Article 62.

Life and Health Insurance Guaranty Association.

§ 58-62-1: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-2. Title.

This Article shall be known and may be cited as the North Carolina Life and Health Insurance Guaranty Association Act. (1991, c. 681, s. 56.)

§ 58-62-5: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-6. Purpose.

(a) The purpose of this Article is to protect, subject to certain limitations, the persons specified in G.S. 58-62-21(a) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in G.S. 58-62-21(b), because of the delinquency of the member insurer that issued the policies.

(b) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Article. (1991, c. 681, s. 56.)

§ 58-62-10: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-11. Construction.

This Article shall be liberally construed to effect the purpose under G.S. 58-62-6, which shall constitute an aid and guide to interpretation. (1991, c. 681, s. 56.)

§ 58-62-15: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-16. Definitions.

As used in this Article:

(1) "Account" means any of the two accounts created under G.S. 58-62-26.

(2) "Association" means the North Carolina Life and Health Insurance Guaranty Association created under G.S. 58-62-26.

(3) "Board" means the board of directors of the Association established under G.S. 58-62-31.

(4) "Contractual obligation" means any obligation under a policy or certificate under a group policy, or part thereof, for which coverage is provided under G.S. 58-62-21.

(5) "Covered policy" means any policy within the scope of this Article under G.S. 58-62-21.

(6) "Delinquent insurer" means an impaired insurer or an insolvent insurer; and "delinquency" means an insurer impairment or insolvency.

(7) "Health insurance" includes hospital or medical service corporation contracts, accident and health insurance, accident insurance, and disability insurance.

(8) "Impaired insurer" means a member insurer that, after the effective date of this Article, is not an insolvent insurer, and (i) is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations or (ii) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(9) "Insolvent insurer" means a member insurer that, after the effective date of this Article, is placed under an order of liquidation with a finding of insolvency by a court of competent jurisdiction.

(10) "Insurance regulator" means the official or agency of another state that is responsible for the regulation of a foreign insurer.

(11) "Member insurer" means any insurer and any hospital or medical service corporation that is governed by Article 65 of this Chapter and that is licensed or that holds a license to transact in this State any kind of insurance for which coverage is provided under G.S. 58-62-21; and includes any insurer whose license in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include an entity governed by Article 67 of this Chapter; fraternal order or fraternal benefit society; mandatory State pooling plan; mutual assessment company or any entity that operates on an assessment basis; insurance exchange; or any entity similar to any of the foregoing.

(12) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(13) "Person" includes an individual, corporation, company, partnership, association, or aggregation of individuals.

(14) "Plan" means the plan of operation established under G.S. 58-62-46.

(15) "Policy" includes a master group contract and subscriber contract under Article 65 of this Chapter, a contract of insurance and an annuity contract.

(16) "Premiums" means amounts received in any calendar year on covered policies less premiums, considerations, and deposits returned thereon, and less dividends and experience credits thereon.

"Premiums" does not include any amounts received for any policies or for the parts of any policies for which coverage is not provided under G.S. 58-62-21(b); except that assessable premium shall not be reduced on account of G.S. 58-62-21(c)(3) relating to interest limitations and G.S. 58-62-21(d)(2) relating to limitations with respect to any one individual, any one participant, and any one contract holder.

(17) "Resident" means any person who resides in this State when a member insurer is determined to be a delinquent insurer and to whom a contractual obligation is 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. "Resident" also means a U.S. citizen residing outside of the United States who owns a covered policy that was purchased from a member insurer while that person resided in this State.

(17a) "Structured settlement annuities" means any contracts or certificates for annuities issued to fund, in whole or in part, a settlement agreement for a matter involving personal injury or illness, including any settlement agreement permitted under Chapter 97 of the General Statutes.

(18) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. (1991, c. 681, s. 56; 1993, c. 452, s. 60; 1995, c. 177, s. 1; 2009-448, s. 1.)

§ 58-62-20: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-21. Coverage and limitations.

(a) This Article provides coverage for the policies and contracts specified in subsection (b) of this section:

(1) To persons other than persons specified in subdivisions (3) and (4) of this subsection who, regardless of where they reside (except for nonresident certificate holders under group policies), are the beneficiaries, assignees, or payees of the persons covered under subdivision (2) of this subsection;

(2) To persons other than persons specified in subdivisions (3) and (4) of this subsection who are owners or certificate holders under the policies, or in the case of unallocated annuity contracts to the persons who are the contract holders, and who are residents of this State, or who are not residents of this State, but only under all of the following

conditions: (i) the insurers that issued the policies are domiciled in this State; (ii) the insurers never held a license in the states in which the persons reside; (iii) the states have associations similar to the association created by this Article; and (iv) the persons are not eligible for coverage by the associations;

