hand and official seal a certificate approving the dissolution and shall transmit a copy of such documents and the certificate of approval to the Secretary of State for recording.

(h) The effective date of each document set forth in this Code section, including but not limited to formation documents, amendments to formation documents, merger documents, conversion documents, and dissolution documents shall be:

(1) The date on which the document is filed with the Commissioner; or

(2) A date specified by the Commissioner, which shall not precede the date on which the document was filed with the Commissioner.

History. — Code 1981, § 33-41-5, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 4/SB 173; Ga. L. 2019, p. 533, § 2-5/HB 99.

The 2019 amendment, effective July 1, 2019, added subsection (a); redesignated former subsection (a) as present subsection (a.1); substituted the present provisions of paragraph (a.1)(2) for the former provisions, which read: "An association captive insurance company, an industrial insured captive insurance company, or a risk retention group captive insurance company may be:

"(A) Incorporated as a stock insurer;

"(B) Incorporated as a mutual insurer; or

"(C) Organized as a manager managed limited liability company."; and added subsection (h).

33-41-6. Name.

(a) A captive insurance company shall not use any name which is either similar, misleading, or confusing with respect to any other name already in use by any other captive insurance company, domestic mutual or stock insurance company, corporation, or association organized or doing business in this state. The Commissioner shall not approve the formation documents of an applicant attempting to use such a name nor shall the Commissioner approve an application for a certificate of authority from such applicant.

(b) The name of a risk retention group captive insurance company shall include the words "risk retention group captive insurance company."

(c) If the captive insurance company is a mutual insurer, the word "mutual" shall be a part of its name.

History. — Code 1981, § 33-41-6, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 5/SB 173.

33-41-7. Directors or managers.

(a) The affairs of every captive insurance company shall be managed by not less than three directors or managers.

(b) At least one of the directors or managers of every captive insurance company shall be a resident of this state.

(c) Every captive insurance company shall report to the Commissioner within 30 days after any change in its directors or managers including in its report a statement of the business and professional background and affiliations of any new director or manager.

History. — Code 1981, § 33-41-7, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-3/HB 552; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 6/SB 173.

33-41-8. Amount of capital or surplus.

(a) The amount of minimum capital or surplus required for each captive insurance company shall be determined on an individual basis, however:

(1) A pure captive insurance company shall maintain at least $250,000.00 in surplus;

(2) An association captive insurance company shall maintain at least $500,000.00 in surplus;

(3) An agency captive insurance company shall maintain at least $250,000.00 in surplus;

(4) An industrial insured captive insurance company shall maintain at least $500,000.00 in surplus;

(5) A risk retention group shall maintain at least $500,000.00 in surplus; and

(6) A sponsored captive insurance company shall maintain at least $250,000.00 in surplus.

The Commissioner may require additional capital or surplus of any captive insurance company in an amount he or she deems appropriate under the circumstances based on the captive insurance company's business plan as described in Code Section 33-41-10. Additional capital or surplus may be required if the captive insurance company's business plan indicates that an increase is required in order for the captive insurance company to meet its contractual obligations to its policyholders or to maintain its solvency.

(b) Minimum capital or surplus of up to $500,000.00 shall be maintained in any of the following:

(1) Cash;

(2) Certificates of deposit or similar certificates or evidences 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;

(3) Savings accounts, certificates of deposit, or similar certificates or evidences 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; or

(4) One or more letters of credit, so long as they are in conformance with Code Section 33-41-9.

(c) Each association captive insurance company, industrial insured captive insurance company, and risk retention group captive insurance company must deposit with the state prior to the issuance of a certificate of authority.

(d) Any additional capital or surplus in excess of $500,000.00 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 under Code Section 33-11-5;

(2) Promissory notes or other obligations of shareholders secured by one or more letters of credit, as described in Code Section 33-41-9; or

(3) Any other investments approved by the Commissioner that do not impair the financial solvency of the captive insurance company.

History. — Code 1981, § 33-41-8, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-4/HB 552; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2019, p. 533, § 2-6/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "and" at the end of paragraph (a)(4); substituted "; and" for the period at the end of paragraph (a)(5); added paragraph (a)(6); deleted "paragraph (2) of subsection (a) of" following "described in" near the end of the first sentence of the ending undesignated paragraph of subsection (a); substituted "One or more letters of credit, so long as they are in conformance with" for "Promissory notes or other obligations of shareholders secured by one or more letters of credit, as described in" in paragraph (b)(4); in subsection (c), substituted "Each" for "One hundred thousand dollars of the minimum capital or surplus of an" at the beginning, deleted "an" preceding "industrial" in the middle, and substituted "and risk retention group captive insurance company must deposit" for "or a risk retention group captive insurance company must be deposited" near the end.

33-41-9. Letters of credit.

(a) Any letter of credit used to meet the requirements set forth in this chapter shall be:

(1) Clean, irrevocable, and unconditional;

(2) Issued by a bank approved by the Commissioner, which is either a bank chartered by the State of Georgia or a national bank which is a member of the Federal Reserve System;

(3) Presentable and payable within the State of Georgia; and

(4) Provided in conformity with any other requirements established by the Commissioner.

(b) The Commissioner may require any captive insurance company to draw upon its letters of credit at any time, in amounts determined by the Commissioner, if the Commissioner determines that such action is necessary for the protection of the interests of the captive insurance company's policyholders.

History. — Code 1981, § 33-41-9, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2019, p. 533, § 2-7/HB 99.

The 2019 amendment, effective July 1, 2019, substituted "this chapter" for "Code Sections 33-41-8, 33-41-12, and 33-41-14" in the introductory paragraph of subsection (a).

33-41-10. Application for and issuance of certificate of authority.

(a) The application for an original certificate of authority for a captive insurance company must be filed with the Commissioner and shall contain the following:

(1) A copy of the captive insurance company's adopted or proposed articles of incorporation and bylaws or articles of organization and operating agreement; and

(2) A business plan which shall contain the following:

(A) A plan of operation or a feasibility study describing the anticipated activities and results of the captive insurance company which shall include:

(i) A description of the coverages, coverage limits and deductibles, and premium rating systems for the lines of insurance or reinsurance that the captive insurance company intends to offer;

(ii) Historical and expected loss experience of the risks to be insured or reinsured by the captive insurance company;

(iii) Pro forma financial statements and projections of the proposed business operations of the captive insurance company;

(iv) An analysis of the adequacy of the captive insurance company's proposed premiums and capital and surplus levels relative to the risks to be insured or reinsured by the captive insurance company;

(v) A statement of the captive insurance company's net retained limit of liability on any contract of insurance or reinsurance it intends to issue and the nature of any reinsurance it intends to cede;

(vi) A statement certifying that the captive insurance company's investment policy is in compliance with this title and specifying the type of investments to be made pursuant to Code Section 33-41-18;

(vii) A statement identifying the geographic areas in which the captive insurance company intends to operate;

(viii) A statement identifying the persons or organizations who will perform the captive insurance company's major operational functions, including management, underwriting, accounting, investment of assets, claims adjusting and loss control, and the adequacy of the expertise, experience, and character of such persons or organizations; and

(ix) Whenever required by the Commissioner, an appropriate opinion by a qualified independent casualty actuary regarding the adequacy of the captive insurance company's proposed capital, surplus, and premium levels; and

(B) Such other items deemed relevant by the Commissioner in ascertaining whether the proposed captive insurance company will be able to meet its contractual obligations.

(b) In determining whether to approve an application for an original or renewal certificate of authority to a captive insurance company, the Commissioner shall examine the applicable items submitted to him or her pursuant to this Code section. The Commissioner may rely upon and accept the reports of independent agents who may include licensed insurance counselors, brokers, agents, or adjusters discussed under Chapter 23 of this title, certified actuarial consultants, certified public accountants, risk managers, and examiners of insurance companies in order to facilitate his or her examination of the application for a certificate of authority by a captive insurance company. The expenses and charges of such independent agents shall be paid directly by the captive insurance company.

(c) Each captive insurance company shall pay to the Commissioner an amount equal to all costs of examining, investigating, and processing its application for an original or renewal certificate of authority. In addition, it shall pay a fee for the initial year of licensure and a renewal fee for each year thereafter in the amount periodically imposed under this title upon captive insurance companies.

(d) Pursuant to Code Section 33-3-15, if the Commissioner is satisfied that the documents and statements filed by the captive insurance company in its application for a certificate of authority comply with the provisions of this chapter, the Commissioner shall promptly issue a certificate of authority authorizing the captive insurance company to transact insurance in this state until the thirtieth day of June thereafter. The effective date of such certificate of authority shall be:

(1) The date on which the Commissioner is satisfied that the documents and statements filed by the captive insurance company in its application for a certificate of authority comply with the provisions of this chapter; or

(2) A date specified by the Commissioner, which shall not precede the date on which the application for a certificate of authority was first filed with the Commissioner.

(e) The captive insurance company shall provide the Commissioner with the following documentation as soon as practicable:

(1) Evidence satisfactory to the Commissioner that the minimum capital or surplus required for the particular captive insurance company under Code Section 33-41-8 has been paid in and that the appropriate amount thereof has been deposited with the state; and

(2) A financial statement showing the assets and liabilities of the captive insurance company which is certified by its president and calculated in accordance with the accounting standards set forth in Chapter 10 of this title, except as modified by this chapter.

Notwithstanding subsection (d) of this Code section, the Commissioner may require that the captive insurance company submit the documentation required by this subsection prior to issuing the captive insurance company a certificate of authority.

(f) Any material change in the items required under subsection (a) of this Code section shall require the prior approval of the Commissioner. Any material change which is not disapproved by the Commissioner within 30 days after its submission shall be deemed approved.

History. — Code 1981, § 33-41-10, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 1989, p. 14, § 33; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 7/SB 173; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2019, p. 533, § 2-8/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "subsections (a), (e), and

(f) of" following "pursuant to" near the end of the first sentence of subsection (b); and, in subsection (d), inserted "in its application for a certificate of authority" near the middle of the first sentence, and added the second sentence.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, "Pro forma" was substituted for "Pro-forma" in subdivision (a)(2)(A)(iii).

Editor's notes. — Ga. L. 2017, p. 774, § 54(e)/HB 323, not codified by the General Assembly, provides: "In the event of conflict between a provision in Sections 1 through 53 of this Act and a provision of another Act enacted at the 2017 regular session of the General Assembly, the provision of such other Act shall control over the conflicting provision in Sections 1 through 53 of this Act to the extent of the conflict." Accordingly, the amendments to paragraph (a)(1) and subsections (b) and (d) of this Code section by Ga. L. 2017, p. 774, § 33(8)/HB 323, were not given effect.

33-41-11. Refusal, suspension, or nonrenewal of certificate; expiration, renewal, amendment.

(a) The certificate of authority of a captive insurance company to transact insurance in this state may be refused or suspended or not be renewed pursuant to Code Sections 33-3-17 through 33-3-19, inclusive.

(b) A certificate of authority shall expire, be renewed, and be amended by the Commissioner pursuant to Code Section 33-3-16; provided, however, that captive insurance companies shall not be subject to the publishing requirements of such Code section.

History. — Code 1981, § 33-41-11, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-12. Assets.

For the purposes of determining the financial condition of a captive insurance company, including, but not limited to, the maintenance of adequate reserves pursuant to Code Section 33-41-13, the reporting of business affairs pursuant to Code Section 33-41-15, and the examinations and investigations pursuant to Code Section 33-41-16, there shall be allowed as assets of a captive insurance company:

(1) Those assets described in Code Section 33-10-1;

(2) Those assets otherwise authorized by Code Sections 33-41-8 and 33-41-14;

(3) Obligations for premium payments, provided that such obligations are secured by letters of credit, as described in Code Section 33-41-9; and

(4) Assets that are approved by the Commissioner as admitted assets under rules adopted pursuant to this chapter.

History. — Code 1981, § 33-41-12, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-13. Reserves.

(a) Every captive insurance company shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all unpaid losses and claims incurred, whether reported or unreported, for which such captive insurance company may be liable, together with the expenses of adjustment or settlement of such losses and claims. Every captive insurance company shall keep a complete and itemized record, in a form satisfactory to the Commissioner, showing all losses and claims on which it has received notice.

(b) If the loss experience of a captive insurance company shows that its loss reserves, however estimated, are inadequate, the Commissioner shall require the captive insurance company to maintain increased amounts of loss reserves as are needed to make its loss reserves adequate.

(c) Every captive insurance company shall maintain an unearned premium reserve on all policies in force which shall never be less in the aggregate than the captive insurance company's actual liability to all its insureds for the return of gross unearned premiums computed pursuant to the method commonly referred to as the monthly pro rata method.

History. — Code 1981, § 33-41-13, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-14. Reinsurance.

(a) A captive insurance company may cede any part of its risks to a reinsurer pursuant to a written reinsurance agreement and may take credit as an asset or a deduction from its liabilities for the amount of reinsurance premiums recoverable under such reinsurance agreement:

(1) If the reinsurer is in compliance with Code Section 33-7-14;

(2) To the extent that assets are deposited or withheld from the reinsurer under a written trust or escrow agreement approved by the Commissioner pursuant to an express provision in the reinsurance agreement as security for the payment of the reinsurer's obligations thereunder, provided that:

(A) The assets deposited or withheld are held subject to withdrawal by, and under the control of, the ceding captive insurance company; or

(B) The assets deposited or withheld are placed in a trust or escrow account for such purposes in a bank which is either chartered by the State of Georgia or a national bank which is a member of the Federal Reserve System and withdrawals cannot be made without the express written consent of the ceding captive insurance company;

(3) To the extent of the amount of a letter of credit, as described in Code Section 33-41-9, given pursuant to an express provision in the reinsurance agreement as security for the payment of the reinsurer's obligations thereunder; or

(4) When the Commissioner shall otherwise authorize such credits or deductions.

(b) Any assets deposited or withheld under paragraph (2) of subsection (a) of this Code section must be in the form of cash, as defined in Code Section 33-11-6, or securities which must have a market value equal to or greater than the credit taken and are qualified as allowed assets for a domestic insurer under Chapter 11 of this title.

(c) No credit shall be allowed for reinsurance in any unauthorized assuming reinsurer unless such reinsurer designates the Commissioner as agent for service of process in any action arising out of, or in connection with, such reinsurance.

History. — Code 1981, § 33-41-14, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-15. Reports.

Each captive insurance company shall be required to file annual and other reports of its business affairs and operations as prescribed by Code Section 33-3-21.

History. — Code 1981, § 33-41-15, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-16. Examination by Commissioner or agent; confidentiality.

(a) The Commissioner or his or her designated agent may visit each captive insurance company at any time and examine its affairs in order to ascertain its financial condition, its ability to fulfill its contractual obligations, and its compliance with this chapter. For these purposes, the Commissioner or his or her designated agent shall have free access to all of the books and records relating to the business of the captive insurance company. The expenses and charges of any examination

conducted pursuant to this Code section shall be paid directly by the captive insurance company examined.

(b) When necessary or desirable to assist in any examination under this Code section, the Commissioner may retain such independent agents as described in subsection (b) of Code Section 33-41-10, as the Commissioner deems appropriate, in order to facilitate his or her examination under this Code section. The expenses and charges of such persons so retained or designated shall be paid directly by the captive insurance company. The provision of subsection (g) of Code Section 33-2-14 shall apply to examinations of any captive insurance company.

(c) All portions of license applications reasonably designated confidential by or on behalf of an applicant pure or agency captive insurance company, all information and documents, and any copies of the foregoing, produced or obtained by or submitted or disclosed to the Commissioner pursuant to this chapter that are reasonably designated confidential by a pure or agency captive insurance company, and all examination reports, preliminary examination reports, working papers, recorded information, other documents, and any copies of any of the foregoing, produced or obtained by or submitted or disclosed to the Commissioner pursuant to this chapter shall be given confidential treatment, except as to disclosures consented to by the pure or agency captive insurance company, and shall not be subject to subpoena, shall not be made public by the Commissioner, and shall not be provided or disclosed to any other person at any time except to:

(1) Insurance commissioners of any state or of any foreign country or jurisdiction, provided that:

(A) Such receiving party shall agree in writing to maintain the confidentiality of such information; and

(B) The laws of the receiving party require such information to be and to remain confidential; or

(2) A law enforcement official or agency of this state, any other state, or the United States of America so long as such official or agency agrees in writing to hold it confidential and in a manner consistent with this Code section.

History. — Code 1981, § 33-41-16, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-5/HB 552; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-17. Fines.

The Commissioner may impose fines as prescribed by Code Section 33-3-20.

History. — Code 1981, § 33-41-17, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-18. Investments.

Except as provided in Code Section 33-41-8:

(1) Risk retention group captive insurance companies, industrial insured captive insurance companies, and association captive insurance companies shall comply with the investment requirements contained in Article 2 of Chapter 11 of this title; and

(2) Pure captive insurance companies and agency captive insurance companies shall not be subject to any restrictions on eligible investments whatever, including those limitations contained in Chapter 11 of this title; provided, however, that the Commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any such captive insurance company.

History. — Code 1981, § 33-41-18, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-19. Rates, underwriting rules, and policy forms.

(a) No captive insurance company shall be required to join or use the rates, rating systems, underwriting rules, or policy or bond forms of a rating or advisory organization as defined in Code Section 33-9-2.

(b) No captive insurance company shall be required to file its premium rates or policy forms with, or seek approval of such rates or forms from, the Commissioner or any other authority of this state. However, the Commissioner shall impose minimum premiums upon association captive insurance companies which write motor vehicle liability insurance coverage required by law and do not participate in the Georgia Insurers Insolvency Pool.

History. — Code 1981, § 33-41-19, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2019, p. 533, § 2-9/HB 99; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "Reserved." for the former provisions of subsection (c), which read: "Each captive insurance company shall provide the following notice in ten-point type on the front page and declaration page on all policies and on the front page of all applications for policies:

"This captive insurance company is not subject to all of the insurance laws and regulations of the State of Georgia. State insurers insolvency guaranty funds are not available to the policyholders of this captive insurance company."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former subsection (c) which was designated as reserved.

33-41-20. Exclusion from insolvency funds; participation in FAIR plan or joint underwriting association; assessment for payments to Subsequent Injury Trust Fund.

(a)(1) No captive insurance company other than an association or industrial insured captive insurance company issuing workers' compensation insurance contracts shall be permitted to join or contribute financially to the Georgia Insurers Insolvency Pool under Chapter 36 of this title or any other plan, pool, or association guaranty or insolvency fund in this state. Other than an association or industrial insured captive insurance company issuing workers' compensation insurance contracts, no captive insurance company, or its insureds or claimants against its insureds, nor its parent or any affiliated company shall receive any benefit from the Georgia Insurers Insolvency Pool or any other plan, pool, or association guaranty or insolvency fund for claims arising out of the operations of such captive insurance company.

(2) No captive insurance company shall be required to participate in any FAIR Plan established and maintained in this state under Chapter 33 of this title.

(3) No captive insurance company shall be required to participate in any joint underwriting association established and maintained in this state under Chapter 9 of this title.

(b) Captive insurance companies shall be assessed on the same basis as self-insurers for the purpose of payments to the Subsequent Injury Trust Fund as described in Chapter 9 of Title 34.

History. — Code 1981, § 33-41-20, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 1989, p. 14, § 33; Ga. L. 2007, p. 236, § 1/HB 408; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-20.1. Membership of captive insurance companies in Georgia Insurers Insolvency Pool.

(a) Every association and industrial insured captive insurance company issuing workers' compensation insurance contracts shall become a member of the Georgia Insurers Insolvency Pool under Chapter 36 of this title as to workers' compensation only. Such captive insurance companies shall be liable for assessments pursuant to Code Section 33-36-7 and for all other obligations imposed pursuant to Chapter 36 of this title as to workers' compensation only.

(b) Except as provided for in Code Section 33-36-20, the Georgia Insurers Insolvency Pool shall not be liable for any claims incurred by any captive insurance company before January 1, 2008.

History. — Code 1981, § 33-41-20.1, enacted by Ga. L. 2007, p. 236, § 2/HB 408; Ga. L. 2010, p. 1085, § 4/HB 1364; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2019, p. 533, § 1-2/HB 99.

The 2019 amendment, effective July 1, 2019, substituted "Every" for "On and after January 1, 2008, every" at the beginning of subsection (a).

33-41-21. Rehabilitation, reorganization, conservation, and liquidation.

The provisions of Chapter 37 of this title shall apply to and govern the rehabilitation, reorganization, conservation, and liquidation of captive insurance companies.

History. — Code 1981, § 33-41-21, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-22. Taxation.

In lieu of any other taxes imposed by this title, all captive insurance companies licensed under this chapter shall pay the following taxes:

(1) A tax at the rate of 0.4 percent on the first $20 million and 0.3 percent on each dollar thereafter on its direct premiums collected, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as return premiums which must include dividends on unabsorbed premiums or premium deposits returned or credited to policyholders. However, risk retention group captive insurance companies shall only be subject to such taxes on direct premiums collected for coverages within the State of Georgia;

(2) A tax at the rate of 0.225 percent on the first $20 million of assumed reinsurance premium, and 0.150 percent on the next $20 million and 0.050 percent on the next $20 million, and 0.025 percent of each dollar thereafter. However, no reinsurance tax applies to premiums for risks or portions of risks that are subject to taxation on a direct basis pursuant to this title. No reinsurance premium tax shall be payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control, provided that the Commissioner verifies that such transaction is part of a plan to discontinue the operations of such other insurer, and if the intent of the parties to such transaction is to renew or maintain such business with the captive insurance company;

(3) If the aggregate taxes to be paid by a captive insurance company calculated under paragraphs (1) and (2) of this Code section amount to more than $100,000.00 in any year, the captive insurance company shall pay a maximum tax of $100,000.00 for that year;

(4) Two or more captive insurance companies under common ownership and control, other than sponsored captive insurance companies, shall be taxed as though they were a single captive insurance company. For the purposes of this Code section, the term "common ownership and control" shall mean the direct or indirect ownership, control or hold with power to vote more than 50 percent of the outstanding voting securities or membership interests of two or more such captive insurance companies;

(5) The tax provided for in paragraphs (1) and (2) of this Code section shall be calculated on an annual basis, notwithstanding policies or contracts of insurance or contracts of reinsurance issued on a multiyear basis. In the case of multiyear policies or contracts, the premium shall be prorated for purposes of determining the tax due; and

(6)(A) For purposes of this Code section, a protected cell, as defined in Article 2 of this chapter, shall be included in the definition of a "captive insurance company."

(B) The common ownership and control aggregation rules set forth in paragraph (4) of this Code section shall apply to each individual protected cell with respect to the participant or participants of such individual protected cell.

(C) Notwithstanding any other provision of this Code section, a sponsored captive insurance company shall be responsible for collecting and remitting taxes due from its protected cells.

History. — Code 1981, § 33-41-22, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-6/HB 552; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 8/SB 173; Ga. L. 2019, p. 533, § 2-10/HB 99.

The 2019 amendment, effective July 1, 2019, substituted the present provisions of paragraph (4) for the former provisions, which read: "Two or more captive insurance companies under common ownership and control shall be taxed as though they were a single captive insurance company; and"; substituted "; and" for the period at the end of paragraph (5); and added paragraph (6).

33-41-23. Certificate of dormancy.

(a) A captive insurance company that meets the definition of a dormant captive insurance company set forth in this chapter may apply to the Commissioner for a certificate of dormancy on a form or forms as may be prescribed by the Commissioner.

(b) A dormant captive insurance company that has been issued a certificate of dormancy pursuant to this Code section shall:

(1) Possess and thereafter maintain unimpaired, paid-in-capital and surplus of at least $25,000.00;

(2) Submit to the Commissioner a report of its financial condition on or before March 1 of each year on a form or in a manner as prescribed by the Commissioner;

(3) Renew such certificate every five years by submitting documentation as prescribed by the Commissioner and paying a renewal fee of $500.00; and

(4) Be subject to an examination pursuant to Code Section 33-41-16 in the discretion of the Commissioner.

(c) A dormant captive insurance company that has been issued a certificate of dormancy pursuant to this Code section shall not:

(1) Be subject to or liable for the payment of any tax pursuant to Code Section 33-41-22; or

(2) Be required to submit any annual forms, fees, or documents that are otherwise required by this chapter, other than those required pursuant to this Code section.

(d) The Commissioner may, upon written request, declare a captive insurance company to be dormant for purposes of this Code section even if such captive insurance company retains liabilities associated with policies written or assumed, provided that such captive insurance company has otherwise ceased the transaction of insurance business. However, in this case, the Commissioner may, in his or her discretion, require such captive insurance company to possess and maintain unimpaired, paid-in-capital and surplus and reserves greater than that required by this Code section.

(e) A certificate of dormancy shall be revoked if a captive insurance company no longer meets the definition of a dormant captive insurance company or fails to meet the requirements as set forth in this Code section.

(f) A dormant captive insurance company shall apply to the Commissioner for approval and shall be granted such approval to surrender its certificate of dormancy and resume conducting the business of insurance prior to issuing any insurance policies and shall pay an application fee as prescribed by the Commissioner.

(g) Any provisions of this title which are inconsistent with the provisions of this Code section shall not apply to dormant captive insurance companies.

History. — Code 1981, § 33-41-23, enacted by Ga. L. 2019, p. 533, § 2-11/HB 99.

Effective date. — This Code section became effective July 1, 2019.

Editor's notes. — Ga. L. 2019, p. 533, § 2-11/HB 99, effective July 1, 2019, repealed the former Code section and enacted the current Code section. The former Code section, relating to rules and

regulations, was based on Code 1981, § 33-41-23, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-24. Rule making authority.

The Commissioner may adopt rules establishing standards to ensure that a pure captive insurance company's parent or any of its affiliated companies is able to exercise control of the risk management function of any controlled unaffiliated business to be insured by the pure captive insurance company; provided, however, that, until such time as rules under this Code section are adopted, the Commissioner may approve or deny the coverage of such risks by a pure captive insurance company on a case by case basis.

History. — Code 1981, § 33-41-24, enacted by Ga. L. 2019, p. 533, § 2-12/HB 99.

Effective date. — This Code section became effective July 1, 2019.

Editor's notes. — Ga. L. 2019, p. 533, § 2-11/HB 99, effective July 1, 2019, repealed the former Code section and enacted the current Code section. The former Code section, relating to inapplicability of inconsistent provisions, was based on Code 1981, § 33-41-24, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2016, p. 825, § 1/SB 347.

33-41-25. Regulatory authority.

The Commissioner may establish such rules and regulations and issue such interpretive rulings as may be necessary to carry out the provisions of this chapter.

History. — Code 1981, § 33-41-25, enacted by Ga. L. 2019, p. 533, § 2-13/HB 99.

Effective date. — This Code section became effective July 1, 2019.

33-41-26. Inconsistent provisions not applicable to captive insurance companies.

Any provisions of this title which are inconsistent with the provisions of this chapter shall not apply to captive insurance companies; provided, however, that pure and agency captive insurance companies shall not be subject to the requirements of Chapter 13 of this title.

History. — Code 1981, § 33-41-26, enacted by Ga. L. 2019, p. 533, § 2-13/HB 99.

Effective date. — This Code section became effective July 1, 2019.

ARTICLE 2

SPONSORED CAPTIVE INSURANCE COMPANIES

Effective date. — This article became effective July 1, 2019.

33-41-100. Application.

In addition to the general provisions of Article 1 of this chapter, the provisions of this article shall apply to sponsored captive insurance companies.

History. — Code 1981, § 33-41-100, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99.

33-41-101. Definitions.

As used in this article, the term:

(1) "General account" means all the assets and liabilities of a sponsored captive insurance company that are not attributable to a protected cell.

(2) "Incorporated protected cell" means a protected cell that is established as a stock corporation or manager-managed limited liability company separate from the sponsored captive insurance company of which it is a part.

(3) "Participant" means a person, and any affiliates thereof, that is insured or reinsured by a sponsored captive insurance company, where the losses of the participant are limited through a participant contract to such participant's protected cell assets or to the pro rata share of the assets of one or more protected cells that are identified in such participant contract.

(4) "Participant contract" means a contract by which a sponsored captive insurance company insures or reinsures the risks of a participant, or the controlled unaffiliated business thereof, and limits the losses to the participant's protected cell assets or to the pro rata share of the assets of one or more protected cells that are identified in such participant contract.

(5) "Protected cell" means a separate and distinct account or accounts established by a sponsored captive insurance company in which an identified pool of assets are maintained for one or more participants in accordance with the terms of one or more participant contracts to fund the liability of the sponsored captive insurance company insured or assumed on behalf of such participants as set

forth in such participant contracts. A protected cell may be an incorporated protected cell or an unincorporated protected cell.

(6) "Protected cell assets" means all assets, contract rights, and general intangibles identified with and attributable to a specific protected cell that may not be used to pay any expenses or claims other than those attributable to such protected cell.

(7) "Protected cell liability" means all liabilities and other obligations identified with and attributable to a specific protected cell.

(8) "Sponsor" means any person, other than a risk retention group, that is approved by the Commissioner, in the exercise of his or her sole discretion, to organize and operate a sponsored captive insurance company and to provide all or part of its required capital and surplus.

(9) "Sponsored captive insurance company" means any domestic stock insurer or manager-managed limited liability company formed by one or more sponsors having been granted a certificate of authority pursuant to this chapter that:

(A) May only be owned by its participants and sponsors, unless the Commissioner has authorized the issuance of nonvoting securities to other persons:

(B) Maintains at least $250,000.00 in capital and surplus subject to Code Section 33-41-8, which shall at all times be available to pay any expenses of or claims against it;

(C) May only insure or reinsure the risks of its participants, or the controlled unaffiliated business thereof, in accordance with separate participant contracts;

(D) Funds its liabilities to each participant through one or more protected cells and keeps the protected cell assets and protected cell liabilities of each protected cell segregated from the general account and from the protected cell assets and protected cell liabilities of other protected cells; and

(E) Establishes administrative and accounting procedures necessary to allocate, identify, separate, and segregate the protected cell assets, protected cell liabilities, insurance and reinsurance obligations, assets, credits, liabilities, losses, tax benefits and refunds attributable to the protected cells.

(10) "Unincorporated protected cell" means a protected cell that is not itself a legal entity separate from the sponsored captive insurance company of which it is a part.

History. — Code 1981, § 33-41-101, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99; 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 at the end of subparagraph (9)(D).

33-41-102. Protected cells; prior written approval; annual filing of financial reports; notification upon insolvency.

(a) A sponsored captive insurance company may establish one or more protected cells if the Commissioner has approved in writing a business plan, or an amendment to such plan, with respect to each protected cell that includes information about the participant, the associated participant contract or contracts, and any other information requested by the Commissioner.

(b) No participant contract shall take effect without the Commissioner's prior written approval. The addition of each new protected cell, the withdrawal of any current participant, or the termination of any existing protected cell shall constitute a change in the business plan of the sponsored captive insurance company and shall require the Commissioner's prior written approval.

(c) Each sponsored captive insurance company shall annually file with the Commissioner such financial reports as he or she shall require. Any such financial report shall include, without limitation, accounting statements detailing the financial experience of each protected cell.

(d) Each sponsored captive insurance company shall notify the Commissioner in writing within ten business days of any protected cell becoming insolvent or otherwise unable to meet its claim, expense, insurance, or reinsurance obligations.

History. — Code 1981, § 33-41-102, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99.

33-41-103. Incorporated protected cells; legal entity status; requirements for formation; naming; rights and authority.

(a) A sponsored captive insurance company licensed under this chapter may establish and maintain one or more protected cells to insure or reinsure risks subject to the provisions, terms, and conditions set forth in this chapter, and it is the intent of the General Assembly to provide sponsored captive insurance companies with the option to establish one or more protected cells as incorporated protected cells without limiting any rights or protections applicable to unincorporated protected cells.

(b) The creation of a protected cell pursuant to this chapter does not create, with respect to such protected cell, a legal person separate from the sponsored captive insurance company of which it is a part unless such protected cell is an incorporated protected cell.

(c) In addition to the provisions required by subparagraphs (c)(1)(B) and (c)(1)(C) of Code Section 33-41-5, an incorporated protected cell must also include the following in its formation documents:

(1) A reference to the sponsored captive insurance company of which it will be a part; and

(2) A statement that the entity is a protected cell incorporated for the limited purposes authorized by the sponsored captive insurance company's certificate of authority.

(d) An incorporated protected cell shall not use any name that is either similar, misleading, or confusing with respect to any other name already in use by any other entity doing business in this state.

(e) An incorporated protected cell shall be entitled to enter into contracts and undertake obligations in its own name and for its own account unless prohibited by an applicable participant contract. In the case of a contract or obligation undertaken directly by an incorporated protected cell to which the sponsored captive insurance company is not a party, either in its own name and for its own account or on behalf of a protected cell, the counterparts to the contract or obligation shall have no right or recourse against the sponsored captive insurance company, any other protected cell not a party to such contract or obligation or any assets other than against assets properly attributable to the incorporated protected cell that is a party to the contract or obligation.

History. — Code 1981, § 33-41-103, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99; 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 at the end of subsection (c).

33-41-104. Accounting and financial matters of incorporated protected cells.

(a) All attributions of assets and liabilities to the protected cells and the general account shall be made by the sponsored captive insurance company in accordance with the business plan and applicable participant contracts as approved by the Commissioner, and unless the sponsor consents and the Commissioner has granted prior written approval, the general account shall not be used to pay any expenses or claims attributed solely to a protected cell.

(b) When establishing a protected cell, the sponsored captive insurance company shall attribute to the protected cell assets with a value at

least equal to the reserves and other insurance liabilities attributable to such protected cell in cash or in readily marketable securities with established market value.

(c) Amounts attributable to a protected cell under this chapter are owned by the protected cell. No sponsored captive insurance company shall be, or hold itself out to be, a trustee with respect to those protected cell assets of such protected cell account. Notwithstanding this subsection, the sponsored captive insurance company may allow for a security interest to attach to protected cell assets when in favor of a creditor of the protected cell and otherwise allowable under applicable law.

(d) Each protected cell shall be accounted for separately on the books and records of the sponsored captive insurance company to reflect each protected cell's financial condition and results of operations, net income or loss, dividends or other distributions to participants, and such other factors regarding each protected cell as may be provided in the applicable participant contract or required by the Commissioner.

(e) The assets of a protected cell shall not be chargeable with liabilities of any other protected cell or, unless otherwise agreed in the applicable participant contract, of the sponsored captive insurance company generally.

(f) No sale, exchange, transfer of assets, dividend, or distribution, other than a transaction in accordance with the applicable participant contract, may be made with respect to a protected cell by or to a sponsored captive insurance company or participant without the Commissioner's written approval. In no event shall such approval be given if the sale, exchange, transfer, dividend, or distribution would result in the insolvency or impairment of a protected cell.

(g) The remedy of tracing is applicable to protected cell assets if they are commingled with protected cell assets of other protected cells or the general account in violation of this article and any applicable participant contracts. The remedy of tracing shall not be construed as an exclusive remedy.

(h) The sponsored captive insurance company shall attribute all insurance obligations, assets, and liabilities relating to a reinsurance contract entered into with respect to a protected cell to such protected cell as set forth in the business plan and participant contracts approved by the Commissioner, which may include a tax allocation agreement to which the sponsored captive insurance company is a party.

(i) Notwithstanding any other provision of this chapter, the assets of two or more protected cells may be combined for purposes of investment, and such combination shall not be construed as defeating the segregation of such assets for accounting or other purposes.

(j) Notwithstanding any other provisions of this title, sponsored captive insurance companies shall not be subject to any restrictions on eligible investments whatever; however, the Commissioner may prohibit or limit any investment that threatens the solvency or liquidity of any sponsored captive insurance company.

(k) If required by the Commissioner, in his or her discretion, the business written by a sponsored captive insurance company, with respect to each protected cell, shall be:

(1) Fronted by an insurance company licensed pursuant to the laws of any state;

(2) Reinsured by a reinsurer authorized or approved by the Commissioner; or

(3) Secured by a trust fund in the United States for the benefit of participants, policyholders, and claimants or funded by an irrevocable letter of credit or other arrangement that is acceptable to the Commissioner. The Commissioner, in his or her sole discretion, shall approve the form, terms, and funding amount of any trust, and may require the sponsored captive insurance company to increase the funding of any security arrangement established under this chapter. If the form of security is a letter of credit, the letter of credit must be in conformance with Code Section 33-41-9 and approved by the Commissioner.

History. — Code 1981, § 33-41-104, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99.

33-41-105. Commingling of assets prohibited; separation of cells.

(a) In connection with the conservation, rehabilitation, or liquidation of captive insurance companies set forth in Code Section 33-41-21, including sponsored captive insurance companies, the assets and liabilities of a protected cell shall at all times be kept separate from, and shall not be commingled with, those of other protected cells and the sponsored captive insurance company except to the extent that the assets and liabilities of any one or more protected cells are determined to have not been allocated, segregated, and separated pursuant to the business plan and participant contracts approved by the Commissioner, and which are subject to the tracing provisions set forth in this article.

(b) Notwithstanding the provisions of this title, in the event of the insolvency of a sponsored captive insurance company where the Commissioner determines that one or more protected cells remain solvent, the Commissioner may separate such cells from the sponsored captive insurance company and may allow, on application of the sponsored

captive insurance company or participant, for the conversion of such protected cells into one or more new or existing other captive insurance companies.

History. — Code 1981, § 33-41-105, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99.

33-41-106. Application of Code Section 33-41-16 to sponsored captive insurance companies.

All provisions set forth in subsection (c) of Code Section 33-41-16 shall also apply to sponsored captive insurance companies in the same manner.

History. — Code 1981, § 33-41-106, enacted by Ga. L. 2019, p. 533, § 2-14/HB 99.

CHAPTER 42

LONG-TERM CARE INSURANCE

Sec.
33-42-1. Short title.
33-42-2. Purpose of chapter.
33-42-3. Applicability of chapter.
33-42-4. Definitions.
33-42-5. Group policy issued in another state.
33-42-6. Disclosures; provisions; definition of preexisting condition; loss ratio standards; right to return policy; outline of coverage; certificate.
33-42-7. Regulations [Repealed].

Code Commission notes. — Two 1988 Acts added a new Chapter 41 to this title. Pursuant to Code Section 28-9-5, the chapter enacted by Ga. L. 1988, p. 966 has retained the Chapter 41 designation, but the chapter enacted by Ga. L. 1988, p. 1541 has been redesignated as Chapter 42 and the Code sections have been renumbered accordingly.

33-42-1. Short title.

This chapter may be known and cited as the "Long-term Care Insurance Act."

History. — Code 1981, § 33-42-1, enacted by Ga. L. 1988, p. 1541, § 1.

Cross references. — Georgia Long-term Care Partnership Program Act, § 49-4-160 et seq.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, Code Sections 33-42-1, 33-42-2, and 33-42-3 as enacted by Ga. L. 1988, p. 1541 were redesignated as Code Sections 33-42-2, 33-42-3, and 33-42-1, respectively.

33-42-2. Purpose of chapter.

The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance as defined from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

History. — Code 1981, § 33-42-2, enacted by Ga. L. 1988, p. 1541, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, Code Sections 33-42-1, 33-42-2, and 33-42-3 as enacted by Ga. L. 1988, p. 1541 were redesignated as Code Sections 33-42-2, 33-42-3, and 33-42-1, respectively.

33-42-3. Applicability of chapter.

The requirements of this chapter shall apply to long-term care insurance policies issued, delivered, or issued for delivery in this state. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable provisions of this title insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed, or offered as long-term care insurance need not meet the requirements of this chapter.

History. — Code 1981, § 33-42-3, enacted by Ga. L. 1988, p. 1541, § 1; Ga. L. 2019, p. 533, § 1-3/HB 99.

The 2019 amendment, effective July 1, 2019, in the first sentence, inserted "long-term care insurance" in the middle, and deleted "on or after July 1, 1988" following "state" at the end.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, Code Sections 33-42-1, 33-42-2, and 33-42-3 as enacted by Ga. L. 1988, p. 1541 were redesignated as Code Sections 33-42-2, 33-42-3, and 33-42-1, respectively.

33-42-4. Definitions.

As used in this chapter, the term:

(1) "Applicant" means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(3) "Group long-term care insurance" means a long-term care insurance policy which is issued, delivered, or issued for delivery in this state and issued to:

(A) Any eligible group as defined in Code Section 33-30-1; or

(B) A group other than as described in Code Section 33-30-1, subject to a finding by the Commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(4) "Long-term care insurance" means any accident and sickness insurance policy or rider advertised, marketed, offered, or designed primarily to provide coverage for not less than 12 consecutive benefit months or which provides coverage for recurring confinements separated by a period not to exceed six months with a minimum aggregate period of one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual accident and sickness policies or riders whether issued by insurers, fraternal benefit societies, health care plans, health maintenance organizations, or any other similar organizations. Long-term care insurance shall not include any accident and sickness insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may be provided through an individual or group life insurance policy by attachment of a long-term care rider or by the automatic inclusion of a long-term care provision which, notwithstanding Code Section 33-42-3, must meet the requirements of this chapter and regulations promulgated by the Commissioner. Any such long-term care riders or policy provisions shall not be exempt from filing requirements and must be filed with the department for approval before being used in this state.

(5) "Policy" means any policy, contract, or subscriber agreement or any rider or endorsement attached thereto, issued, delivered, issued for delivery, or renewed in this state by an insurer, fraternal benefit society, health care plan, health maintenance organization, or any other similar organization. Such term shall also include a Georgia Qualified Long-term Care Partnership Program approved policy, as defined in paragraph (4) of Code Section 49-4-161, meeting the requirements of the Georgia Qualified Long-term Care Partnership Program as enacted in subsection (a) of Code Section 49-4-162.

History. — Code 1981, § 33-42-4, enacted by Ga. L. 1988, p. 1541, § 1; Ga. L. 1989, p. 894, § 1; Ga. L. 2007, p. 239, § 1/HB 648; Ga. L. 2017, p. 164, § 53/HB 127; Ga. L. 2019, p. 533, § 1-4/HB 99.

The 2019 amendment, effective July 1, 2019, deleted former paragraph (3), which read: "'Commissioner' means the Commissioner of Insurance of this state."; and redesignated former paragraphs (4)

through (6) as present paragraphs (3) through (5), respectively.

33-42-5. Group policy issued in another state.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in subparagraph (B) of paragraph (3) of Code Section 33-42-4 unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

History. — Code 1981, § 33-42-5, enacted by Ga. L. 1988, p. 1541, § 1; Ga. L. 2019, p. 533, § 1-5/HB 99.

The 2019 amendment, effective July 1, 2019, substituted "paragraph (3)" for "paragraph (4)" in the middle of this Code section.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, the internal reference was changed to "Code Section 33-42-4" and a comma was deleted following "Code Section 33-42-4".

33-42-6. Disclosures; provisions; definition of preexisting condition; loss ratio standards; right to return policy; outline of coverage; certificate.

(a) The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies and for any applicable terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definition of terms.

(b) No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new policy or other form of policy within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide coverage for other levels of care which is unreasonably lower than the coverage provided for skilled nursing care in a facility.

(c)(1) No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in paragraphs (1) and (2) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of "preexisting condition" shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period provided in paragraph (2) of this subsection expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this subsection.

(d)(1) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related condition within a period of less than 30 days after discharge from the institution.

(2) Notwithstanding paragraph (1) of this subsection, no long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this state unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement.

(e) The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the regulation.

(f) Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(g) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall comply with the applicable provisions of Code Section 33-29-13.

(h) A certificate issued pursuant to a group long-term care insurance policy, which policy is issued, delivered, issued for delivery, or renewed in this state, shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement that the group master policy determines governing contractual provisions; and

(4) Such other provisions as the Commissioner may reasonably require.

(i) No policy may be advertised, marketed, or offered as long-term care insurance unless it complies with the provisions of this chapter.

History. — Code 1981, § 33-42-6, enacted by Ga. L. 1988, p. 1541, § 1; Ga. L. 1989, p. 894, § 2.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1988, "or" was substituted for "of" following "examination of the policy" near the end of the last sentence of subsection (f).

33-42-7. Regulations.

Repealed by Ga. L. 2019, p. 533, § 1-6/HB 99, effective July 1, 2019.

Editor's notes. — Ga. L. 2020, p. 493, § 33/SB 429, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted the reservation of this Code section.

CHAPTER 43

MEDICARE SUPPLEMENT INSURANCE

Sec.
33-43-1. Definitions.
33-43-2. Applicability of chapter.
33-43-3. Duplicate benefits prohibited; establishment of standards.
33-43-4. Reasonable return of benefits required; minimum standards for loss ratios.
33-43-5. Outline of coverage; informational brochures; captions or notice requirements; disclosure of information regarding replacement of policies, contracts, or certificates.
33-43-6. Notice of right to return policy and of right to refund.
33-43-7. Review and approval of Medicare supplement advertisements.
33-43-8. Regulations.
33-43-9. Enforcement.

33-43-1. Definitions.

As used in this chapter, the term:

(1) "Applicant" means:

(A) In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(B) In the case of a group medicare supplement policy, the proposed certificate holder.

(1.1) "Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(3.1) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(3.2)(A) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) Part A or Part B of Title XVIII of the Social Security Act (medicare);

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

(v) Chapter 5 of Title 10 of the United States Code (CHAMPUS);

(vi) A medical care program of the Indian Health Service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program);

(ix) A public health plan as defined in federal regulation; or

(x) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).

(B) Creditable coverage shall not include one or more, or any combination of, the following:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in the Code of Federal Regulations as of July 1, 2000, under which benefits for medical care are secondary or incidental to other insurance benefits.

(C) Creditable coverage shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community based care, or any combination thereof; or

(iii) Such other similar, limited benefits as are specified in the Code of Federal Regulations as of July 1, 2000.

(D) Creditable coverage shall not include the following benefits if offered as independent, noncoordinated benefits:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) Creditable coverage shall not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(ii) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; or

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(3.3) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

(3.4) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(5) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Act Amendments of 1965, as then constituted or later amended.

(6) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395, et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g) (1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

(6.1) "Medicare+Choice plan" means a plan of coverage for health benefits under medicare Part C as defined in P.L. 105-33, and includes:

(A) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider sponsored organizations, and preferred provider organization plans;

(B) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(C) Medicare+Choice private fee-for-service plans.

(7) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(8) "Secretary" means the secretary of the United States Department of Health and Human Services.

History. — Code 1981, § 33-43-1, enacted by Ga. L. 1992, p. 1395, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 1996, p. 705, § 17; Ga. L. 2000, p. 1246, § 6.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2000, "July 1, 2000" was substituted for "the effective date of this Act" in divisions (3.2)(B)(viii) and (3.2)(C)(iii).

33-43-2. Applicability of chapter.

(a) Except as otherwise specifically provided, this chapter shall apply to:

(1) All medicare supplement policies delivered or issued for delivery in this state; and

(2) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(b) This chapter shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof of the labor organizations.

(c) Except as provided under subsection (d) of Code Section 33-43-5, the provisions of this chapter shall not be construed to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons, which policies are not marketed or held to be medicare supplement policies or benefit plans.

History. — Code 1981, § 33-43-2, enacted by Ga. L. 1992, p. 1395, § 1; Ga. L. 1996, p. 705, § 18; Ga. L. 2000, p. 1246, § 7; Ga. L. 2019, p. 533, § 1-7/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "on or after July 1, 2000" following "this state" in paragraph (a)(1).

33-43-3. Duplicate benefits prohibited; establishment of standards.

(a) No medicare supplement insurance policy or certificate in force in this state shall contain benefits which duplicate benefits provided by medicare.

(b) Notwithstanding any other provision of Georgia law, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) The Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this chapter, shall apply to medicare supplement policies and certificates. The standards shall cover, but shall not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions, and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definitions of terms.

(d) The Commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates.

(e) The Commissioner may adopt from time to time such reasonable regulations as are necessary to conform medicare supplement policies

and certificates to the requirements of federal law and regulations promulgated thereunder, including, but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms, certificate forms, and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for medicare select policies and certificates.

(f) The Commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

(g) Insurers offering medicare supplement policies in this state to persons 65 years of age or older shall also offer medicare supplement policies to persons in this state who are eligible for and enrolled in medicare by reason of disability or end-stage renal disease. Except as otherwise provided in this Code section, all benefits, protections, policies, and procedures that apply to persons 65 years of age or older shall also apply to persons who are eligible for and enrolled in medicare by reason of disability or end-stage renal disease.

(h) Persons may enroll in a medicare supplement policy at any time authorized or required by the federal government or within six months of:

(1) Enrolling in medicare Part B for an individual who is under 65 years of age and is eligible for medicare because of disability or end-stage renal disease, whichever is later;

(2) Receiving notice that such person has been retroactively enrolled in medicare Part B due to a retroactive eligibility decision made by the Social Security Administration; or

(3) Experiencing a qualifying event identified in regulations adopted pursuant to subsection (c) of this Code section.

(i) No policy or certificate issued pursuant to this chapter shall prohibit payment made by third parties on behalf of individual applicants or individuals within a group applicant so long as:

(1) The third party is an immediate family member of a person lawfully exercising an in-force power of attorney or legal guardianship; or

(2) The third party is a nonprofit, charitable organization that:

(A) Is the named requestor of an advisory opinion issued by the United States Department of Health and Human Services (HHS) Office of Inspector General under the requirements of 42 C.F.R. Part 1008; and

(B) Provides, upon request by the medicare supplement issuer, the specific advisory opinion relied upon by the third party to make such payment and a written certification that the advisory opinion is in full force and effect and has not been rescinded, modified, or terminated by the United States Department of Health and Human Services (HHS) Office of Inspector General.

(j) Premiums for medicare supplemental insurance policies may differ between persons who qualify for medicare who are 65 years of age or older and those who qualify for medicare who are younger than 65 years of age; provided, however, that such differences in premiums shall not be excessive, inadequate, or unfairly discriminatory and shall be based on sound actuarial principles and reasonable in relation to the benefits provided.

History. — Code 1981, § 33-43-3, enacted by Ga. L. 1992, p. 1395, § 1; Ga. L. 1993, p. 91, § 33; Ga. L. 1996, p. 705, § 19; Ga. L. 2010, p. 120, § 1/SB 316; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2019, p. 533, § 1-8/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "or by May 1, 2011," following "Part B" in paragraph (h)(1).

33-43-4. Reasonable return of benefits required; minimum standards for loss ratios.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The Commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

History. — Code 1981, § 33-43-4, enacted by Ga. L. 1992, p. 1395, § 1.

JUDICIAL DECISIONS

Interest assumption. — Insurer was properly required to include an interest assumption in calculating the insurer's loss projections, to support the insurer's application for a rate increase, as that was necessary to return to policyholders reasonable benefits in relation to the premiums charged, and it was not a retroactive law. United Am. Ins. Co. v. Ins. Dep't of Ga., 258 Ga. App. 735, 574 S.E.2d 830 (2002).

33-43-5. Outline of coverage; informational brochures; captions or notice requirements; disclosure of information regarding replacement of policies, contracts, or certificates.

(a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this Code section. For purposes of this Code section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. Such outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the exceptions, reductions, and limitations contained in the policy;

(3) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and

(4) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The Commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the Commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the Commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare, but in no event shall the brochure be provided later than the time of policy delivery.

(d) The Commissioner may prescribe by regulation for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(1) Medicare supplement policies; or

(2) Disability income policies.

(e) The Commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for medicare.

History. — Code 1981, § 33-43-5, enacted by Ga. L. 1992, p. 1395, § 1; Ga. L. 1996, p. 705, § 20.

33-43-6. Notice of right to return policy and of right to refund.

Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this Code section shall be paid directly to the applicant by the issuer in a timely manner.

History. — Code 1981, § 33-43-6, enacted by Ga. L. 1992, p. 1395, § 1.

33-43-7. Review and approval of Medicare supplement advertisements.

Every issuer of medicare supplement insurance in this state shall provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the Commissioner for review and approval by the Commissioner.

History. — Code 1981, § 33-43-7, enacted by Ga. L. 1992, p. 1395, § 1.

33-43-8. Regulations.

Regulations adopted pursuant to this chapter shall be subject to the provisions of this chapter and Code Section 33-2-9.

History. — Code 1981, § 33-43-8, enacted by Ga. L. 1992, p. 1395, § 1.

33-43-9. Enforcement.

In addition to any other applicable penalties for violations of this title, the Commissioner may require issuers violating any provision of this chapter or regulations promulgated pursuant to this chapter to cease marketing any medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require such issuer to take such actions as are necessary to comply with the provisions of this chapter, or both.

History. — Code 1981, § 33-43-9, enacted by Ga. L. 1992, p. 1395, § 1.

CHAPTER 44

HIGH RISK HEALTH INSURANCE PLAN

Sec.
33-44-1 through 33-44-10 [Repealed].

33-44-1 through 33-44-10.

Reserved. Repealed by Ga. L. 2019, p. 533, § 1-9/HB 99, effective July 1, 2019.

Editor's notes. — This chapter consisted of Code Sections 33-44-1 through 33-44-10, relating to high risk health insurance plan, and was based on Code 1981, §§ 33-44-1 through 33-44-10, enacted by Ga. L. 1989, p. 1701, § 1; Ga. L. 1990, p. 8, § 33; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2011, p. 705, § 6-3/HB 214; Ga. L. 2017, p. 164, § 54/HB 127.

Ga. L. 2019, p. 533, § 1-9/HB 99, effective July 1, 2019, repealed the provisions of this chapter concerning the high risk health insurance plan. This chapter never became effective as there was no specific appropriation of funds by the General Assembly necessary to carry out the purposes of the Act in any appropriations Act by the General Assembly at any session of the General Assembly from 1989 through 2018.

CHAPTER 45

CONTINUING CARE PROVIDERS AND FACILITIES

Sec.
33-45-1. Definitions.
33-45-2. Use of powers; providers or facilities charging an entrance fee.
33-45-3. Certificate of authority required for operation of life plan communities.
33-45-4. Administration by Insurance Department.
33-45-5. Application for approval or renewal of certificate of authority.
33-45-6. Annual revised disclosure statement; statement to be made available to all residents of facility; submission of other necessary information as determined by Commissioner.
33-45-7. Requirements for continuing care agreements, addenda, and amendments.
33-45-7.1. Provider authorized to offer continuing care when resident purchases resident owned living unit.
33-45-8. Portion of entrance fee paid by resident to be held in escrow account.
33-45-9. Provisions of this chapter not subject to waiver.
33-45-10. Information disclosure requirements.
33-45-11. Maintaining financial reserves; requirements.
33-45-12. Actions for recovery of damages and attorney's fees.
33-45-13. Penalties for violation of chapter provisions; department authorized to take remedial action, including suspension and revocation of certificate of authority.
33-45-14. Period of applicability of chapter.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, Chapter 45 of Title 33 as enacted by Ga. L. 1990, p. 1088, § 1 was renumbered as Chapter 46 of Title 33 because Ga. L. 1990, p. 1817, § 1 also enacted a Chapter 45 of Title 33.

Administrative rules and regulations. — Long Term Care Insurance, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-16.

Continuing Care Providers and Facilities, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-51.

33-45-1. Definitions.

As used in this chapter, the term:

(1) "Continuing care" means furnishing pursuant to a continuing care agreement:

(A) Lodging that is not:

(i) In a skilled nursing facility, as such term is defined in Code Section 31-6-2;

(ii) An intermediate care facility, as such term is defined in Code Section 31-6-2;

(iii) An assisted living community, as such term is defined in Code Section 31-7-12.2; or

(iv) A personal care home, as such term is defined in Code Section 31-7-12;

(B) Food; and

(C) Nursing care provided in a facility or in another setting designated by the agreement for continuing care to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee including skilled or intermediate nursing services and, at the discretion of the continuing care provider, personal care services including, without limitation, assisted living care services designated by the continuing care agreement, including such services being provided pursuant to a contract to ensure the availability of such services to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

Such term shall not include continuing care at home.

(2) "Continuing care agreement" means a contract or agreement to provide continuing care, continuing care at home, or limited continuing care. Continuing care agreements include agreements to provide care for any duration, including agreements that are terminable by either party.

(3) "Continuing care at home" means the furnishing of services pursuant to a continuing care agreement at a location other than at a facility and which includes the obligation to provide nursing care, assisted living care, or personal care home services. A continuing care at home agreement may, but is not required to, include an obligation to provide food.

(4) "Entrance fee" means an initial or deferred payment of a sum of money or property made as full or partial payment to assure the resident continuing care, limited continuing care, or continuing care upon the purchase of a resident owned living unit; provided, however, that any such initial or deferred payment which is greater than or equal to 12 times the monthly care fee shall be presumed to be an entrance fee so long as such payment is intended to be a full or partial payment to assure the resident lodging in a residential unit. An accommodation fee, admission fee, or other fee of similar form and application greater than or equal to 12 times the monthly care fee shall be considered to be an entrance fee. Such term shall not include any portion of the purchase or sale of a resident owned living unit.

(5) "Facility" means a place which is owned or operated by a provider and provides continuing care or limited continuing care.

Such term includes a facility which contains resident owned living units.

(6) "Licensed" means that the provider has obtained a certificate of authority from the department.

(7) "Life plan community" means a licensed provider furnishing continuing care or limited continuing care which has been issued a certificate of authority pursuant to this chapter.

(8) "Limited continuing care" means furnishing pursuant to a continuing care agreement:

(A) Lodging that is not:

(i) In a skilled nursing facility, as such term is defined in Code Section 31-6-2;

(ii) An intermediate care facility, as such term is defined in Code Section 31-6-2;

(iii) An assisted living community, as such term is defined in Code Section 31-7-12.2; or

(iv) A personal care home, as such term is defined in Code Section 31-7-12;

(B) Food; and

(C) Personal services, whether such personal services are provided in a facility such as a personal care home or an assisted living community or in another setting designated by the continuing care agreement, to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee.

Such term shall not include continuing care at home.

(9) "Monthly care fee" means the fee charged to a resident for continuing care or limited continuing care on a monthly or periodic basis. Monthly care fees may be increased by the provider to provide care to the resident as outlined in the continuing care agreement. Periodic fee payments or other prepayments shall not be monthly care fees.

(10) "Nursing care" means services which are provided to residents of skilled nursing facilities or intermediate care facilities.

(11) "Personal services" means, but is not limited to, such services as individual assistance with eating, bathing, grooming, dressing, ambulation, and housekeeping; supervision of self-administered medication; arrangement for or provision of social and leisure services; arrangement for appropriate medical, dental, nursing, or

mental health services; and other similar services which the department may define. Personal services may be provided at a facility or at a home on or off site of a facility. Personal services shall not be construed to mean the provision of medical, nursing, dental, or mental health services. Personal services provided, if any, shall be designated in the continuing care agreement.

(12) "Provider" means the owner or operator, whether a natural person, partnership, or other unincorporated association, however organized, trust, or corporation, of an institution, building, residence, or other place, whether operated for profit or not, which owner or operator undertakes to provide continuing care, limited continuing care, or continuing care at home for a fixed or variable fee, or for any other remuneration of any type for the period of care, payable in a lump sum or lump sum and monthly maintenance charges or in installments.

(13) "Resident" means a purchaser of or a nominee of or a subscriber to a continuing care agreement. Such an agreement may permit a resident to live at a home on or off site of a facility but shall not be construed to give the resident a part ownership of the facility in which the resident is to reside unless expressly provided for in the agreement.

(14) "Resident owned living unit" means a residence or apartment, the purchase or sale of which is not included in an entrance fee, which is a component part of a facility and in which the resident has an individual real property ownership interest.

(15) "Residential unit" means a residence or apartment in which a resident lives that is not a skilled nursing facility as defined in Code Section 31-6-2, an intermediate care facility as defined in Code Section 31-6-2, an assisted living community as defined in Code Section 31-7-12.2, or a personal care home as defined in Code Section 31-7-12.

History. — Code 1981, § 33-45-1, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2014, p. 375, § 1/SB 304; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2015, p. 581, § 1/SB 111; Ga. L. 2019, p. 945, § 4/HB 300.

The 2019 amendment, effective July 1, 2019, deleted "paragraph (34) of" following "defined in" in division (1)(A)(i), in division (8)(A)(i), and in paragraph (15); deleted "paragraph (22) of" following "defined in" in division (1)(A)(ii), in division (8)(A)(ii), and in paragraph (15); redesignated former paragraphs (2.1) through (5) as present paragraphs (3) through (6), respectively; added paragraph (7); and redesignated former paragraphs (6) through (13) as present paragraphs (8) through (15), respectively.

33-45-2. Use of powers; providers or facilities charging an entrance fee.

(a) For the purpose of enforcing the requirements of this chapter, the Commissioner and the department shall be authorized to use the powers granted in Chapters 1 and 2 of this title.

(b) A provider or facility which charges a resident an entrance fee for lodging in a residential unit and provides limited continuing care shall not call itself nor be considered a provider of continuing care, but such provider or facility shall otherwise be subject to the requirements imposed upon the providers and facilities regulated by this chapter; provided, however, that a facility that has received a certificate of authority and has been in conformance with the provisions of this chapter prior to July 1, 2011, may continue to call and present itself to the public as a provider of continuing care.

History. — Code 1981, § 33-45-2, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166.

33-45-3. Certificate of authority required for operation of life plan communities.

(a) Nothing in this title or chapter shall be deemed to authorize any provider to transact any insurance business other than that of continuing care insurance or limited continuing care insurance or otherwise to engage in any other type of insurance unless it is authorized under a certificate of authority issued by the department under this title. Nothing in this chapter shall be construed so as to interfere with the jurisdiction of the Department of Community Health or any other regulatory body exercising authority over providers regulated by this chapter or real property law related to the purchase and sale of resident owned living units.

(b) Nothing in this chapter shall be construed so as to modify or limit in any way:

(1) Provisions of Article 3 of Chapter 6 of Title 31 and any rules and regulations promulgated by the Department of Community Health pursuant to such article relating to certificates of need for life plan communities or home health agencies, as such terms are defined in Code Section 31-6-2; or

(2) Provisions of Chapter 7 of Title 31 relating to licensure or permit requirements and any rules and regulations promulgated by the Department of Community Health pursuant to such chapter, including, without limitation, licensure or permit requirements for

nursing home care, assisted living care, personal care home services, home health services, and private home care services.

(c) Nothing in this chapter shall be construed so as to allow private home care services to be provided by any person or entity other than a licensed private home care provider.

(d) A provider of continuing care at home may contract with a licensed home health agency to provide home health services to a resident. In order to provide home health services directly, a provider of continuing care at home shall obtain a certificate of need for a home health agency, as such term is defined in Code Section 31-6-2, pursuant to the same criteria and rules as are applicable to freestanding home health agencies that are not components of life plan communities.

History. — Code 1981, § 33-45-3, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 1999, p. 296, § 22; Ga. L. 2000, p. 136, § 33; Ga. L. 2009, p. 453, § 1-43/HB 228; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2014, p. 375, § 2/SB 304; Ga. L. 2015, p. 581, § 2/SB 111; Ga. L. 2019, p. 945, § 5/HB 300.

The 2019 amendment, effective July 1, 2019, substituted "life plan communities" for "continuing care retirement communities" in the middle of paragraph (b)(1); and, in subsection (d), in the second sentence, deleted "paragraph (20) of" following "defined in" in the middle, and substituted "life plan" for "continuing care retirement" near the end.

33-45-4. Administration by Insurance Department.

The administration of this chapter is vested in the department, which shall:

(1) Prepare and furnish all forms necessary under the provisions of this chapter;

(2) Collect in advance, and the applicant shall pay in advance at the time of filing, a fee for an application for a certificate of authority or a renewal of a certificate of authority, both as provided in Code Section 33-8-1, and a late fee to be determined by the department. The department may also levy a fine not to exceed $50.00 a day for each day of noncompliance; and

(3) Adopt rules, within the standards of this chapter, necessary to effect the purposes of this chapter. Specific provisions in this chapter relating to any subject shall not preclude the department from adopting rules concerning such subject if such rules are within the standards and purposes of this chapter.

History. — Code 1981, § 33-45-4, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 1992, p. 2725, § 32; Ga. L. 2005, p. 60, § 33/HB 95; Ga. L. 2011, p. 315, § 1/SB 166.

33-45-5. Application for approval or renewal of certificate of authority.

No person may engage in the business of providing continuing care or limited continuing care or issuing continuing care agreements in this state without a certificate of authority therefor obtained from the department as provided in this chapter. For purposes of this Code section, the term "engage in the business of" shall include the development or construction of a facility subject to regulation under this chapter or the holding of oneself out to the public as a provider. The application for approval or renewal of a certificate of authority shall be on such forms as provided by the department. The department shall issue such certificate of authority if the applicant pays the required fees, and the continuing care agreement for the applicant meets the requirements of Code Section 33-45-7. The department shall renew a certificate of authority if the provider pays the required fees and furnishes the annual disclosure statement required by Code Section 33-45-6 and is otherwise not in violation of this chapter.

History. — Code 1981, § 33-45-5, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942.

33-45-6. Annual revised disclosure statement; statement to be made available to all residents of facility; submission of other necessary information as determined by Commissioner.

(a) Annually, on or before June 1, the provider shall file a revised disclosure statement and such other information and data showing its condition as of the last day of the preceding calendar year or fiscal year of the provider. If the department does not receive the required information on or before June 1, a late fee may be charged. The department may approve an extension of up to 30 days.

(b)(1) The provider shall also make the revised disclosure statement available to all the residents of the facility.

(2) A provider shall also revise its disclosure statement and have the revised disclosure statement recorded at any other time if revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or omitting a material fact required to be stated therein. Only the most recently recorded disclosure statement, with respect to a facility, and in any event, only a disclosure statement dated within one year plus 120 days prior to the due date of the time of renewal of a certificate of authority required by this chapter, shall be considered current.

(c) Notwithstanding the provisions of Code Section 33-45-9, the Commissioner may require a provider to submit such other information as he or she deems necessary to enforce this chapter.

History. — Code 1981, § 33-45-6, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166.

33-45-7. Requirements for continuing care agreements, addenda, and amendments.

(a) In addition to other provisions considered proper to effectuate any continuing care agreement, addendum, or amendment, each such agreement, addendum, or amendment shall be in writing and shall:

(1) Provide for the continuing care or limited continuing care of only one resident, or for two persons occupying space designed for double occupancy under appropriate regulations established by the provider, and shall state the total consideration to be paid, including a list of all properties transferred and their market value at the time of transfer, including donations, subscriptions, fees, and any other amounts paid or payable by, or on behalf of, the resident or residents;

(2) Specify all services which are to be provided by the provider to each resident, including, in detail, all items which each resident will receive, whether the items will be provided for a designated time period or for life, and whether the services will be available on the premises or at another specified location. The provider shall indicate which services or items are included in the monthly care fee and which services or items are made available at or by the facility at extra charge. Such items may include, but are not limited to, food, lodging, personal services or nursing care, drugs, burial, and incidentals;

(3) Describe the terms and conditions under which the continuing care agreement may be canceled by the provider or by a resident and the conditions, if any, under which all or any portion of the entrance fee will be refunded in the event of cancellation of the continuing care agreement by the provider or by the resident, including the effect of death of or any change in the health or financial condition of a person between the date of entering a continuing care agreement and the date of initial occupancy of a residential unit by that person;

(4) Describe:

(A) The residential unit;

(B) Any property rights of the resident;

(C) The health and financial conditions required for a person to be accepted as a resident and to continue as a resident, once

accepted, including the effect of any change in the health or financial condition of a person between the date of entering into a continuing care agreement and the date of taking occupancy in a residential unit;

(D) The conditions under which a residential unit occupied by a resident may be made available by the provider to a different or new resident other than on the death of the prior resident;

(E) The policies to be implemented and the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident; and

(F) The procedures the provider shall follow to change the resident's accommodation if necessary for the protection of the health or safety of the resident or of the general and economic welfare of the facility;

(5) State the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry;

(6) State whether the funds or property transferred for the care of the resident is:

(A) Nonrefundable, in which event the continuing care agreement shall comply with this subparagraph. Such continuing care agreement shall allow a 90 day trial period of residency in the facility during which time the provider, resident, or person who provided the transfer of funds or property for the care of such resident may cancel the agreement after written notice. A refund shall be made of such funds, property, or both within 120 days after the receipt of such notice and shall be calculated on a pro rata basis with the provider retaining no more than 10 percent of the amount of the entry fee. Notwithstanding the provisions of this subparagraph, the provisions of paragraph (7) of this subsection and the provisions of subsections (b) and (e) of this Code section shall apply to nonrefundable continuing care agreements; or

(B) Refundable, in which event the continuing care agreement shall comply with this subparagraph. Such continuing care agreement may be canceled upon the giving of written notice of cancellation of at least 30 days by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident; provided, however, that if a continuing care agreement is canceled because there has been a good faith determination that a resident is a threat to his or her health or safety or to the health or safety of others, only such notice as is reasonable under the

circumstances shall be required. The continuing care agreement shall further provide in clear and understandable language, in print no smaller than the largest type used in the body of the continuing care agreement, the terms governing the refund of any portion of the entrance fee, which terms shall include a provision that all refunds be made within 120 days of notification. The moneys refunded to the resident may be from the escrow account required by Code Section 33-45-8 or from other funds available to the provider, and the continuing care agreement shall further comply with the following requirements:

(i) For a resident whose continuing care agreement with the facility provides that the resident does not receive a transferable membership or ownership right in the facility and who has occupied his or her residential unit, the refund shall be calculated on a pro rata basis with the facility retaining no more than 2 percent per month of occupancy by the resident and no more than a 4 percent fee for processing. Such refund shall be paid no later than 120 days after the giving of notice of intention to cancel; or

(ii) If the continuing care agreement provides for the facility to retain no more than 1 percent per month of occupancy by the resident, it may provide that such refund will be payable upon receipt by the provider of the next entrance fee for any comparable residential unit upon which there is no prior claim by any resident; provided, however, that the agreement may define the term "comparable residential unit upon which there is no prior claim"; specifically delineate when such refund is due; and establish the order of priority of refunds to residents. Unless the provisions of subsection (e) of this Code section apply, for any prospective resident, except when such resident receives a transferable membership or ownership right in a resident owned living unit, who cancels the agreement prior to occupancy of the residential unit, the refund shall be the entire amount paid toward the entrance fee, less a processing fee not to exceed 4 percent of the entire entrance fee, but in no event shall such processing fee exceed the amount paid by the prospective resident. Such refund shall be paid no later than 60 days after the giving of notice of intention to cancel. For a resident who has occupied his or her residential unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions shall not apply but shall be deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider shall not charge any fee for the transfer of membership or sale of an ownership right. Nothing in this paragraph shall be construed to

require a continuing care agreement to provide a refund to more than one resident at a time upon the vacation of a specific comparable residential unit;

(7) State the terms under which a continuing care agreement is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident shall be considered earned and shall become the property of the provider. When the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents shall be included in the continuing care agreement;

(8) Require:

(A) The continuing care agreement to provide for advance notice to the resident, of not less than 60 days, before any change in fees or charges or the scope of care or services may be effective, except for changes required by state or federal assistance programs;

(B) A description of the manner by which the provider may adjust periodic charges or other recurring fees and the limitations on these adjustments, if any; and

(C) A description of any policy regarding fee adjustments if the resident is voluntarily absent from the facility;

(9) Provide that charges for care paid in one lump sum shall not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs; and

(10) Describe the policy of the provider regarding reserve funding.

(b) Notwithstanding the provisions of subparagraph (a)(6)(A) of this Code section, a resident has the right to rescind a continuing care agreement, without penalty or forfeiture, within seven days after executing such continuing care agreement. During the seven-day period, the resident's funds shall be retained in an escrow account in accordance with the provisions of subsection (a) of Code Section 33-45-8. A resident shall not be required to move into the facility designated in the continuing care agreement before the expiration of the seven-day period. In the event that the prospective resident exercises his or her right to rescind the continuing care agreement within seven days of executing such continuing care agreement, the facility shall return any portion of the entrance fee paid by the resident within 30 days of receipt of the prospective resident's notice of rescission.

(c) The continuing care agreement shall include or shall be accompanied by a statement, printed in boldface type, which reads: "This facility and all continuing care agreements in this state are regulated

by Chapter 45 of Title 33 of the Official Code of Georgia Annotated. A copy of the law is on file in this facility. The law gives you or your legal representative the right to inspect our most recent disclosure statement before signing the agreement."

(d) Before the transfer of any money or other property, other than an application fee which shall not exceed $1,500.00, to a provider by or on behalf of a prospective resident, the provider shall present a typewritten or printed copy of the continuing care agreement and the disclosure statement required pursuant to Code Section 33-45-10 to the prospective resident and all other parties to the agreement. The provider shall secure a signed, dated statement from each party to the contract certifying that a copy of the continuing care agreement and the disclosure statement was received.

(e) If a resident dies before occupying the facility or, through illness, injury, or incapacity, is precluded from becoming a resident under the terms of the continuing care agreement, the agreement shall be automatically canceled, and the resident or his or her legal representative shall receive a full refund of all moneys paid to the facility, except those costs specifically incurred by the facility at the request of the resident and set forth in writing in a separate addendum, signed by both parties, to the agreement.

(f) In order to comply with this Code section, a provider may furnish information not contained in the continuing care agreement through an addendum.

(g) The Commissioner may also require the provider to submit to him or her a copy of the continuing care agreement generally used by the provider; provided, however, that nothing in this subsection shall prohibit the department from requiring the submission of an individual contract between the provider and the resident.

History. — Code 1981, § 33-45-7, enacted by Ga. L. 1990, p. 1817, § 1; Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942; Ga. L. 2014, p. 375, § 3/SB 304.

33-45-7.1. Provider authorized to offer continuing care when resident purchases resident owned living unit.

A provider which has obtained a certificate of authority pursuant to Code Section 33-45-5 and the written approval of the Commissioner is authorized to offer, as a part of the continuing care agreement, continuing care at home or continuing care in which the resident purchases a resident owned living unit, subject to the provisions of Chapters 6 and 7 of Title 31 and rules and regulations promulgated by the Department of Community Health pursuant to such chapters relating to certificate of need and licensure requirements.

History. — Code 1981, § 33-45-7.1, enacted by Ga. L. 2014, p. 375, § 4/SB 304; Ga. L. 2015, p. 581, § 3/SB 111; Ga. L. 2019, p. 533, § 1-10/HB 99.

The 2019 amendment, effective July 1, 2019, substituted "Commissioner" for "commissioner" near the middle of this Code section.

33-45-8. Portion of entrance fee paid by resident to be held in escrow account.

(a) Any portion of the entrance fee paid by a resident to the provider shall be held in an escrow account. The escrow agreement shall state that its purpose is to protect the resident or the prospective resident. Escrow funds may be released to the resident, prospective resident, or provider in accordance with the provisions of this Code section.

(b) Entrance fees placed in escrow may be released in accordance with the provisions of this subsection as follows:

(1) Escrow funds may be released to the resident during or following the seven-day right of rescission period required in subsection (b) of Code Section 33-45-7. Such release shall be in accordance with the provisions of that Code section;

(2) When a continuing care agreement between a resident and provider is nonrefundable, escrow funds or a portion thereof may be released to the resident if the resident exercises his or her right to receive a refund as provided in subparagraph (a)(6)(A) of Code Section 33-45-7. The amount and timing of the release of funds to the resident shall be in compliance with the provisions of that subparagraph;

(3) When the continuing care agreement between a provider and resident or prospective resident is refundable, escrow funds may be released by the provider to such resident or prospective resident. The amount and timing of the release of funds to the resident shall be in compliance with the provisions of subparagraph (a)(6)(B) of Code Section 33-45-7;

(4) For a facility under construction or in development, escrow funds may be released to the provider when:

(A) The provider has presold at least 50 percent of the residential units, having received a minimum 10 percent deposit on each of the presold residential units;

(B) The provider has received a commitment for any first mortgage loan or other financing, and any conditions of the commitment prior to disbursement of funds thereunder have been substantially satisfied; and

(C) Aggregate entrance fees received or receivable by the provider pursuant to binding continuing care agreements, plus the

anticipated proceeds of any first mortgage loan or other financing commitment, are equal to not less than 90 percent of the aggregate cost of constructing or purchasing, equipping, and furnishing the facility, and not less than 90 percent of the funds estimated in the statement of cash flows submitted by the provider as that part of the disclosure statement required by this chapter, to be necessary to fund start-up losses and assure full performance of the obligations of the provider pursuant to continuing care contracts shall be on hand;

(5) At the time a new project is financed or after the opening of a facility by a provider, escrow funds may be released to the provider, so long as the provider is in compliance with the financial reserves required by Code Section 33-45-11 and sufficient funds are maintained in escrow to meet the provider's obligations under subparagraphs (1) and (2) of this subsection; or

(6) Escrow funds may be released to the provider under terms submitted to and approved by the Commissioner.

History. — Code 1981, § 33-45-8, enacted by Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2012, p. 775, § 33/HB 942.

Editor's notes. — Ga. L. 2011, p. 315, § 1/SB 166, effective July 1, 2011, redesignated former Code Section 33-45-8 as present Code Section 33-45-9.

33-45-9. Provisions of this chapter not subject to waiver.

No act, agreement, or statement of any resident, or of an individual purchasing continuing care or limited continuing care for a resident, under any continuing care agreement to furnish care to the resident shall constitute a valid waiver of any provision of this chapter intended for the benefit or protection of the resident or the individual purchasing care for the resident; provided, however, that nothing in this Code section shall be construed to prohibit a continuing care agreement from providing for a resident or prospective resident to agree to arbitration prior to bringing any action pursuant to Code Section 33-45-12.

History. — Code 1981, § 33-45-8, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-9, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.

Editor's notes. — Ga. L. 2011, p. 315, § 1/SB 166, effective July 1, 2011, redesignated former Code Section 33-45-9 as present Code Section 33-45-10.

33-45-10. Information disclosure requirements.

(a) Each facility shall maintain as public information, available upon request, a copy of its current disclosure statement and the disclosure and all previous disclosure statements that have been filed with the department. Each facility shall post in a prominent position in the facility, so as to be accessible to all residents and to the general public,

a notice explaining where such disclosure statements may be viewed. In conjunction with the disclosure statement, the facility shall notify residents of any proposed changes in policies, programs, and services.

(b) Each facility shall post in a prominent position in the facility so as to be accessible to all residents and to the general public a brief summary of the disclosure statement required pursuant to subsection (a) of this Code section, indicating in the summary where the full disclosure statement may be inspected in the facility. A listing of any proposed changes in policies, programs, and services shall also be posted.

(c) Before entering into a continuing care agreement to furnish continuing care or at the time of, or prior to, the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever occurs first, the provider undertaking to furnish the care, or the agent of the provider, shall provide the current disclosure statement required pursuant to subsection (a) of this Code section and copies to the prospective resident, or his or her legal representative, of the continuing care agreement.

(d) The text of the disclosure statement required by this Code section shall contain at least:

(1) The name and business address of the provider and a statement as to whether the provider is a partnership, corporation, or other type of legal entity;

(2) The names and business addresses and description of the business experience of the person, if any, in the operation or management of similar facilities of the officers, directors, trustees, managing or general partners, any person having a 10 percent or greater equity or beneficial interest in the provider, and any person who will be managing the facility on a day to day basis and a description of these persons' interests in or occupations with the provider;

(3) Information on all persons named in response to paragraph (2) of this subsection which details:

(A) Any conflict or potential conflict of interest; and

(B) Any relevant criminal record, including a plea of nolo contendere, background on relevant civil judicial proceedings, and relevant action brought by a governmental agency or department, if the order or action arose out of or related to business activity of health care;

(4) A statement as to whether the provider is or is not affiliated with a religious, charitable, or other nonprofit organization; the extent of the affiliation, if any; the extent to which the affiliate

organization will be responsible for the financial and contract obligations of the provider; and the provision of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax;

(5) An estimate of the number of residents of the facility to be provided services;

(6) The location and description of the physical property or properties of the facility, existing or proposed, and to the extent proposed, the estimated completion date or dates, whether construction has begun, and the contingencies subject to which construction may be deferred;

(7) The location of other facilities, if any, which the provider owns or operates;

(8) A statement that the provider maintains financial reserves in conformance with the requirements of Code Section 33-45-11 or otherwise meets the requirements of that Code section; the provisions that the provider has made or will make to provide reserve funding or security to enable the provider to perform its obligations fully under continuing care agreements to provide continuing care or limited continuing care at the facility, including the establishment of escrow accounts, trusts, or reserve funds, together with the manner in which these funds will be invested; and the names and experience of any individuals in the direct employment of the provider who will make the investment decisions;

(9) A financial statement audited by an independent certified public accountant which shall provide the information required by this Code section for two or more fiscal years if the facility has been in existence that long. If the facility has been in existence for a lesser length of time, the financial statements of the provider shall be for the most recent fiscal year or such shorter period of time as the provider shall have been in existence. If the provider's fiscal year ended more than 120 days prior to the date the disclosure statement is recorded, interim financial statements as of a date not more than 90 days prior to the date of recording the statement shall also be included but need not be certified to by an independent certified public accountant. The financial statement shall contain the following:

(A) An accountant's opinion and, in accordance with generally accepted accounting principles:

(i) A balance sheet;

(ii) A statement of income and expenses;

(iii) A statement of equity or fund balances; and

(iv) A statement of changes in financial position; and

(B) Notes to the financial statements considered customary or necessary for full disclosure or adequate understanding of the financial statements, financial condition, and operation and additional costs to the resident;

(10) The level of participation in medicare or Medicaid programs, or both; and

(11) A statement concerning all fees required of residents, including, but not limited to:

(A) A statement of the entrance fee charged, the monthly service charges, the proposed application of the proceeds of the entrance fee by the provider, and the plan by which the amount of the entrance fee is determined if the entrance fee is not the same in all cases; and

(B) A record of past increases in entrance fees and monthly care fees and other similar charges during the previous three years;

(12) If a facility is in a stage of being proposed or developed, it shall additionally provide:

(A) The summary of the report of an actuary estimating the capacity of the provider to meet its contractual obligation to the residents; and

(B) A statement of cash flows and narrative disclosure detailing all significant assumptions used in the preparation of the statement of cash flows. The Commissioner may establish by rule or regulation the necessary and significant assumptions used in the preparation of the statements of cash flow; and

(13) Any additional costs to the resident.

(e) The cover page of the disclosure statement shall state, in a prominent location and in boldface type, the date of the disclosure statement, the last date through which the disclosure statement may be delivered if not earlier revised, and that the delivery of the disclosure statement to a contracting party before the execution of a continuing care agreement is required by this chapter, but that the disclosure statement has not been reviewed or approved by any government agency or representative to ensure accuracy or completeness of the information set out.

(f) A copy of the continuing care agreement generally used by the provider shall be attached to each disclosure statement.

(g) The Commissioner may prescribe a standardized format for the disclosure statement required by this Code section.

(h) The department may require a provider to alter or amend its disclosure statement in order to provide full and fair disclosure to prospective residents. The department may also require the revision of a disclosure statement which it finds to be unnecessarily complex, confusing, or illegible.

History. — Code 1981, § 33-45-9, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-10, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2014, p. 375, § 5/SB 304; Ga. L. 2017, p. 774, § 33/HB 323.

Editor's notes. — Ga. L. 2011, p. 315, § 1/SB 166, effective July 1, 2011, redesignated former Code Section 33-45-10 as present Code Section 33-45-13.

33-45-11. Maintaining financial reserves; requirements.