(3) To persons who are payees (or beneficiaries of payees if the payees are deceased) under structured settlement annuities if the payees are residents of this State, regardless of where the contract owners of the structured settlement annuities reside; and

(4) To persons who are payees (or beneficiaries of payees if the payees are deceased) under structured settlement annuities if the payees are not residents of this State, but only if all of the following conditions are met:

a. The contract owners of the structured settlement annuities are residents of this State or, if not residents of this State, (i) the insurers that issued the structured settlement annuities are domiciled in this State and (ii) the state in which the contract owners reside has an association similar to the Association created by this Article; and

b. Neither the payees (or beneficiaries of payees if the payees are deceased) nor the contract owners of the structured settlement annuities are eligible for coverage by an association of the state in which the payees or contract owners reside.

(b) This Article provides coverage to the persons specified in subsection (a) of this section for direct, nongroup life, health, annuity, and supplemental policies, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Article. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(c) This Article does not provide coverage for:

(1) Any part of a policy not guaranteed by the insurer, or under which the risk is borne by the policyholder;

(2) Any policy or contract of reinsurance, unless assumption certificates have been issued;

(3) Any part of a policy to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by the use of an index or other external reference stated in the policy or contract and employed in calculating returns or changes in value:

a. Averaged over the period of four years before the date on which the Association becomes obligated with respect to the policy, exceeds a 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 a lesser period if the policy was issued less than four years before the Association became obligated; and

b. On and after the date on which the Association becomes obligated with respect to the policy, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or similar entity under:

a. A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

b. A minimum premium group insurance plan;

c. A stop-loss group insurance plan; or

d. An administrative services only contract;

(5) Any part of a policy to the extent that it provides dividends or experience-rating credits, or provides that any fees or allowances be paid to any person, including the policyholder, in connection with the service to or administration of the policy;

(6) Any policy issued in this State by a member insurer at a time when it was not licensed to issue the policy in this State;

(7) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation; and

(8) Any part of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(9) 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 Parts C & D) or any regulations issued pursuant thereto.

(10) 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 Act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

(d) The benefits for which the Association is liable do not, in any event, exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not a delinquent insurer; or

(2) With respect to any one individual, regardless of the number of policies, three hundred thousand dollars ($300,000) for all benefits, including cash values; or

(2a) With respect to health insurance benefits for any one individual, regardless of the number of policies:

a. Three hundred thousand dollars ($300,000) for coverages not defined as basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter, including disability insurance and long-term care insurance; or

b. Five hundred thousand dollars ($500,000) for basic hospital, medical, and surgical insurance or major medical insurance as defined in this Chapter and regulations adopted pursuant to this Chapter;

(3) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code covered by an unallocated annuity contract, or the beneficiaries of each individual if deceased, in the aggregate, three hundred thousand dollars ($300,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or

(4) With respect to any one contract holder covered by any unallocated annuity contract not included in subdivision (3) of this subsection,

five million dollars ($5,000,000) in benefits, regardless of the number of such contracts held by that contract holder; or

(5) With respect to any one payee (or beneficiaries of one payee if the payee is deceased) of a structured settlement annuity, one million dollars ($1,000,000) for all benefits, including cash values.

(6) However, in no event shall the Association be obligated to cover more than (i) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one individual under subdivisions (2) and (3) and sub-subdivision (2a)a. except with respect to benefits for basic hospital, medical, and surgical and major medical insurance under sub-subdivision (2a)b. of this subsection, in which case the aggregate liability of the Association shall not exceed five hundred thousand dollars ($500,000) with respect to any one individual.

(e) Repealed by Session Laws 2010-11, s. 2, effective June 23, 2010, and applicable to claims submitted to the North Carolina Life and Health Insurance Guaranty Association on or after August 7, 2009. (1991, c. 681, s. 56; c. 720, s. 93; 1993, c. 452, s. 61; 2009-448, ss. 2, 3, 4; 2010-11, ss. 1, 2; 2013-136, s. 1.)

§ 58-62-25: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-26. Creation of the Association.

(a) There is created a nonprofit legal entity to be known as the North Carolina 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 in this State. The Association shall perform its functions under the Plan established and approved under G.S. 58-62-46 and shall exercise its powers through the Board established under G.S. 58-62-31. For purposes of administration and assessment, the Association shall maintain two accounts:

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

a. Life insurance account;

b. Annuity account.

(2) The health insurance account.

(b) The Association is under the immediate supervision of the Commissioner and is subject to the applicable provisions of this Chapter. Meetings or records of the Association may be opened to the public upon majority vote of the Board. (1991, c. 681, s. 56.)

§ 58-62-30: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-31. Board of directors.

(a) The Board shall consist of not less than five nor more than nine member insurers serving terms as established in the Plan. The members of the Board shall be selected by member insurers, subject to the Commissioner's approval. 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 Commissioner's approval. To select the initial Board, and initially organize the Association, the Board's predecessor shall notify all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the Board is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members.