(a) A provider or facility shall maintain financial reserves equal to 25 percent of the total operating costs of the facility projected for the 12 month period following the period covered by the most recent audited financial statements included in the disclosure statement required by Code Section 33-45-10. In addition to total operating expenses, total operating costs shall include debt service, consisting of principal and interest payments, along with taxes and insurance on any mortgage loan or other financing, but shall exclude depreciation, amortized expenses, and extraordinary items as approved by the Commissioner. If the debt service portion is accounted for by way of another reserve account, the debt service portion may be excluded.

(b) A provider or facility which has opened but not yet achieved full occupancy, as defined by its lender or financing documents, if any, or 95 percent occupancy of its residential units; or a provider or facility that has received a certificate of authority and has been in conformance with the provisions of this chapter shall be required to achieve the level of financial reserves required by subsection (a) of this Code section as follows:

(1) The provider or facility shall submit a plan to the Commissioner the terms of which assure that the provider or facility shall maintain sufficient progress to achieving the level of financial reserves required by this Code section; and

(2) The plan demonstrates that the provider or facility is substantially likely to achieve the required level of financial reserves within five years of opening. For purposes of this paragraph, the term "substantially likely" means a provider or facility shall meet the level of financial reserves required by subsection (a) of this Code section at a minimum rate of 20 percent per year as of the end of each fiscal year

after the date the facility opens, up to a total of 100 percent as of the end of the fifth fiscal year.

(c) The financial reserves required by this Code section may be funded by cash, by invested cash, or by investment grade securities, including bonds, stocks, United States Treasury obligations, obligations of United States government agencies, any reserves required by lenders or established by the facility, or any other financial resources approved by the Commissioner that can be used by the facility to meet its operating reserve.

(d) The provider or facility shall notify the Commissioner as soon as the provider or facility has knowledge of the need to expend any funds which reduce the balance in the financial reserves to an amount less than the amount required by this Code section. Such notice shall be made within at least 30 business days of the provider or facility having such knowledge. If the provider or facility does not have such knowledge within 30 business days, the provider or facility shall notify the Commissioner as soon as possible, but not more than 30 business days after the expenditure of such funds. In the event that the amount in the reserves falls to an amount less than the amount required by this Code section, the Commissioner:

(1) Shall require that the provider or facility submit a corrective action plan to be approved by the department such that the Commissioner finds that the provider or facility can be reasonably expected to be able to reinstate the level of financial reserves required by this Code section within sufficient time to ensure that the contractual liabilities of the provider and the best interests of the residents of the facility will be adequately protected; and

(2) May require the provider or facility to make additional financial arrangements to ensure that the contractual liabilities of the provider and the best interests of the residents of the facility are adequately protected. Such arrangements may include:

(A) The posting of a security bond;

(B) Requiring that the proceeds from any entrance fees from new residents be placed in escrow. Any requirement to escrow funds shall not be applied to funds which are subject to prior claims by a resident of the facility;

(C) Any other security which the Commissioner determines provides adequate assurance that the provider or facility will be able to fulfill its obligations to its residents to the same extent as it would be if the financial reserves were funded at the amount required by this Code section; or

(D) Requiring the provider or facility to work with lenders to refinance or reevaluate the current debt of the provider or facility.

(e) Upon written application by a provider, the Commissioner may authorize a facility to maintain financial reserves in an amount less than the amount set forth in this Code section, or at a lesser rate than the minimum rate of 20 percent per year as of the end of each fiscal year set forth in paragraph (2) of subsection (b) of this Code section, if the Commissioner determines that the contractual liabilities of the provider and the best interests of the residents of the facility may be adequately protected by the financial reserves in a lesser amount or by achieving the required financial reserves at a lesser rate than 20 percent per year.

History. — Code 1981, § 33-45-11, enacted by Ga. L. 2011, p. 315, § 1/SB 166; Ga. L. 2019, p. 533, § 1-11/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "prior to July 1, 2011," following "provisions of this chapter" in the middle of the introductory paragraph of subsection (b); in paragraph (b)(2), deleted "or for existing facilities that received a certificate of authority and have been in conformance with the provisions of this chapter prior to July 1, 2011, within five years of July 1, 2011" at the end of the first sentence, in the second sentence, substituted "required by subsection (a) of this Code section" for "required by paragraph (1) of this subsection" in the middle, deleted "the later of" following "year after", and deleted "or July 1, 2011" following "facility opens" near the end.

Editor's notes. — Ga. L. 2011, p. 315, § 1/SB 166, effective July 1, 2011, redesignated former Code Section 33-45-11 as present Code Section 33-45-12.

33-45-12. Actions for recovery of damages and attorney's fees.

Any resident injured by a violation of this chapter may bring an action for the recovery of damages plus reasonable attorney's fees.

History. — Code 1981, § 33-45-11, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-12, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.

Editor's notes. — Ga. L. 2011, p. 315, § 1/SB 166, effective July 1, 2011, redesignated former Code Section 33-45-12 as present Code Section 33-45-14.

33-45-13. Penalties for violation of chapter provisions; department authorized to take remedial action, including suspension and revocation of certificate of authority.

(a) Any person who knowingly maintains, enters into, performs, or, as manager or officer or in any other administrative capacity, assists in entering into, maintaining, or performing any continuing care agreement subject to this chapter without a valid certificate of authority or renewal thereof, as contemplated by or provided in this chapter, or who otherwise violates any provision of this chapter, is guilty of a misdemeanor. Each violation of this chapter constitutes a separate offense.

(b) In addition to the powers granted pursuant to Chapters 1 and 2 of this title, the department may bring an action to enjoin a violation, threatened violation, or continued violation of this chapter in the

superior court of the county in which the violation occurred, is occurring, or is about to occur.

(c) If, after a period of 180 days, or such additional time as the department shall deem appropriate, the corrective action plan required by paragraph (1) of subsection (d) of Code Section 33-45-11 has been submitted and approved by the department and the department deems the facility or provider to be unable to achieve the necessary financial reserves or is not making substantial progress toward achieving the required financial reserves, the department shall be authorized to take immediate action against the facility or provider's certificate of authority, including suspension or revocation of the certificate of authority; provided, however, that before the Commissioner suspends or revokes a certificate of authority, the Commissioner shall conduct a hearing in accordance with Chapter 2 of this title.

(d) Any action brought by the department against a provider shall not abate by reason of a sale or other transfer of ownership of the facility used to provide care, which provider is a party to the action, except with the express written consent of the Commissioner.

History. — Code 1981, § 33-45-10, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-13, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.

33-45-14. Period of applicability of chapter.

Any contract or continuing care agreement executed before July 1, 1991, which is amended or renewed subsequent to July 1, 1991, and any contract or continuing care agreement executed on or after July 1, 1991, shall be subject to this chapter.

History. — Code 1981, § 33-45-12, enacted by Ga. L. 1990, p. 1817, § 1; Code 1981, § 33-45-14, as redesignated by Ga. L. 2011, p. 315, § 1/SB 166.

CHAPTER 46

CERTIFICATION OF PRIVATE REVIEW AGENTS

Sec.
33-46-1. Legislative purposes and intent.
33-46-2. Definitions.
33-46-3. Certification of private review agents; exemption.
33-46-4. Requirements for certification.
33-46-5. Certificate application fees; information to be submitted with application.
33-46-6. Expiration and renewal of certificate.
33-46-7. Jurisdiction of Commissioner over private review agents.
33-46-8. Applicability of Chapter 39 of Title 33.
33-46-9. Listings of certificate holders.
33-46-10. Reporting requirements.
33-46-11. Adoption of rules and regulations.
33-46-12. Exemptions from certificate requirements.
33-46-13. Exemptions from applicability of chapter.
33-46-14. Commissioner to issue annual report.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, Chapter 45 of Title 33, as enacted by Ga. L. 1990, p. 1088, § 1 was renumbered as this chapter because Ga. L. 1990, p. 1817, § 1 also enacted a Chapter 45 of Title 33.

33-46-1. Legislative purposes and intent.

(a) The purpose of this chapter is to promote the delivery of quality health care in Georgia. Furthermore, it is to foster the delivery of such care in a cost-effective manner through greater coordination between health care providers, claims administrators, payors, employers, patients, and private review agents; to improve communication and knowledge of health care benefits among all parties; to protect patients, claims administrators, payors, private review agents, employers, and health care providers by ensuring that utilization review activities are based upon accepted standards of treatment and patient care; to ensure that such treatment is accessible and done in a timely and effective manner; and to ensure that private review agents maintain confidentiality of information obtained in the course of utilization review.

(b) In order to carry out the intent and purposes of this chapter, it is declared to be the policy of this chapter to protect Georgia residents by imposing minimum standards on private review agents who engage in utilization review with respect to health care services provided in Georgia, such standards to include regulations concerning certification of private review agents, disclosure of utilization review standards and appeal procedures, minimum qualifications for utilization review personnel, minimum standards governing accessibility of utilization review, and such other standards, requirements, and rules or regulations promulgated by the Commissioner which are not inconsistent with the

foregoing. Notwithstanding the foregoing, it is neither the policy nor the intent of the General Assembly to regulate the terms of self-insured employee welfare benefit plans as defined in Section 31(I) of the Employee Retirement Income Security Act of 1974, as amended, and therefore any regulations promulgated pursuant to this chapter shall relate only to persons subject to this chapter.

History. — Code 1981, § 33-46-1, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 1996, p. 6, § 33.

33-46-2. Definitions.

As used in this chapter, the term:

(1) "Certificate" means a certificate of registration granted by the Commissioner to a private review agent.

(2) "Claim administrator" means any entity that reviews and determines whether to pay claims to enrollees of health care providers on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions including medical necessity and other factors. Claim administrators may be payors or their designated review organization, self-insured employers, management firms, third-party administrators, or other private contractors.

(3) "Commissioner" means the Commissioner of Insurance.

(4) "Enrollee" means the individual who has elected to contract for or participate in a health benefit plan for himself or himself and his eligible dependents.

(5) "Health benefit plan" means a plan of benefits that defines the coverage provisions for health care for enrollees offered or provided by any organization, public or private.

(6) "Health care advisor" means a health care provider licensed in a state representing the claim administrator or private review agent who provides advice on issues of medical necessity or other patient care issues.

(7) "Health care provider" means any person, corporation, facility, or institution licensed by this state or any other state to provide or otherwise lawfully providing health care services, including but not limited to a doctor of medicine, doctor of osteopathy, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, occupational therapist, professional counselor, pharmacist, chiropractor, marriage and family therapist, or social worker.

(8) "Payor" means any insurer, as defined in this title, or any preferred provider organization, health maintenance organization, self-insurance plan, or other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health care benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract of accident and sickness insurance as defined in Code Section 33-7-2.

(9) "Private review agent" means any person or entity which performs utilization review for:

(A) An employer with employees who are treated by a health care provider in this state;

(B) A payor; or

(C) A claim administrator.

(10) "Reasonable target review period" means the assignment of a proposed number of days for review for the proposed health care services based upon reasonable length of stay standards such as the Professional Activities Study of the Commission on the Professional and Hospital Activities or other Georgia state-specific length of stay data.

(11) "Utilization review" means a system for reviewing the appropriate and efficient allocation or charges of hospital, outpatient, medical, or other health care services given or proposed to be given to a patient or group of patients for the purpose of advising the claim administrator who determines whether such services or the charges therefor should be covered, provided, or reimbursed by a payor according to the benefits plan. Utilization review shall not include the review or adjustment of claims or the payment of benefits arising under liability, workers' compensation, or malpractice insurance policies as defined in Code Section 33-7-3.

(12) "Utilization review plan" means a reasonable description of the standards, criteria, policies, procedures, reasonable target review periods, and reconsideration and appeal mechanisms governing utilization review activities performed by a private review agent.

History. — Code 1981, § 33-46-2, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-3. Certification of private review agents; exemption.

(a) A private review agent may not conduct utilization review of health care provided in this state unless the Commissioner has granted the private review agent a certificate pursuant to this chapter. No individual conducting utilization review shall require certification if

such utilization review is performed within the scope of such person's employment with an entity already certified pursuant to this Code section.

(b) The Commissioner shall issue a certificate to an applicant that has met all the requirements of this chapter and all applicable regulations of the Commissioner.

(c) A certificate issued under this chapter is not transferable without the prior approval of the Commissioner.

History. — Code 1981, § 33-46-3, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-4. Requirements for certification.

As a condition of certification or renewal thereof, a private review agent shall be required to maintain compliance with the following:

(1) The medical protocols including reconsideration and appeal processes as well as other relevant medical issues used in the private review program shall be established with input from health care providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency and shall be made available upon request of health care providers; or protocols, including reconsideration and appeal processes as well as other relevant health care issues used in the private review program, shall be established based on input from persons who are licensed in the appropriate health care provider's specialty recognized by a licensure agency of such a health care provider;

(2) All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating health care provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented;

(3) In the absence of any contractual agreement between the health care provider and the payor, the responsibility for obtaining precertification as well as concurrent review required by the payor shall be the responsibility of the enrollee;

(4) In cases where a private review agent is responsible for utilization review for a payor or claim administrator, the utilization review agent should respond promptly and efficiently to all requests including concurrent review in a timely method and a method for an expedited authorization process shall be available in the interest of efficient patient care;

(5) In any instances where the utilization review agent is questioning the medical necessity or appropriateness of care, the attend-

ing health care provider shall be able to discuss the plan of treatment with an identified health care provider trained in a related specialty and no adverse determination shall be made by the utilization review agent until an effort has been made to discuss the patient's care with the patient's attending provider during normal working hours. In the event of an adverse determination, notice to the provider and patient will specify the reasons for the review determination;

(6) To the extent that utilization review programs are administered according to recognized standards and procedures, efficiently with minimal disruption to the provision of medical care, additional payment to providers should not be necessary;

(7) A private review agent shall assign a reasonable target review period for each admission promptly upon notification by the health care provider. Once a target length of stay has been agreed upon with the health care provider, the utilization review agent will not attempt to contact the health care provider or patient for further information until the end of that target review period except for discharge planning purposes or in response to a contact by a patient or health care provider. The provider or the health care facility will be responsible for alerting the utilization review agent in the event of a change in proposed treatment. At the end of the target period, the private review agent will review the care for a continued stay;

(8) A private review agent shall not enter into any incentive payment provision contained in a contract or agreement with a payor which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings; and

(9) Any health care provider may designate one or more individuals to be contacted by the private review agent for information or data. In the event of any such designation, the private review agent shall not contact other employees or personnel of the health care provider except with prior consent to the health care provider. An alternate will be available during normal business hours if the designated individual is absent or unavailable.

History. — Code 1981, § 33-46-4, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-5. Certificate application fees; information to be submitted with application.

(a) An applicant for a certificate shall submit an application on a form prescribed by the Commissioner and pay an application fee and a certificate fee as provided in Code Section 33-8-1. The application shall be signed and verified by the applicant.

(b) In conjunction with the application, the private review agent shall submit such information that the Commissioner requires, including but not limited to:

(1) A utilization review plan;

(2) The type and qualifications of the personnel either employed or under contract to perform the utilization review; and

(3) A copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan.

The information provided must demonstrate to the satisfaction of the Commissioner that the private review agent will comply with the requirements of this chapter.

History. — Code 1981, § 33-46-5, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 1992, p. 2725, § 33.

33-46-6. Expiration and renewal of certificate.

(a) A certificate shall expire on the second anniversary of its effective date unless the certificate is renewed for a two-year term as provided in this Code section.

(b) Before the certificate expires but no sooner than 90 days prior to such expiration, a certificate may be renewed for an additional two-year term if the applicant:

(1) Otherwise is entitled to the certificate;

(2) Pays to the Commissioner the renewal fee as provided in Code Section 33-8-1;

(3) Submits to the Commissioner:

(A) A renewal application on the form that the Commissioner requires; and

(B) Satisfactory evidence of compliance with any requirements established by the Commissioner for certificate renewal; and

(4)(A) Establishes and maintains a complaint system which has been approved by the Commissioner and which provides reasonable procedures for the resolution of written complaints initiated by enrollees or health care providers concerning utilization review;

(B) Maintains records of such written complaints for five years from the time the complaints are filed and submits to the Commissioner a summary report at such times and in such format as the Commissioner may require; and

(C) Permits the Commissioner to examine the complaints at any time.

History. — Code 1981, § 33-46-6, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 1992, p. 2725, § 34.

33-46-7. Jurisdiction of Commissioner over private review agents.

Private review agents shall be subject to the jurisdiction of the Commissioner in all matters regulated by this chapter and the Commissioner shall have such powers and authority with regard to private review agents as provided in Code Sections 33-2-9 through 33-2-28 with regard to insurers.

History. — Code 1981, § 33-46-7, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-8. Applicability of Chapter 39 of Title 33.

Private review agents shall be subject to the provisions of Chapter 39 of this title.

History. — Code 1981, § 33-46-8, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-9. Listings of certificate holders.

The Commissioner shall periodically, not less than once a year, provide a list of private review agents issued certificates and the renewal date for those certificates to all hospitals and to any other individual or organization requesting such list.

History. — Code 1981, § 33-46-9, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-10. Reporting requirements.

The Commissioner shall establish such reporting requirements upon private review agents as are necessary to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable rules and regulations.

History. — Code 1981, § 33-46-10, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-11. Adoption of rules and regulations.

The Commissioner shall adopt rules and regulations to implement the provisions of this chapter.

History. — Code 1981, § 33-46-11, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-12. Exemptions from certificate requirements.

No certificate is required for utilization review by any Georgia licensed pharmacist or pharmacy while engaged in the practice of pharmacy, including but not limited to review of the dispensing of drugs, participation in drug utilization review, and monitoring patient drug therapy.

History. — Code 1981, § 33-46-12, enacted by Ga. L. 1990, p. 1088, § 1.

33-46-13. Exemptions from applicability of chapter.

(a) This chapter shall not apply to any contract with the federal government for utilization and review of patients eligible for hospital services under Title XVIII or XIX of the Social Security Act.

(b) This chapter shall not apply to any private review agent when such private review agent is working under contract, or an extension or renewal thereof, with a licensed insurer operating under an agreement, providing administrative services pursuant to the provisions of subsection (b) of Code Section 33-20-17 to a health care benefit plan negotiated through collective bargaining as that term is defined in the federal National Labor Relations Act, as amended, if the original agreement was executed and in effect prior to January 1, 1990.

(c) This chapter shall not apply to audits of the medical record for the purposes of verifying that health care services were ordered and delivered.

History. — Code 1981, § 33-46-13, enacted by Ga. L. 1990, p. 1088, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1990, "Title" was substituted for "Titles" in subsection (a).

33-46-14. Commissioner to issue annual report.

The Commissioner shall issue an annual report to the Governor and the General Assembly concerning the conduct of utilization review in this state. Such report shall include a description of utilization review programs and the services they provide, an analysis of complaints filed against private review agents by patients or providers, and an evalua-

tion of the impact of utilization review programs on patient access to care. The Commissioner shall not be required to distribute copies of the annual report to the members of the General Assembly but shall notify the members of the availability of the report in the manner which he or she deems to be most effective and efficient.

History. — Code 1981, § 33-46-14, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 2005, p. 1036, § 26/SB 49.

CHAPTER 47

MANAGING GENERAL AGENTS

Sec.
33-47-1. Short title.
33-47-2. Definitions.
33-47-3. License required; surety bond; errors and omissions policy.
33-47-4. Written contract with insurer required; contents.
33-47-4.1. Fully earned policy fees.
33-47-5. Insurer's oversight responsibilities; notice to Commissioner of relationship with managing general agent; conflict of interest.
33-47-6. Principal and agent relationship created.
33-47-7. Violation of chapter; penalties.

Code Commission notes. — Ga. L. 1991, p. 1021; Ga. L. 1991, p. 1424; and Ga. L. 1991, p. 1606 all enacted a Chapter 47 of Title 33. Pursuant to Code Section 28-9-5, the chapter added by Ga. L. 1991, p. 1021, has been redesignated as Chapter 50 and the chapter added by Ga. L. 1991, p. 1606, has been redesignated as Chapter 51 (which was subsequently repealed by Ga. L. 2008, p. 292).

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 (d) of Ga. L. 1991, p. 1424, § 9, referenced the section which enacted this chapter and provides: "Section 6 of this Act shall become effective on July 1, 1991; provided, however, that persons required to be licensed under Section 6 shall have until January 1, 1992, to procure such license."

Law reviews. — For note on 1991 enactment of this chapter, see 8 Ga. St. U.L. Rev. 89 (1992).

RESEARCH REFERENCES

Am. Jur. 2d. — 43 Am. Jur. 2d, Insurance, § 109 et seq.

C.J.S. — 44 C.J.S., Insurance, § 148 et seq.

33-47-1. Short title.

This chapter shall be known and may be cited as the "Managing General Agents Act."

History. — Code 1981, § 33-47-1, enacted by Ga. L. 1991, p. 1424, § 8.

33-47-2. Definitions.

As used in this chapter, the term:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(2) "Insurer" means an insurer as defined in Code Section 33-1-2.

(3)(A) "Managing general agent" means any person, firm, association, or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department, or underwriting office and acts as an agent for such insurer whether known as a managing general agent, general agent, manager, or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than 5 percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following:

(i) Adjusts or pays claims in excess of an amount determined by the Commissioner; or

(ii) Negotiates reinsurance on behalf of the insurer.

(B) Notwithstanding the provisions of subparagraph (A) of this paragraph, the following persons shall not be considered as managing general agents for the purposes of this chapter:

(i) An employee of the insurer;

(ii) A United States manager of the United States branch of an alien insurer; or

(iii) An underwriting manager which provides underwriting services only, pursuant to contract, manages any of the insurance underwriting operations of the insurer, is under common control with the insurer, subject to Chapter 13 of this title, and whose compensation is not based on the volume of premiums written.

(4) "Producer" means an agent or subagent as defined in Chapter 23 of this title.

(5) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

History. — Code 1981, § 33-47-2, enacted by Ga. L. 1991, p. 1424, § 8; Ga. L. 1992, p. 2877, § 10.

33-47-3. License required; surety bond; errors and omissions policy.

(a) No person, firm, association, or corporation shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed producer in this state.

(b) No person, firm, association, or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as a producer in this state pursuant to the provisions of this chapter.

(c) The Commissioner may require the managing general agent to maintain a surety bond in an amount acceptable to him for the protection of the insurer. The Commissioner may require the managing general agent to maintain an errors and omissions policy.

History. — Code 1981, § 33-47-3, enacted by Ga. L. 1991, p. 1424, § 8.

33-47-4. Written contract with insurer required; contents.

No person, firm, association, or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities, and which contains the following minimum provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(2) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;

(3) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three months' estimated claims payments and allocated loss adjustment expenses;

(4) Separate records of business written by the managing general agent will be maintained. The insurer shall have access to and right to copy all accounts and records related to its business in a form usable by the insurer and the Commissioner shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the Commissioner. Such records shall be retained according to rules and regulations promulgated by the Commissioner;

(5) The contract may not be assigned in whole or part by the managing general agent;

(6) Appropriate underwriting guidelines including:

(A) The maximum annual premium volume;

(B) The basis of the rates to be charged;

(C) The types of risks which may be written;

(D) Maximum limits of liability;

(E) Applicable exclusions;

(F) Territorial limitations;

(G) Policy cancellation provisions; and

(H) The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the provisions of Chapter 24 of this title which relate to cancellation and nonrenewal of policies;

(7) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(A) All claims must be reported to the company in a timely manner;

(B) A copy of the claim file will be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed an amount determined by the Commissioner or exceeds the limit set by the company, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of an amount set by the Commissioner or an amount set by the company, whichever is less;

(C) All claim files will be the joint property of the insurer and the managing general agent. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate; the managing general agent shall have reasonable access to and the right to copy the files on a timely basis; and

(D) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority

during the pendency of any dispute regarding the cause for termination;

(8) Where electronic claims files are in existence, the contract must address the timely transmission of the data;

(9) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits will not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and not until the profits have been verified pursuant to Code Section 33-47-5; and

(10) The managing general agent shall not:

(A) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(B) Commit the insurer to participate in insurance or reinsurance syndicates;

(C) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which he is appointed;

(D) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed 1 percent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(E) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer, without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(F) Permit its subproducer to serve on the insurer's board of directors;

(G) Jointly employ an individual who is employed with the insurer; or

(H) Appoint a substitute managing general agent.

History. — Code 1981, § 33-47-4, enacted by Ga. L. 1991, p. 1424, § 8.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, a period was substituted for the semicolon at the end of subparagraph (6)(H); a semicolon was substituted for the period at the end of the undesignated language of paragraph (6); and a comma was inserted following "reinsured" near the end of subparagraph (10)(A).

33-47-4.1. Fully earned policy fees.

No licensed managing general agent may charge a fully earned policy fee in connection with the issuance of an insurance policy unless such fee shall be a component of the insurer's rate filing. No fully earned policy fee may exceed $25.00.

History. — Code 1981, § 33-47-4.1, enacted by Ga. L. 2009, p. 616, § 3/SB 144.

33-47-5. Insurer's oversight responsibilities; notice to Commissioner of relationship with managing general agent; conflict of interest.

(a) The insurer shall have on file an independent financial examination, in a form acceptable to the Commissioner, of each managing general agent with which it has done business.

(b) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

(c) The insurer shall periodically and at least semiannually conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

(e) Within 30 days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of such appointment or termination to the Commissioner. Notices of appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the Commissioner may request.

(f) An insurer shall review its books and records each quarter to determine if any producer has become, by operation of paragraph (3) of Code Section 33-47-2, a managing general agent. If the insurer deter-

mines that a producer has become a managing general agent, the insurer shall promptly notify the producer and the Commissioner of such determination and the insurer and producer must fully comply with the provisions of this chapter within 30 days of such determination.

(g) An insurer shall not appoint to its board of directors an officer, director, employee, subproducer, or controlling shareholder of its managing general agents. This subsection shall not apply to relationships governed by Chapter 13 of this title or, if applicable, Chapter 48 of this title.

History. — Code 1981, § 33-47-5, enacted by Ga. L. 1991, p. 1424, § 8; Ga. L. 1995, p. 10, § 33.

33-47-6. Principal and agent relationship created.

The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

History. — Code 1981, § 33-47-6, enacted by Ga. L. 1991, p. 1424, § 8.

33-47-7. Violation of chapter; penalties.

(a) If the Commissioner finds, after a hearing conducted in accordance with Chapter 2 of this title, that any person has violated any provision of this chapter, the Commissioner may order:

(1) For each separate violation, a penalty in an amount not to exceed $10,000.00;

(2) Revocation or suspension of the producer's license; and

(3) The managing general agent to reimburse the insurer or the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this chapter committed by the managing general agent.

(b) The decision, determination, or order of the Commissioner pursuant to subsection (a) of this Code section shall be subject to judicial review as provided in Chapter 2 of this title.

(c) Nothing contained in this Code section shall affect the right of the Commissioner to impose any other penalties provided for in this title.

(d) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, and auditors.

History. — Code 1981, § 33-47-7, enacted by Ga. L. 1991, p. 1424, § 8.

CHAPTER 48

PRODUCER CONTROLLED PROPERTY AND CASUALTY INSURERS

Sec.		Sec.	
33-48-1.	Short title.		tions on reinsurance intermediary.
33-48-2.	Definitions.	33-48-4.	Proceedings upon violation of chapter; burden of proof; penalties.
33-48-3.	Limitations on producer who has control of licensed property and casualty insurer; limita-		

Law reviews. — For note on 1991 enactment of this chapter, see 8 Ga. St. U.L. Rev. 89 (1992).

33-48-1. Short title.

This chapter shall be known and may be cited as the "Business Transacted with Producer Controlled Property and Casualty Insurer Act."

History. — Code 1981, § 33-48-1, enacted by Ga. L. 1991, p. 1424, § 8.

33-48-2. Definitions.

As used in this chapter, the term:

(1) "Control" or "controlled" shall have the same meaning as provided in paragraph (3) of Code Section 33-13-1, relating to definitions used with regard to insurance company holding systems.

(2) "Independent casualty actuary" means a casualty actuary who is a member of the American Academy of Actuaries and who is not affiliated with; an employee, principal, or direct or indirect owner of; or in any way controlled by the insurer or producer.

(3) "Licensed property and casualty insurer" or "insurer" means any person, firm, association, or corporation duly licensed to transact a property and casualty insurance business in this state and which issues policies covered by Chapter 36 of this title. The following, inter alia, are not licensed property and casualty insurers for the purposes of this chapter:

(A) All nonadmitted insurers;

(B) All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, P.L. No. 99-499, 100

Stat. 1613 (1986) and the Risk Retention Act, 15 U.S.C. Section 3901, et seq. (1982 & Supp. 1986) and Chapter 40 of this title;

(C) All residual market pools and joint underwriting authorities or associations; and

(D) All captive insurers as defined in Chapter 41 of this title.

(4) "Producer" means an insurance agent or broker or agents or brokers or any other person, firm, association, or corporation, when, for any compensation, commission, or other thing of value, such person, firm, association, or corporation acts or aids in any manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of an insured other than himself or itself.

(5) "Reinsurance intermediary" means any person, firm, association, or corporation who acts as a producer in soliciting, negotiating, or procuring the making of any reinsurance contract or binder on behalf of a ceding insurer or acts as a producer in accepting any reinsurance contract or binder on behalf of an assuming insurer.

(6) "Violation" means, for purposes of this chapter, a finding by the Commissioner that:

(A) The controlling producer did not materially comply with Code Section 33-48-3;

(B) The controlled insurer, with respect to business placed by the controlling producer, engaged in a pattern of charging premiums that were lower than those being charged by such insurer or other insurers for similar risks written during the same period and placed by noncontrolling producers. When determining whether premiums were lower than those prevailing in the market, the Commissioner shall take into consideration applicable industry or actuarial standards at the time the business was written;

(C) The controlling producer failed to maintain records, sufficient:

(i) To demonstrate that such producer's dealings with its controlled insurer were fair and equitable and in compliance with Chapter 13 of this title; or

(ii) To accurately disclose the nature and details of its transactions with the controlled insurer, including such information as is necessary to support the charges or fees to the respective parties;

(D) The controlled insurer, with respect to business placed by the controlling producer, either failed to establish or deviated from its underwriting procedures;

(E) The controlled insurer's capitalization at the time the business was placed by the controlling producer and with respect to such business was not in compliance with criteria established by the Commissioner or this title; or

(F) The controlling producer or the controlled insurer failed to comply substantially with Chapter 13 of this title and any rules and regulations promulgated by the Commissioner pursuant to such chapter.

History. — Code 1981, § 33-48-2, enacted by Ga. L. 1991, p. 1424, § 8; Ga. L. 1992, p. 2877, § 11; Ga. L. 1993, p. 91, § 33; Ga. L. 1995, p. 1348, § 7.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, a comma was inserted following "15 U.S.C. Section 3901" in subparagraph (3)(B).

33-48-3. Limitations on producer who has control of licensed property and casualty insurer; limitations on reinsurance intermediary.

(a) No producer which has control of a licensed property and casualty insurer may directly or indirectly place business with such insurer in any transaction in which such producer, at the time the business is placed, is acting as such on behalf of the insured for any compensation, commission, or other thing of value, unless:

(1) There is a written contract between the controlling producer and the insurer, which contract has been approved by the board of directors of the insurer;

(2) Such producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between such producer and the controlled insurer. Such disclosure, signed by the insured, shall be retained in the underwriting file until the filing of the report on examination covering the period in which the coverage is in effect. Except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured;

(3) All funds collected for the account of the insurer by the controlling producer must be paid, net of commissions, cancellations, and other adjustments, to the insurer no less often than quarterly;

(4) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the Commissioner an opinion of an independent casualty actuary or other independent loss reserve specialist acceptable to the Commis-

sioner reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred, including losses incurred but not reported, and outstanding as of the end of the current year on business placed by such producer;

(5) The controlled insurer shall annually report to the Commissioner the amount of commissions paid to such producer, the percentage such amount represents of the net premiums written, and comparable amounts and percentages paid to noncontrolling producers for placements of the same kinds of insurance; and

(6) Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. Prior to approval of the annual financial statement, the audit committee shall meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the Commissioner to review the adequacy of the insurer's loss reserves.

(b) No reinsurance intermediary which has control of an assuming insurer may directly or indirectly place business with such insurer in any transaction in which such reinsurance intermediary is acting as a broker on behalf of the ceding insurer. No reinsurance intermediary which has control of a ceding insurer may directly or indirectly accept business from such insurer in any transaction in which such reinsurance intermediary is acting as a producer on behalf of the assuming insurer. The prohibitions in this subsection shall not apply to a reinsurance intermediary which makes a full and complete written disclosure to the parties of its relationship with the assuming or ceding insurer prior to completion of the transaction.

History. — Code 1981, § 33-48-3, enacted by Ga. L. 1991, p. 1424, § 8.

33-48-4. Proceedings upon violation of chapter; burden of proof; penalties.

(a)(1) If the Commissioner has reason to believe that a controlling producer has committed or is committing an act which could be determined to be a violation, as defined in paragraph (6) of Code Section 33-48-2, he shall serve upon the controlling producer a statement of the charges and notice of a hearing to be conducted in accordance with Chapter 2 of this title at a time not less than 30 days after the service of the notice and at a place fixed in the notice.

(2) At such hearing, the Commissioner must establish that the controlling producer engaged in a violation, as defined in paragraph (6) of Code Section 33-48-2. The controlling producer shall have an opportunity to be heard and to present evidence rebutting the

charges and to establish that the insolvency of the controlled insurer arose out of events not attributable to the violation. The decision, determination, or order of the Commissioner shall be subject to judicial review pursuant to Chapter 2 of this title.

(3) Upon the finding, pursuant to the proceeding set forth in this subsection that the controlling producer committed a violation, as defined in paragraph (6) of Code Section 33-48-2, and the controlling producer failed to establish that such violation did not substantially contribute to the insolvency, the controlling producer shall reimburse the Georgia Insurers Insolvency Pool or the Georgia Life and Health Insurance Guaranty Association for all payments made for losses, loss adjustment, and administrative expenses on the business placed by such producer in excess of gross earned premiums and investment income earned on premiums and loss reserves for such business.

(4) Nothing contained in this Code section shall affect the right of the Commissioner to impose any other penalties provided for in this title.

(b) Nothing contained in this chapter is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors, or other third parties.

History. — Code 1981, § 33-48-4, enacted by Ga. L. 1991, p. 1424, § 8; Ga. L. 1992, p. 6, § 33; Ga. L. 1993, p. 91, § 33.

CHAPTER 49

REINSURANCE INTERMEDIARIES

Sec.
33-49-1. Short title.
33-49-2. Definitions.
33-49-3. Brokers and managers required to be licensed producers; surety bond; errors and omissions policy; reinsurance intermediary license; exemption.
33-49-4. Written authorization of relationship required; contents.
33-49-5. Retention of records.
33-49-6. Prohibition against employing unlicensed broker or individual employed by broker; annual statement of broker's financial condition required.
33-49-7. Written contract required between manager and reinsurer; contents.
33-49-8. Restrictions on manager's operations.
33-49-9. Restrictions on reinsurer's operations.
33-49-10. Examination of reinsurance intermediaries and managers by Commissioner.
33-49-11. Violations; penalties.

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 (d) of Ga. L. 1991, p. 1424, § 9, referenced the section which enacted this chapter and provides: "Section 6 of this Act shall become effective on July 1, 1991; provided, however, that persons required to be licensed under Section 6 shall have until January 1, 1992, to procure such license."

Law reviews. — For note on 1991 enactment of this chapter, see 8 Ga. St. U.L. Rev. 89 (1992).

RESEARCH REFERENCES

Am. Jur. Pleading and Practice Forms. — 14B Am. Jur. Pleading and Practice Forms, Insurance, § 717 et seq.

33-49-1. Short title.

This chapter shall be known and may be cited as the "Reinsurance Intermediary Act."

History. — Code 1981, § 33-49-1, enacted by Ga. L. 1991, p. 1424, § 8.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-49-2. Definitions.

As used in this chapter, the term:

(1) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(2) "Controlling person" means any person, firm, association, or corporation who directly or indirectly has the power to direct or cause to be directed the management, control, or activities of the reinsurance intermediary.

(3) "Insurer" means any person, firm, association, or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer.

(4) "Licensed producer" means an agent, broker, or reinsurance intermediary licensed pursuant to the applicable provision of this title.

(5) "Qualified United States financial institution" means an institution that:

(A) Is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state thereof;

(B) Is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(C) Has been determined by either the 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.

(6) "Reinsurance intermediary" means a reinsurance intermediary broker or a reinsurance intermediary manager as these terms are defined in paragraphs (7) and (8) of this Code section.

(7) "Reinsurance intermediary broker" or "broker" means any person, other than an officer or employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

(8) "Reinsurance intermediary manager" or "manager" means any person, firm, association, or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a

reinsurer, including the management of a separate division, department, or underwriting office, and acts as an agent for such reinsurer whether known as a reinsurance intermediary manager, manager, or other similar term. Notwithstanding the above, for the purposes of this chapter the following persons shall not be considered as reinsurance intermediary managers with respect to such reinsurer:

(A) An employee of the reinsurer;

(B) A United States manager of the United States branch of an alien reinsurer;

(C) An underwriting manager which, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to Chapter 13 of this title, and whose compensation is not based on the volume of premiums written; or

(D) The manager of a group, association, pool, or organization of insurers which engages in joint underwriting or joint reinsurance and who is subject to examination by the commissioner of insurance of the state in which the manager's principal business office is located.

(9) "Reinsurer" means any person, firm, association, or corporation duly licensed in this state pursuant to the applicable provisions of this title as an insurer with the authority to assume reinsurance.

(10) "To be in violation" means that the reinsurance intermediary, insurer, or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this chapter.

History. — Code 1981, § 33-49-2, enacted by Ga. L. 1991, p. 1424, § 8.

33-49-3. Brokers and managers required to be licensed producers; surety bond; errors and omissions policy; reinsurance intermediary license; exemption.

(a) No person, firm, association, or corporation shall act as a broker in this state if the broker maintains an office either directly or as a member or employee of a firm or association or as an officer, director, or employee of a corporation:

(1) In this state, unless such broker is a licensed producer in this state; or

(2) In another state, unless such broker is a licensed producer in this state or another state having a law substantially similar to this

chapter or unless such broker is licensed in this state as a nonresident reinsurance intermediary.

(b) No person, firm, association, or corporation shall act as a manager:

(1) For a reinsurer domiciled in this state, unless such manager is a licensed producer in this state;

(2) In this state, if the manager maintains an office either directly or as a member or employee of a firm or association or as an officer, director, or employee of a corporation in this state, unless such manager is a licensed producer in this state;

(3) In another state for a nondomestic insurer, unless such manager is a licensed producer in this state or another state having a law substantially similar to this chapter or such person is licensed in this state as a nonresident reinsurance intermediary.

(c) The Commissioner may require a manager subject to subsection (b) of this Code section to:

(1) File a bond in an amount from an insurer acceptable to the Commissioner for the protection of the reinsurer; and

(2) Maintain an errors and omissions policy in an amount acceptable to the Commissioner.

(d)(1) The Commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation who has complied with the requirements of this chapter. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such authorized persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof, to act as reinsurance intermediaries on behalf of such corporation, and all such authorized persons shall be named in the application and any supplements thereto.

(2) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the Commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this chapter for designation of service of process upon unauthorized insurers; and also shall furnish the Commissioner with the name and address of a resident of this state upon whom notices or orders of the Commissioner or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall

promptly notify the Commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commissioner.

(e) The Commissioner may refuse to issue a reinsurance intermediary license if in his judgment the applicant; any person named on the application; any member, principal, officer, or director of the applicant; or any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary or that any of the foregoing has given cause for revocation or suspension of such license or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the Commissioner will furnish a summary of the basis for refusal to issue a license, which document shall be privileged and not subject to Article 4 of Chapter 18 of Title 50, relating to the inspection of public records.

(f) Licensed attorneys at law of this state when acting in their professional capacity as such shall be exempt from this Code section.

History. — Code 1981, § 33-49-3, enacted by Ga. L. 1991, p. 1424, § 8; Ga. L. 1996, p. 6, § 33.

33-49-4. Written authorization of relationship required; contents.

Transactions between a broker and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

(1) The insurer may terminate the broker's authority at any time;

(2) The broker will render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the broker, and remit all funds due to the insurer within 30 days of receipt;

(3) All funds collected for the insurer's account will be held by the broker in a fiduciary capacity in a bank which is a qualified United States financial institution;

(4) The broker will comply with Code Section 33-49-5;

(5) The broker will comply with the written standards established by the insurer for the cession or retrocession of all risks; and

(6) The broker will disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

History. — Code 1981, § 33-49-4, enacted by Ga. L. 1991, p. 1424, § 8.

33-49-5. Retention of records.

(a) For at least ten years after expiration of each contract of reinsurance transacted by the broker, the broker will keep a complete record for each transaction showing:

(1) The type of contract, limits, underwriting restrictions, classes or risks, and territory;

(2) The period of coverage, including effective and expiration dates, cancellation provisions, and notice required of cancellation;

(3) Reporting and settlement requirements of balances;

(4) The rate used to compute the reinsurance premium;

(5) The names and addresses of assuming reinsurers;

(6) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the broker;

(7) Related correspondence and memoranda;

(8) Proof of placement;

(9) Details regarding retrocessions handled by the broker including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

(10) Financial records, including, but not limited to, premium and loss accounts; and

(11) When the broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(b) The insurer will have access and the right to copy and audit all accounts and records maintained by the broker related to its business in a form usable by the insurer.

History. — Code 1981, § 33-49-5, enacted by Ga. L. 1991, p. 1424, § 8.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, the semicolon at the end of the introductory language of paragraph (a)(11) was changed to a colon.

33-49-6. Prohibition against employing unlicensed broker or individual employed by broker; annual statement of broker's financial condition required.

(a) An insurer shall not engage the services of any person, firm, association, or corporation to act as a broker on its behalf unless such person is licensed as required by subsection (a) of Code Section 33-49-3.

(b) An insurer may not employ an individual who is employed by a broker with which it transacts business unless such broker is under common control with the insurer and subject to Chapter 13 of this title.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each broker with which it transacts business.

History. — Code 1981, § 33-49-6, enacted by Ga. L. 1991, p. 1424, § 8.

33-49-7. Written contract required between manager and reinsurer; contents.

Transactions between a manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least 30 days before such reinsurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the Commissioner for approval. The contract shall, at a minimum, provide that:

(1) The reinsurer may terminate the contract for cause upon written notice to the manager. The reinsurer may immediately suspend the authority of the manager to assume or cede business during the pendency of any dispute regarding the cause for termination;

(2) The manager will render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis;

(3) All funds collected for the reinsurer's account will be held by the manager in a fiduciary capacity in a bank which is a qualified United States financial institution as defined in paragraph (5) of Code Section 33-49-2. The manager may retain no more than three months' estimated claims payments and allocated loss adjustment expenses. The manager shall maintain a separate bank account for each reinsurer that it represents;

(4) For at least ten years after expiration of each contract of reinsurance transacted by the manager, the manager will keep a complete record for each transaction showing:

(A) The type of contract, limits, underwriting restrictions, classes or risks, and territory;

(B) The period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(C) Reporting and settlement requirements of balances;

(D) The rate used to compute the reinsurance premium;

(E) The names and addresses of reinsurers;

(F) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the manager;

(G) Related correspondence and memoranda;

(H) Proof of placement;

(I) Details regarding retrocessions handled by the manager, as permitted by subsection (d) of Code Section 33-49-9, including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

(J) Financial records, including, but not limited to, premium and loss accounts; and

(K) When the manager places a reinsurance contract on behalf of a ceding insurer:

(i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative;

(5) The reinsurer will have access and the right to copy all accounts and records maintained by the manager related to its business in a form usable by the reinsurer;

(6) The contract cannot be assigned in whole or in part by the manager;

(7) The manager will comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks;

(8) The rates, terms, and purposes of commissions, charges, and other fees which the manager may levy against the reinsurer are set forth;

(9) If the contract permits the manager to settle claims on behalf of the reinsurer:

(A) All claims will be reported to the reinsurer in a timely manner;

(B) A copy of the claim file will be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) Has the potential to exceed the lesser of an amount determined by the Commissioner or the limit set by the reinsurer;

(ii) Involves a coverage dispute;

(iii) May exceed the manager's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of the lesser of an amount set by the Commissioner or an amount set by the reinsurer;

(C) All claim files will be the joint property of the reinsurer and manager. However, upon an order of liquidation of the reinsurer such files shall become the sole property of the reinsurer or its estate; the manager shall have reasonable access to and the right to copy the files on a timely basis; and

(D) Any settlement authority granted to the manager may be terminated for cause upon the reinsurer's written notice to the manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination;

(10) If the contract provides for a sharing of interim profits by the manager, that such interim profits will not be paid until one year after the end of each underwriting period for property business and five years after the end of each underwriting period for casualty business or a later period set by the Commissioner for specified lines of insurance and not until the adequacy of reserves on remaining claims has been verified pursuant to subsection (c) of Code Section 33-49-9;

(11) The manager will annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant;

(12) The reinsurer shall periodically and at least semi-annually conduct an on-site review of the underwriting and claims processing operations of the manager;

(13) The manager will disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract; and

(14) Within the scope of its actual or apparent authority the acts of the manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

History. — Code 1981, § 33-49-7, enacted by Ga. L. 1991, p. 1424, § 8.

33-49-8. Restrictions on manager's operations.

The manager shall not:

(1) Cede retrocessions on behalf of the reinsurer, except that the manager may cede facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(2) Commit the reinsurer to participate in reinsurance syndicates;

(3) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed;

(4) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or 1 percent of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

(5) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer;

(6) Jointly employ an individual who is employed by the reinsurer unless such manager is under common control with the reinsurer subject to Chapter 13 of this title; or

(7) Appoint a submanager.

History. — Code 1981, § 33-49-8, enacted by Ga. L. 1991, p. 1424, § 8.

33-49-9. Restrictions on reinsurer's operations.

(a) A reinsurer shall not engage the services of any person, firm, association, or corporation to act as a manager on its behalf unless such person is licensed as required by subsection (b) of Code Section 33-49-3.

(b) The reinsurer shall annually obtain a copy of statements of the financial condition of each manager which such reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the Commissioner.

(c) If a manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the manager. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the manager.

(e) Within 30 days of termination of a contract with a manager, the reinsurer shall provide written notification of such termination to the Commissioner.

(f) A reinsurer shall not appoint to its board of directors any officer, director, employee, controlling shareholder, or subproducer of its manager. This subsection shall not apply to relationships governed by Chapter 13 or Chapter 48 of this title.

History. — Code 1981, § 33-49-9, enacted by Ga. L. 1991, p. 1424, § 8.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, the comma was deleted following "board of directors" in subsection (f).

33-49-10. Examination of reinsurance intermediaries and managers by Commissioner.

(a) A reinsurance intermediary shall be subject to examination by the Commissioner. The Commissioner shall have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the Commissioner.

(b) A manager may be examined as if it were the reinsurer.

History. — Code 1981, § 33-49-10, enacted by Ga. L. 1991, p. 1424, § 8.

33-49-11. Violations; penalties.

(a) A reinsurance intermediary, insurer, or reinsurer found by the Commissioner, after a hearing conducted in accordance with Chapter 2 of this title, to be in violation of any provision of this chapter, shall:

(1) For each separate violation, pay a penalty in an amount not exceeding $10,000.00;

(2) Be subject to revocation or suspension of its license; and

(3) If a violation was committed by the reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

(b) The decision, determination, or order of the Commissioner pursuant to subsection (a) of this Code section shall be subject to judicial review pursuant to Chapter 2 of this title.

(c) Nothing contained in this Code section shall affect the right of the Commissioner to impose any other penalties provided in this title.

(d) Nothing contained in this chapter is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights to such persons.

History. — Code 1981, § 33-49-11, enacted by Ga. L. 1991, p. 1424, § 8.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1991, "Code" was inserted preceding "section" in subsection (c).

CHAPTER 50

MULTIPLE EMPLOYER SELF-INSURED HEALTH PLANS

Sec.
33-50-1. Definition of multiple employer self-insured health plan.
33-50-2. License required to transact business; health plans of municipalities, counties, or other political subdivisions.
33-50-3. Application for license; payment of fees; payment of premium taxes.
33-50-4. Filing of bylaws, schedules of benefits, and management, administration, and trust agreements.
33-50-5. Minimum surplus; capital requirements; security deposit; annual audit; aggregate excess stop-loss coverage; individual excess stop-loss coverage.
33-50-6. Requirements for holding of funds collected.
33-50-7. Required disclosure statements.
33-50-8. Health plans subject to examinations.
33-50-9. Dissolution of plan.
33-50-10. Rules and regulations promulgated by Commissioner.
33-50-11. Power of Commissioner to suspend license.
33-50-12. Legislative intent.
33-50-13. Multiple employer self-insured plans to make necessary filings.
33-50-14. Commissioner approval of plans offering coverage in other states.

Code Commission notes. — Ga. L. 1991, p. 1021; Ga. L. 1991, p. 1424; and Ga. L. 1991, p. 1606 all enacted a Chapter 47 of Title 33. Pursuant to Code Section 28-9-5, the chapter added by Ga. L. 1991, p. 1021, has been redesignated as Chapter 50 and the chapter added by Ga. L. 1991, p. 1606, has been redesignated as Chapter 51.

33-50-1. Definition of multiple employer self-insured health plan.

As used in this chapter, the term "multiple employer self-insured health plan" means any plan or arrangement which is established or maintained for the purpose of offering or providing health, dental, or short-term disability benefits to employees of two or more employers but which is not fully insured. A plan or arrangement is considered fully insured only if all benefits payable are guaranteed under a contract or policy of insurance issued by an insurer authorized to transact business in this state.

History. — Code 1981, § 33-50-1, enacted by Ga. L. 1991, p. 1021, § 1.

33-50-2. License required to transact business; health plans of municipalities, counties, or other political subdivisions.

(a) It is unlawful for any multiple employer self-insured health plan to transact business in this state without a license issued by the Commissioner. Any of the acts described as the transaction of insurance in Code Section 33-1-2, effected by mail or otherwise, by or on behalf of a multiple employer self-insured health plan constitutes the transaction of business in this state. Any multiple employer self-insured health plan which transacts business in this state without the license required by this chapter shall be considered to be an unauthorized insurer within the meaning of Chapter 5 of this title and all remedies and penalties prescribed in such chapter shall be fully applicable.

(b) This chapter does not apply to any plan or arrangement established or maintained by municipalities, counties, or other political subdivisions of this state; any multiple employer self-insured health plan which is not subject to the application of state insurance laws under the provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.; to organizations established under the authority of or receiving funds pursuant to 42 U.S.C. Section 254(b) or 254(c), the federal Public Health Service Act; any other nonprofit organization exempt from federal taxation whose primary purpose is providing access to primary health care services for indigent citizens of Georgia; any plan or arrangement established or maintained by a nonprofit educational organization with assets of more than $100 million for the benefit of the employees of such organization and the employees of any affiliated or associated persons, firms, associations, or corporations which perform functions related to those of such educational organization or of which a majority of the membership of the governing body is composed of employees or members of the governing body of the nonprofit educational organization; or to any plan or arrangement established or maintained, directly or through a legal entity, by two or more accredited independent nonproprietary institutions of higher education located in this state that have combined assets of more than $100 million and are members of the Georgia nonprofit corporation representing a majority of the accredited independent nonproprietary institutions of higher education located in this state for the benefit of the employees, including retired employees, of:

(1) Such institutions;

(2) Any affiliated or associated persons, firms, associations, trusts, or corporations that perform functions similar or related to those of one or more of such institutions or of which a majority of the membership of the governing body is composed of employees or

members of the governing body of one or more of such institutions; and

(3) The Georgia nonprofit corporation representing a majority of the accredited independent nonproprietary institutions of higher education located in this state.

History. — Code 1981, § 33-50-2, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 1993, p. 329, § 1; Ga. L. 2009, p. 724, § 1/SB 63.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1993, a comma was inserted following "U.S.C. Section 1001" in subsection (b).

OPINIONS OF THE ATTORNEY GENERAL

Self-insurers deemed regulated entities. — Self-insurance health plans are regulated entities for purposes of O.C.G.A. § 21-5-30.1. 1994 Op. Att'y Gen. No. 94-20.

33-50-3. Application for license; payment of fees; payment of premium taxes.

(a) Application for a license shall be made on forms prescribed by the Commissioner.

(b) Every multiple employer self-insured health plan shall pay to the Commissioner annual license fees, as established by rule or regulation of the Commissioner.

(c) Every multiple employer self-insured health plan shall be exempt from the payment of premium taxes on the plan's net premium.

History. — Code 1981, § 33-50-3, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 2/SB 310; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2016, p. 515, § 1/HB 866.

33-50-4. Filing of bylaws, schedules of benefits, and management, administration, and trust agreements.

At the time application for a license is made, the multiple employer self-insured health plan shall file with the Commissioner a copy of the plan's bylaws, all schedules of benefits, and all management, administration, and trust agreements which the plan had made or proposes to make for the conduct of its business and affairs. Any proposed changes or amendments to the foregoing must also be filed with the Commissioner.

History. — Code 1981, § 33-50-4, enacted by Ga. L. 1991, p. 1021, § 1.

33-50-5. Minimum surplus; capital requirements; security deposit; annual audit; aggregate excess stop-loss coverage; individual excess stop-loss coverage.

(a) No multiple employer self-insured health plan shall be licensed unless it shall possess and thereafter maintain a minimum surplus of at least $200,000.00.

(b) A multiple employer self-insured health plan shall be subject to and comply with the applicable regulatory action level risk-based capital requirements prescribed by Chapter 56 of this title.

(c) Every multiple employer self-insured health plan shall maintain a security deposit with the Commissioner. The amount of the deposit shall be $100,000.00 and shall be in the form of securities eligible for the investment of capital funds of domestic insurers. The deposit shall be administered in accordance with the provisions of Chapter 12 of this title.

(d) Every multiple employer self-insured health plan shall annually obtain an opinion from a qualified actuary as to the adequacy of its loss reserves. Such opinion shall be prepared and issued based on standards adopted from time to time by the Actuarial Standards Board and in accordance with instruction prescribed by the National Association of Insurance Commissioners.

(e) Every multiple employer self-insured health plan licensed pursuant to this chapter shall have an annual audit by an independent certified public accountant in accordance with Georgia Department of Insurance Regulation 120-2-60 and instructions prescribed by the National Association of Insurance Commissioners.

(f) Every multiple employer self-insured health plan shall file financial statements with the Commissioner in accordance with the provisions of Georgia Department of Insurance Regulation 120-2-18-.06.

(g)(1) Every multiple employer self-insured health plan shall obtain and thereafter maintain aggregate excess stop-loss coverage and individual excess stop-loss coverage.

(2) Excess stop-loss coverage required by this Code section shall be issued by an insurer licensed by the state.

(3) The retention limits for both the aggregate excess stop-loss coverage and individual excess stop-loss coverage shall be determined annually by a qualified actuary based on sound actuarial principles.

(4) Any stop-loss contract maintained pursuant to this Code section shall contain a provision that the stop-loss insurer shall give the

multiple employer self-insured health plan and the Commissioner a minimum of 180 days' notice of cancellation or nonrenewal.

(5) If the multiple employer self-insured health plan fails to obtain replacement coverage within 90 days after receipt of the notice of cancellation or nonrenewal, the trustees of the plan shall provide for the orderly liquidation of the multiple employer self-insured health plan.

(h)(1) Each participating employer shall be jointly and severally liable for all legal obligations of the multiple employer self-insured health plans created on or after July 1, 2010.

(2) If the assets of the multiple employer self-insured health plan are at any time insufficient to enable the plan to discharge its legal liabilities and other obligations and to maintain the surplus required under this Code section, it shall forthwith make up the deficiency or levy an assessment upon its participating employers for the amount needed to make up the deficiency.

(3) If the multiple employer self-insured health plan fails to make up the deficiency or make the required assessment within 30 days after the Commissioner orders it to do so or if the deficiency is not fully made up within 60 days after the date on which any such assessment is made or within such longer period as may be specified by the Commissioner, the plan shall be deemed to be insolvent.

(4) If the liquidation of a multiple employer self-insured health plan is ordered, an assessment shall be levied upon its participating employers for such an amount as the Commissioner determines to be necessary to discharge all liabilities of the plan, including the reasonable costs of liquidation.

History. — Code 1981, § 33-50-5, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 3/SB 310; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2019, p. 533, § 1-12/HB 99; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "Georgia Department of Insurance" for "Georgia Insurance Department" in subsections (e) and (f); and substituted "Reserved" for the former provisions of subsection (i), which read: "A multiple employer self-insured health plan licensed before January 1, 2010, shall have until December 31, 2011, to comply with the provisions of this Code section."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former subsection (i) which was designated as reserved.

33-50-6. Requirements for holding of funds collected.

Funds collected from the participating employers under multiple employer self-insured health plans shall be held in trust subject to the following requirements:

(1) A board of trustees elected by participating employers shall serve as fund managers on behalf of participants. Trustees shall be plan participants or be an employee or owner of a participating employer or an employee of a sponsoring association. No participating employer shall be represented by more than one trustee. A minimum of three and a maximum of seven trustees may be elected. Trustees shall not receive remuneration but they may be reimbursed for actual and reasonable expenses incurred in connection with duties as trustee;

(2) Trustees shall be bonded in an amount not less than $150,000.00 from a licensed surety company or covered under a directors and officers liability policy issued to the multiple employer self-insured health plan;

(3) Investment of plan funds shall be subject to the same restrictions which are applicable to insurers as provided in Chapter 11 of this title; and

(4) A multiple employer self-insured health plan shall maintain a minimum loss ratio of at least 70 percent. Compliance with such minimum loss ratio standard shall be evaluated annually by a multiple employer self-insured health plan. Failure to comply with minimum loss ratio standards shall result in a premium refund to participating employers.

History. — Code 1981, § 33-50-6, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 4/SB 310.

33-50-7. Required disclosure statements.

Every application for benefits and every benefit plan issued by a multiple employer self-insured health plan shall contain in contrasting color, in not less than ten-point type, the following statements:

(1) The plan is a self-insured plan, and benefits are not guaranteed by a licensed insurer;

(2) The plan is not covered by the Georgia Life and Health Guaranty Association;

(3) This is a fully assessable benefit plan. In the event that the multiple employer self-insured health plan is unable to pay its obligations, participating employers shall be required to contribute on a joint and several basis the funds necessary to meet any unpaid obligations; and

(4) Certain other major protections offered to Georgia residents under the Georgia Insurance Code and Rules and Regulations, such

as conversion rights and certain mandated or required benefits, may not be available through the multiple employer self-insured plan.

History. — Code 1981, § 33-50-7, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2010, p. 757, § 5/SB 310.

33-50-8. Health plans subject to examinations.

Every multiple employer self-insured health plan shall be subject to examination in accordance with Chapter 2 of this title.

History. — Code 1981, § 33-50-8, enacted by Ga. L. 1991, p. 1021, § 1.

33-50-9. Dissolution of plan.

(a) A plan that desires to cease existence shall apply to the Commissioner for authority to dissolve. Applications to dissolve must be on forms prescribed by the Commissioner and must be approved or disapproved by the Commissioner within 60 days of receipt. Dissolution without authorization is prohibited and does not absolve a plan or its participants from fulfilling the plan's continuing obligations. An application to dissolve must be granted if either of the following conditions is met:

(1) The plan demonstrates that it has no outstanding liabilities, including incurred but not reported liabilities; or

(2) The plan has obtained an irrevocable commitment from a licensed insurer which provides for payment of all outstanding liabilities and for providing all related services, including payment of claims, preparation of reports, and administration of transactions associated with the period when the plan provided coverage.

(b) Upon dissolution, after payment of all outstanding liabilities and indebtedness, the assets of the plan must be distributed to all employers participating in the plan during the last five years immediately preceding dissolution. The distributive share of each employer must be in the proportion that all contributions made by the employer during such five-year period bear to the total contributions made by all participating employers during such five-year period.

History. — Code 1981, § 33-50-9, enacted by Ga. L. 1991, p. 1021, § 1.

33-50-10. Rules and regulations promulgated by Commissioner.

The Commissioner may promulgate rules or regulations which are necessary to implement the provisions of this chapter and to ensure the safe and proper operation of multiple employer self-insured health plans in this state.

History. — Code 1981, § 33-50-10, enacted by Ga. L. 1991, p. 1021, § 1.

33-50-11. Power of Commissioner to suspend license.

(a) If the Commissioner is of the opinion that a multiple employer self-insured health plan is in an unsound condition, that it has failed to comply with the law or any applicable rule or regulations or orders issued by the Commissioner, or that it is in a condition which renders its proceedings hazardous to the public or to persons covered under the plan, the Commissioner may, after a hearing, revoke or suspend the license of the plan or, in lieu thereof, impose a monetary penalty in accordance with Chapter 2 of this title.

(b) If the Commissioner is of the opinion that any of the grounds set forth in subsection (a) of this Code section exists, the Commissioner may commence delinquency proceedings against the plan and supervise, rehabilitate, or liquidate the plan in accordance with the procedures set forth in Chapter 37 of this title.

History. — Code 1981, § 33-50-11, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 1996, p. 6, § 33.

33-50-12. Legislative intent.

It is the intent of the General Assembly that a multiple employer self-insured health plan be created and maintained by and for the benefit of participating employers and operated under their exclusive management and control. This chapter is not intended to permit third-party administrators or other entrepreneurial promoters to establish a trust or plan and then proceed to solicit employers as participants. It is specifically intended that the impetus for the creation of the plan must come from the employers themselves, and the employers must at all times exercise absolute control over the management and conduct of the plan's business and affairs.

History. — Code 1981, § 33-50-12, enacted by Ga. L. 1991, p. 1021, § 1.

33-50-13. Multiple employer self-insured plans to make necessary filings.

All multiple employer self-insured health plans who have member employees in this state shall make all filings necessary to comply with this chapter.

History. — Code 1981, § 33-50-13, enacted by Ga. L. 1991, p. 1021, § 1; Ga. L. 2019, p. 533, § 1-13/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "as of July 1, 1991," preceding "shall", and deleted "have until October 1, 1991, to" preceding "make all filings".

33-50-14. Commissioner approval of plans offering coverage in other states.

A multiple employer self-insured health plan which covers lives in other states may cover lives in this state only if the Commissioner deems the plan to be in compliance with the requirements of this chapter.

History. — Code 1981, § 33-50-14, enacted by Ga. L. 2010, p. 757, § 6/SB 310; Ga. L. 2011, p. 752, § 33/HB 142.

CHAPTER 51

GEORGIA AFFORDABLE HSA ELIGIBLE HIGH DEDUCTIBLE HEALTH PLAN

Sec.
33-51-1. Short title.
33-51-2. Legislative intent.
33-51-3. Development of guidelines; promotion by Commissioner; authority of Commissioner.
33-51-4. Programs not considered unfair trade practice.
33-51-5. Nonpreferred provider reimbursement.
33-51-6. Incentives for preferred providers.
33-51-7. Health reimbursement arrangement only.

Cross references. — Tax credit for qualified health insurance expenses, § 48-7-29.13.

Code Commission notes. — Ga. L. 1991, p. 1021; Ga. L. 1991, p. 1424; and Ga. L. 1991, p. 1606, all enacted a Chapter 47 of Title 33. Pursuant to Code Section 28-9-5, the chapter added by Ga. L. 1991, p. 1021, has been redesignated as Chapter 50 and the chapter added by Ga. L. 1991, p. 1606, has been redesignated as Chapter 51 (which was subsequently repealed by Ga. L. 2008, p. 292).

The repeal and reenactment of this chapter by Ga. L. 2008, p. 289, § 2, irreconcilably conflicted with and was treated as superseded by Ga. L. 2008, p. 292, § 3. See County of Butts v. Strahan, 151 Ga. 417 (1921).

Editor's notes. — Ga. L. 2008, p. 292, § 3/HB 977, effective May 7, 2008, repealed the Code sections formerly codified at this chapter and enacted the current chapter. The former chapter consisted of Code Sections 33-51-1 through 33-51-4, relating to Georgia Basic Health Insurance Plan, and was based on Ga. L. 1991, p. 1606, § 1; Ga. L. 1993, p. 1985, § 1.

Administrative rules and regulations. — Georgia Affordable HSA Eligible High Deductible Health Plan, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-96.

RESEARCH REFERENCES

ALR. — 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.

33-51-1. Short title.

This chapter shall be known and may be cited as the "Georgia Affordable HSA Eligible High Deductible Health Plan."

History. — Code 1981, § 33-51-1, enacted by Ga. L. 2008, p. 292, § 3/HB 977.

33-51-2. Legislative intent.

It is the intent of the General Assembly:

(1) To authorize the Commissioner to establish flexible guidelines for health savings account eligible high deductible plan designs which will be affordable to Georgians and to increase the availability of these types of plans by accident and sickness insurers licensed to transact such insurance in this state;

(2) To encourage the offering of affordable health savings account eligible high deductible plans, as required under the rules of the federal Internal Revenue Service related to the establishment of health savings accounts, with the specific intent of reaching many otherwise uninsured Georgians and the general intent of creating affordable comprehensive health insurance for all Georgians; and

(3) To enhance the affordability of insurance with the flexible health savings account eligible high deductible plans allowed under this chapter by allowing rewards and incentives for participation in and adherence to health behaviors that recognize the value of the personal responsibility of each citizen to maintain good health, seek preventive care services, and comply with approved treatments.

History. — Code 1981, § 33-51-2, enacted by Ga. L. 2008, p. 292, § 3/HB 977; Ga. L. 2013, p. 141, § 33/HB 79.

33-51-3. Development of guidelines; promotion by Commissioner; authority of Commissioner.

(a) The Commissioner shall develop flexible guidelines for coverage and approval of health savings account eligible high deductible plans which are designed to qualify under federal and state requirements as high deductible health plans for use with health savings accounts which comply with federal requirements under the applicable provisions of the federal Internal Revenue Code for high deductible health plans sold in connection with health savings accounts.

(b) The Commissioner shall be authorized to encourage and promote the marketing of health savings account eligible high deductible plans by accident and sickness insurers in this state; provided, however, that nothing in this Code section shall be construed to authorize the sale of insurance in violation of Chapter 3 of this title or interstate sales of insurance.

(c) The Commissioner shall be authorized to conduct a national study of health savings account eligible high deductible plans available in other states and to determine if and how these products serve the uninsured and if they should be made available to Georgians.

(d) The Commissioner shall be authorized to develop an automatic or fast track approval process for health savings account eligible high deductible plans already approved under the laws and regulations of this state or other states.

History. — Code 1981, § 33-51-3, enacted by Ga. L. 2008, p. 292, § 3/HB 977; Ga. L. 2019, p. 533, § 1-14/HB 99; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "Reserved." for the former provisions of subsection (e), which read: "The Commissioner shall be authorized to promulgate such rules and regulations as he or she deems necessary and appropriate for the design, promotion, and regulation of health savings account eligible high deductible plans, including rules and regulations for the expedited review of standardized policies, advertisements and solicitations, and other matters deemed relevant by the Commissioner."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former subsection (e) which was designated as reserved.

33-51-4. Programs not considered unfair trade practice.

Insurers that include and operate wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and similar provisions in their high deductible health policies in keeping with federal requirements shall not be considered to be engaging in unfair trade practices under Code Section 33-6-4 with respect to references to the practices of illegal inducements, unfair discrimination, and rebating.

History. — Code 1981, § 33-51-4, enacted by Ga. L. 2008, p. 292, § 3/HB 977.

33-51-5. Nonpreferred provider reimbursement.

There shall be no required relationship between preferred provider and nonpreferred provider plan reimbursements for health savings account eligible high deductible plans using nonpreferred provider reimbursements. Such plans, however, shall not:

(1) Unfairly deny health benefits for medically necessary covered services;

(2) Have differences in benefit levels payable to preferred providers compared to other providers that unfairly deny benefits for covered services;

(3) Have a plan coinsurance percentage applicable to benefit levels for services provided by nonpreferred providers that is less than 60 percent of the benefit levels under the policy for such services; or

(4) Have an adverse effect on the availability or the quality of services.

History. — Code 1981, § 33-51-5, enacted by Ga. L. 2008, p. 292, § 3/HB 977.

33-51-6. Incentives for preferred providers.

Notwithstanding the provisions of paragraphs (2) and (3) of Code Section 33-51-5, health benefit plans providing incentives for covered persons to use pharmaceutical or dental services of preferred providers shall provide, and clearly indicate, that the payment or reimbursement for a noncontracting provider of covered pharmaceutical or dental services shall be the same as the payment or reimbursement for a preferred provider of covered pharmaceutical or dental services; provided, however, that the health benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the actual fee charged by the provider for such dental or pharmaceutical services.

History. — Code 1981, § 33-51-6, enacted by Ga. L. 2008, p. 292, § 3/HB 977.

33-51-7. Health reimbursement arrangement only.

(a) The Commissioner shall be authorized to allow health reimbursement arrangement only plans that encourage employer financial support of health insurance or health related expenses recognized under the rules of the federal Internal Revenue Service to be approved for sale in connection with or packaged with individual health insurance policies otherwise approved by the Commissioner.

(b) Health reimbursement arrangement only plans that are not sold in connection with or packaged with individual health insurance policies shall not be considered insurance under this title.

(c) Individual insurance policies offered or funded through health reimbursement arrangements shall not be considered employer sponsored or group coverage for purposes of this title, and nothing in this Code section shall be interpreted to require an insurer to offer an individual health insurance policy for sale in connection with or packaged with a health reimbursement arrangement or to accept premiums from health reimbursement arrangement plans for individual health insurance policies.

History. — Code 1981, § 33-51-7, enacted by Ga. L. 2009, p. 737, § 2/SB 94.

CHAPTER 52

ASSUMPTION REINSURANCE AGREEMENTS

Sec.
33-52-1. Applicability of chapter.
33-52-2. Definitions.
33-52-3. Notice of transfer; contents and form of notice; prior approval of Commissioner.
33-52-4. Rejection of transaction by policyholders; receipt of notice; transfers involving companies deemed to be in hazardous condition.
33-52-5. Novation of insurance contract.
33-52-6. Approval or disapproval by Commissioner.

Administrative rules and regulations. — Assumption Reinsurance, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-62.

33-52-1. Applicability of chapter.

(a) This chapter shall apply to any insurer authorized or doing business in this state which transfers or assumes the obligations or risks on contracts of insurance written or assumed in this state to or from another insurer pursuant to an assumption reinsurance agreement.

(b) This chapter shall not apply to:

(1) Any reinsurance agreement or transaction in which the ceding insurer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement;

(2) The substitution of one insurer for another upon expiration of insurance coverage pursuant to statutory or contractual requirements and the issuance of a new contract of insurance by another insurer;

(3) The transfer of contracts of insurance pursuant to mergers or consolidations of two or more insurers to the extent that those transactions are regulated by statute;

(4) Any insurer subject to a judicial order of liquidation or rehabilitation; or

(5) Any contract controlled by a state guaranty association or a state insolvency pool.

History. — Code 1981, § 33-52-1, enacted by Ga. L. 1992, p. 1385, § 1.

RESEARCH REFERENCES

ALR. — Who may enforce liability of reinsurer, 87 A.L.R.6th 319.

33-52-2. Definitions.

As used in this chapter:

(1) "Assuming insurer" means the insurer which acquires an insurance obligation or risk from the transferring insurer pursuant to an assumption reinsurance agreement.

(2) "Assumption reinsurance agreement" means any contract which both:

(A) Transfers insurance obligations or risks of existing or in-force contracts of insurance from a transferring insurer to an assuming insurer; and

(B) Is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks under such contracts are extinguished.

(3) "Contract of insurance" means any written agreement between an insurer and policyholder pursuant to which the insurer, in exchange for a premium or other consideration, agrees to assume an obligation or risk of the policyholder or to make payments on behalf of or to the policyholder or its beneficiaries; it shall include all property, casualty, life, health, accident, accident and sickness, surety, title, and annuity business authorized to be written pursuant to the provisions of this title.

(4) "Notice of transfer" means the written notice to policyholders required by subsection (a) of Code Section 33-52-3.

(5) "Policyholder" means any individual or entity which has the right to terminate or otherwise alter the terms of a contract of insurance. It includes any person issued a group certificate under a group insurance contract if the certificate vests in such person, separate from the rights of the group contract holder, rights against the insurer that the group contract holder may not terminate. The right to keep the policy in force referred to in this chapter shall not include the right to elect individual coverage under the federal consolidated Omnibus Budget Reconciliation Act (COBRA) Section 601, et seq., of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. Section 1161, et seq., or under continuation and conversion provisions found in Chapter 24 of this title.

(6) "Transferring or ceding insurer" means the insurer which transfers or cedes an insurance obligation or risk to an assuming insurer pursuant to an assumption reinsurance agreement.

History. — Code 1981, § 33-52-2, enacted by Ga. L. 1992, p. 1385, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, "Section" was substituted for "section" in paragraph (4), and, in paragraph (5), a comma was inserted following "seq." and "contract holder" was substituted for "contract-holder".

Pursuant to Code Section 28-9-5, in 1993, "contract holder" was substituted for "contractholder" in paragraph (5).

33-52-3. Notice of transfer; contents and form of notice; prior approval of Commissioner.

(a)(1) The transferring insurer shall provide or cause to be provided to each policyholder by first-class mail, addressed to the policyholder's last known address or to the address to which premium notices or other policy documents are sent, a notice of transfer; provided, however, that, upon application by the transferring insurer, the Commissioner may approve an alternative method of notification. The notice of transfer shall state or provide the following:

(A) A detailed statement explaining the reason or reasons for the transfer;

(B) The date the transfer and novation of the policyholder's contract of insurance is proposed to take place;

(C) The names, addresses, and telephone numbers of the assuming and transferring insurers;

(D) That the policyholder may reject the transfer and novation;

(E) The procedure and time limit for rejecting the transfer and novation;

(F) A summary of any effect that rejecting the transfer and novation will have on the policyholder's rights including, for participating policyholders, dividend payments or payments under the contract of insurance;

(G) The states in which the assuming insurer is licensed;

(H) The name and address of the person at the transferring insurer to whom the policyholder should send its written statement of rejection of the transfer and novation; and

(I) The address of the insurance department where the policyholder resides so that the policyholder may contact its insurance department for further information regarding the financial condition of the assuming insurer.

(2) The Commissioner may prescribe the form of the notice to be delivered to policyholders.

(3) The notice of transfer shall include a pre-addressed postage-paid response card which a policyholder may return as its written statement of rejection of the transfer and novation.

(b) Prior approval by the Commissioner is required for any transaction before an insurer assumes or transfers obligations or risks on contracts of insurance in this state under an assumption reinsurance agreement.

History. — Code 1981, § 33-52-3, enacted by Ga. L. 1992, p. 1385, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1992, a comma was inserted following "addresses" in subparagraph (a)(1)(C).

Editor's notes. — Ga. L. 2019, p. 337, § 1-93/SB 132, purported to substitute "Department of Insurance" for "Insurance Department", but the term "Insurance Department" (as capitalized) does not exist in this Code section.

33-52-4. Rejection of transaction by policyholders; receipt of notice; transfers involving companies deemed to be in hazardous condition.

(a) Every policyholder shall have the right to reject the transfer and novation of his or her contract of insurance. Policyholders electing to reject the assumption transaction shall provide the transferring insurer with the pre-addressed, postage-paid response card or other written notice that the assumption is rejected no later than 60 days after the date on which the transferring insurer mails the notice required under subsection (a) of Code Section 33-52-3. If the ceding insurer does not receive written rejection within the 60 day period, it shall send a second notice in accordance with subsection (a) of Code Section 33-52-3. If the ceding insurer does not receive a rejection within 30 days after the date of mailing, the policyholder shall be deemed to have accepted the transfer.

(b) The transferring insurer will be deemed to have received the response card or other written notice on the date it is postmarked. A policyholder may also send its response card or other written notice by facsimile or other electronic transmission or by certified mail or statutory overnight delivery, express delivery, personal delivery, or courier service, in which case the response card or other written notice shall be deemed to have been received by the assuming insurer on the date of actual receipt by the transferring insurer.

(c) If the transferring company is deemed by the Commissioner to be in hazardous condition or is under a supervision order, rehabilitation, liquidation, conservation, or receivership and the transfer of policies is in the best interest of the policyholders as determined by the Commis-

sioner, a transfer may be effected notwithstanding the provisions of this chapter. This may include adequate notification to the policyholder of the circumstances requiring the transfer as approved by the Commissioner.

History. — Code 1981, § 33-52-4, enacted by Ga. L. 1992, p. 1385, § 1; Ga. L. 2000, p. 1589, § 3.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to subsection (b) is applicable with respect to notices delivered on or after July 1, 2000.

JUDICIAL DECISIONS

Cited in Fiffee v. Jiggetts, 353 Ga. App. 730, 839 S.E.2d 224 (2020).

33-52-5. Novation of insurance contract.

If a transfer takes place pursuant to Code Section 33-52-4, there shall be a novation of the contract of insurance subject to the assumption reinsurance agreement with the result that the transferring insurer shall thereby be relieved of all insurance obligations or risks transferred under the assumption reinsurance agreement and the assuming insurer shall become directly and solely liable to the policyholder for those insurance obligations or risks.

History. — Code 1981, § 33-52-5, enacted by Ga. L. 1992, p. 1385, § 1.

33-52-6. Approval or disapproval by Commissioner.

(a) The Commissioner shall approve or disapprove the entire assumption reinsurance transaction. The following items shall be submitted to the Commissioner:

(1) A detailed statement explaining the reason or reasons for the transfer;

(2) The assumption reinsurance agreement;

(3) The certificate of assumption;

(4) If either the ceding company or the assuming company is not domiciled in Georgia, copies of the approvals of the entire transaction by the insurance supervisory officials of the states of domicile of the ceding and assuming insurers; and

(5) A statement as to what provision has been made for servicing those policyholders who have rejected the transfer. However, the Commissioner may permit 100 percent reinsurance without novation of these risks with the servicing of those policyholders to be done by

the assuming company or may order the transfer and novation of all of the contracts of insurance under the assumption reinsurance agreement.

(b) When seeking the Commissioner's approval of an assumption of a participating business by a stock or mutual company, the applicant should address the disposition of the accumulated surplus connected with the block of business and the level of future dividends.

(c) If protection under the Georgia Insurers Insolvency Pool, the Georgia Life and Health Insurance Guaranty Association, or a similar state guaranty association or insolvency pool will be lost or reduced, the Commissioner shall not approve the assumption of any policy unless the transfer of policies is in the best interest of the policyholders.

History. — Code 1981, § 33-52-6, enacted by Ga. L. 1992, p. 1385, § 1.

CHAPTER 53

COVERAGE FOR CERTAIN TYPES OF ANTI-CANCER DRUG THERAPY

Sec.
33-53-1. Definitions.
33-53-2. Conditions of coverage.
33-53-3. Enforcement [Repealed].
33-53-4. Exceptions to requirements for coverage.

33-53-1. Definitions.

As used in this chapter:

(1) "Drug" means a drug or biologic that is used in an antineoplastic regimen.

(2) "Insurance policy" means an individual accident and sickness policy of insurance issued pursuant to Chapter 29 of this title or a group accident and sickness insurance policy issued pursuant to Chapter 30 of this title.

(3) "Standard reference compendium" means any of the following:

(A) The United States Pharmacopeia Drug Information;

(B) The American Medical Association Drug Evaluations;

(C) The American Hospital Formulary Service Drug Information.

History. — Code 1981, § 33-53-1, enacted by Ga. L. 1993, p. 539, § 1; Ga. L. 2019, p. 533, § 1-15/HB 99.

The 2019 amendment, effective July 1, 2019, deleted former paragraph (1), which read: "'Commissioner' means the Commissioner of Insurance of the State of Georgia."; and redesignated former paragraphs (2) through (4) as present paragraphs (1) through (3), respectively.

33-53-2. Conditions of coverage.

An insurance policy that provides coverage for drugs may not exclude coverage of a covered drug on the grounds that the drug has not been approved by the federal Food and Drug Administration for the particular indication if any of the following conditions are met:

(1) The drug is recognized for treatment of the indication in at least one standard reference compendium;

(2) The drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in either the United States or Great Britain.

History. — Code 1981, § 33-53-2, enacted by Ga. L. 1993, p. 539, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1993, "peer reviewed" was substituted for "peer-reviewed" in paragraph (2).

33-53-3. Enforcement.

Reserved. Repealed by Ga. L. 2019, p. 533, § 1-16/HB 99, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1981, § 33-53-3, enacted by Ga. L. 1993, p. 539, § 1.

33-53-4. Exceptions to requirements for coverage.

This chapter shall not be deemed to do any of the following:

(1) Require coverage for any drug when the federal Food and Drug Administration has determined the drug's use to be contraindicated;

(2) Require coverage for an experimental drug not approved for any indication by the federal Food and Drug Administration;

(3) Alter any other law limiting the coverage of drugs that have not been approved by the federal Food and Drug Administration.

History. — Code 1981, § 33-53-4, enacted by Ga. L. 1993, p. 539, § 1.

CHAPTER 54

GENETIC TESTING

Sec.		Sec.	
33-54-1.	Legislative findings and determinations; intent of chapter.	33-54-5.	Use of information in criminal investigation or prosecution authorized.
33-54-2.	Definitions.	33-54-6.	Use of information for scientific research purposes authorized.
33-54-3.	Purpose of testing; consent required; confidential and privileged information.	33-54-7.	Applicability of chapters.
33-54-4.	Prohibited use of information.	33-54-8.	Violations of chapter.

Administrative rules and regulations. — Prohibition Against Use of Genetic Information and Requests for Genetic Testing, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Sec. 120-2-8-.24.

Law reviews. — For comment, "Closing the Gap: Protecting Predictive Neuroscience Information from Health Insurance Discrimination," see 64 Emory L.J. 1433 (2015).

RESEARCH REFERENCES

Am. Jur. 2d. — 60 Am. Jur. 2d, Patents, § 80.

C.J.S. — 25A C.J.S., Dead Bodies, § 28

33-54-1. Legislative findings and determinations; intent of chapter.

The General Assembly finds and determines that recent advances in genetic science have led to improvements in the diagnosis, treatment, and understanding of a significant number of human diseases. The General Assembly further finds and declares that:

(1) Genetic information is the unique property of the individual tested;

(2) The use and availability of information concerning an individual obtained through the use of genetic testing techniques may be subject to abuses if disclosed to unauthorized third parties without the willing consent of the individual tested;

(3) To protect individual privacy and to preserve individual autonomy with regard to an individual's genetic information, it is appropriate to limit the use and availability of genetic information; and

(4) The intent of this chapter is to prevent accident and sickness insurance companies, health maintenance organizations, managed

care organizations, and other payors from using information derived from genetic testing to deny access to accident and sickness insurance.

History. — Code 1981, § 33-54-1, enacted by Ga. L. 1995, p. 1242, § 4.

Law reviews. — For article, "The Burden of Knowledge," see 43 Ga. L. Rev. 297 (2009).

33-54-2. Definitions.

As used in this chapter, the term:

(1) "Genetic testing" means laboratory tests of human DNA or chromosomes for the purpose of identifying the presence or absence of inherited alterations in genetic material or genes which are associated with a disease or illness that is asymptomatic at the time of testing and that arises solely as a result of such abnormality in genes or genetic material. For purposes of this chapter, genetic testing shall not include routine physical measurements; chemical, blood, and urine analysis; tests for abuse of drugs; and tests for the presence of the human immunodeficiency virus.

(2) "Insurer" means an insurer, a fraternal benefit society, a health care corporation, a health maintenance corporation, or a self-insured health plan not subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.

History. — Code 1981, § 33-54-2, enacted by Ga. L. 1995, p. 1242, § 4; Ga. L. 2019, p. 533, § 1-17/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "a nonprofit medical service corporation," following "benefit society," near the middle of paragraph (2).

33-54-3. Purpose of testing; consent required; confidential and privileged information.

(a) Except as otherwise provided in this chapter, genetic testing may only be conducted to obtain information for therapeutic or diagnostic purposes. Genetic testing may not be conducted without the prior written consent of the person to be tested.

(b) Information derived from genetic testing shall be confidential and privileged and may be released only to the individual tested and to persons specifically authorized by such individual to receive the information. Any insurer that possesses information derived from genetic testing may not release the information to any third party without the explicit written consent of the individual tested. Information derived from genetic testing may not be sought by any insurer as defined in Code Section 33-54-2.

History. — Code 1981, § 33-54-3, enacted by Ga. L. 1995, p. 1242, § 4.

33-54-4. Prohibited use of information.

Any insurer that receives information derived from genetic testing may not use the information for any nontherapeutic purpose.

History. — Code 1981, § 33-54-4, enacted by Ga. L. 1995, p. 1242, § 4.

33-54-5. Use of information in criminal investigation or prosecution authorized.

Notwithstanding the provisions of Code Sections 33-54-3 and 33-54-4, information derived from genetic testing regarding the identity of any individual who is the subject of a criminal investigation or a criminal prosecution may be disclosed to appropriate legal authorities conducting the investigation or prosecution. The information may be used during the course of the investigation or prosecution with respect to the individual tested without the consent of such individual.

History. — Code 1981, § 33-54-5, enacted by Ga. L. 1995, p. 1242, § 4.

33-54-6. Use of information for scientific research purposes authorized.

Notwithstanding the provisions of Code Sections 33-54-3 and 33-54-4, any research facility may conduct genetic testing and may use the information derived from genetic testing for scientific research purposes so long as the identity of any individual tested is not disclosed to any third party, except that the individual's identity may be disclosed to the individual's physician with the consent of the individual.

History. — Code 1981, § 33-54-6, enacted by Ga. L. 1995, p. 1242, § 4.

33-54-7. Applicability of chapters.

This chapter shall not apply to a life insurance policy, disability income policy, accidental death or dismemberment policy, medicare supplement policy, long-term care insurance policy, credit insurance policy, specified disease policy, hospital indemnity policy, blanket accident and sickness policy, franchise policy issued on an individual basis to members of an association, limited accident policy, health insurance policy written as a part of workers' compensation equivalent coverage, or other similar limited accident and sickness policy.

History. — Code 1981, § 33-54-7, enacted by Ga. L. 1995, p. 1242, § 4.

33-54-8. Violations of chapter.

(a) Any violation of this chapter by an insurer shall be unfair trade practice subject to the provisions of Article 1 of Chapter 6 of this title, and a violation of this chapter by any other person shall be an unfair practice and shall be subject to the provisions of Part 2 of Article 15 of Chapter 1 of Title 10, the "Fair Business Practices Act of 1975." In addition, any individual who is harmed as a result of a violation of this chapter shall have a cause of action against the person whose violation caused the harm.

(b) Any insurer that is found in violation of the provisions of this chapter by a court of competent jurisdiction is liable to the individual injured by the violation in an amount equal to any actual damages suffered by the individual. In the alternative, the court may issue an order directing the insurer to provide accident and sickness insurance to the injured individual under the same terms and conditions as would have applied had the violation not occurred.

(c) The court shall award costs and reasonable attorney's fees to any individual who is successful in enforcing the provision of this chapter.

History. — Code 1981, § 33-54-8, enacted by Ga. L. 1995, p. 1242, § 4.

CHAPTER 55

REPORTING OF TRANSACTIONS BY INSURERS

Sec.
33-55-1. Insurers to report acquisitions and dispositions of assets and material changes to ceded reinsurance agreements to Commissioner.
33-55-2. "Material" acquisition or disposition defined; scope of reporting requirement; information to be included in report.
33-55-3. "Material" nonrenewal, cancellation, or revision of ceded reinsurance agreement defined; scope of reporting requirement; information to be included in report.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1995, this chapter, originally designated as Chapter 54 of this title, was redesignated as Chapter 55.

33-55-1. Insurers to report acquisitions and dispositions of assets and material changes to ceded reinsurance agreements to Commissioner.

(a) Every insurer domiciled in this state shall file a report with the Commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless such acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the Commissioner for review, approval, or information purposes pursuant to other provisions of this title, regulations, or other requirements.

(b)(1) The report required in subsection (a) of this Code section is due within 15 days after the end of the calendar month in which any of the covered transactions occur.

(2) One complete copy of the report, including any exhibits or other attachments filed as part thereof, shall be filed with:

(A) The Commissioner; and

(B) The National Association of Insurance Commissioners.

(c) All reports obtained by or disclosed to the Commissioner pursuant to this Code section shall be given confidential treatment, shall not be subject to subpoena, and shall not be made public by the Commissioner, the National Association of Insurance Commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the Commissioner, after giving the insurer who would be affected thereby

notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by the publication thereof, in which event the Commissioner may publish all or any part thereof in such manner as he or she may deem appropriate.

History. — Code 1981, § 33-55-1, enacted by Ga. L. 1995, p. 1348, § 8; Ga. L. 2019, p. 533, § 1-18/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "of Insurance" following "Commissioner" in subparagraph (b)(2)(A).

33-55-2. "Material" acquisition or disposition defined; scope of reporting requirement; information to be included in report.

(a) No acquisitions or dispositions of assets need be reported pursuant to Code Section 33-55-1 if the acquisitions or dispositions are not material. For purposes of this chapter, a material acquisition or disposition or the aggregate of any series of related acquisitions or related dispositions during any 30 day period is one that is nonrecurring and not in the ordinary course of business and involves more than 5 percent of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(b)(1) Asset acquisitions subject to this chapter include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(2) Asset dispositions subject to this chapter include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(c)(1) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(A) Date of the transaction;

(B) Manner of acquisition or disposition;

(C) Description of the assets involved;

(D) Nature and amount of the consideration given or received;

(E) Purpose of or reason for the transaction;

(F) Manner by which the amount of consideration was determined;

(G) Gain or loss recognized or realized as a result of the transaction; and

(H) Name or names of the person or persons from whom the assets were acquired or to whom they were disposed.

(2) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct premiums plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5 percent of the insurer's capital and surplus.

History. — Code 1981, § 33-55-2, enacted by Ga. L. 1995, p. 1348, § 8.

Editor's notes. — Ga. L. 2019, p. 337, § 1-93/SB 132, purported to substitute "Department of Insurance" for "Insurance Department", but the term "Insurance Department" (as capitalized) does not exist in this Code section.

33-55-3. "Material" nonrenewal, cancellation, or revision of ceded reinsurance agreement defined; scope of reporting requirement; information to be included in report.

(a) Nonrenewals, cancellations, or revisions of ceded reinsurance agreements shall not be required to be reported pursuant to Code Section 33-55-1 if the nonrenewals, cancellations, or revisions are not material. For purposes of this chapter, a material nonrenewal, cancellation, or revision is one that affects:

(1) With respect to property and casualty business, including accident and health business written by a property and casualty insurer:

(A) More than 50 percent of the insurer's total ceded written premium; or

(B) More than 50 percent of the insurer's total ceded indemnity and loss adjustment reserves;

(2) With respect to life, annuity, and accident and sickness business, more than 50 percent of the total reserve credit taken for business ceded on an annualized basis, as indicated in the insurer's most recent annual statement; or

(3) With respect to either property and casualty or life, annuity, and accident and sickness business, either of the following events shall constitute a material revision which must be reported:

(A) An authorized reinsurer representing more than 10 percent of a total cession is replaced by one or more unauthorized reinsurers; or

(B) Previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10 percent of a total cession.

(b) Notwithstanding the provisions of subsection (a) of this Code section, no filing shall be required if:

(1) With respect to property and casualty business, including accident and sickness business written by a property and casualty insurer, the insurer's total written premium represents, on an annualized basis, less than 10 percent of its total written premium for direct and assumed business; or

(2) With respect to life, annuity, and accident and sickness business, the total reserve credit taken for business ceded represents, on an annualized basis, less than 10 percent of the statutory reserve requirement prior to any cession.

(c)(1) The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(A) The effective date of the nonrenewal, cancellation, or revision;

(B) The description of the transaction with an identification of the initiator thereof;

(C) The purpose of or reason for the transaction; and

(D) The identity of the replacement reinsurers, if applicable.

(2) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct premiums plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5 percent of the insurer's capital and surplus.

History. — Code 1981, § 33-55-3, enacted by Ga. L. 1995, p. 1348, § 8.

CHAPTER 56

RISK-BASED CAPITAL LEVELS

Sec.
33-56-1. Definitions.
33-56-2. Annual risk-based capital level report required; computations.
33-56-3. Company action level events; preparation and submission of risk-based capital level plan; hearing; out-of-state filing.
33-56-4. Regulatory action level events; preparation and submission of risk-based capital level plan; determination of corrective actions; hearing; expenses.
33-56-5. Authorized control level events; actions by Commissioner.
33-56-6. Mandatory control level events; actions by Commissioner.
33-56-7. Notification to insurer of determination or action by Commissioner; right to hearing.
33-56-8. Confidentiality of certain information and corrective orders.
33-56-9. Chapter supplemental to other laws; exemption for certain domestic property and casualty insurance.
33-56-10. Foreign insurers; responsibility of domestic insurers to other states.
33-56-11. Immunity of Commissioner and department.
33-56-12. Severability [Repealed].
33-56-13. Effective date of notices by Commissioner.

33-56-1. Definitions.

As used in this chapter, the term:

(1) "Adjusted RBC report" means an RBC report which has been adjusted in accordance with subsection (e) of Code Section 33-56-2.

(2) "Corrective order" means an order issued by the Commissioner specifying corrective actions which the Commissioner has determined are required.

(3) "Domestic insurer" means an insurer as defined in paragraph (4) of Code Section 33-3-1.

(4) "Foreign insurer" means any insurance company which is licensed to do business in this state under Chapter 3 of this title, but is not a domestic insurer.

(4.1) "Health organization" means any health maintenance organization; limited health service organization; hospital, medical, or dental indemnity or service corporation; or other managed care organization licensed under this title; provided, however, that health organization does not include any life and health insurer or property and casualty insurer.

(4.2) "Insurer" includes without limitation any health organization.

(5) "Life and health insurer" means any insurance company licensed to write insurance as defined in Code Section 33-7-2 or 33-7-4

or a licensed property and casualty insurer writing only accident and health insurance.

(6) "NAIC" means the National Association of Insurance Commissioners.

(7) "Negative trend" means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the life RBC instructions.

(8) "Property and casualty insurer" means any insurance company licensed to write insurance as defined in Code Section 33-7-3 or 33-7-6 but shall not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC" means risk-based capital.

(10) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(11) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(A) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(B) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(C) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(D) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(12) "RBC plan" means a comprehensive financial plan containing the elements specified in subsection (b) of Code Section 33-56-3. If the Commissioner rejects the RBC plan and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the revised RBC plan.

(13) "RBC report" means the report required in Code Section 33-56-2.

(14) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus, which in the case of a health organization shall be determined in accordance with the

statutory accounting applicable to the annual financial statements required to be filed; and

(B) Such other items, if any, as the RBC instructions may provide.

History. — Code 1981, § 33-56-1, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, §§ 8, 9; Ga. L. 2011, p. 449, § 12/HB 413.

Law reviews. — For review of 1996 risk-based capital legislation, see 13 Ga. St. U.L. Rev. 212 (1996).

33-56-2. Annual risk-based capital level report required; computations.

(a) Every domestic insurer shall, on or prior to each March 1, prepare and submit to the Commissioner a report of its RBC levels, as of the end of the previous calendar year, containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(1) With the NAIC in accordance with the RBC instructions; and

(2) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(A) Fifteen days from the receipt of notice to file its RBC report with that state; or

(B) March 1.

(b) A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(1) The risk with respect to the insurer's assets;

(2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) The interest rate risk with respect to the insurer's business; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions,

determined in each case by applying the factors in the manner set forth in the RBC instructions.

(c) A property and casualty insurer's or health organization's RBC shall be determined in accordance with the formula set forth in the RBC

instructions. The formula shall take into account and may adjust for the covariance between:

(1) Asset risk;

(2) Credit risk;

(3) Underwriting risk; and

(4) All other business risks and such other relevant risks as are set forth in the RBC instructions,

determined in each case by applying the factors in the manner set forth in the RBC instructions.

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in the chapter and the formulas, schedules, and instructions referenced in this chapter is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this chapter. Additional capital is useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and is not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.

(e) If a domestic insurer files an RBC report which in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC report and notify the insurer of the inaccuracy. The notice shall contain a statement of the reason for the inaccuracy. The insurer must, within 30 days, correct the inaccuracy or request a hearing. If the insurer fails to correct the inaccuracy or to request a hearing, the Commissioner may order a hearing to determine the corrections that are necessary. An RBC report adjusted in accordance with this subsection is referred to as an adjusted RBC report.

History. — Code 1981, § 33-56-2, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, § 10.

33-56-3. Company action level events; preparation and submission of risk-based capital level plan; hearing; out-of-state filing.

(a) As used in this Code section, "company action level event" means any of the following events:

(1) The filing of an RBC report by an insurer which indicates that:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(B) If a life and health insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and has a negative trend;

(C) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions; or

(D) If a health organization has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(2) The notification by the Commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (1) of this subsection, provided the insurer does not challenge the adjusted RBC report under Code Section 33-56-7; or

(3) If, pursuant to Code Section 33-56-7, an insurer challenges an adjusted RBC report that indicates the event in paragraph (1) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the Commissioner an RBC plan which shall:

(1) Identify the conditions which contribute to the company action level event;

(2) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(3)(A) Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus, or surplus, except as otherwise provided by subparagraph (B) of this paragraph.

(B) In the case of a health organization, provide projections of the health organization's financial results in the current year and at least the two succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective

actions, including projections of statutory balance sheet, operating income, net income, capital and surplus, and RBC levels. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(c) An RBC plan shall be submitted:

(1) Within 45 days of the company action level event; or

(2) If the insurer challenges an adjusted RBC report pursuant to Code Section 33-56-7, within 45 days after notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within 60 days after the submission by an insurer of an RBC plan to the Commissioner, the Commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination and may set forth proposed revisions which will render the RBC plan satisfactory in the judgment of the Commissioner. Upon notification from the Commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the revised RBC plan to the Commissioner:

(1) Within 45 days after the notification from the Commissioner; or

(2) If the insurer challenges the notification from the Commissioner under Code Section 33-56-7, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the Commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the Commissioner may at the Commissioner's discretion, subject to the insurer's right to a hearing under Code Section 33-56-7, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer which files an RBC plan or revised RBC plan with the Commissioner shall file a copy of the RBC plan or revised

RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(1) Such state has an RBC provision substantially similar to subsection (a) of Code Section 33-56-8; and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) Fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date on which the RBC plan or revised RBC plan is filed under subsection (c) or (d) of this Code section.

History. — Code 1981, § 33-56-3, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, § 11; Ga. L. 2011, p. 449, § 13/HB 413; Ga. L. 2016, p. 519, § 2/HB 884; Ga. L. 2017, p. 142, § 1/HB 74; Ga. L. 2017, p. 774, § 33/HB 323.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "a" was deleted preceding "company action" in subsection (a) and the quotation marks were added.

33-56-4. Regulatory action level events; preparation and submission of risk-based capital level plan; determination of corrective actions; hearing; expenses.

(a) For the purposes of this Code section, "regulatory action level event" means, with respect to any insurer, any of the following events:

(1) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(2) The notification by the Commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (1) of this subsection, provided the insurer does not challenge the adjusted RBC report under Code Section 33-56-7;

(3) If, pursuant to Code Section 33-56-7, the insurer challenges an adjusted RBC report that indicates the event in paragraph (1) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has corrected the failure within ten days after the filing date;

(5) The failure of the insurer to submit an RBC plan to the Commissioner within the time period set forth in subsection (c) of Code Section 33-56-3;

(6) Notification by the Commissioner to the insurer that:

(A) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

(B) Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under Code Section 33-56-7;

(7) If, pursuant to Code Section 33-56-7, the insurer challenges a determination by the Commissioner under paragraph (6) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

(8) Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under Code Section 33-56-7; or

(9) If, pursuant to Code Section 33-56-7, the insurer challenges a determination by the Commissioner under paragraph (8) of this subsection, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the challenge.

(b) In the event of a regulatory action level event, the Commissioner shall:

(1) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(2) Perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(3) Subsequent to the examination or analysis described in paragraph (2) of this subsection, issue an order specifying such corrective actions as the Commissioner shall determine are required.

(c) In determining corrective actions, the Commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(1) Within 45 days after the occurrence of the regulatory action level event;

(2) If the insurer challenges an adjusted RBC report pursuant to Code Section 33-56-7 and the challenge is not frivolous in the judgment of the Commissioner within 45 days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge; or

(3) If the insurer challenges a revised RBC plan pursuant to Code Section 33-56-7 and the challenge is not frivolous in the judgment of the Commissioner, within 45 days after the notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review a health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities, and operations, including contractual relationships, of the health organization, and formulate the corrective order with respect to the health organization. The fees, costs, and expenses relating to consultants shall be borne by the affected health organization or such other party as directed by the Commissioner.

History. — Code 1981, § 33-56-4, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, § 12.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "a" was deleted preceding "regulatory action" in subsection (a) and the quotation marks were added, and "the" was inserted preceding "Commissioner" near the end of paragraph (c)(2).

33-56-5. Authorized control level events; actions by Commissioner.

(a) For the purposes of this Code section, "authorized control level event" means any of the following events:

(1) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(2) The notification by the Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (1) of this subsection, provided the insurer does not challenge the adjusted RBC report under Code Section 33-56-7;

(3) If, pursuant to Code Section 33-56-7, the insurer challenges an adjusted RBC report that indicates the event in paragraph (1) of this subsection, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

(4) The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a corrective order; or

(5) If the insurer has challenged a corrective order under Code Section 33-56-7 and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(b) In the event of an authorized control level event with respect to an insurer, the Commissioner shall:

(1) Take such actions as are required under Code Section 33-56-4 regarding an insurer with respect to which a regulatory action level event has occurred; or

(2) If the Commissioner deems it to be in the best interests of the policy holders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Chapter 37 of this title.

In the event the Commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 37 of this title, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Chapter 37 of this title. In the event the Commissioner takes actions under this paragraph pursuant to an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Chapter 2 of this title pertaining to summary proceedings.

History. — Code 1981, § 33-56-5, enacted by Ga. L. 1996, p. 928, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, the comma and quotation marks were inserted in subsection (a).

33-56-6. Mandatory control level events; actions by Commissioner.

(a) For purposes of this Code section, "mandatory control level event" means any of the following events:

(1) The filing of an RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(2) Notification by the Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (1) of this subsection, provided that the insurer does not challenge the adjusted RBC report under Code Section 33-56-7; or

(3) If, pursuant to Code Section 33-56-7, the insurer challenges an adjusted RBC report that indicates the event in paragraph (1) of this

subsection, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a mandatory control level event:

(1) With respect to a life insurer or health organization, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 37 of this title. In that event, the mandatory control level event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 37 of this title, and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Chapter 37 of this title. If the Commissioner takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of Chapter 2 of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forgo action for up to 90 days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90 day period.

(2) With respect to a property and casualty insurer, the Commissioner shall take such actions as are necessary to place the insurer under regulatory control under Chapter 37 of this title, or in the case of an insurer which is writing no business and which is running-off its existing business may allow the insurer to continue its run-off under the supervision of the Commissioner. In either event, the mandatory control level event shall be deemed sufficient grounds for the Commissioner to take action under Chapter 37 of this title and the Commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Chapter 37 of this title. If the Commissioner takes actions pursuant to an adjusted RBC report, the insurer shall be entitled to the protections of Chapter 2 of this title pertaining to summary proceedings. Notwithstanding any of the foregoing, the Commissioner may forgo action for up to 90 days after the mandatory control level event if the Commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90 day period.

History. — Code 1981, § 33-56-6, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1246, § 13; Ga. L. 2005, p. 60, § 33/HB 95.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "forgo" was substituted for "forego" in the last sentence of paragraph (b)(1).

33-56-7. Notification to insurer of determination or action by Commissioner; right to hearing.

Upon notification:

(1) To an insurer by the Commissioner of an adjusted RBC report;

(2) To an insurer by the Commissioner that:

(A) The insurer's RBC plan or revised RBC plan is unsatisfactory; and

(B) Such notification constitutes a regulatory action level event with respect to such insurer;

(3) To any insurer by the Commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(4) To an insurer by the Commissioner of a corrective order with respect to the insurer,

the insurer shall have the right to a departmental hearing, on a record, at which the insurer may challenge any determination or action by the Commissioner. The insurer shall notify the Commissioner of its request for a hearing within five days after the notification by the Commissioner under this Code section. Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which date shall be no less than ten nor more than 30 days after the date of the insurer's request.

History. — Code 1981, § 33-56-7, enacted by Ga. L. 1996, p. 928, § 1.

33-56-8. Confidentiality of certain information and corrective orders.

(a) Notwithstanding the provisions of Article 4 of Chapter 18 of Title 50, all RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant hereto, and any corrective order issued by the Commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer, which are filed with the Commissioner, constitute information that might be damaging to the insurer if made available to its competitors and therefore shall be kept confidential by the Commissioner. This information shall not be made public or be subject to subpoena, other

than by the Commissioner, and then only for the purpose of enforcement actions taken by the Commissioner pursuant to this chapter or any other provision of the insurance laws of this state.

(b) It is the judgment of the General Assembly that the comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this chapter, the making, publishing, disseminating, circulating, or placing before the public or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio or television station or in any other way an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or of any component derived in the calculation by any insurer, agent, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, of such statement, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false or inappropriate statement.

(c) It is the further judgment of the General Assembly that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the Commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the Commissioner for rate-making purposes, considered or introduced as evidence in any rate proceeding, or used by the Commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

History. — Code 1981, § 33-56-8, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2005, p. 60, § 33/HB 95.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, seven commas were deleted and five commas were inserted in the second sentence of subsection (b).

33-56-9. Chapter supplemental to other laws; exemption for certain domestic property and casualty insurance.

(a) The provisions of this chapter are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the Commissioner under such laws, including, but not limited to, Chapters 2, 3, 13, 14, 20, 21, and 37 of this title.

(b) The Commissioner may exempt from the application of this chapter any domestic property and casualty insurer which:

(1) Meets all three of the following criteria:

(A) Writes direct business only in this state;

(B) Writes direct annual premiums of $2 million or less; and

(C) Assumes no reinsurance in excess of 5 percent of direct premium written; or

(2) Demonstrates to the satisfaction of the Commissioner by other means that preparation and submission of an RBC report would create an unusual and unnecessary hardship or would result in a report which is ambiguous or misleading based upon the unique nature of the company's product offerings or financial structure.

(c) The Commissioner may exempt from the application of this chapter any health organization which:

(1) Has less than 1,000 covered lives; and

(2) Has less than $1 million in direct written premiums.

History. — Code 1981, § 33-56-9, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 1999, p. 1234, § 1; Ga. L. 2000, p. 1246, § 14; Ga. L. 2019, p. 533, § 1-19/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "18, 19," following "14," in subsection (a); deleted former subsection (b), which read: "The Commissioner may adopt reasonable rules necessary for the implementation of this chapter."; and redesignated former subsections (c) and (d) as present subsections (b) and (c), respectively.

33-56-10. Foreign insurers; responsibility of domestic insurers to other states.

(a) Any foreign insurer shall, upon the written request of the Commissioner, submit to the Commissioner an RBC report as of the end of the previous calendar year the later of:

(1) The date an RBC report would be required to be filed by a domestic insurer under this chapter; or

(2) Fifteen days after the request is received by the foreign insurer.

(b) Any foreign insurer shall, at the written request of the Commissioner, promptly submit to the Commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(c) In the event of a company action level event, regulatory action level event, or authorized control level event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer, or, if no RBC statute is in force in that state, under the provisions of this chapter, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute, or, if no RBC statute is in force in that state, under Code Section 33-56-2, the Commissioner may require the foreign insurer to file an RBC plan with the Commissioner. In such event, the failure of the foreign insurer to file an RBC plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(d) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the superior court permitted under Chapter 37 of this title with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

(e) The primary responsibility for requiring a domestic insurer to submit RBC reports and take any corrective action rests exclusively with the Commissioner. If, in the judgment of the Commissioner, a domestic insurer has responded promptly and adequately to the department according to the requirements of this Code section, then such domestic insurer should be exempt from responding to separate requests for reports or corrective action from the commissioner of insurance of any other state where the domestic insurer does business. The domestic insurer may request that the information supplied to the Commissioner be shared with the insurance commissioner of any other state, and such information should be accepted by such other insurance commissioner in recognition of the Georgia Commissioner's primary responsibility for, and oversight of, the risk-based capital law as it pertains to domestic insurers.

(f) If the Commissioner determines that a domestic insurer is still being required to respond to separate requests for reports or corrective action under the terms of this Code section, then such request shall constitute prima-facie evidence that such other state is imposing a requirement which exceeds the requirements imposed by Georgia law,

triggering the provisions of the retaliatory law in Code Section 33-3-26. In such cases, the Commissioner is thereupon authorized to require separate risk-based capital reports or corrective action requirements from each and every insurer doing business in Georgia whose home state commissioner has imposed such requirements on any Georgia domestic insurer.

History. — Code 1981, § 33-56-10, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 1999, p. 1234, § 2.

33-56-11. Immunity of Commissioner and department.

There shall be no liability on the part of, and no cause of action shall arise against, the Commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

History. — Code 1981, § 33-56-11, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2019, p. 533, § 1-20/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "insurance" preceding "department" in the middle of this Code section.

33-56-12. Severability.

Reserved. Repealed by Ga. L. 2019, p. 533, § 1-21/HB 99, effective July 1, 2019.

Editor's notes. — This Code section was based on Code 1981, § 33-56-12, enacted by Ga. L. 1996, p. 928, § 1.

33-56-13. Effective date of notices by Commissioner.

All notices by the Commissioner to an insurer which may result in regulatory action under this chapter shall be effective upon dispatch if transmitted by registered or certified mail or statutory overnight delivery or, in the case of any other transmission, shall be effective upon the insurer's receipt of such notice.

History. — Code 1981, § 33-56-13, enacted by Ga. L. 1996, p. 928, § 1; Ga. L. 2000, p. 1589, § 3.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 1996, "under this chapter" was substituted for "hereunder" in this Code section.

Editor's notes. — Ga. L. 2000, p. 1589, § 16, not codified by the General Assembly, provides that the amendment to this Code section is applicable with respect to notices delivered on or after July 1, 2000.

CHAPTER 57

CONSUMERS' INSURANCE ADVOCATE

Sec.
33-57-1 through 33-57-8 [Repealed].

Law reviews. — For annual survey article discussing developments in insurance law, see 51 Mercer L. Rev. 313 (1999).

For note on 1999 enactment of this chapter, see 16 Ga. St. U. L. Rev. 133 (1999).

33-57-1 through 33-57-8.

Reserved. Repealed by Ga. L. 2015, p. 1088, § 24/SB 148, effective July 1, 2015.

Editor's notes. — This chapter was based on Code 1981, § 33-57-1, enacted by Ga. L. 1999, p. 335, § 2; Ga. L. 2000, p. 1589, § 3; Ga. L. 2012, p. 701, § 2/HB 786.

CHAPTER 58

CHARITABLE GIFT ANNUITIES

Sec.
33-58-1. Definitions.
33-58-2. Qualified charitable gift annuities.
33-58-3. Agreement for annuity; notice.
33-58-4. Notice of annuity to Commissioner.
33-58-5. Failure to comply with notice.
33-58-6. Issuance not violation of Title 10.

Law reviews. — For note on 2000 enactment of this chapter, see 17 Ga. St. U.L. Rev. 208 (2000).

33-58-1. Definitions.

As used in this chapter, the term:

(1) "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes.

(2) "Charitable organization" means an entity described by:

(A) Section 501(c)(3), Internal Revenue Code of 1986 (26 U.S.C. Section 501(c)(3)); or

(B) Section 170(c), Internal Revenue Code of 1986 (26 U.S.C. Section 170(c)).

(3) "Qualified charitable gift annuity" means a charitable gift annuity described in Section 501(m)(5), Internal Revenue Code of 1986 (26 U.S.C. Section 501(m)(5)), and Section 514(c)(5), Internal Revenue Code of 1986 (26 U.S.C. Section 514(c)(5)), that is issued by a charitable organization that on the date of the annuity agreement:

(A) Has a minimum of $300,000.00 in unrestricted cash, cash equivalents, or publicly traded securities, exclusive of the assets funding the annuity agreement; and

(B) Has been in continuous operation for at least three years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least three years.

History. — Code 1981, § 33-58-1, enacted by Ga. L. 2000, p. 868, § 1.

33-58-2. Qualified charitable gift annuities.

(a) The issuance of a qualified charitable gift annuity does not constitute engaging in the business of insurance in this state.

(b) A charitable gift annuity issued before July 1, 2000, is a qualified charitable gift annuity for purposes of this chapter, and the issuance of that charitable gift annuity does not constitute engaging in the business of insurance in this state.

History. — Code 1981, § 33-58-2, enacted by Ga. L. 2000, p. 868, § 1.

33-58-3. Agreement for annuity; notice.

(a) When entering into an agreement for a qualified charitable gift annuity, the charitable organization shall disclose to the donor in writing in the annuity agreement that a qualified charitable gift annuity is not insurance under the laws of this state and is not subject to regulation by the Commissioner of Insurance or protected by an insurance guaranty association.

(b) The notice provisions required by this Code section must be in a separate paragraph in a print size no smaller than that employed in the annuity agreement generally.

History. — Code 1981, § 33-58-3, enacted by Ga. L. 2000, p. 868, § 1.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2000, "Commissioner of Insurance" was substituted for "Insurance Commissioner" in subsection (a).

33-58-4. Notice of annuity to Commissioner.

(a) A charitable organization that issues qualified charitable gift annuities shall notify the Commissioner in writing by the date on which it enters into the organization's first qualified charitable gift annuity agreement. The notice shall:

(1) Be signed by an officer or director of the organization;

(2) Identify the organization; and

(3) Certify that:

(A) The organization is a charitable organization; and

(B) The annuities issued by the organization are qualified charitable gift annuities.

(b) The charitable organization shall not be required to submit additional information except to determine appropriate penalties that may be applicable under Code Section 33-58-5.

History. — Code 1981, § 33-58-4, enacted by Ga. L. 2000, p. 868, § 1; Ga. L. 2019, p. 533, § 1-22/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "later of October 1, 2000, or the" following "writing by the" in the middle of the first sentence of subsection (a).

33-58-5. Failure to comply with notice.

The failure of a charitable organization to comply with the notice requirements imposed under Code Section 33-58-3 or Code Section 33-58-4 does not prevent a charitable gift annuity that otherwise meets the requirements of this chapter from constituting a qualified charitable gift annuity. The Commissioner may enforce performance of the requirements of Code Section 33-58-3 or Code Section 33-58-4 by sending a letter by certified mail, or statutory overnight delivery, return receipt requested, demanding that the charitable organization comply with the requirements of such Code sections. The Commissioner may fine the charitable organization in an amount not to exceed $1,000.00 per qualified charitable gift annuity agreement issued until such time as the charitable organization complies with such Code sections.

History. — Code 1981, § 33-58-5, enacted by Ga. L. 2000, p. 868, § 1; Ga. L. 2001, p. 1212, § 4.

Editor's notes. — Ga. L. 2001, p. 1212, § 7, not codified by the General Assembly, provides that this Act is applicable with respect to notices delivered on or after July 1, 2001.

33-58-6. Issuance not violation of Title 10.

The issuance of a qualified charitable gift annuity does not constitute a violation of Article 15 of Chapter 1 of Title 10.

History. — Code 1981, § 33-58-6, enacted by Ga. L. 2000, p. 868, § 1.

CHAPTER 59

LIFE SETTLEMENTS

Sec.
33-59-1. Short title.
33-59-2. Definitions.
33-59-3. License requirements; representation of producers; exceptions; application and renewal; fees; licenses for legal entities; investigations; nonresident applicants; required information from provider; continued training requirements.
33-59-4. Suspension, revocation, or refusal to renew licenses; grounds; hearing required.
33-59-5. Filing of contracts and disclosure statements with the Commissioner; approval or disapproval.
33-59-6. Filing of annual statement with the Commissioner; confidential information.
33-59-7. Examination of licensees and businesses; record retention requirements; examination reports; orders; hearings; confidentiality of examination information; conflict of interest; immunity; investigative authority of the Commissioner.
33-59-8. Advertising.
33-59-9. Required written disclosures; consequence for failure to provide.
33-59-10. Lender-financed premiums using policy as collateral; disclosures and certifications.
33-59-11. Required documents and information; confidentiality; seller's right to rescind; escrow proceedings; failure to tender consideration; limitation on contracts with the insured for the purpose of determining the insured's health status.
33-59-12. Determining governing law when multiple owners.
33-59-13. Unlawful activities deemed fraudulent life settlement act.
33-59-14. Violations; required statement; reporting of fraudulent acts to the Commissioner; immunity for providing information concerning fraudulent acts; confidentiality of documents and evidence; mandatory adoption of antifraud initiatives by providers.
33-59-15. Remedies and penalties for violations; procedural issues.
33-59-16. Fraudulent life settlement acts prohibited; criminal and civil penalties; revocation of license.
33-59-17. Unfair trade practice.
33-59-18. Transacting business permitted while the provider's license application is pending [Repealed].

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, Code Sections 33-59-1 through 33-59-6, as enacted by Ga. L. 2005, p. 1229, § 1, were redesignated as Code Sections 33-60-1 through 33-60-6.

Editor's notes. — Ga. L. 2005, p. 998, § 2/SB 217, not codified by the General Assembly, provides for severability.

33-59-1. Short title.

This chapter shall be known and may be cited as the "Life Settlements Act."

History. — Code 1981, § 33-59-1, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.

RESEARCH REFERENCES

ALR. — State regulation of viatical life insurance programs, viatical settlements, and viatical investments, 28 A.L.R.6th 281.

33-59-2. Definitions.

As used in this chapter, the term:

(1) "Advertisement" means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed directly before the public in this state for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract.

(2) "Business of life settlements" means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking of life settlement contracts.

(3) "Chronically ill" means:

(A) Being unable to perform at least two activities of daily living such as eating, toileting, transferring, bathing, dressing, or continence;

(B) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or

(C) Having a level of disability similar to that described in subparagraph (A) of this paragraph as determined by the United States Secretary of Health and Human Services.

(4) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, but:

(A) Whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of one or more policies; and

(B) Who has an agreement in writing with one or more providers to finance the acquisition of life settlement contracts.

"Financing entity" does not include a nonaccredited investor or purchaser.

(5) "Financing transaction" means a transaction in which a licensed provider obtains financing from a financing entity including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

(6) "Fraudulent life settlement act" includes:

(A) Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, engages in acts, or permits its employees or its agents to engage in acts, including, but not limited to:

(i) Presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, life settlement broker, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(I) An application for the issuance of a life settlement contract or insurance policy;

(II) The underwriting of a life settlement contract or insurance policy;

(III) A claim for payment or benefit pursuant to a life settlement contract or insurance policy;

(IV) Premiums paid on an insurance policy;

(V) Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or insurance policy;

(VI) The reinstatement or conversion of an insurance policy;

(VII) The solicitation, offer to enter into, or effectuation of a life settlement contract or insurance policy;

(VIII) The issuance of written evidence of life settlement contracts or insurance;

(IX) Any application for or the existence of or any payments related to a loan secured directly or indirectly by an interest in a life insurance policy; or

(X) Stranger originated life insurance as defined in paragraph (24) of this Code section;

(ii) Failing to disclose to the insurer where the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy;

(iii) Employing any device, scheme, or artifice to defraud in the business of life settlements; or

(iv) In the solicitation, application, or issuance of a life insurance policy, employing any device, scheme, or artifice in violation of state insurable interest laws; and

(B) In the furtherance of a fraud or to prevent the detection of a fraud, acts or omissions of any person, its employees, or its agents acting with such person's permission, to:

(i) Remove, conceal, alter, destroy, or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of life settlements;

(ii) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person;

(iii) Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements;

(iv) File with the Commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise conceal information about a material fact from the Commissioner;

(v) Engage in embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a provider, insurer, insured, insurance policy owner, or any other person engaged in the business of life settlements or insurance;

(vi) Knowingly and with intent to defraud, enter into, broker, or otherwise deal in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer;

(vii) Attempt to commit, assist, aid, or abet in the commission of, or conspiracy to commit, the acts or omissions specified in this paragraph; or

(viii) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this chapter for the purpose of evading or avoiding the provisions of this chapter.

(7) "Insured" means the person covered under the policy being considered for sale in a life settlement contract.

(8) "Life expectancy" means the arithmetic mean of the number of months the insured under the life insurance policy to be settled can be expected to live as determined by professionally competent individuals considering medical records and appropriate experiential data.

(9) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to Chapter 23 of this title.

(10) "Life settlement broker" means a person who, on behalf of an owner and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and providers. A life settlement broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner's instructions, and in the best interest of the owner, notwithstanding the manner in which the life settlement broker is compensated. A life settlement broker does not include an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in their professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person, except the owner.

(11)(A) "Life settlement contract" means a written agreement entered into between a provider and an owner establishing the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or any portion of an insurance policy or certificate of insurance for compensation; provided, however, that the minimum value for a life settlement contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract. "Life settlement contract" also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of a person residing in this state.

(B) "Life settlement contract" also includes:

(i) A written agreement for a loan or other lending transaction, secured primarily by an individual or group life insurance policy; and

(ii) A premium finance loan made for a policy on or before the date of issuance of the policy where:

(I) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing;

(II) The owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(III) The owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

(C) Life settlement contract does not include:

(i) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider;

(ii) A premium finance loan, as defined in paragraph (18) of this Code section, or any loan made by a bank or other licensed financial institution, provided that neither default on such loan nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this chapter;

(iii) A collateral assignment of a life insurance policy by an owner;

(iv) A loan made by a lender that does not violate Chapter 22 of this title, provided such loan is not described in this paragraph as being included in the definition of a life settlement contract and is not otherwise within the definition of life settlement contract;

(v) An agreement where all the parties are closely related to the insured by blood or law or have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured or are trusts established primarily for the benefit of such parties;

(vi) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by

the employer, or trust established by the employer, of life insurance on the life of the employee;

(vii) A bona fide business succession planning arrangement between:

(I) One or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trust established by its shareholders;

(II) One or more partners in a partnership or between a partnership and one or more of its partners or one or more trust established by its partners; or

(III) One or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trust established by its members;

(viii) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(ix) Any other contract, transaction, or arrangement from the definition of life settlement contract that the Commissioner determines is not of the type intended to be regulated by this chapter.

(12) "Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens.

(13) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a life settlement contract. For the purposes of this chapter, an owner shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except where specifically addressed. "Owner" does not include:

(A) Any provider or other licensee under this chapter;

(B) A qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as amended;

(C) A financing entity;

(D) A special purpose entity; or

(E) A related provider trust.

(14) "Patient identifying information" means an insured's address, telephone number, facsimile number, e-mail address, photograph or

likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

(15) "Person" means any natural person or a legal entity, including, but not limited to, a partnership, limited liability company, association, trust, or corporation.

(16) "Policy" means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(17) "Premium finance loan" is a loan made primarily for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(18) "Provider" means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner. A provider does not include:

(A) Any bank, savings bank, savings and loan association, or credit union;

(B) A licensed lending institution or creditor or secured party pursuant to a premium finance loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;

(C) The insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders under this title or cash surrender value;

(D) Any natural person who enters into or effectuates no more than one agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy for compensation or any thing of value less than the expected death benefit payable under the policy;

(E) A purchaser;

(F) Any authorized or eligible insurer that provides stop-loss coverage to a provider, purchaser, financing entity, special purpose entity, or related provider trust;

(G) A financing entity;

(H) A special purpose entity;

(I) A related provider trust;

(J) A life settlement broker; or

(K) An accredited investor or qualified institutional buyer as defined in, respectively, Regulation D, Rule 501, or Rule 144A of the federal Securities Act of 1933, as amended, who purchases a life settlement policy from a provider.

(19) "Purchased policy" means a policy or group certificate that has been acquired by a provider pursuant to a life settlement contract.

(20) "Purchaser" means a person who pays compensation or any thing of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a life settlement contract.

(21) "Related provider trust" means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. In order to qualify as a related provider trust, the trust must have a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the department as if those records and files were maintained directly by the licensed provider.

(22) "Settled policy" means a life insurance policy or certificate that has been acquired by a provider pursuant to a life settlement contract.

(23) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets for a financing entity or provider; or in connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a qualified institutional buyer as defined in Rule 144 promulgated under the federal Securities Act of 1933, as amended, or the securities pay a fixed rate of return commensurate with established asset-backed institutional capital markets.

(24) "Stranger originated life insurance" is a series of acts or a practice to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger originated life insurance acts or practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity who, at the time of policy inception, could not lawfully initiate the policy himself or herself or itself, and where, at

the time of inception, there is an arrangement or agreement to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life. Stranger originated life insurance arrangements do not include those practices set forth in subparagraph (C) of paragraph (11) of this Code section.

(25) "Terminally ill" means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

History. — Code 1981, § 33-59-2, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61; Ga. L. 2010, p. 878, § 33/HB 1387.

33-59-3. License requirements; representation of producers; exceptions; application and renewal; fees; licenses for legal entities; investigations; nonresident applicants; required information from provider; continued training requirements.

(a) No person, wherever located, shall act as a provider or life settlement broker with an owner or multiple owners who are residents of this state without first having obtained a license or acknowledgment of registration from the Commissioner. If there is more than one owner on a single policy and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners.

(b) Application for a provider license or life settlement broker registration shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner and the application shall be accompanied by a fee in an amount established by the Commissioner; provided, however, that the license and renewal fees for a provider license shall be reasonable and that the registration and renewal fees for a life settlement broker registration shall not exceed those established for an insurance producer, as such fees are otherwise provided for in this title.

(c) A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing and registration requirements of this Code section and shall be permitted to operate as a life settlement broker.

(d) Not later than 30 days from the first day of operating as a life settlement broker, the life insurance producer shall notify the Commis-

sioner that he or she is acting as a life settlement broker on a form prescribed by the Commissioner and shall pay any applicable fee to be determined by the Commissioner. Notification shall include an acknowledgment by the life insurance producer that he or she will operate as a life settlement broker in accordance with this chapter.

(e) The insurer that issued the policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a life settlement broker, provider, or purchaser arising out of or in connection with the life settlement transaction unless the insurer receives compensation for the placement of a life settlement contract from the provider, purchaser, or life settlement broker in connection with the life settlement contract.

(f) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency who is retained to represent the owner and whose compensation is not paid directly or indirectly by the provider or purchaser may negotiate life settlement contracts on behalf of the owner without having to obtain a license as a life settlement broker.

(g) Licenses may be renewed every year on May 1 upon payment of the periodic renewal fee. Failure to pay the fee within the terms prescribed shall result in the automatic revocation of the license requiring periodic renewal.

(h) The term of a provider license shall be equal to that of a domestic stock life insurance company and the term of a life settlement broker registration shall be equal to that of an insurance producer license. Licenses or registrations requiring periodic renewal may be renewed on their anniversary date upon payment of the periodic renewal fee as specified in subsection (b) of this Code section. Failure to pay the fees on or before the renewal date shall result in expiration of the license or registration.

(i) The applicant shall provide such information as the Commissioner may require on forms prepared by the Commissioner. The Commissioner shall have the authority, at any time, to require such applicant to fully disclose the identity of its stockholders, except stockholders owning fewer than 10 percent of the shares of an applicant whose shares are publicly traded, partners, officers, and employees, and the Commissioner may, in the exercise of the Commissioner's sole discretion, refuse to issue such a license in the name of any person if not satisfied that any officer, employee, stockholder, or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(j) A license issued to a partnership, corporation, or other entity authorizes all members, officers, and designated employees to act as a

licensee under the license if those persons are named in the application and any supplements to the application.

(k) Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and may issue a license if the Commissioner finds that the applicant:

(1) If a provider, has provided a detailed plan of operation;

(2) Is competent and trustworthy and intends to transact its business in good faith;

(3) Has a good business reputation and has had experience, training, or education so as to be qualified in the business for which the license is applied;

(4) If the applicant is a legal entity, is formed or organized pursuant to the laws of this state or is a foreign legal entity authorized to transact business in this state or provides a certificate of good standing from the state of its domicile; and

(5) Has provided to the Commissioner an antifraud plan that meets the requirements of Code Section 33-59-14 and includes:

(A) A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(B) A description of the procedures for reporting fraudulent insurance acts to the Commissioner;

(C) A description of the plan for antifraud education and training of its underwriters and other personnel; and

(D) A written description or chart outlining the arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(l) The Commissioner shall not issue any license to any nonresident applicant unless a written designation of an agent for service of process is filed and maintained with the Commissioner or unless the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner.

(m) The Commissioner shall not issue a license to any applicant unless the applicant has an adequate net worth as prescribed by order, rule, or regulation.

(n) Each licensee shall file with the Commissioner on or before the first day of May of each year an annual statement containing such information as the Commissioner by rule may prescribe.

(o) A provider shall not use any person to perform the functions of a life settlement broker as defined in paragraph (10) of Code Section 33-59-2 unless the person holds a current, valid registration as a life settlement broker and as provided in this Code section.

(p) A life settlement broker shall not use any person to perform the functions of a provider as defined in paragraph (18) of Code Section 33-59-2 unless such person holds a current, valid license as a provider and as provided in this Code section.

(q) A provider and a life settlement broker shall provide to the Commissioner new or revised information about officers, 10 percent or more stockholders, partners, directors, members, and designated employees within 30 days of any change.

(r) An individual registered as a life settlement broker shall complete on a biennial basis 15 hours of training related to life settlements and life settlement transactions as required by the Commissioner; provided, however, that a life insurance producer who is operating as a life settlement broker pursuant to this Code section shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the Commissioner.

History. — Code 1981, § 33-59-3, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.

33-59-4. Suspension, revocation, or refusal to renew licenses; grounds; hearing required.

(a) The Commissioner may suspend, revoke, or refuse to renew the license of any licensee if the Commissioner finds that:

(1) There was any material misrepresentation in the application for the license;

(2) The licensee or any officer, partner, member, or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action, or is otherwise shown to be untrustworthy or incompetent to act as a licensee;

(3) The provider demonstrates a pattern of unreasonably withholding payments to policy owners;

(4) The licensee no longer meets the requirements for initial licensure;

(5) The licensee or any officer, partner, member, or director has been convicted of a felony or any misdemeanor of which criminal fraud is an element; or the licensee has pleaded guilty or nolo contendere to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element regardless of whether a judgment of conviction has been entered by the court;

(6) The provider has entered into any life settlement contract using a form that has not been approved pursuant to this chapter;

(7) The provider has failed to honor contractual obligations set out in a life settlement contract;

(8) The provider has assigned, transferred, or pledged a settled policy to a person other than a provider licensed in this state, purchaser, accredited investor or qualified institutional buyer as defined, respectively, in Regulation D, Rule 501, or Rule 144A of the federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust;

(9) The licensee or any officer, partner, member, or key management personnel has violated any of the provisions of this chapter; or

(10) The provider has failed to maintain an adequate net worth.

(b) Before the Commissioner denies a license application or suspends, revokes, or refuses to renew the license of any licensee under this chapter, the Commissioner shall conduct a hearing in accordance with Chapter 2 of this title.

History. — Code 1981, § 33-59-4, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.

33-59-5. Filing of contracts and disclosure statements with the Commissioner; approval or disapproval.

(a) No person may use any form of life settlement contract in this state unless it has been filed with and approved, if required, by the Commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies, and contracts.

(b) No insurer may, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a life settlement contract, require that the owner, insured, provider, or life settlement broker sign any form, disclosure, consent, waiver, or acknowledgment that has not been expressly approved by the Commissioner for use in connection with life settlement contracts in this state.

(c) A person shall not use a life settlement contract form or provide to an owner a disclosure statement form in this state unless first filed with and approved by the Commissioner. The Commissioner shall disapprove a life settlement contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of Code Sections 33-59-8, 33-59-9, 33-59-11, and 33-59-15 or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the owner. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

History. — Code 1981, § 33-59-5, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.

33-59-6. Filing of annual statement with the Commissioner; confidential information.

(a)(1) Each provider shall file with the Commissioner on or before May 1 of each year an annual statement containing such information as the Commissioner may prescribe by rule or regulation in addition to any other requirements for any policy settled within five years of policy issuance. In addition to any other requirements, the annual statement shall specify the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the life settlement brokers that have settled said policies.

(2) Such information shall be limited to only those transactions where the insured is a resident of this state and shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

(3) Every provider that willfully fails to file an annual statement as required in this Code section or willfully fails to reply within 30 days to a written inquiry by the Commissioner in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to $250.00 per day of delay, not to exceed $25,000.00 in the aggregate, for each such failure.

(b) Except as otherwise allowed or required by law, a provider, life settlement broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity shall not disclose the identity of an

insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

(1) Is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure;

(2) Is necessary to effectuate the sale of life settlement contracts, or interests therein, as investments, provided that the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure;

(3) Is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of Code Section 33-59-7;

(4) Is a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall be required to comply with the confidentiality requirements of this subsection;

(5) Is necessary to allow the provider or life settlement broker or its authorized representatives to make contacts for the purpose of determining health status. For the purposes of this paragraph, the term "authorized representative" shall not include any person who has or may have any financial interest in the settlement contract other than a provider, registered life settlement broker, financing entity, related provider trust, or special purpose entity. A provider or life settlement broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this chapter; or

(6) Is required to purchase stop-loss coverage.

(c) Nonpublic personal information solicited or obtained in connection with a proposed or actual life settlement contract shall be subject to the provisions applicable to financial institutions under the federal Gramm-Leach-Bliley Act, P.L. 106-102 (1999), and all other state and federal laws relating to confidentiality of nonpublic personal information.

History. — Code 1981, § 33-59-6, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "its" was substituted for "their" preceding "authorized representatives" in the last sentence of paragraph (b)(5).

U.S. Code. — The Gramm-Leach-Bliley Act, referred to in this Code section, is codified at 15 U.S.C. § 6801 et seq.

33-59-7. Examination of licensees and businesses; record retention requirements; examination reports; orders; hearings; confidentiality of examination information; conflict of interest; immunity; investigative authority of the Commissioner.

(a) The Commissioner may, when the Commissioner deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The Commissioner may order any licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether such licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(b) In lieu of an examination under this chapter of any foreign or alien licensee licensed in this state, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

(c) Names of and individual identification data for all owners and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner unless required by law.

(d) Records of all consummated transactions and life settlement contracts shall be maintained by the provider for three years after the death of the insured and shall be available to the Commissioner for inspection during reasonable business hours.

(e)(1) Upon determining that an examination should be conducted, the Commissioner shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and should use those guidelines and procedures set forth in an examiners' handbook adopted by a national organization. The Commissioner may also employ such other guidelines as the Commissioner may deem appropriate.

(2) Every licensee or person from whom information is sought, its officers, directors, and agents shall provide to the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets, and computer or other recordings relating to the property, assets, business, and affairs of the licensee being examined. The officers, directors, employees, and agents of the licensee or person shall facilitate the examination and

aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation, or refusal of any license or authority shall be conducted pursuant to Chapter 2 of this title.

(3) The Commissioner shall have the power to issue subpoenas, to administer oaths, and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a 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.

(4) When making an examination under this Code section, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.

(5) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima-facie evidence in any legal or regulatory action.

(6) Nothing contained in this Code section shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee 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.

(f)(1) Examination reports shall be composed of (A) only facts appearing upon the books, records, or other documents of the licensee, its agents, or other persons examined or as ascertained from the testimony of the licensee's officers or agents or other persons examined concerning the licensee's affairs and (B) such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than 60 days following completion of the examination, the examiner in charge shall file with the Commissioner a verified

written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report and which shall become part of the report or to request a hearing on any matter in dispute if the Commissioner deems such written submission or rebuttal comments appropriate and consistent with the findings of the examination.

(3) In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

(g)(1) Names and individual identification data for all owners, purchasers, and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner unless the disclosure is to another regulator or is required by law.

(2) Except as otherwise provided in this chapter, all examination reports, working papers, recorded information, documents, and copies thereof produced by, 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 or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to the provisions of 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. The Commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties. The licensee being examined may have access to all documents used to make the report except documents and work papers that the Commissioner has deemed privileged.

(h)(1) An examiner shall not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter. This subsection shall not be construed to preclude automatically an examiner from being:

(A) An owner;

(B) An insured in a life settlement contract or insurance policy; or

(C) A beneficiary in an insurance policy that is proposed for a life settlement contract.

(2) Notwithstanding the requirements of this subsection, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions even though these persons may from time to time be similarly employed or retained by persons subject to examination under this chapter.

(i)(1) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives, or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this chapter.

(2) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this chapter if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph shall not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in paragraph (1) of this subsection.

(3) A person identified in paragraph (1) or (2) of this subsection shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this subsection, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(j) The Commissioner may investigate suspected fraudulent life settlement acts and persons engaged in the business of life settlements.

History. — Code 1981, § 33-59-7, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2009, p. 370, § 1/SB 61.

33-59-8. Advertising.

(a) A registered life settlement broker or licensed provider who is registered or licensed pursuant to this chapter may conduct or participate in advertisements within this state. Such advertisements shall comply with all advertising and marketing laws of this state and rules and regulations promulgated by the Commissioner that are applicable to life insurers or to life settlement brokers and providers licensed pursuant to this chapter.

(b) Advertisements shall be accurate, truthful, and not misleading in fact or by implication.

(c) No person or trust shall:

(1) Directly or indirectly, market, advertise, solicit, or otherwise promote the purchase of a policy for the sole purpose of or with a primary emphasis on settling the policy; or

(2) Use the words "free," "no cost," or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy.

History. — Code 1981, § 33-59-8, enacted by Ga. L. 2009, p. 370, § 1/SB 61.
Editor's notes. — Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009, redesignated former Code Section 33-59-8 as present Code Section 33-59-9.

33-59-9. Required written disclosures; consequence for failure to provide.

(a) The provider or broker shall provide in writing, in a separate document that is signed by the owner, the following information no later than the date of the application for a life settlement contract:

(1) The fact that possible alternatives to life settlement contracts exist, including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy;

(2) The fact that some or all of the proceeds of a life settlement contract may be taxable and that assistance should be sought from a professional tax adviser;

(3) The fact that the proceeds from a life settlement contract could be subject to the claims of creditors;

(4) The fact that receipt of proceeds from a life settlement contract may adversely affect the recipient's eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

(5) The fact that the owner has a right to terminate a life settlement contract within 15 days of the date it is executed by all parties and the owner has received the disclosures contained in this Code section. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider;

(6) The fact that proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract;

(7) The fact that entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy, to be forfeited by the owner and that assistance should be sought from a professional financial adviser;

(8) The method of calculating the compensation paid or to be paid to the life settlement broker or any other person acting for the owner in connection with the transaction, where the term "compensation" includes any thing of value paid or given;

(9) The date by which the funds will be available to the owner and the transmitter of the funds;

(10) The fact that the Commissioner shall require delivery of a buyer's guide or a similar consumer advisory package in the form prescribed by the Commissioner to owners during the solicitation process;

(11) The disclosure document shall contain the following language:

"All medical, financial, or personal information solicited or obtained by a provider or life settlement broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other, may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years.";

(12) The fact that the Commissioner shall require providers and life settlement brokers to print separate signed fraud warnings on their applications and on their life settlement contracts as follows:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.";

(13) The fact that the insured may be contacted by either the provider or life settlement broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three months

if the insured has a life expectancy of more than one year and no more than once per month if the insured has a life expectancy of one year or less;

(14) The affiliation, if any, between the provider and the issuer of the insurance policy to be settled;

(15) That a life settlement broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner;

(16) The document shall include the name, address, and telephone number of the provider;

(17) The name, business address, and telephone number of the independent third-party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents; and

(18) The fact that a change of ownership could in the future limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.

(b) The written disclosures shall be conspicuously displayed in any life settlement contract furnished to the owner by a provider including any affiliations or contractual arrangements between the provider and the life settlement broker.

(c) A life settlement broker shall provide the owner and the provider with at least the following disclosures no later than the date the life settlement contract is signed by all parties. The disclosures shall be conspicuously displayed in the life settlement contract or in a separate document signed by the owner and provide the following information:

(1) The name, business address, and telephone number of the life settlement broker;

(2) A full, complete, and accurate description of all the offers, counter-offers, acceptances, and rejections relating to the proposed life settlement contract;

(3) A written disclosure at the inception of the brokerage arrangement of any affiliations or contractual arrangements between the life settlement broker and any person making an offer in connection with the proposed life settlement contracts;

(4) The name of each life settlement broker who receives compensation and the amount of compensation received by that life settlement broker, which compensation includes any thing of value paid or

given to the life settlement broker in connection with the life settlement contract; and

(5) A complete reconciliation of the gross offer or bid by the provider to the net amount of proceeds or value to be received by the owner. For the purpose of this paragraph, "gross offer or bid" means the total amount or value offered by the provider for the purchase of one or more life insurance policies, inclusive of commissions and fees.

(d) The failure to provide the disclosures or rights described in this Code section shall be deemed an unfair trade practice pursuant to Code Section 33-59-17.

History. — Code 1981, § 33-59-8, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-9, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.

Editor's notes. — Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009, redesignated former Code Section 33-59-9 as present Code Section 33-59-11.

33-59-10. Lender-financed premiums using policy as collateral; disclosures and certifications.

(a) In addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(b) If, as described in paragraph (11) of Code Section 33-59-2, the loan provides funds which can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application shall be rejected as a violation of the prohibited practices in Code Section 33-59-13.

(c) If the financing does not violate Code Section 33-59-13 in this manner, the insurance carrier:

(1) May make disclosures, including, but not limited to, disclosures such as the following, to the applicant and the insured, either on the application or an amendment to the application to be completed no later than the delivery of the policy:

"If you have entered into a loan arrangement where the policy is used as collateral and the policy changes ownership at some point in the future in satisfaction of the loan, the following may be true:

(A) A change of ownership could lead to a stranger owning an interest in the insured's life;

(B) A change of ownership could in the future limit your ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life;

(C) Should there be a change of ownership and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, or other factors may reduce the ability to obtain coverage or may result in significantly higher premiums; and

(D) You should consult a professional adviser since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan."; and

(2) May require certifications, such as the following, from the applicant and the insured:

"(A) I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy;

(B) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy; and

(C) The borrower has an insurable interest in the insured."

History. — Code 1981, § 33-59-10, enacted by Ga. L. 2009, p. 370, § 1/SB 61.

Editor's notes. — Former Code Section 33-59-10 (Code 1981, § 33-59-10, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to contracts entered into within two years of the issuance of the policy being prohibited, was repealed by Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009.

33-59-11. Required documents and information; confidentiality; seller's right to rescind; escrow proceedings; failure to tender consideration; limitation on contracts with the insured for the purpose of determining the insured's health status.

(a) A provider entering into a life settlement contract, wherein the insured is terminally or chronically ill, shall first obtain:

(1) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a settlement contract; and

(2) A document in which the insured consents to the release of his or her medical records to a provider, life settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

(b) The insurer shall respond to a request for verification of coverage submitted by a provider, life settlement broker, or life insurance

producer not later than 30 calendar days after the date the request is received. The request for verification of coverage must be made on a form approved by the Commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(c) Before or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract, represents that the owner has a full and complete understanding of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

(d) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(e) If a life settlement broker or life insurance producer performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this Code section.

(f) If a life settlement broker performs those verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of subsection (a) of Code Section 33-59-9.

(g) Within 20 days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by the documents required by Code Section 33-59-10.

(h) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information if not otherwise provided in this chapter.

(i) All life settlement contracts entered into in this state shall provide that the owner may rescind the contract on or before 15 days after the date it is executed by all parties thereto. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract

shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(j) Within three business days after receipt from the owner of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgment of the transfer by issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the owner within three business days of acknowledgment of the transfer from the insurer.

(k) Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until 30 days after the written notice of the right of rescission has been given.

(l) Any fee paid by a provider, party, individual, or an owner to a life settlement broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this Code section shall be construed to prohibit a life settlement broker from reducing such life settlement broker's fee below this percentage if the life settlement broker so chooses.

(m) The life settlement broker shall disclose to the owner any thing of value paid or given to a life settlement broker which relates to a life settlement contract.

(n) No person at any time prior to, or at the time of, the application for, or issuance of, a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a life settlement contract regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy is to occur. This prohibition shall not apply if the owner certifies to the provider that:

(1) The policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided that the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy shall be calculated without regard to a change in insurance carriers, provided that the coverage has been continuous and under the same group sponsorship; or

(2) The owner submits independent evidence to the provider that one or more of the following conditions have been met within the two-year period:

(A) The owner or insured is terminally or chronically ill;

(B) The owner or insured disposes of his or her ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;

(C) The owner's spouse dies;

(D) The owner divorces his or her spouse;

(E) The owner retires from full-time employment;

(F) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment; or

(G) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets.

Copies of the independent evidence required by paragraph (2) of this subsection shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. Nothing in this Code section shall prohibit an insurer from exercising its right to contest the validity of any policy. If the provider submits to the insurer a copy of independent evidence provided for in paragraph (2) of this subsection when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this subsection.

History. — Code 1981, § 33-59-9, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-11, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61; Ga. L. 2019, p. 533, § 1-23/HB 99.

The 2019 amendment, effective July 1, 2019, substituted "Code Section 33-59-9" for "Code Section 33-5-9" at the end of subsection (f).

Editor's notes. — Former Code Section 33-59-11 (Code 1981, § 33-59-11, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to permissible and impermissible conduct in advertising, was repealed by Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009.

33-59-12. Determining governing law when multiple owners.

(a) If there is more than one owner on a single policy, and the owners are residents of different states, the life settlement contract shall be

governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured shall govern in the event that equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

(b) A provider from this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts shall be governed in the effectuation of that life settlement contract by the statutes and regulations of the owner's state of residence. If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the Commissioner.

(c) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws.

History. — Code 1981, § 33-59-12, enacted by Ga. L. 2009, p. 370, § 1/SB 61; Ga. L. 2019, p. 533, § 1-24/HB 99.

The 2019 amendment, effective July 1, 2019, deleted former subsection (a), which read: "The Commissioner may promulgate regulations implementing this chapter and regulating the activities and relationships of providers, life settlement brokers, insurers, and their agents subject to statutory limitations on administrative rule making."; and redesignated former paragraphs (b)(1) through (b)(3) as present subsections (a) through (c), respectively.

Editor's notes. — Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009, redesignated former Code Section 33-59-12 as present Code Section 33-59-14.

33-59-13. Unlawful activities deemed fraudulent life settlement act.

(a) It shall be unlawful for any person to:

(1) Enter into a life settlement contract if such person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive, or misleading application for such policy;

(2) Engage in any transaction, practice, or course of business if such person knows or reasonably should have known that the intent was to avoid the notice requirements of this Code section;

(3) Engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

(4) Issue, solicit, market, or otherwise promote the purchase of an insurance policy for the purpose of or with an emphasis on settling the policy;

(5) Enter into a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which such person shall receive any proceeds, fees, or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest, service charges, and any cost or expense incurred by the lender or borrower in connection with the premium finance agreement or subsequent sale of such agreement; provided, further, that any payments, charges, fees, or other amounts in addition to the amounts required to pay the principal, interest, service charges, and any cost or expense incurred by the lender or borrower in connection with the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of the overpayment;

(6) With respect to any settlement contract or insurance policy and a life settlement broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such life settlement broker unless such relationship is disclosed to the owner in accordance with paragraph (3) of subsection (c) of Code Section 33-59-9;

(7) With respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with an owner, if, in connection with such life settlement contract, any thing of value will be paid to a life settlement broker that is controlling, controlled by, or under common control with such provider or the financing entity or related provider trust that is involved in such settlement contract unless such relationship is disclosed to the owner in accordance with paragraph (3) of subsection (c) of Code Section 33-59-9;

(8) With respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertisement, and marketing materials, as may be prescribed by rule or regulation, have been filed with the Commissioner. In no event shall any marketing materials expressly reference that the insurance is “free” for any

period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of this chapter; or

(9) With respect to any life insurance producer, insurance company, life settlement broker, or provider, make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(b) A violation of this Code section shall be deemed a fraudulent life settlement act.

History. — Code 1981, § 33-59-13, enacted by Ga. L. 2009, p. 370, § 1/SB 61.
Editor's notes. — Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009, redesignated former Code Section 33-59-13 as present Code Section 33-59-15.

33-59-14. Violations; required statement; reporting of fraudulent acts to the Commissioner; immunity for providing information concerning fraudulent acts; confidentiality of documents and evidence; mandatory adoption of antifraud initiatives by providers.

(a)(1) It shall be illegal for a person to commit a fraudulent life settlement act.

(2) A person shall not knowingly and intentionally interfere with the enforcement of the provisions of this chapter or investigations of suspected or actual violations of this chapter.

(3) A person in the business of life settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

(b)(1) Life settlement contracts and applications for life settlement contracts, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines or confinement in prison."

(2) The lack of a statement as required in paragraph (1) of this subsection does not constitute a defense in any prosecution for a fraudulent life settlement act.

(c)(1) Any person engaged in the business of life settlements having knowledge or a reasonable belief that a fraudulent life settlement act

is being, will be, or has been committed shall provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(2) Any other person having knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

(d)(1) No civil liability shall be imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts or suspected or completed fraudulent insurance acts if the information is provided to or received from:

(A) The Commissioner or the Commissioner's employees, agents, or representatives;

(B) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;

(C) A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

(D) Any regulatory body or their employees, agents, or representatives overseeing life insurance or life settlements, securities, or investment fraud;

(E) The life insurer that issued the life insurance policy covering the life of the insured; or

(F) The licensee and any agents, employees, or representatives.

(2) Paragraph (1) of this subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that paragraph (1) of this subsection does not apply because the person filing the report or furnishing the information did so with actual malice.

(3) A person identified in paragraph (1) of this subsection shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander, or any other relevant tort arising out of activities in carrying out the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this paragraph, a proceeding is substantially justified if it had a reasonable basis in law or fact at the time that it was initiated.

(4) This subsection does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in paragraph (1) of this subsection.

(e)(1) The documents and evidence provided pursuant to subsection (d) of this Code section or obtained by the Commissioner in an investigation of suspected or actual fraudulent life settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(2) Paragraph (1) of this subsection shall not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

(A) In administrative or judicial proceedings to enforce laws administered by the Commissioner;

(B) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent life settlement acts, or to the National Association of Insurance Commissioners; or

(C) At the discretion of the Commissioner, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(3) Release of documents and evidence under paragraph (2) of this subsection does not abrogate or modify the privilege granted in paragraph (1) of this subsection.

(f) This chapter shall not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder;

(3) Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the department; or

(4) Limit the powers granted elsewhere by the laws of this state to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(g)(1) Providers and life settlement brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. At the discretion of the

Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this subsection. Antifraud initiatives shall include:

(A) Fraud investigators, who may be provider or life settlement broker employees or independent contractors; and

(B) An antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:

(i) A description of the procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(ii) A description of the procedures for reporting possible fraudulent life settlement acts to the Commissioner;

(iii) A description of the plan for antifraud education and training of underwriters and other personnel; and

(iv) A description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

(2) Antifraud plans submitted to the Commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

History. — Code 1981, § 33-59-12, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-14, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.

Editor's notes. — Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009, redesignated former Code Section 33-59-14 as present Code Section 33-59-17.

33-59-15. Remedies and penalties for violations; procedural issues.

(a) In addition to the penalties and other enforcement provisions of this chapter, if any person violates this chapter or any rule or regulation implementing this chapter, the Commissioner may seek an injunction in a court of competent jurisdiction in the county where the person resides or has a principal place of business and may apply for temporary and permanent orders as the Commissioner determines necessary to restrain the person from further committing the violation.

(b) Any person damaged by the acts of any other person in violation of this chapter or any rule or regulation implementing this chapter may bring a civil action for damages against the person committing the violation in a court of competent jurisdiction.

(c) The Commissioner may issue a cease and desist order upon a person who violates any provision of this chapter, any rule, regulation, or order adopted by the Commissioner, or any written agreement entered into with the Commissioner, in accordance with Chapter 2 of this title.

(d) When the Commissioner finds that such an action presents an immediate danger to the public and requires an immediate final order, he or she may issue an emergency cease and desist order reciting with particularity the facts underlying such findings. The emergency cease and desist order shall become effective immediately upon service of a copy of the order on the respondent and shall remain effective for 90 days. If the department begins nonemergency cease and desist proceedings under subsection (a) of this Code section, the emergency cease and desist order shall remain effective, absent an order by an appellate court of competent jurisdiction pursuant to Chapter 13 of Title 50. In the event of a willful violation of this chapter, the trial court may award statutory damages in addition to actual damages in an additional amount up to three times the actual damage award. The provisions of this chapter may not be waived by agreement. No choice of law provision may be utilized to prevent the application of this chapter to any settlement in which a party to the settlement is a resident of this state.

History. — Code 1981, § 33-59-13, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-15, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.

Editor's notes. — Former Code Section 33-59-15 (Code 1981, § 33-59-15, enacted by Ga. L. 2005, p. 998, § 1/SB 217), relating to the authority of the commissioner, was repealed by Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009.

33-59-16. Fraudulent life settlement acts prohibited; criminal and civil penalties; revocation of license.

(a) It is a violation of this chapter for any person, provider, life settlement broker, or any other party related to the business of life settlements to commit a fraudulent life settlement act.

(b) For criminal liability purposes, a person that commits a fraudulent life settlement act shall be guilty of committing insurance fraud and shall be guilty of a felony and, upon conviction, 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.

(c) The Commissioner shall be empowered to levy a civil penalty:

(1) Not exceeding $1,000.00 for each and every act in violation of this chapter or, if the person knew or reasonably should have known the acts that he or she committed were in violation of this chapter, the monetary penalty provided for in this subsection may be increased to an amount up to $5,000.00 for each and every act in violation; and

(2) The amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this chapter, who is found to have committed a fraudulent life settlement act or violated any other provision of this chapter.

(d) The license of a person licensed under this chapter that commits a fraudulent life settlement act shall be revoked for a period of at least one year.

History. — Code 1981, § 33-59-16, enacted by Ga. L. 2009, p. 370, § 1/SB 61.

Editor's notes. — Former Code Section 33-59-16 (Code 1981, § 33-59-16, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Ga. L. 2008, p. 381, § 10/SB 358), relating to compliance with security laws, was repealed by Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009.

33-59-17. Unfair trade practice.

A violation of this chapter shall be considered an unfair trade practice pursuant to state law and subject to the penalties provided by state law.

History. — Code 1981, § 33-59-14, enacted by Ga. L. 2005, p. 998, § 1/SB 217; Code 1981, § 33-59-17, as redesignated by Ga. L. 2009, p. 370, § 1/SB 61.

Editor's notes. — Ga. L. 2009, p. 370, § 1/SB 61, effective July 1, 2009, redesignated former Code Section 33-59-17 as Code Section 33-59-18 (now repealed).

33-59-18. Transacting business permitted while the provider's license application is pending.

Repealed by Ga. L. 2019, p. 533, § 1-25/HB 99, effective July 1, 2019.

Editor's notes. — Ga. L. 2020, p. 493, § 33/SB 429, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted the reservation of this Code section.

CHAPTER 59A

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Sec.
33-59A-1. Compact enacted and entered into by the State of Georgia; text of compact.
33-59A-2. Membership on Interstate Insurance Product Regulation Commission; Commissioner of Insurance to be state's representative.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2006, Chapter 59, as enacted by Ga. L. 2006, p. 1033, § 1/SB 384, was redesignated as Chapter 59A.

33-59A-1. Compact enacted and entered into by the State of Georgia; text of compact.

The Interstate Insurance Product Regulation Compact is enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Article I. Purposes.

The purposes of this Interstate Insurance Product Regulation Compact are, through means of joint and cooperative action among the Compacting States:

(1) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

(2) To develop uniform standards for insurance products covered under the Compact;

(3) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

(4) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

(5) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

(6) To create the Interstate Insurance Product Regulation Commission; and

(7) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

Article II. Definitions.

For purposes of this Compact:

(1) "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

(2) "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

(3) "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

(4) "Commission" means the Interstate Insurance Product Regulation Commission established by this Compact.

(5) "Commissioner" means the chief insurance regulatory official of a State including, but not limited to, commissioner, superintendent, director or administrator.

(6) "Domiciliary State" means the state in which an Insurer is incorporated or organized, or, in the case of an alien Insurer, its state of entry.

(7) "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

(8) "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

(9) "Noncompacting State" means any State which is not at the time a Compacting State.

(10) "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard, or a provision of this Compact.

(11) "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability

income, or long-term care insurance product that an Insurer is authorized to issue.

(12) "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

(13) "State" means any state, district, or territory of the United States of America.

(14) "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

(15) "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable, or against public policy as determined by the Commission.

Article III. Establishment of the Commission and Venue.

(1) The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

(2) The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

(3) The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

(4) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

Article IV. Powers of the Commission.

The Commission shall have the following powers:

(1) To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

(2) To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

(3) To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

(4) To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

(5) To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

(6) To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

(7) To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(8) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) To establish and maintain offices;

(10) To purchase and maintain insurance and bonds;

(11) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compacting State;

(12) To hire employees, professionals, or specialists, and elect or appoint officers, and to fix their compensation, define their duties, and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

(13) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(14) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(15) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(16) To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules, or Operating Procedures;

(17) To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures, and Bylaws;

(18) To provide for dispute resolution among Compacting States;

(19) To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;

(20) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

(21) To establish a budget and make expenditures;

(22) To borrow money;

(23) To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

(24) To provide and receive information from, and to cooperate with law enforcement agencies;

(25) To adopt and use a corporate seal; and

(26) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

Article V. Organization of the Commission.

(1) Membership, Voting, and Bylaws.

(a) Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

(b) Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

(c) The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

(i) Establishing the fiscal year of the Commission;

(ii) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

(iii) Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

(iv) Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

(v) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(vi) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(vii) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

(d) The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

(2) Management Committee, Officers, and Personnel.

(a) A Management Committee comprising no more than fourteen (14) members shall be established as follows:

(i) One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products, determined from the records of the NAIC for the prior year;

(ii) Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume

described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

(iii) Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

(b) The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

(i) Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

(ii) Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

(iii) Overseeing the offices of the Commission; and

(iv) Planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the Commission.

(c) The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

(d) The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

(3) Legislative and Advisory Committees.

(a) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws.

Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget, or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

(b) The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

(c) The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

(4) Corporate Records of the Commission.

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

(5) Qualified Immunity, Defense, and Indemnification.

(a) The Members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

(b) The Commission shall defend any Member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

(c) The Commission shall indemnify and hold harmless any Member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment,

duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided, that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. Meetings and Acts of the Commission.

(1) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(2) Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

(3) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

Article VII. Rules and Operating Procedures.

(1) **Rulemaking Authority.** The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

(2) **Rulemaking Procedure.** Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981, as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(3) **Effective Date and Opt Out of a Uniform Standard.** A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission

may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure, or amendment.

(4) **Opt Out Procedure.** A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the Products subject to this Compact; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

(5) **Effect of Opt Out.** If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform

Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

(6) **Stay of Uniform Standard.** If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and, while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

(7) Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

Article VIII. Commission Records and Enforcement.

(1) The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(2) Except as to privileged records, data, and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data, or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

(3) The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

(4) The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

(a) With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards, or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

(b) Before a Commissioner may bring an action for violation of any provision, standard, or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

Article IX. Dispute Resolution.

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact

and which may arise between two or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

Article X. Product Filing and Approval.

(1) Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

(2) The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

(3) Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

Article XI. Review of Commission Decisions Regarding Filings.

(1) Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section (4).

(2) The Commission shall have authority to monitor, review, and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section (1) above.

Article XII. Finance.

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States, and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

(2) The Commission shall collect a filing fee from each Insurer and Third Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

(3) The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

(4) The Commission shall be exempt from all taxation in and by the Compacting States.

(5) The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

(6) The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(7) No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

Article XIII. Compacting States, Effective Date, and Amendment.

(1) Any State is eligible to become a Compacting State.

(2) The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

(3) Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

Article XIV. Withdrawal, Default, and Termination.

(1) Withdrawal.

(a) Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph (e) of this section.

(c) The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

(d) The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

(e) The Withdrawing State is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal,

including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

(2) Default.

(a) If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges, and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges, and benefits conferred by this Compact shall be terminated from the effective date of termination.

(b) Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section (1) of this article.

(c) Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

(3) Dissolution of Compact.

(a) The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

(b) Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

Article XV. Severability and Construction.

(1) The provisions of this Compact shall be severable; and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(2) The provisions of this Compact shall be liberally construed to effectuate its purposes.

Article XVI. Binding Effect of Compact and Other Laws.

(1) Other Laws.

(a) Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph (b) of this section.

(b) For any Product approved or certified to the Commission, the Rules, Uniform Standards, and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval, and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard, or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including, but not limited to, maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual States shall be subject to the laws of those States.

(2) Binding Effect of this Compact.

(a) All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

(b) All agreements between the Commission and the Compacting States are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers, or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

History. — Code 1981, § 33-59A-1, enacted by Ga. L. 2006, p. 1033, § 1/SB 384.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2006, Code Section 33-59-1, as enacted by Ga. L. 2006, p. 1033, § 1/SB 384, was redesignated as Code Section 33-59A-1.

33-59A-2. Membership on Interstate Insurance Product Regulation Commission; Commissioner of Insurance to be state's representative.

Pursuant to terms and conditions of this chapter, the State of Georgia seeks to join with other states and establish the Interstate Insurance Product Regulation Compact, and thus become a member of the Interstate Insurance Product Regulation Commission. The Commissioner of Insurance is hereby designated to serve as the representative of the State of Georgia to the commission.

History. — Code 1981, § 33-59A-2, enacted by Ga. L. 2006, p. 1033, § 1/SB 384; Ga. L. 2007, p. 47, § 33/SB 103.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2006, Code Section 33-59-2, as enacted by Ga. L. 2006, p. 1033, § 1/SB 384, was redesignated as Code Section 33-59A-2.

CHAPTER 60

SMALL BUSINESS EMPLOYEE CHOICE OF BENEFITS HEALTH INSURANCE PLAN ACT

Sec.
33-60-1. Short title.
33-60-2. Legislative intent.
33-60-3. Definitions.
33-60-4. Requirements for insurers and employers; sale by health maintenance organizations permitted; purchase of additional coverage permitted.
33-60-5. Required notice and acknowledgement.
33-60-6. Authority of the Commissioner with respect to this chapter [Repealed].

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, Code Sections 33-59-1 through 33-59-6, as enacted by Ga. L. 2005, p. 1229, § 1, were redesignated as Code Sections 33-60-1 through 33-60-6.

Law reviews. — For article, "Small-Business Health Insurance: A Symptom of the Diseased American Health Care System . . . What is th Cure?," see 69 Mercer L. Rev. 533 (2018).

33-60-1. Short title.

This chapter shall be known and may be cited as the "Small Business Employee Choice of Benefits Health Insurance Plan Act."

History. — Code 1981, § 33-60-1, enacted by Ga. L. 2005, p. 1229, § 1/SB 174.

33-60-2. Legislative intent.

The General Assembly recognizes the need for employers and individuals in this state to have the opportunity to choose among group and individual health insurance plans that are more affordable and flexible than standard market policies of accident and sickness insurance and the need to increase the availability of health insurance coverage by authorizing the transaction of this type of plan or policy by accident and sickness insurers licensed to transact business in this state. This chapter shall require insurers which provide major medical coverage to offer policies that contain all state mandated health benefits as well as policies that contain the limited selection of state mandated health benefits set forth in Code Section 33-60-3; provided, however, that employees in group plans or individuals may choose pursuant to this chapter among new health insurance plans offered by insurers that either include all state mandated health benefits or include the limited state mandated health benefits set forth in Code Section 33-60-3.

History. — Code 1981, § 33-60-2, enacted by Ga. L. 2005, p. 1229, § 1/SB 174; Ga. L. 2019, p. 533, § 1-26/HB 99.

The 2019 amendment, effective July 1, 2019, deleted ", on and after July 1, 2005," following "however, that" in the proviso of the second sentence.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2005, "Code Section 33-60-3" was substituted for "Code Section 33-59-3" twice in the last sentence of this Code section.

33-60-3. Definitions.

As used in this chapter, the term:

(1) "Alternative health benefit plan" means a group or individual health benefit plan that contains:

(A) Major medical benefits;

(B) Standard provisions or rights required to be present in an individual, blanket, or group policy or contract for accident and sickness insurance pursuant to state law or regulations unrelated to specific health illnesses, injuries, or conditions of the insured, including, but not limited to, those related to continuation of coverage in Code Section 33-24-21.1, Code Section 33-24-21.2, paragraph (4) of Code Section 33-30-4, and paragraph (8) of subsection (b) of Code Section 33-30-6; entitlement to conversion privileges in Code Section 33-24-21.1; termination of coverage in Code Sections 33-24-21 and 33-24-28; and coverage of newly born or adopted children in Code Section 33-24-22; and

(C) Coverage of testing for chlamydia in Code Section 31-17-4.1; coverage for complications of pregnancy in Code Section 33-24-24; coverage for general anesthesia and related hospital and outpatient facility charges for dental care for persons who are developmentally disabled, seven or younger, neurologically impaired, or suffering severe face or head trauma in Code Section 33-24-28.4; surveillance tests for ovarian cancer in Code Section 33-24-56.2; colorectal cancer screening and testing in Code Section 33-24-56.3; coverage for hospital stays after delivery in Code Section 33-24-58.2; direct access to obstetricians and gynecologists in Code Section 33-24-59; treatment of dependent children with cancer in Code Section 33-24-59.1; coverage for equipment and self-management training for individuals with diabetes in Code Section 33-24-59.2; coverage for prescribed female contraceptive drugs or devices in Code Section 33-24-59.6, provided that nothing contained in this paragraph shall be construed to require any insurance company to provide coverage for abortion; coverage for prescription inhalers in Code Section 33-24-59.8; coverage for autism in Code Section 33-24-59.10; coverage for mastectomy and lymph node dissection in Code Section 33-24-72; coverage for

mammograms, Pap smears, and screening for prostate cancer in Code Sections 33-29-3.2 and 33-30-4.2; provisions concerning mail-order pharmaceuticals in Code Section 33-30-4.3; and coverage for child wellness exams in Code Sections 33-29-3.4 and 33-30-4.5.

(2) "Group" means any employer group of 50 employees or less.

(3) "Insurer" means any insurer or nonprofit organization authorized to sell accident and sickness policies, subscriber contracts, certificates, or agreements of any form under Chapters 15, 20, 21, 29, and 30 of this title.

History. — Code 1981, § 33-60-3, enacted by Ga. L. 2005, p. 1229, § 1/SB 174; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 533, § 1-27/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "18, 19," following "15," in paragraph (3).

33-60-4. Requirements for insurers and employers; sale by health maintenance organizations permitted; purchase of additional coverage permitted.

(a) Notwithstanding any other provision of law:

(1) Any insurer authorized to transact business in this state offering group accident and sickness policies or contracts shall be required to offer, through a licensed agent or agency, a group health benefit plan that contains all state mandated health benefits and may offer a group alternative health benefit plan as defined in this chapter; and

(2) Any insurer authorized to transact business in this state offering individual accident and sickness policies or contracts shall be required to offer, through a licensed agent or agency, an individual health benefit plan that contains all state mandated health benefits and may offer an individual alternative health benefit plan as defined in this chapter.

(b) An employer who chooses to offer group health benefit plans to its employees shall offer to each eligible employee a group health benefit plan that contains all state mandated health benefits and may offer to each eligible employee a group alternative health benefit plan as defined in this chapter.

(c) The provisions of Chapter 21 of this title shall not be deemed to prohibit licensees thereunder from selling the policies provided for in this Code section.

(d) The purchase of an accident and sickness policy or contract under this Code section shall not preclude the purchaser from purchasing additional limited benefit insurance policies or contracts.

History. — Code 1981, § 33-60-4, enacted by Ga. L. 2005, p. 1229, § 1/SB 174; Ga. L. 2019, p. 533, § 1-28/HB 99.

The 2019 amendment, effective July 1, 2019, deleted "and on and after July 1, 2005" following "law" at the end of subsection (a); and substituted "An" for "On and after July 1, 2005, an" at the beginning of subsection (b).

33-60-5. Required notice and acknowledgement.

(a) In each sale of an alternative health benefit plan, the insurer shall provide to each proposed individual group member or individual policyholder a notice and an acknowledgment at the beginning of the application for the alternative health benefit plan containing the following language in boldface type:

> "You have the option to choose this Small Business Employee Choice of Benefits Health Insurance Plan which does not provide all of the state mandated health benefits normally required in accident and sickness insurance policies in Georgia. This health benefits plan may provide a more affordable health insurance policy for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state mandated health benefits in policies in Georgia. If you choose this option, please consult with your insurance agent to discover which state mandated health benefits are excluded in this policy."

(b) An acknowledgment separate from the notice and application provided for in subsection (a) of this Code section shall be provided to and completed by each individual policyholder or individual group member. Such acknowledgment shall contain a comparison of the benefits contained in each of the health benefit plan options being offered to the individual policyholder or individual group member. In the case of group health benefit plans being offered by an employer, a copy of the acknowledgment for each individual group member shall be maintained by the employer.

History. — Code 1981, § 33-60-5, enacted by Ga. L. 2005, p. 1229, § 1/SB 174; Ga. L. 2019, p. 533, § 1-29/HB 99.

The 2019 amendment, effective July 1, 2019, deleted the former third sentence of subsection (b), which read: "The Commissioner shall promulgate such rules and regulations as he or she deems necessary to implement this subsection including rules and regulations concerning the form and contents of such acknowledgment."

33-60-6. Authority of the Commissioner with respect to this chapter.

Repealed by Ga. L. 2019, p. 533, § 1-30/HB 99, effective July 1, 2019.

Editor's notes. — Ga. L. 2020, p. 493, § 33/SB 429, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted the reservation of this Code section.

CHAPTER 61

REGULATION OF AUTOMOBILE CLUBS

Sec.
33-61-1. Definitions.
33-61-2. Automobile club performing services.

Administrative rules and regulations. — Vehicle and Automobile Club Service Contracts, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-47.

33-61-1. Definitions.

As used in this chapter, the term:

(1) "Automobile club" or "club" means any person, who in consideration of fees, dues, periodic payments, or other specifically stated charges, promises its members to provide automobile club services.

(2) "Automobile club services" shall include, but not be limited to, the assumption of or reimbursement of the expense or a portion thereof for towing of a motor vehicle, emergency road service, matters relating to the operation, use, and maintenance of a motor vehicle, and the supplying of services which includes, augments, or is incidental to theft or reward services, discount services, arrest bond services, lock and key services, trip interruption services, and legal fee reimbursement services in defense of traffic related offenses.

History. — Code 1981, § 33-61-1, enacted by Ga. L. 2006, p. 331, § 1/HB 1291; Ga. L. 2019, p. 533, § 1-31/HB 99; Ga. L. 2020, p. 493, § 33/SB 429.

The 2019 amendment, effective July 1, 2019, substituted "Reserved." for the former provisions of paragraph (3), which read: "'Commissioner' shall mean the Commissioner of Insurance of the State of Georgia."

The 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, deleted former paragraph (3) which was designated as reserved.

33-61-2. Automobile club performing services.

An automobile club performing services as defined in this chapter shall not be subject to any laws respecting insurance companies of any class, kind, or character in this state or regulation under such laws because of performance of those services.

History. — Code 1981, § 33-61-2, enacted by Ga. L. 2006, p. 331, § 1/HB 1291.

CHAPTER 62

PROPERTY AND CASUALTY ACTUARIAL OPINION LAW

Sec.
33-62-1. Short title.
33-62-2. Submission of annual statement of actuarial opinion of appointed actuary by property and casualty insurance companies licensed to do business in Georgia.
33-62-3. Submission of supporting documentation; confidentiality; disclosure.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, T. 33, C. 62, as enacted by Ga. L. 2008, p. 1097, § 1, was redesignated as T. 33, C. 63.

33-62-1. Short title.

This chapter shall be known and may be cited as the "Property and Casualty Actuarial Opinion Law."

History. — Code 1981, § 33-62-1, enacted by Ga. L. 2008, p. 1090, § 4/SB 471.

33-62-2. Submission of annual statement of actuarial opinion of appointed actuary by property and casualty insurance companies licensed to do business in Georgia.

(a) Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion." This opinion shall be filed in accordance with rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions.

(b)(1) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions and shall be considered as a document supporting the actuarial opinion required in subsection (a) of this Code section.

(2) A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

(c)(1) An actuarial report and underlying work papers as required by rules and regulations promulgated by the Commissioner regarding

property and casualty annual statement instructions shall be prepared to support each actuarial opinion.

(2) If the insurance company fails to provide a supporting actuarial report or work papers at the request of the Commissioner or the Commissioner determines that the supporting actuarial report or work papers provided by the insurance company are otherwise unacceptable to the Commissioner, the Commissioner may engage a qualified actuary at the expense of the insurance company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or work papers.

(d) 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 actuary's opinion except in cases of fraud or willful misconduct on the part of the appointed actuary.

History. — Code 1981, § 33-62-2, enacted by Ga. L. 2008, p. 1090, § 4/SB 471.

33-62-3. Submission of supporting documentation; confidentiality; disclosure.

(a) The statement of actuarial opinion shall be provided with the annual statement in accordance with rules and regulations promulgated by the Commissioner regarding property and casualty annual statement instructions and shall be treated as a public document.

(b)(1) Documents, materials, or other information in the possession or control of the department that are considered an actuarial report, work papers, or actuarial opinion summary provided in support of the opinion and any other material provided by the insurance company to the Commissioner in connection with the actuarial report, work papers, or the actuarial opinion summary shall be confidential by law and privileged, shall not be subject to 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.

(2) The provisions of this subsection shall not be construed to limit the Commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline so long as the material is required for the purpose of professional disciplinary proceedings and that the Actuarial Board for Counseling and Discipline establishes procedures satisfactory to the Commissioner for preserving the confidentiality of the documents. In addition, the provisions of this subsection shall not be construed to limit the Commissioner's authority to use the documents, materials, or other information in further-

ance of any regulatory or legal action brought as a part of the Commissioner's official duties.

(c) 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 such confidential documents, materials, or other information subject to subsection (b) of this Code section.

(d) In order to assist the Commissioner in the performance of his or her duties, the Commissioner may:

(1) Share documents, materials, and other information, including confidential and privileged documents, materials, and information subject to subsection (b) 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, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or other information and has the legal authority to maintain confidentiality;

(2) Receive documents, materials, and other 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. The Commissioner shall maintain as confidential and privileged any document, material, or information received with notice and 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

(3) Enter into agreements concerning sharing and use of information consistent with this subsection and subsections (b) and (c) of this Code section.

(e) 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 Code section or as a result of sharing as authorized by subsection (d) of this Code section.

History. — Code 1981, § 33-62-3, enacted by Ga. L. 2008, p. 1090, § 4/SB 471.

CHAPTER 63

GUARANTEED ASSET PROTECTION WAIVERS

Sec.
33-63-1. Legislative findings.
33-63-2. Purpose; exemptions from applicability of chapter; guaranteed asset protection waivers exempt from state's insurance laws.
33-63-3. Definitions.
33-63-4. Offering, selling, or providing to borrowers guaranteed asset protection waivers.
33-63-5. Contractual liability or other insurance policies.
33-63-6. Required disclosures.
33-63-7. Cancellation.
33-63-8. Exempted commercial transactions.
33-63-9. Commissioner to enforce provisions; penalty for violations.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, T. 33, C. 62, as enacted by Ga. L. 2008, p. 1097, § 1, was redesignated as T. 33, C. 63.

Editor's notes. — Ga. L. 2008, p. 1097, § 2/SB 470, not codified by the General Assembly, provides: "This Act shall become effective on July 1, 2008, and apply to all guaranteed asset protection waivers which shall become effective on or after January 1, 2009."

33-63-1. Legislative findings.

The General Assembly finds that guaranteed asset protection waivers are not insurance. All guaranteed asset protection waivers issued on or after the date of enactment of this chapter shall not be construed as insurance.

History. — Code 1981, § 33-63-1, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2019, p. 533, § 1-32/HB 99.

The 2019 amendment, effective July 1, 2019, inserted "on or" in the middle of the second sentence of this Code section.

33-63-2. Purpose; exemptions from applicability of chapter; guaranteed asset protection waivers exempt from state's insurance laws.

(a) The purpose of this chapter is to provide a framework within which guaranteed asset protection waivers are defined and may be offered within this state.

(b) This chapter shall not apply to:

(1) An insurance policy offered by an insurer under the insurance laws of this state; or

(2) A debt cancellation or debt suspension contract being offered in compliance with 12 C.F.R. Part 37 or 12 C.F.R. Part 721 or other federal law.

(c) Guaranteed asset protection waivers governed under this chapter are not insurance and are exempt from the insurance laws of this state. Persons marketing, selling, or offering to sell guaranteed asset protection waivers to borrowers that comply with this chapter are exempt from this state's insurance licensing requirements.

History. — Code 1981, § 33-63-2, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.

33-63-3. Definitions.

The following terms are defined for purposes of this chapter and are not intended to provide actual terms required in guaranteed asset protection waivers:

(1) "Administrator" means a person, other than an insurer or creditor, that performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

(2) "Borrower" means a debtor, retail buyer, or lessee under a finance agreement.

(3) "Creditor" means:

(A) The lender in a loan or credit transaction;

(B) The lessor in a lease transaction;

(C) Any retail installment seller that provides credit to any retail buyer of motor vehicles, provided that such entity complies with the provisions of this chapter;

(D) The seller in commercial retail installment transactions; or

(E) The assignees of any of the creditors listed in subparagraphs (A) through (D) of this paragraph to whom the credit obligation is payable.

(4) "Finance agreement" means a loan, lease, or retail installment sales contract for the purchase or lease of a motor vehicle.

(5) "Free look period" means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the guaranteed asset protection waiver without penalty, fees, or costs to the borrower. This period of time must not be shorter than 30 days.

(6) "Guaranteed asset protection waiver" means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle, which agreement must be part of, or a separate

addendum to, the finance agreement or a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive all or part of the excess wear and use charges owed by the borrower to the creditor under the lease contract when the borrower returns a leased vehicle to the creditor at termination of the lease, which agreement must be part of, or a separate addendum to, the lease contract.

(7) "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(8) "Motor vehicle" means self-propelled or towed vehicles designed for personal or commercial use, including but not limited to automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, campers, boats, personal watercraft, and motorcycle, boat, camper, and personal watercraft trailers.

(9) "Person" includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

(10) "Retail buyer" shall have the same meaning as provided in Code Section 10-1-31.

(11) "Retail installment seller" shall have the same meaning as provided in Code Section 10-1-31.

History. — Code 1981, § 33-63-3, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2014, p. 181, § 6/HB 610.

33-63-4. Offering, selling, or providing to borrowers guaranteed asset protection waivers.

(a) Guaranteed asset protection waivers may be offered, sold, or provided to borrowers in this state in compliance with this chapter.

(b) Guaranteed asset protection waivers may, at the option of the creditor, be sold for a single payment or may be offered with a monthly or periodic payment option.

(c) Notwithstanding any other provision of law, any cost to the borrower for a guaranteed asset protection waiver entered into in compliance with the federal Truth in Lending Act, 15 U.S.C. Section 1601, et seq., and its implementing regulations, as they may be amended from time to time, must be separately stated and is not to be considered a finance charge or interest.

(d) A retail installment seller must insure its guaranteed asset protection waiver obligations under a contractual liability or other

insurance policy issued by an insurer. A creditor other than a retail installment seller may insure its guaranteed asset protection waiver obligations under a contractual liability policy or other such policy issued by an insurer. Any such insurance policy may be directly obtained by a creditor or retail installment seller or may be procured by an administrator to cover a creditor's or retail installment seller's obligations. However, retail installment sellers that are lessors on motor vehicles are not required to insure obligations related to guaranteed asset protection waivers on such leased vehicles.

(e) The guaranteed asset protection waiver shall remain a part of the finance agreement upon the assignment, sale, or transfer of such finance agreement by the creditor.

(f) Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a guaranteed asset protection waiver.

(g) Any creditor that offers a guaranteed asset protection waiver must report the sale of, and forward funds received on, all such waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy or other specified program documents.

(h) Funds received or held by a creditor or administrator and belonging to an insurer, creditor, or administrator pursuant to the terms of a written agreement must be held by such creditor or administrator in a fiduciary capacity.

(i) A retail installment seller that offers, provides, or sells a guaranteed asset protection waiver in connection with the sale of a motor vehicle shall not be required to insure its guaranteed asset protection waiver if the retail installment seller does both of the following:

(1) Maintains, or has a parent company that maintains, 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 guaranteed asset protection waivers underwritten pursuant to this subsection; and

(2) Files a copy of its Form 10-K or Form 20-F disclosure statements, or, if it does not file with the United States Securities and Exchange Commission, a copy of its audited financial statements reported on generally accepted accounting principles. If the retail installment seller's financial statements are consolidated with those of its parent company, then the retail installment seller may comply with the provisions of this paragraph by filing the statements of its parent company. The statement shall be filed with the Commissioner at least 30 days prior to the retail installment seller's initial offering

or delivering a guaranteed asset protection waiver, and thereafter the statement shall be filed with the Commissioner annually.

History. — Code 1981, § 33-63-4, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2009, p. 8, § 33/SB 46; Ga. L. 2012, p. 1350, § 11/HB 1067.

33-63-5. Contractual liability or other insurance policies.

(a) Contractual liability or other insurance policies insuring guaranteed asset protection waivers must state the obligation of the insurer to reimburse or pay to the creditor any sums the creditor is legally obligated to waive under the guaranteed asset protection waivers issued by the creditor and purchased or held by the borrower.

(b) Coverage under a contractual liability or other insurance policy insuring a guaranteed asset protection waiver must also cover any subsequent assignee upon the assignment, sale, or transfer of the finance agreement.

(c) Coverage under a contractual liability or other insurance policy insuring a guaranteed asset protection waiver must remain in effect unless cancelled or terminated in compliance with the applicable insurance laws of this state.

(d) The cancellation or termination of a contractual liability or other insurance policy must not reduce the insurer's responsibility for guaranteed asset protection waivers issued by the creditor prior to the date of cancellation or termination and for which premium has been received by the insurer.

History. — Code 1981, § 33-63-5, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.

33-63-6. Required disclosures.

Guaranteed asset protection waivers must disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

(1) The name and address of the initial creditor and the borrower at the time of sale and the identity of any administrator if different from the creditor;

(2) The purchase price and the terms of the guaranteed asset protection waiver, including without limitation the requirements for protection, conditions, or exclusions associated with the guaranteed asset protection waiver;

(3) That the borrower may cancel the guaranteed asset protection waiver within a free look period, as specified in the waiver, and will

be entitled to a full refund of the purchase price, provided no benefits have been made; or in the event benefits have been made, the borrower may receive a full or partial refund if the waiver so provides;

(4) The procedure the borrower must follow, if any, to obtain guaranteed asset protection waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits;

(5) Whether or not the guaranteed asset protection waiver is cancelable after the free look period and the conditions under which it may be canceled or terminated, including the procedures for requesting any refund due;

(6) That in order to receive any refund due in the event of a borrower's cancellation of the guaranteed asset protection waiver agreement or early termination of the finance agreement after the free look period of the guaranteed asset protection waiver, the borrower, in accordance with terms of the waiver, must provide a written request to cancel to the creditor, administrator, or such other party within 90 days after the borrower's decision to cancel the waiver or the occurrence of the event terminating the finance agreement;

(7) The methodology for calculating any refund of the unearned purchase price of the guaranteed asset protection waiver due in the event of cancellation of the guaranteed asset protection waiver or early termination of the finance agreement; and

(8) That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease may be conditioned upon the purchase of the guaranteed asset protection waiver.

History. — Code 1981, § 33-63-6, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.

33-63-7. Cancellation.

(a) Guaranteed asset protection waiver agreements may be cancelable or noncancelable after the free look period. Guaranteed asset protection waivers must provide that if a borrower cancels a waiver within the free look period, the borrower will be entitled to a full refund of the purchase price, provided no benefits have been paid; or in the event benefits have been paid, the borrower may receive a full or partial refund if the waiver so provides.

(b) In the event of a borrower's cancellation of the guaranteed asset protection waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free look period, the

borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. In order to receive a refund, the borrower, in accordance with any applicable terms of the waiver, must provide a written request to the creditor, administrator, or other party within 90 days after the borrower's decision to cancel the waiver or the occurrence of the event terminating the finance agreement.

(c) If the cancellation of a guaranteed asset protection waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection (d) of this Code section.

(d) Any cancellation refund under subsection (a), (b), or (c) of this Code section may be applied by the creditor as a reduction of the amount owed under the finance agreement unless the borrower can show that the finance agreement has been paid in full.

History. — Code 1981, § 33-63-7, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.

33-63-8. Exempted commercial transactions.

Subsection (c) of Code Section 33-63-4 and Code Sections 33-63-6 and 33-63-9 shall not be applicable to a guaranteed asset protection waiver offered in connection with a lease or retail installment sale associated with a commercial transaction.

History. — Code 1981, § 33-63-8, enacted by Ga. L. 2008, p. 1097, § 1/SB 470.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2008, "33-63-4", "33-63-6", and "33-63-9" were substituted for "33-62-4", "33-62-6", and "33-62-9", respectively.

33-63-9. Commissioner to enforce provisions; penalty for violations.

The Commissioner may take action which is necessary or appropriate to enforce the provisions of this chapter and to protect guaranteed asset protection waiver holders in this state. After proper notice and opportunity for hearing, the Commissioner may:

(1) Order the creditor, administrator, or any other person not in compliance with this chapter to cease and desist from further guaranteed asset protection waiver related operations which are in violation of this chapter; and

(2) Impose a penalty of not more than $500.00 per violation and not more than $10,000.00 in the aggregate for all violations of a

similar nature. For purposes of this paragraph, violations must be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the conduct, action, or practice which is determined to be a violation of this chapter occurred.

History. — Code 1981, § 33-63-9, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2019, p. 533, § 1-33/HB 99.

The 2019 amendment, effective July 1, 2019, in the introductory paragraph, deleted "of Insurance" following "Commissioner" near the beginning of the first sentence and substituted "Commissioner" for "commissioner" near the end of the second sentence; and inserted "a" near the end of the first sentence of paragraph (2).

CHAPTER 64

REGULATION AND LICENSURE OF PHARMACY BENEFITS MANAGERS

Sec.
33-64-1. (For effective date, see note.) Definitions.
33-64-2. (For effective date, see note.) License requirements and filing fees.
33-64-3. Requirements and procedures affecting pharmacy benefits managers; surety bond.
33-64-4. (For effective date, see note.) Pharmacy benefits manager shall not engage in the practice of medicine; recommended use of licensed physician.
33-64-5. Audit requirements applicable to pharmacy benefits managers.
33-64-6. Pharmacy benefits manager shall not have to be licensed as an administrator.
33-64-7. (For effective date, see note.) Commissioner's authority over rules and regulations.
33-64-8. Electronic prior authorization drug requests with health care providers.
33-64-9. Requirements for use of maximum allowable cost pricing by pharmacy benefits managers; appeals; enforcement authority.
33-64-9.1. (Effective January 1, 2021) Reimbursement methodologies utilized by pharmacy benefits managers.
33-64-10. (Effective until July 1, 2021) Administration of claims by pharmacy benefits manager.
33-64-10. (Effective July 1, 2021) Administration of claims by pharmacy benefits manager.
33-64-11. (For effective date, see note.) Prohibited activities of pharmacy benefits manager.
33-64-12. (Effective July 1, 2021) Legislative findings; surcharges and reporting on steering or imposing point-of-sale fees or retroactive fees.
33-64-13. (Effective July 1, 2021) Federal law governs.

Administrative rules and regulations. — Pharmacy Benefits Managers Regulation, Official Compilation of the Rules and Regulations of the State of Georgia, Comptroller General, Commissioner of Insurance, Subject 120-2-97.

Retail Pharmacy Regulations, Official Compilation of the Rules and Regulations of the State of Georgia, Georgia State Board of Pharmacy, Chapter 480-10.

33-64-1. (For effective date, see note.) Definitions.

As used in this chapter, the term:

(1) "Affiliate pharmacy" means a pharmacy which, either directly or indirectly through one or more intermediaries:

(A) Has an investment or ownership interest in a pharmacy benefits manager licensed under this chapter;

(B) Shares common ownership with a pharmacy benefits manager licensed under this chapter; or

(C) Has an investor or ownership interest holder which is a pharmacy benefits manager licensed under this chapter.

(2) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(3) "Dispenser" shall have the same meaning as in paragraph (10) of Code Section 16-13-21.

(4) "Health plan" means an individual or group plan or program which is established by contract, certificate, law, plan, policy, subscriber agreement, or any other method and which is entered into, issued, or offered for the purpose of arranging for, delivering, paying for, providing, or reimbursing any of the costs of health care or medical care, including pharmacy services, drugs, or devices. Such term includes any health care coverage provided under the state health benefit plan pursuant to Article 1 of Chapter 18 of Title 45; the medical assistance program pursuant to Article 7 of Chapter 4 of Title 49; the PeachCare for Kids Program pursuant to Article 13 of Chapter 5 of Title 49; and any other health benefit plan or policy administered by or on behalf of this state.

(5) "Health system" means a hospital or any other facility or entity owned, operated, or leased by a hospital and a long-term care home.

(6) "Insured" means a person who receives prescription drug benefits administered by a pharmacy benefits manager.

(7) "Maximum allowable cost" means the per unit amount that a pharmacy benefits manager reimburses a pharmacist for a prescription drug, excluding dispensing fees and copayments, coinsurance, or other cost-sharing charges, if any.

(8) "National average drug acquisition cost" means the monthly survey of retail pharmacies conducted by the federal Centers for Medicare and Medicaid Services to determine average acquisition cost for Medicaid covered outpatient drugs.

(9) "Pharmacy" means a pharmacy or pharmacist licensed pursuant to Chapter 4 of Title 26 or another dispensing provider.

(10) "Pharmacy benefits management" means the administration of a plan or program that pays for, reimburses, and covers the cost of drugs, devices, or pharmacy care to insureds on behalf of a health plan. The term shall not include the practice of pharmacy as defined in Code Section 26-4-4.

(11) "Pharmacy benefits manager" means a person, business entity, or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a pharmacy benefits

manager in a contractual or employment relationship in the performance of pharmacy benefits management for a health plan. The term does not include services provided by pharmacies operating under a hospital pharmacy license. The term also does not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. The term also does not include services provided by pharmacies affiliated with a facility licensed under Code Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(12) "Point-of-sale fee" means all or a portion of a drug reimbursement to a pharmacy or other dispenser withheld at the time of adjudication of a claim for any reason.

(13) "Rebate" means any and all payments that accrue to a pharmacy benefits manager or its health plan client, directly or indirectly, from a pharmaceutical manufacturer, including but not limited to discounts, administration fees, credits, incentives, or penalties associated directly or indirectly in any way with claims administered on behalf of a health plan client.

(14) "Retroactive fee" means all or a portion of a drug reimbursement to a pharmacy or other dispenser recouped or reduced following adjudication of a claim for any reason, except as otherwise permissible as described in Code Section 26-4-118.

(15) "Steering" means:

(A) Ordering an insured to use its affiliate pharmacy for the filling of a prescription or the provision of pharmacy care;

(B) Ordering an insured to use an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter pursuant to an arrangement or agreement for the filling of a prescription or the provision of pharmacy care;

(C) Offering or implementing plan designs that require an insured to utilize its affiliate pharmacy or an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter or that increases plan or insured costs, including requiring an insured to pay the full cost for a prescription when an insured chooses not to use any affiliate pharmacy; or

(D) Advertising, marketing, or promoting its affiliate pharmacy or an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter to insureds. Subject to the foregoing, a pharmacy benefits manager may include its affiliated pharmacy or

an affiliate pharmacy of another pharmacy benefits manager licensed under this chapter in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the pharmacy benefits manager includes information regarding eligible nonaffiliated pharmacies in such communications and that the information provided is accurate.

History. — Code 1981, § 33-64-1, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2015, p. 337, § 2/HB 470; Ga. L. 2019, p. 533, § 1-34/HB 99; Ga. L. 2019, p. 940, § 1/HB 323; Ga. L. 2020, p. 768, § 1/HB 946; Ga. L. 2020, p. 780, § 1/SB 313.

Delayed effective date. — This Code section, as set out above, becomes effective January 1, 2021. For version of this Code section in effect until January 1, 2021, see the 2020 amendment note.

The 2019 amendments. — The first 2019 amendment, effective July 1, 2019, deleted former paragraph (2), which read: "'Commissioner' means the Commissioner of Insurance."; and redesignated former paragraphs (3) through (9) as present paragraphs (2) through (8), respectively. The second 2019 amendment, effective January 1, 2020, added paragraph (4.1). See Editor's notes for applicability.

The 2020 amendments. — The first 2020 amendment, effective January 1, 2021, added paragraphs (1), (4), (6), (8), and (12) through (15); redesignated former paragraph (1) as present paragraph (2); deleted former paragraphs (2) and (3), which provided the definitions of "covered entity" and "covered individual"; redesignated former paragraph (3.1) as present paragraph (3); and redesignated former paragraph (4) as present paragraph (5); redesignated former paragraphs (6) through (8) as present paragraphs (9) through (11), respectively; and rewrote paragraph (10). The second 2020 amendment, effective January 1, 2021, made identical changes. See the Editor's notes for applicability.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2019, paragraph (4.1) was redesignated as paragraph (3.1) to maintain alphabetical order.

Editor's notes. — Ga. L. 2019, p. 940, § 4/HB 323 not codified by the General Assembly, provides, in part, that this Act shall apply to all contracts issued, delivered, or issued for delivery in this state on and after January 1, 2020.

Ga. L. 2020, p. 768, § 9(b)/HB 946 and Ga. L. 2020, p. 780, § 9(b)/SB 313, not codified by the General Assembly, provide that the amendment to this Code section is applicable to all contracts issued, delivered, or issued for delivery in this state on and after January 1, 2021.

33-64-2. (For effective date, see note.) License requirements and filing fees.

(a) No person, business entity, or other entity shall act as or hold itself out to be a pharmacy benefits manager in this state, other than an applicant licensed in this state for the kinds of business for which it is acting as a pharmacy benefits manager, unless such person, business entity, or other entity holds a license as a pharmacy benefits manager issued by the Commissioner pursuant to this chapter. The license shall be renewable on an annual basis. Failure to hold such license shall subject such person, business entity, or other entity to the fines and other appropriate penalties as provided in Chapter 2 of this title.

(b) (For effective date, see note.) An application for a pharmacy benefits manager's license or an application for renewal of such license shall be accompanied by a filing fee of $2,000.00 for an initial license and $1,000.00 for renewal.

(c) (For effective date, see note.) A license shall be issued or renewed by the Commissioner unless the Commissioner finds that the applicant for or holder of the license:

(1) Has intentionally misrepresented or concealed any material fact in the application for the license;

(2) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(3) Has committed fraud;

(4) Has failed to obtain for initial licensure or retain for annual licensure renewal a net worth of at least $200,000.00; or

(5) Has violated any provision of this chapter while on probation, if for license renewal.

(d) If the Commissioner moves to suspend, revoke, or nonrenew a license for a pharmacy benefits manager, the Commissioner shall provide notice of that action to the pharmacy benefits manager, and the pharmacy benefits manager may invoke the right to an administrative hearing in accordance with Chapter 2 of this title.

(e) No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if judicial review of such revocation is sought, within five years from the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

(f) Appeal from any order or decision of the Commissioner made pursuant to this chapter shall be taken as provided in Chapter 2 of this title.

(g)(1) The Commissioner shall have the authority to issue a probationary license to any applicant under this title.

(2) A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

(3) The Commissioner shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period in accordance with rules and regulations.

(h) (For effective date, see note.) A pharmacy benefits manager's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. A pharmacy benefits manager may not contract or subcontract any of its negotiated formulary services to any unlicensed business entity.

(i) (For effective date, see note.) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to assess a monetary penalty against any person, business entity, or other entity acting as a pharmacy benefits manager without a license of up to $2,000.00 for each transaction in violation of this chapter, unless such person, business entity, or other entity knew or reasonably should have known it was in violation of this chapter, in which case the monetary penalty provided for in this subsection may be increased to an amount of up to $10,000.00 for each and every act in violation.

(j) A licensed pharmacy benefits manager shall not market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.

(k) (For effective date, see note.) In addition to all other penalties provided for under this title, the Commissioner shall have the authority to place any pharmacy benefits manager on probation for a period of time not to exceed one year for each and every act in violation of this chapter and shall subject such pharmacy benefits manager to a monetary penalty of up to $2,000.00 for each and every act in violation of this chapter, unless the pharmacy benefits manager knew or reasonably should have known he or she was in violation of this chapter, in which case the monetary penalty provided for in this subsection shall be increased to an amount of up to $10,000.00 for each and every act in violation. In the event a pharmacy benefits manager violates any provision of this chapter while on probation, the Commissioner shall have the authority to suspend the pharmacy benefits manager's license. For purposes of this subsection, a violation shall be considered to have occurred each time an act in violation of this chapter is committed.

History. — Code 1981, § 33-64-2, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2019, p. 533, § 1-35/HB 99; Ga. L. 2020, p. 768, § 2/HB 946; Ga. L. 2020, p. 780, § 2/SB 313.

Delayed effective date. — Subsections (b), (c), (h), (i), (k), as set out above, become effective July 1, 2021. For version of subsections (b), (c), (h), (i), (k), and (l) in effect until July 1, 2021, see the 2020 amendment note.

The 2019 amendment, effective July 1, 2019, in subsection (l), deleted "hospital service corporation, medical service corporation," following "health care center," twice in the first sentence and once in the second sentence.

The 2020 amendments. — The first 2020 amendment, effective July 1, 2021, in subsection (b), substituted "$2,000.00" for "$500.00" and "$1,000.00" for "$400.00"; deleted "and shall not be suspended or revoked" following "renewed" near the beginning of subsection (c); deleted "or" at the end of paragraph (c)(3); substituted "; or" for the period at the end

of paragraph (c)(4); and added paragraph (c)(5); substituted "business entity" for "nonaffiliated business entity unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement" at the end of subsection (h); in subsection (i), substituted "$2,000.00" for "$1,000.00" and substituted "$10,000.00" for "$5,000.00"; in subsection (k), in the first sentence, substituted "shall subject" for "may subject", substituted "$2,000.00" for "$1,000.00", substituted "shall be" for "may be" and substituted "$10,000.00" for "$5,000.00", and added the last sentence; and deleted former subsection (l), which read: "A pharmacy benefits manager operating as a line of business or affiliate of a health insurer, health care center, or fraternal benefit society licensed in this state or of any affiliate of such health insurer, health care center, or fraternal benefit society shall not be required to obtain a license pursuant to this chapter. Such health insurer, health care center, or fraternal benefit society shall notify the Commissioner annually, in writing, on a form provided by the Commissioner, that it is affiliated with or operating as a line of business as a pharmacy benefits manager." The second 2020 amendment, effective July 1, 2021, made identical changes. See the Editor's notes for applicability.

Editor's notes. — Ga. L. 2020, p. 768, § 9(a)/HB 946 and Ga. L. 2020, p. 780, § 9(a)/SB 313, not codified by the General Assembly, provide, in part, that the amendment by that Act shall apply to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2021.

33-64-3. Requirements and procedures affecting pharmacy benefits managers; surety bond.

(a) Every applicant for a pharmacy benefits manager's license shall file with the application and shall thereafter maintain in force a bond in the amount of $100,000.00 in favor of the Commissioner executed by a corporate surety insurer authorized to transact insurance in this state. The terms and type of the bond shall be established by rules and regulations.

(b) The bond shall remain in force until the surety is released from liability by the Commissioner or until the bond is canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel the bond upon 30 days' advance notice, in writing, filed with the Commissioner.

(c) Every applicant for a pharmacy benefits manager's license shall obtain and shall thereafter maintain in force errors and omissions coverage or other appropriate liability insurance, written by an insurer authorized to transact insurance in this state, in an amount of at least $250,000.00.

(d) The coverage required in subsection (c) of this Code section shall remain in force for a term of at least one year and shall contain language that includes that the insurer may cancel the insurance upon 60 days' advance notice filed with the Commissioner. Other terms and conditions relating to the errors and omissions policy may be imposed on the applicant in accordance with rules and regulations.

(e) In the event a licensed pharmacy benefits manager fails to renew, surrenders, or otherwise terminates its license, it must retain both the

bond and the errors and omissions coverage for a period of not less than one year after the licensee has failed to renew, surrendered, or otherwise terminated the license.

History. — Code 1981, § 33-64-3, enacted by Ga. L. 2010, p. 757, § 1/SB 310.

33-64-4. (For effective date, see note.) Pharmacy benefits manager shall not engage in the practice of medicine; recommended use of licensed physician.

(a) No pharmacy benefits manager shall engage in the practice of medicine, except as otherwise provided in subsection (b) of this Code section.

(b) Any physician employed by or contracted with a pharmacy benefits manager advising on or making determinations specific to a Georgia insured in connection with a prior authorization or step therapy appeal or determination review shall:

(1) Have actively seen patients within the past five years; and

(2) Have practiced in the same specialty area for which he or she is providing advisement within the past five years.

(c) For contracts and amendments entered into with a pharmacy benefits manager on and after July 1, 2021, the department is encouraged to require the use of a licensed Georgia physician for prior authorization or step therapy appeal or determination reviews.

History. — Code 1981, § 33-64-4, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2020, p. 768, § 3/HB 946; Ga. L. 2020, p. 780, § 3/SB 313.

Delayed effective date. — This Code section, as set out above, becomes effective July 1, 2021. For version of this Code section in effect until July 1, 2021, see the 2020 amendment note.

The 2020 amendments. — The first 2020 amendment, effective July 1, 2021, designated the existing provisions as subsection (a); added ", except as otherwise provided in subsection (b) of this Code section" at the end of subsection (a); and added subsections (b) and (c). The second 2020 amendment, effective July 1, 2021, made identical changes. See the Editor's notes for applicability.

Code Commission notes. — Pursuant to Code Section 28-9-5, in 2020, "July 1, 2021" was substituted for "the effective date of this Act" in the middle of subsection (c).

Editor's notes. — Ga. L. 2020, p. 768, § 9(a)/HB 946 and Ga. L. 2020, p. 780, § 9(a)/SB 313, not codified by the General Assembly, provide, in part, that the amendment by that Act shall apply to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2021.

33-64-5. Audit requirements applicable to pharmacy benefits managers.

Pharmacy benefits managers, whether licensed pursuant to this chapter or exempt from licensure pursuant to subsection (l) of Code

Section 33-64-2, shall be subject to Code Section 26-4-118, "The Pharmacy Audit Bill of Rights," to the same extent and in the same manner as pharmacies.

History. — Code 1981, § 33-64-5, enacted by Ga. L. 2010, p. 757, § 1/SB 310.

33-64-6. Pharmacy benefits manager shall not have to be licensed as an administrator.

A pharmacy benefits manager licensed pursuant to this chapter shall not be required to obtain a license as an administrator pursuant to Article 2 of Chapter 23 of this title to perform any function as a pharmacy benefits manager pursuant to this chapter.

History. — Code 1981, § 33-64-6, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2011, p. 752, § 33/HB 142.

33-64-7. (For effective date, see note.) Commissioner's authority over rules and regulations.

(a) The Commissioner shall enforce the provisions of this chapter and may promulgate rules and regulations to implement the provisions of this chapter to ensure the safe and proper operations of pharmacy benefits managers in this state.

(b) In addition to all other authority granted by this title, the Commissioner may:

(1) Conduct financial examinations and compliance audits of pharmacy benefits managers to ensure compliance with the provisions of this chapter and rules and regulations implemented pursuant to this chapter; provided, however, that such authority shall not extend to financial examination and compliance audits of pharmacy benefits managers' conduct in performing services on behalf of the state health benefit plan pursuant to Article 1 of Chapter 18 of Title 45 or the medical assistance program pursuant to Article 7 of Chapter 4 of Title 49. The pharmacy benefits manager subject to a financial examination or compliance audit shall pay all the actual expenses incurred in conducting the examination or audit. When the examination or audit is made by an examiner or auditor who is not a regular employee of the department, the pharmacy benefits manager examined or audited shall pay the proper expenses for the services of the examiner or auditor and his or her assistants and the actual travel and lodging expenses incurred by such examiners, auditors, and assistants in an amount approved by the Commissioner. The examiner or auditor shall file a consolidated accounting of expenses

for the examination or audit with the Commissioner. No pharmacy benefits manager shall pay, and no examiner or auditor shall accept, any additional emolument on account of any examination or audit. When the examination or audit 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 pharmacy benefits manager examined or audited to the Commissioner. The Commissioner shall be authorized to keep a portion of examination or audit fees paid by the pharmacy benefits manager examined or audited to pay for any costs incurred as a result of the examination or audit, and any fees remaining shall be deposited in the state treasury; provided, however, that when a pharmacy benefits manager is examined or audited because of a complaint filed against such pharmacy benefits manager and it is determined by the Commissioner that the complaint was not justified, the expenses incurred as a result of the examination or audit shall not be assessed against the pharmacy benefits manager but shall be borne by the department;

(2) Investigate complaints of alleged violations of this chapter;

(3) Issue cease and desist orders when a pharmacy benefits manager is taking or threatening to take action in violation of this chapter or rules and regulations implemented pursuant to this chapter; and

(4) Order reimbursement to an insured, pharmacy, or dispenser who has incurred a monetary loss as a result of a violation of this chapter or rules and regulations implemented pursuant to this chapter as well as order payment of a fine not to exceed $1,000.00 per violation to an insured, pharmacy, or dispenser who has been aggrieved as a result of a violation of this chapter or rules and regulations implemented pursuant to this chapter. Such fine shall be in addition to and shall not preclude any other fines imposed pursuant to this title. For purposes of this paragraph, a violation shall be considered to have occurred each time a prohibited act is committed.

(c) A pharmacy benefits manager shall make its records available to the Commissioner, deidentified of any protected health information, upon written demand and provide cooperation in connection with financial examinations, compliance audits, and investigations.

(d) In the event a violation of this chapter or rules and regulations implemented pursuant to this chapter is found following a complaint, the Commissioner may, at his or her discretion, conduct a compliance audit to identify whether any other similar violations have occurred within the state.

History. — Code 1981, § 33-64-7, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2015, p. 337, § 3/HB 470; Ga. L. 2017, p. 494, § 1/HB 276; Ga. L. 2017, p.

497, § 1/SB 103; Ga. L. 2020, p. 768, § 4/HB 946; Ga. L. 2020, p. 780, § 4/SB 313.

Delayed effective date. — This Code section, as set out above, becomes effective July 1, 2021. For version of this Code section in effect until July 1, 2021, see the 2020 amendment note.

The 2020 amendments. — The first 2020 amendment, effective July 1, 2021, designated the existing provisions as subsection (a); substituted the present provisions of subsection (a) for the former provisions, which read: "The Commissioner may not enlarge upon or extend the specific provisions of this chapter through any act, rule, or regulation; provided, however, that the Commissioner is authorized to enforce any specific provision of this chapter and may promulgate rules and regulations to effectuate the specific provisions of this chapter."; and added subsections (b) — (d). The second 2020 amendment, effective July 1, 2021, made identical changes. See the Editor's notes for applicability.

Editor's notes. — Ga. L. 2017, p. 494, § 3/HB 276 and Ga. L. 2017, p. 497, § 3/SB 103, not codified by the General Assembly, provide that the amendments by these Acts shall apply to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2017.

Ga. L. 2020, p. 768, § 9(a)/HB 946 and Ga. L. 2020, p. 780, § 9(a)/SB 313, not codified by the General Assembly, provide, in part, that the amendment by that Act shall apply to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2021.

33-64-8. Electronic prior authorization drug requests with health care providers.

(a) As used in this Code section, "electronic prior authorization" or "e-prior authorization" means a requirement that a prescriber obtain approval via electronic media from a health plan to prescribe a specific medication prior to dispensing. Facsimiles shall not be considered an electronic submission under this Code section except in the event that such electronic media is temporarily unavailable due to system failure or outage.

(b) No later than 24 months after the adoption of standards by the National Council of Prescription Drug Programs, the department shall under the direction of the Commissioner adopt standards by which the pharmacy benefits manager shall exchange standard e-prior authorization requests with health care providers for drugs and devices using electronic data interchange standards consistent with those adopted by the National Council of Prescription Drug Programs. Such standards shall support clinical workflow decision support of the physician provider.

(c) No later than 24 months after the adoption of standards by the National Council of Prescription Drug Programs, e-prior authorization requests shall be accessible and submitted by providers to pharmacy benefits managers and health plans through secure electronic transmissions utilizing the current National Council of Prescription Drug Programs electronic prior authorization standard.

(d) Nothing in this Code section shall require any health care provider to participate in e-prior authorization or electronic prior

authorization in order to obtain the necessary authorization for patient care.

History. — Code 1981, § 33-64-8, enacted by Ga. L. 2012, p. 1134, § 1/SB 416.

33-64-9. Requirements for use of maximum allowable cost pricing by pharmacy benefits managers; appeals; enforcement authority.

(a) Upon each contract execution or renewal between a pharmacy benefits manager and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, a pharmacy benefits manager shall, with respect to such contract or renewal:

(1) Include in such contract or renewal the sources utilized to determine multi-source generic drug pricing, such as maximum allowable cost or any successive benchmark pricing formula, and update such pricing information at least every five business days, provided that such pricing information update shall be at least every 14 business days for those contracts pursuant to Article 7 of Chapter 4 of Title 49; and

(2) Maintain a procedure to eliminate products from the multi-source generic list of drugs subject to such pricing or modify multi-source generic drug pricing within five business days when such drugs do not meet the standards and requirements of this Code section in order to remain consistent with pricing changes in the marketplace.

(b) A pharmacy benefits manager shall reimburse pharmacies for drugs subject to multi-source generic drug pricing based upon pricing information which has been updated within five business days as set forth in paragraph (1) of subsection (a) of this Code section.

(c) A pharmacy benefits manager may not place a drug on a multi-source generic list unless there are at least two therapeutically equivalent, multi-source generic drugs, or at least one generic drug available from only one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

(d) All contracts between a pharmacy benefits manager and a contracted pharmacy or between a pharmacy benefits manager and a pharmacy's contracting representative or agent, such as a pharmacy services administrative organization, shall include a process to internally appeal, investigate, and resolve disputes regarding multi-source generic drug pricing. The process shall include the following:

(1) The right to appeal shall be limited to 14 calendar days following reimbursement of the initial claim; and

(2) A requirement that the health benefit plan issuer or pharmacy benefits manager shall respond to an appeal described in subsection (a) of this Code section no later than 14 calendar days after the date the appeal was received by such health benefit plan issuer or pharmacy benefits manager.

(e) For appeals that are denied, the pharmacy benefits manager shall provide the reason for the denial and identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost.

(f) If the appeal is successful, the health benefit plan issuer or pharmacy benefits manager shall:

(1) Adjust the maximum allowable cost price that is the subject of the appeal effective on the day after the date the appeal is decided;

(2) Apply the adjusted maximum allowable cost price to all similarly situated pharmacists and pharmacies as determined by the health plan issuer or pharmacy benefits manager; and

(3) Allow the pharmacist or pharmacy that succeeded in the appeal to reverse and rebill the pharmacy benefits claim giving rise to the appeal.

(g) Appeals shall be upheld if:

(1) The pharmacy being reimbursed for the drug subject to the multi-source generic drug pricing in question was not reimbursed as required in subsection (b) of this Code section; or

(2) The drug subject to the multi-source generic drug pricing in question does not meet the requirements set forth in subsection (c) of this Code section.

(h) The Commissioner shall have enforcement authority over this Code section.

History. — Code 1981, § 33-64-9, enacted by Ga. L. 2015, p. 337, § 4/HB 470.

33-64-9.1. (Effective January 1, 2021) Reimbursement methodologies utilized by pharmacy benefits managers.

(a)(1) Any methodologies utilized by a pharmacy benefits manager in connection with reimbursement pursuant to Code Section 33-64-9 shall be filed with the Commissioner for use in determining maximum allowable cost appeals; provided, however, that methodologies not otherwise subject to disclosure under Article 4 of Chapter 18 of Title 50 shall be treated as confidential and shall not be subject to disclosure.

(2) A pharmacy benefits manager shall utilize the national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's reimbursement for drugs appearing on the national average drug acquisition cost list and shall produce a report every four months, which shall be provided to the Commissioner and published by the pharmacy benefits manager on a website available to the public for no less than 24 months, of all drugs appearing on the national average drug acquisition cost list reimbursed 10 percent and below the national average drug acquisition cost, as well as all drugs reimbursed 10 percent and above the national average drug acquisition cost. For each drug in the report, a pharmacy benefits manager shall include the month the drug was dispensed, the quantity of the drug dispensed, the amount the pharmacy was reimbursed per unit or dosage, whether the dispensing pharmacy was an affiliate, whether the drug was dispensed pursuant to a state or local government health plan, and the average national average drug acquisition cost for the month the drug was dispensed. Such report shall exclude drugs dispensed pursuant to 42 U.S.C. Section 256b.

(3) This subsection shall not apply to Medicaid under Chapter 4 of Title 49 when the department reimburses providers directly for each covered service; provided, however, that it shall apply to Medicaid managed care programs administered through care management organizations.

(4) This subsection shall take effect on January 1, 2021; provided, however, that prior to July 1, 2021, upon written request, a pharmacy benefits manager shall be granted an extension by the Commissioner of up to six months for its initial filing required pursuant to paragraph (1) of this subsection if the pharmacy benefits manager certifies it is in need of such extension.

(b) On and after July 1, 2021, a pharmacy benefits manager shall not:

(1) Discriminate in reimbursement, assess any fees or adjustments, or exclude a pharmacy from the pharmacy benefit manager's network on the basis that the pharmacy dispenses drugs subject to an agreement under 42 U.S.C. Section 256b; or

(2) Engage in any practice that:

(A) In any way bases pharmacy reimbursement for a drug on patient outcomes, scores, or metrics; provided, however, that nothing shall prohibit pharmacy reimbursement for pharmacy care, including dispensing fees from being based on patient outcomes, scores, or metrics so long as the patient outcomes, scores, or metrics are disclosed to and agreed to by the pharmacy in advance;

(B) Includes imposing a point-of-sale fee or retroactive fee; or

(C) Derives any revenue from a pharmacy or insured in connection with performing pharmacy benefits management services; provided, however, that this shall not be construed to prohibit pharmacy benefits managers from receiving deductibles or copayments.

(c) This Code section shall also apply to pharmacy benefits managers' reimbursements to dispensers.

History. — Code 1981, § 33-64-9.1, enacted by Ga. L. 2020, p. 768, § 5/HB 946; Ga. L. 2020, p. 780, § 5/SB 313.

Effective date. — This Code Section becomes effective January 1, 2021. See Editor's note for applicability.

Editor's notes. — Ga. L. 2020, p. 768, § 5/HB 946 and Ga. L. 2020, p. 780, § 5/SB 313, both enacted a Code section designated 33-64-9.1 and contained identical provisions.

Ga. L. 2020, p. 768, § 9(b)/HB 946 and Ga. L. 2020, p. 780, § 9(b)/SB 313, not codified by the General Assembly, provide that the amendment to this Code section is applicable to all contracts issued, delivered, or issued for delivery in this state on and after January 1, 2021.

U.S. Code. — Section 256b of 42 U.S.C., referred to in this Code section, concerns the limitation on prices of drugs purchased by covered entities.

33-64-10. (Effective until July 1, 2021) Administration of claims by pharmacy benefits manager.

(a) A pharmacy benefits manager shall administer claims in compliance with Code Section 33-30-4.3 and shall not require insureds to use a mail-order pharmaceutical distributor including a mail-order pharmacy.

(b) A pharmacy benefits manager shall report annually to each client, including but not limited to insurers and payors, the aggregate amount of all rebates that the pharmacy benefits manager received from pharmaceutical manufacturers in connection with claims if administered on behalf of the client and the aggregate amount of such rebates the pharmacy benefits manager received from pharmaceutical manufacturers that it did not pass through to the client.

(c) This Code section shall not apply to:

(1) A care management organization, as defined in Chapter 21A of this title;

(2) The Department of Community Health, as defined in Chapter 2 of Title 31;

(3) The State Health Benefit Plan under Article 1 of Chapter 18 of Title 45; or

(4) Any licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

History. — Code 1981, § 33-64-10, enacted by Ga. L. 2017, p. 494, § 2/HB 276; Ga. L. 2017, p. 497, § 2/SB 103; Ga. L. 2019, p. 940, § 2/HB 323; Ga. L. 2020, p. 493, § 33/SB 429; Ga. L. 2020, p. 654, § 4/HB 918.

Delayed effective date. — Code Section 33-64-10 is set out twice in this Code. The first version is effective until July 1, 2021, and the second version becomes effective on that date.

The 2019 amendment, effective January 1, 2020, substituted "A pharmacy" for "When administering claims on behalf of group or blanket accident and sickness insurers subject to Chapter 30 of this title, a pharmacy" at the beginning of subsection (a); and substituted the present provisions of subsection (b) for the former provisions, which read: "Code Section 33-30-4.3 shall apply to individual accident and sickness policies issued pursuant to Chapter 29 of this title and, when administering claims on behalf of individual accident and sickness insurers subject to Chapter 29 of this title, a pharmacy benefits manager shall administer claims in compliance with Code Section 33-30-4.3 and shall not require insureds to use a mail-order pharmaceutical distributor including a mail-order pharmacy." See Editor's notes for applicability.

The 2020 amendments. — The first 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in subsection (b). The second 2020 amendment, effective July 1, 2020, near the end of paragraph (c)(4), inserted "which are" and substituted "Code Section 26-4-110" for "Code Section 26-4-110.1"

Editor's notes. — Ga. L. 2017, p. 494, § 2/HB 276 and Ga. L. 2017, p. 497, § 2/SB 103 both enacted a Code section designated 33-64-10 and containing identical provisions.

Ga. L. 2017, p. 494, § 3/HB 276 and Ga. L. 2017, p. 497, § 3/SB 103, not codified by the General Assembly, provide that this Code section shall apply to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2017.

Ga. L. 2019, p. 940, § 4/HB 323, not codified by the General Assembly, provides, in part, that this Act shall apply to all contracts issued, delivered, or issued for delivery in this state on and after January 1, 2020.

33-64-10. (Effective July 1, 2021) Administration of claims by pharmacy benefits manager.

(a) A pharmacy benefits manager shall administer claims in compliance with Code Section 33-30-4.3 and shall not require insureds to use a mail-order pharmaceutical distributor including a mail-order pharmacy.

(b) A pharmacy benefits manager shall offer a health plan the ability to receive 100 percent of all rebates it receives from pharmaceutical manufacturers. In addition, a pharmacy benefits manager shall report annually to each health plan and the department the aggregate amount of all rebates and other payments that the pharmacy benefits manager received from pharmaceutical manufacturers in connection with claims if administered on behalf of the health plan.

(c) A pharmacy benefits manager shall offer a health plan the option of charging such health plan the same price for a prescription drug as it pays a pharmacy for the prescription drug; provided, however, that a pharmacy benefits manager shall charge a health benefit plan administered by or on behalf of the state or a political subdivision of the state, including any county or municipality, the same price for a prescription drug as it pays a pharmacy for the prescription drug.

(d) A pharmacy benefits manager shall report in the aggregate to a health plan the difference between the amount the pharmacy benefits manager reimbursed a pharmacy and the amount the pharmacy benefits manager charged a health plan. Such information shall be confidential and shall not be subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that such information as it relates to health plans administered by or through the Department of Community Health, including Medicaid care management organizations, or any other state agency shall not be confidential and shall be subject to disclosure under Article 4 of Chapter 18 of Title 50.

(e) When calculating an insured's contribution to any out-of-pocket maximum, deductible, or copayment responsibility, a pharmacy benefits manager shall include any amount paid by the insured or paid on his or her behalf through a third-party payment, financial assistance, discount, or product voucher for a prescription drug that does not have a generic equivalent or that has a generic equivalent but was obtained through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process. Nothing in this subsection shall be construed to require that a pharmacy benefits manager accept a third-party payment, financial assistance, discount, or product voucher submitted on behalf of an insured.

(f) This Code section shall not apply to any licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(g) As used in this Code section, the term "generic equivalent":

(1) Means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium, and that, if administered in the same amounts, will provide comparable therapeutic effects; and

(2) Does not include a drug that is listed by the federal Food and Drug Administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

History. — Code 1981, § 33-64-10, enacted by Ga. L. 2017, p. 494, § 2/HB 276; Ga. L. 2017, p. 497, § 2/SB 103; Ga. L. 2019, p. 940, § 2/HB 323; Ga. L. 2020, p. 493, § 33/SB 429; Ga. L. 2020, p. 654, § 4/HB 918; Ga. L. 2020, p. 768, § 6/HB 946; Ga. L. 2020, p. 780, § 6/SB 313.

Delayed effective date. — This Code section as set out above, becomes effective July 1, 2021. For version of this Code section in effect until July 1, 2021, see the 2020 amendment note.

The 2020 amendments. — The first 2020 amendment, effective July 29, 2020, part of an Act to revise, modernize, and correct the Code, revised punctuation in

subsection (b). The second 2020 amendment, effective July 1, 2020, near the end of paragraph (c)(4), inserted "which are" and substituted "Code Section 26-4-110" for "Code Section 26-4-110.1" The third 2020 amendment, effective July 1, 2021, in subsection (b), inserted "offer a health plan the ability to receive 100 percent of all rebates it receives from pharmaceutical manufacturers. In addition, a pharmacy benefits manager shall", substituted "health plan and the department" for "client, including but not limited to insurers and payors", inserted "and other payments", and substituted "health plan" for "client and the aggregate amount of such rebates the pharmacy benefits manager received from pharmaceutical manufacturers that it did not pass through to the client" at the end; added subsections (c), (d), (e) and (g); redesignated former subsection (c) as present subsection (f); and, in present subsection (f), substituted "any" for ": (1) A care management organization, as defined in Chapter 21A of this title; (2) The Department of Community Health, as defined in Chapter 2 of Title 31; (3) The State Health Benefit Plan under Article 1 of Chapter 18 of Title 45; or (4) Any" and substituted "Code Section 26-4-110" for "Code Section 26-4-110.1". The fourth 2020 amendment, effective July 1, 2021, made identical changes as the third 2020 amendment. See the Editor's notes for applicability.

Editor's notes. — Ga. L. 2020, p. 768, § 9(a)/HB 946 and Ga. L. 2020, p. 780, § 9(a)/SB 313, not codified by the General Assembly, provide that the amendment to this Code section is applicable to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2021.

33-64-11. (For effective date, see note.) Prohibited activities of pharmacy benefits manager.

(a) A pharmacy benefits manager shall be proscribed from:

(1) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from providing an insured individual information on the amount of the insured's cost share for such insured's prescription drug and the clinical efficacy of a more affordable alternative drug if one is available. No pharmacist, pharmacy, or other dispenser or dispenser practice shall be penalized by a pharmacy benefits manager for disclosing such information to an insured or for selling to an insured a more affordable alternative if one is available;

(2) (For effective date, see note.) Prohibiting a pharmacist, pharmacy, or other dispenser or dispenser practice from offering and providing delivery services to an insured as an ancillary service of the pharmacy or dispenser practice;

(3) Charging or collecting from an insured a copayment that exceeds the total submitted charges by the network pharmacy or other dispenser practice for which the pharmacy or dispenser practice is paid;

(4) (For effective date, see note.) Charging or holding a pharmacist or pharmacy or dispenser or dispenser practice responsible for a fee or penalty relating to the adjudication of a claim or an audit conducted pursuant to Code Section 26-4-118, provided that this shall not restrict recoupments made in accordance with Code Section 26-4-118;

(5) Recouping funds from a pharmacy in connection with claims for which the pharmacy has already been paid without first complying with the requirements set forth in Code Section 26-4-118, unless such recoupment is otherwise permitted or required by law;

(6) Penalizing or retaliating against a pharmacist or pharmacy for exercising rights under this chapter or Code Section 26-4-118;

(7) (For effective date, see note.) Steering. This paragraph shall not be construed to prohibit a pharmacy benefits manager from entering into an agreement with an affiliated pharmacy or an affiliated pharmacy of another pharmacy benefits manager licensed pursuant to this chapter to provide pharmacy care to patients;

(8) Transferring or sharing records relative to prescription information containing patient-identifiable and prescriber-identifiable data to an affiliated pharmacy for any commercial purpose; provided, however, that nothing shall be construed to prohibit the exchange of prescription information between a pharmacy benefits manager and an affiliated pharmacy for the limited purposes of pharmacy reimbursement, formulary compliance, pharmacy care, or utilization review;

(9) (For effective date, see note.) Knowingly making a misrepresentation to an insured, pharmacist, pharmacy, dispenser, or dispenser practice;

(10) (For effective date, see note.) Taking any action in violation of subparagraphs (a)(21)(D) and (a)(21)(E) of Code Section 26-4-28 or charging a pharmacy a fee in connection with network enrollment;

(11) (For effective date, see note.) Withholding coverage or requiring prior authorization for a lower cost therapeutically equivalent drug available to an insured or failing to reduce an insured's cost share when an insured selects a lower cost therapeutically equivalent drug; and

(12) (For effective date, see note.) Removing a drug from a formulary or denying coverage of a drug for the purpose of incentivizing an insured to seek coverage from a different health plan.

(b) To the extent that any provision of this Code section is inconsistent or conflicts with applicable federal law, rule, or regulation, such applicable federal law, rule, or regulation shall apply.

(c) (For effective date, see note.) This Code section shall not apply to any licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

History. — Code 1981, § 33-64-11, enacted by Ga. L. 2017, p. 494, § 2/HB 276; Ga. L. 2017, p. 497, § 2/SB 103; Ga. L. 2019, p. 940, § 3/HB 323; Ga. L. 2020, p. 654, § 5/HB 918; Ga. L. 2020, p. 768, § 7/HB 946; Ga. L. 2020, p. 780, § 7/SB 313.

Delayed effective date. — This Code section, as set out above, becomes effective January 1, 2021. For version of this Code section in effect until January 1, 2021, see the 2020 amendment note.

The 2019 amendment, effective January 1, 2020, substituted "pharmacist, pharmacy, or other dispenser or dispenser practice" for "pharmacist or pharmacy" near the beginning of the first sentence in paragraph (a)(1) and in paragraph (a)(2); substituted "No pharmacist, pharmacy, or other dispenser or dispenser practice" for "Neither a pharmacy nor a pharmacist" at the beginning of the second sentence in paragraph (a)(1); added "or dispenser practice" at the end of paragraph (a)(2); in paragraph (a)(3), inserted "or other dispenser practice" in the middle and inserted "or dispenser practice" near the end; in paragraph (a)(4), inserted "or dispenser or dispenser practice" near the beginning, inserted "or penalty" near the middle, and added the language beginning with "or an audit" and ending with "permitted by law" at the end; deleted "and" at the end of paragraph (a)(5); substituted a semicolon for a period at the end of paragraph (a)(6); and added paragraphs (a)(7) through (a)(10). See Editor's notes for applicability.

The 2020 amendments. — The first 2020 amendment, effective July 1, 2020, near the end of paragraph (c)(4), inserted "which are" and substituted "Code Section 26-4-110" for "Code Section 26-4-110.1". The second 2020 amendment, effective January 1, 2021, deleted "store direct" in the middle of paragraph (a)(2), deleted "or pay for performance recoupments otherwise permitted by law" from the end of paragraph (a)(4); rewrote paragraph (a)(7), which read: "Ordering an insured for the filling of a prescription or the provision of pharmacy care services to an affiliated pharmacy; offering or implementing plan designs that require patients to utilize an affiliated pharmacy; or advertising, marketing, or promoting a pharmacy by an affiliate to patients or prospective patients. Subject to the foregoing, a pharmacy benefits manager may include an affiliated pharmacy in communications to patients, including patient and prospective patient specific communications, regarding network pharmacies and prices, provided that the pharmacy benefits manager includes information regarding eligible nonaffiliated pharmacies in such communications and the information provided is accurate. This paragraph shall not be construed to prohibit a pharmacy benefits manager from entering into an agreement with an affiliated pharmacy to provide pharmacy care to patients. The restrictions in this paragraph shall not apply to limited distribution prescription drugs requiring special handling and not commonly carried at retail pharmacies or oncology clinics or practices;"; deleted "and" from the end of paragraph (a)(9); added "or charging a pharmacy a fee in connection with network enrollment" at the end of paragraph (a)(10); added paragraphs (a)(11) and (a)(12); and substituted the present provisions of subsection (c) for the former provisions, which read: "This Code section shall not apply to: (1) A care management organization, as defined in Chapter 21A of this title; (2) The Department of Community Health, as defined in Chapter 2 of Title 31; (3) The State Health Benefit Plan under Article 1 of Chapter 18 of Title 45; or (4) Any licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110." The third 2020 amendment, effective January 1, 2021, made identical changes as the second 2020 amendment. See Editor's notes for applicability.

Editor's notes. — Ga. L. 2017, p. 494, § 2/HB 276 and Ga. L. 2017, p. 497, § 2/SB103 both enacted a Code section designated 33-64-11 and containing identical provisions.

Ga. L. 2017, p. 494, § 3/HB 276 and Ga. L. 2017, p. 497, § 3/SB 103, not codified by the General Assembly, provides that this Code section shall apply to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2017.

Ga. L. 2019, p. 940, § 4/HB 323, not codified by the General Assembly, provides, in part, that this Act shall apply to all contracts issued, delivered, or issued for delivery in this state on and after January 1, 2020.

Ga. L. 2020, p. 768, § 9(b)/HB 946 and Ga. L. 2020, p. 780, § 9(b)/SB 313, not codified by the General Assembly, provide that the amendment to this Code section is applicable to all contracts issued, delivered, or issued for delivery in this state on and after January 1, 2021.

33-64-12. (Effective July 1, 2021) Legislative findings; surcharges and reporting on steering or imposing point-of-sale fees or retroactive fees.

(a) The General Assembly finds that:

(1) The practice of steering by a pharmacy benefits manager represents a conflict of interest;

(2) The practice of imposing point-of-sale fees or retroactive fees obscures the true cost of prescription drugs in this state;

(3) These practices have resulted in harm, including increasing drug prices, overcharging insureds and payors, restricting insureds' choice of pharmacies and other dispensers, underpaying community pharmacies and other dispensers, and fragmenting and creating barriers to care, particularly in rural Georgia and for patients battling life-threatening illnesses and chronic diseases; and

(4) Imposing a surcharge on pharmacy benefits managers that engage in these practices in this state may encourage entities licensed under this title and other payors to use pharmacy benefits managers that are committed to refraining from such practices.

(b)(1) A pharmacy benefits manager that engages in the practices of steering or imposing point-of-sale fees or retroactive fees shall be subject to a surcharge payable to the state of 10 percent on the aggregate dollar amount it reimbursed pharmacies in the previous calendar year for prescription drugs for Georgia insureds.

(2) Any other person operating a health plan and licensed under this title whose contracted pharmacy benefits manager engages in the practices of steering or imposing point-of-sale fees or retroactive fees in connection with its health plans shall be subject to a surcharge payable to the state of 10 percent on the aggregate dollar amount its pharmacy benefits manager reimbursed pharmacies on its behalf in the previous calendar year for prescription drugs for Georgia insureds.

(c)(1) By March 1 of each year, a pharmacy benefits manager shall provide a letter to the Commissioner attesting as to whether or not, in the previous calendar year, it engaged in the practices of steering or imposing point-of-sale fees or retroactive fees. The pharmacy

benefits manager shall also submit to the Commissioner, in a form and manner and by a date specified by the Commissioner, data detailing all prescription drug claims it administered for Georgia insureds on behalf of each health plan client and any other data the Commissioner deems necessary to evaluate whether a pharmacy benefits manager may be engaged in the practice of steering or imposing point-of-sale fees or retroactive fees. Such data shall be confidential and not subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that the Commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting pharmacy benefits manager on behalf of all health plans in the state along with the total sum due to the state. The Department of Audits and Accounts shall have access to all confidential data collected by the Commissioner for audit purposes.

(2) By March 1 of each year, any other person operating a health plan and licensed under this title that utilizes a contracted pharmacy benefits manager shall provide a letter to the Commissioner attesting as to whether or not, in the previous calendar year, its contracted pharmacy benefits manager engaged in the practices of steering or imposing point-of-sale fees or retroactive fees in connection with its health plans. The health plan shall also submit to the Commissioner, in a form and manner and by a date specified by the Commissioner, data detailing all prescription drug claims its contracted pharmacy benefits manager administered for Georgia insureds and any other data the Commissioner deems necessary to evaluate whether a health plan's pharmacy benefits manager may be engaged in the practice of steering or imposing point-of-sale fees or retroactive fees. Such data shall be confidential and not subject to Article 4 of Chapter 18 of Title 50, relating to open records; provided, however, that the Commissioner shall prepare an aggregate report reflecting the total number of prescriptions administered by the reporting health plan along with the total sum due to the state. The Department of Audits and Accounts shall have access to all confidential data collected by the Commissioner for audit purposes.

(d) By April 1 of each year, a pharmacy benefits manager or other person operating a health plan and licensed under this title shall pay into the general fund of the state treasury the surcharge owed, if any, as contained in the report submitted pursuant to subsection (c) of this Code section.

(e) Nothing in this Code section shall be construed to authorize the practices of steering or imposing point-of-sale fees or retroactive fees where otherwise prohibited by law.

History. — Code 1981, § 33-64-12, enacted by Ga. L. 2020, p. 768, § 8/HB 946; Ga. L. 2020, p. 780, § 8/SB 313.

Effective date. — This Code section becomes effective July 1, 2021. See Editor's notes for applicability.

Editor's notes. — Ga. L. 2020, p. 768, § 8/HB 946 and Ga. L. 2020, p. 780, § 8/SB 313, both enacted a Code section designated 33-64-12 and contained identical provisions.

Ga. L. 2020, p. 768, § 9(a)/HB 946 and Ga. L. 2020, p. 780, § 9(a)/SB 313, not codified by the General Assembly, provide that this Code section is applicable to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2021.

33-64-13. (Effective July 1, 2021) Federal law governs.

To the extent that any provision of this chapter is inconsistent or conflicts with applicable federal law, rule, or regulation, such applicable federal law, rule, or regulation shall apply.

History. — Code 1981, § 33-64-13, enacted by Ga. L. 2020, p. 768, § 8/HB 946; Ga. L. 2020, p. 780, § 8/SB 313.

Effective date. — This Code section becomes effective July 1, 2021. See Editor's note for applicability.

Editor's notes. — Ga. L. 2020, p. 768, § 8/HB 946 and Ga. L. 2020, p. 780, § 8/SB 313, both enacted a Code section designated 33-64-13 and contained identical provisions.

Ga. L. 2020, p. 768, § 9(a)/HB 946 and Ga. L. 2020, p. 780, § 9(a)/SB 313, not codified by the General Assembly, provide that this Code section is applicable to all contracts issued, delivered, or issued for delivery in this state on and after July 1, 2021.

CHAPTER 65

CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sec.
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33-65-8. Failure to file corporate governance annual disclosures; penalty.
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33-65-10. Application.
33-65-11. First filing requirement.

Effective date. — This chapter became effective January 1, 2020.

Editor's notes. — Ga. L. 2019, p. 1038, § 2/HB 367, not codified by the General Assembly, provides: "Nothing in this Act shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this Act shall be construed to limit the Commissioner's authority, or the rights or obligations of third parties, under Code Section 33-2-14."

33-65-1. Short title.

This chapter shall be known and may be cited as the "Corporate Governance Annual Disclosure Act."

History. — Code 1981, § 33-65-1, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-2. Definitions.

As used in this chapter, the term:

(1) "Corporate governance annual disclosure" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this chapter.

(2) "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.

(3) "Insurer" has 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 territo-

ries, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(4) "Own Risk and Solvency Assessment Summary Report" means the report filed in accordance with Article 2 of Chapter 13 of this title.

History. — Code 1981, § 33-65-2, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-3. Corporate governance annual disclosures; requirements; cross-referencing data.

(a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Commissioner a corporate governance annual disclosure that contains the information described in subsection (b) of Code Section 33-65-5. Notwithstanding any request from the Commissioner made pursuant to subsection (c) of this Code section, if the insurer is a member of an insurance group, the insurer shall submit the report required by this subsection to the Commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) The corporate governance annual disclosure must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a corporate governance annual disclosure under this Code section shall do so upon the Commissioner's request.

(d) For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors is coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based

on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in subsection (a) of this Code section.

(f) Insurers providing information substantially similar to the information required by this chapter in other documents provided to the Commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to the department shall not be required to duplicate that information in the corporate governance annual disclosure, but shall only be required to cross-reference the document in which the information is included.

History. — Code 1981, § 33-65-3, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-4. Issuance of rules, regulations, and orders.

The Commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations, and orders as shall be necessary to carry out the provisions of this chapter.

History. — Code 1981, § 33-65-4, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-5. Required information in corporate governance annual disclosures; additional information.

(a) The insurer or insurance group shall have discretion over the responses to the corporate governance annual disclosure inquiries, provided that the corporate governance annual disclosure shall contain the material information necessary to permit the Commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The Commissioner may request additional information that he or she deems material and necessary to provide the Commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

(b) Notwithstanding subsection (a) of this Code section, the corporate governance annual disclosure shall be prepared consistent with the Corporate Governance Annual Disclosure Regulation as promulgated by the Commissioner. Documentation and supporting information shall be maintained and made available upon examination or upon request of the Commissioner.

History. — Code 1981, § 33-65-5, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-6. Proprietary and confidential nature of disclosures; limitation on testimony.

(a) Documents, materials, or other information including the corporate governance annual disclosure, in the possession or control of the department that are obtained by, created by, or disclosed to the Commissioner or any other person under this chapter, are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials, or other information shall be confidential by law and privileged, shall not be 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. The Commissioner shall not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this Code section shall be construed to require written consent of the insurer before the Commissioner may share or receive confidential documents, materials, or other corporate governance annual disclosure related information pursuant to subsection (c) of this Code section to assist in the performance of the Commissioner's regular duties.

(b) Neither the Commissioner nor any person who received documents, materials, or other corporate governance annual disclosure 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 chapter 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 corporate governance annual disclosure 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 subsection (c) of Code Section 33-13-7, with the National Association of Insurance Commissioners, and with third-party consultants pursuant to Code Section

33-65-7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure related documents, material, or other information and has verified in writing the legal authority to maintain confidentiality; and

(2) May receive documents, materials, or other corporate governance annual disclosure related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other states, federal and international financial regulatory agencies, including members of any supervisory college as described in subsection (c) of 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 it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(d) The sharing of information and documents by the Commissioner pursuant to this chapter 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 chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other corporate governance annual disclosure related information shall occur as a result of disclosure of such corporate governance annual disclosure related information or documents to the Commissioner under this Code section or as a result of sharing as authorized in this chapter.

History. — Code 1981, § 33-65-6, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-7. Use of third-party consultants by Commissioner; advisory capacity; confidentiality standards; free of conflict of interests.

(a) The Commissioner may retain, at the insurer's expense, third-party consultants, including 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 corporate governance annual disclosure and related information or the insurer's compliance with this chapter.

(b) Any persons retained under subsection (a) of this Code section shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(c) The National Association of Insurance Commissioners and third-party consultants shall be subject to the same confidentiality standards and requirements as the Commissioner.

(d) As part of the retention process, a third-party consultant shall verify to the Commissioner, with notice to the insurer, that it is free of conflicts of interest and that it has internal procedures in place to monitor compliance of potential conflicts and to comply with the confidentiality standards and requirements of this chapter.

(e) A written agreement between the Commissioner and the National Association of Insurance Commissioners or a third-party consultant governing sharing and use of information provided pursuant to this chapter shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this chapter:

(1) Specific procedures and protocols for maintaining the confidentiality and security of corporate governance annual disclosure related information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter;

(2) Procedures and protocols for sharing by the National Association of Insurance Commissioners only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(3) A provision specifying that ownership of the corporate governance annual disclosure related information shared with the National Association of Insurance Commissioners or a third-party consultant remains with the department, and the National Association of Insurance Commissioners' or third-party consultant's use of the information is subject to the direction of the Commissioner;

(4) A provision that prohibits the National Association of Insurance Commissioners or a third-party consultant from storing the information shared pursuant to this chapter in a permanent data base after the underlying analysis is completed;

(5) A provision requiring the National Association of Insurance Commissioners or a third-party consultant to provide prompt notice to the Commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's corporate governance annual disclosure related information; and

(6) A requirement that the National Association of Insurance Commissioners or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or a third-party consultant may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this chapter.

History. — Code 1981, § 33-65-7, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-8. Failure to file corporate governance annual disclosures; penalty.

Any insurer failing, without just cause, to timely file the corporate governance annual disclosure as required in this chapter shall be required, after notice and hearing, to pay a penalty of $100.00 for each day's delay, to be recovered by the Commissioner, and the penalty so recovered shall be paid into the general fund of the state treasury. The maximum penalty under this Code section is $10,000.00. The Commissioner 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.

History. — Code 1981, § 33-65-8, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-9. Severability.

If any provision of this chapter other than Code Section 33-65-6, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter, with the exception of Code Section 33-65-6, are severable.

History. — Code 1981, § 33-65-9, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-10. Application.

The requirements of this chapter shall apply to all insurers domiciled in this state.

History. — Code 1981, § 33-65-10, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

33-65-11. First filing requirement.

The first filing of the corporate governance annual disclosure shall be in 2020.

History. — Code 1981, § 33-65-11, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.

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Home state.
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Insurance companies, §33-23-1.
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Independent review organization.
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Insurance groups.
Insurance companies, corporate governance annual disclosure, §33-65-2.
Insurance companies, own risk and solvency assessment (ORSA) summary reports, §33-13-32.
Insurance holding company system, §33-13-1.
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Morbid obesity anti-discrimination act, §33-24-59.7.
Payment of benefits, §33-24-59.5.
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Genetic testing, §33-54-2.
Group or blanket accident and sickness insurance, §33-30-13.1.
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Health benefit policies, §33-24-56.3.
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Health insurance, accurate provider directories, §33-20C-1.
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Insurance companies.
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Insurer —Cont'd
Insurance companies —Cont'd
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Insurance identification cards, §33-24-57.1.
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Off-label prescription drug coverage, §33-24-59.11.
Ovarian cancer, §33-24-56.2.
Parental access to child's health insurance information, §33-24-59.16.
Preexisting health conditions, §33-30-15.
Prepaid legal services plans, §33-35-2.
Producer controlled property and casualty insurers, §33-48-2.
Registered nurse first assistant consumer act, §33-24-59.9.
Rehabilitation, reorganization, etc., §33-37-3.
Reinsurance intermediary, §33-49-2.
Right to shop for insurance coverage, §33-24-59.27.
Risk-based capital levels, §33-56-1.
Small business employee choice of benefits in health insurance, §33-60-3.
Unclaimed life insurance benefits act, §33-25-14.
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Insurance company rehabilitation, etc., §33-37-3.
Intermediate stock holding company.
Mutual insurance holding companies, §33-13A-2.
Internationally active insurance group.
Insurance holding company systems, §33-13-1.
Investigative consumer report.
Insurance information, §33-39-3.
Involved insurer.
Insurance holding company systems, §33-13-3.1.

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Issuer.
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Knowledge of death.
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Law.
Fraternal benefit society, §33-15-4.
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Motor vehicle insurance, §33-7-11.1.
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Licensed medical practitioner.
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Licensed producer.
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Licensed property and casualty insurer.
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Licensee.
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Risk-based capital levels, §33-56-1.
Life expectancy.
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Life insurance, §33-7-4.
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Limited purpose subsidiary life insurance companies, §33-14-100.
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Local anesthetic.
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Location.
Insurance licensing, §33-23-12.
Lodges.
Fraternal benefit society, §33-15-4.
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Health insurance, §33-42-4.
Loss ratio.
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Insurance companies.
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Majority of the voting stock of the reorganized stock insurer.
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Major medical coverage.
Accident and sickness insurance, §33-24-24.
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Reinsurance intermediary, §33-49-2.
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Insurance companies.
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Medicaid.
Medicaid care management organizations, §33-21A-2.
Medicaid care management member.
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Managed health care plans.
Patient's right to independent review, §33-20A-31.
Medical-care institution.
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Accident and sickness insurance, §33-24-28.2.
Medical malpractice claim.
Insurance policies, §33-3-27.
Medical necessity.
Managed health care plans.
Patient's right to independent review, §33-20A-31.
Medical outcome.
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Medical professional.
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Medical-record information.
Insurance information, §33-39-3.
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Medicare supplement insurance, §33-43-1.
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Medicare supplement insurance, §33-43-1.
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Medium grade investment.
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Protection and furtherance of investments, §33-11-51.
Member insurer.
Life and health insurance guaranty association, §33-38-4.
Members.
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Insurance rating and advisory organizations, §33-9-2.
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Membership fees.
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Mental disorder.
Accident and sickness insurance.
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Investment pools, §33-11-82.
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Life and health insurance guaranty association, §33-38-4.
Morbid obesity, §33-24-59.7.
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Risk-based capital levels, §33-56-1.
National average drug acquisition cost.
Pharmacy benefits managers, §33-64-1.
Natural person.
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Navigators.
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Negative trend.
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Negotiate.
Insurance companies, §33-23-1.
Net death benefit.
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Insurers insolvency pool, §33-36-3.
Network.
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Health insurance, accurate provider directories, §33-20C-1.
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Surplus line insurance, §33-5-20.1.
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Health insurance, surprise billing, §33-20E-2.
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Offer and disseminate.
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Operative date of the valuation manual.
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Organizing domestic reinsurer.
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Health insurance coverage for telemedicine, §33-24-56.4.
ORSA.
Insurance companies, own risk and solvency assessment (ORSA) summary reports, §33-13-32.
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Insurance companies, own risk and solvency assessment (ORSA) summary reports, §33-13-32.
Out-of-network.
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Out of network.
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Insurance companies.
Protection and furtherance of investments, §33-11-51.
Owners.
Insurance licensing, §33-23-12.
Life and health insurance guaranty association, §33-38-4.
Life settlements act, §33-59-2.
Motor vehicle insurance, §33-34-2.
Own risk and solvency assessment.
Insurance companies, own risk and solvency assessment (ORSA) summary reports, §33-13-32.
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Insurance companies, corporate governance annual disclosure, §33-65-2.
Papanicolaou smear.
Group or blanket accident and sickness insurance, §33-30-4.2.
Individual accident and sickness insurance, §33-29-3.2.
Pap smear.
Group or blanket accident and sickness insurance, §33-30-4.2.
Individual accident and sickness insurance, §33-29-3.2.
Parents.
Captive insurance company, §33-41-2.
Participant.
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Participant contract.
Sponsored captive insurance companies, §33-41-101.
Participating facility.
Health care plans, §33-20-3.
Participating physician.
Health care plans, §33-20-3.
Participating provider.
Health insurance, surprise billing, §33-20E-2.
Patient.
Health maintenance organizations, §33-21-1.
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Patient identifying information.
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Patient navigators.
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Payor.
Insurance, §33-46-2.
PeachCare for kids.
Medicaid care management organizations, §33-21A-2.
Perioperative nursing.
Registered nurse first assistant consumer act, §33-24-59.9.
Person.
Guaranteed asset protection waivers, §33-63-3.
Health care plans, §33-20-3.
Health maintenance organizations, §33-21-1.
Insurance, §33-1-2.
Insurance companies, §§33-6-2, 33-23-1.
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Life and health insurance guaranty association, §33-38-4.
Life insurance, §33-25-15.
Life settlements act, §33-59-2.
Unclaimed life insurance benefits act, §33-25-14.
Unfair insurance claims settlement practices, §33-6-32.
Personal information.
Insurance information, §33-39-3.
Personal insurance.
Insurance underwriting and rate risking, §33-24-90.

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Personal property.
Insurance licensing, §33-23-12.
Personal risk liability.
Insurance risk retention groups, §33-40-2.
Personal service.
Continuing care providers and facilities, §33-45-1.
Personal vehicles.
Transportation network companies and drivers, insurance, §33-1-24.
Pharmacy.
Pharmacy benefits managers, §33-64-1.
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Physician.
Direct primary care agreements, §33-7-2.1.
Essential rural health care provider access, §33-20B-2.
Physician contract.
Managed health care plans, §33-20A-60.
Plan.
Health care spending accounts and consumer driven health plans, §33-30B-3.
Plan administrator.
Health insurance, §33-24-21.2.
Plan of operation or a feasibility study.
Insurance risk retention groups, §33-40-2.
Plan sponsor.
Health care spending accounts and consumer driven health plans, §33-30B-3.
Life and health insurance guaranty association, §33-38-4.
Point-of-sale fee.
Pharmacy benefits managers, §33-64-1.
Point of service.
Managed health care plans, §33-20A-3.
Point-of-service option.
Health maintenance organizations, §33-21-29.
Policy.
Automobile or motorcycle insurance, §33-24-45.
Cancellation of certain property insurance policies, §33-24-46.
DEFINED TERMS —Cont'd
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Child wellness insurance coverage, §33-29-3.4.
Child wellness services, §33-30-4.5.
Group or blanket accident and sickness insurance, §33-30-4.2.
Health insurance, §§33-24-57, 33-30-4.2.
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