(b) In approving selections or in appointing 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 expenses they incur as members of the Board, but they shall not otherwise be compensated by the Association for their services. (1991, c. 681, s. 56.)

§ 58-62-35: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-36. Powers and duties of the Association.

(a) If a member insurer is an impaired domestic insurer, the Association may, subject to any conditions imposed by the Association and approved by the Commissioner that do not impair the contractual obligations of the impaired insurer and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies of the impaired insurer;

(2) Provide such monies, pledges, notes, guarantees, or other means as are proper to carry out subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection; or

(3) Lend money to the impaired insurer.

(b), (c) Repealed by Session Laws 2013-136, s. 2, effective July 1, 2013.

(d) If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:

(1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies of the insolvent insurer; or

(2) Assure payment of the contractual obligations of the insolvent insurer; and

(3) Provide such monies, pledges, guarantees, or other means as are reasonably necessary to discharge those duties; or

(4) With respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection (e) of this section.

(d1) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsections (a) and (d) of this section, the Association may, subject to approval of the receivership court, 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:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate, (ii) payment of dividends with minimum guarantees, or (iii) a different method for calculating interest or changes in value;

(2) 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

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(e) When proceeding under subdivision (b)(2) or (d)(4) of this section, the Association shall, with respect to only life and health insurance policies:

(1) Assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:

a. With respect to group policies, not later than the earlier of the next renewal date under the policies 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;

b. With respect to individual policies, not later than the earlier of the next renewal date (if any) under the policies 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;

(2) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies 30 days' notice of the termination of the benefits provided; and

(3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an

individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (f) of this section, if the insured had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(f) In providing the substitute coverage required under subdivision (e)(3) of this section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy. An alternative or reissued policy 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. The Association may reinsure any alternative or reissued policy.

(g) Alternative life or health insurance policies adopted by the Association are subject to the Commissioner's approval. The Association may adopt alternative policies of various types for future issuance without regard to any particular delinquency. Alternative policies shall contain at least the minimum statutory provisions required in this State and provide benefits that are not unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates, which 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 it shall not reflect any changes in the health of the insured after the original policy was last underwritten. Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy issued by the delinquent insurer, as determined by the Association.

(h) If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated life or health insurance policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the Commissioner or by a court of competent jurisdiction.

(i) The Association's obligations with respect to coverage under any life or health insurance policy of the delinquent insurer or under any reissued or alternative policy cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the Association.

(j) When proceeding under subdivision (b)(2) of this section or under subsection (c) of this section with respect to any policy carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with G.S. 58-62-21(c)(3).

(k) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or substitute coverage terminates the Association's obligations under the policy or coverage under this Article with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due under this Article.

(l) Premiums due for coverage after an entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the Association; and the Association is liable for unearned premiums owed to policyowners arising after the entry of the order.

(m) The protection provided by this Article does not apply where any similar guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of a delinquent foreign or alien insurer.

(n) In carrying out its duties under subsections (b) through (d) of this section, the Association may, subject to approval by the court:

(1) Impose permanent policy liens in connection with any guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts that can be assessed under this Article are less than the amounts needed to assure full and prompt performance of the Association's duties under this Article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of the permanent policy liens to be in the public interest;

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

(o) If the Association fails to act within a reasonable period of time as provided in subdivision (b)(2) of this section and subsections (d) and (e) of this section, the Commissioner has the powers and duties of the Association under this Article with respect to delinquent insurers.

(p) The Association may render assistance and advice to the Commissioner, upon the Commissioner's request concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any delinquent insurer.

(q) The Association has standing to appear before any court in this State with jurisdiction over a delinquent insurer for which the Association is or may become obligated under this Article. This standing extends to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies of the delinquent insurer and the determination of the policies and contractual obligations. The Association also has the right to appear or intervene before a court in another state with jurisdiction over a

delinquent insurer for which the Association is or may become obligated or with jurisdiction over a third party against whom the Association may have rights through subrogation of the insurer's policyholders.

(r) Any person receiving benefits under this Article is considered to have been assigned the rights under, and any causes of action relating to, the covered policy to the Association to the extent of the benefits received because of this Article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policyowner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Article upon the person. The subrogation rights of the Association under this subsection have the same priority against the delinquent insurer's assets as that possessed by the person entitled to receive benefits under this Article. In addition to other provisions of this subsection, the Association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the delinquent insurer or holder of a policy with respect to the policy.

(s) The Association may:

(1) Enter into contracts that are necessary or proper to carry out the provisions and purposes of this Article;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under G.S. 58-62-41 and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this Article; any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain persons that are necessary to handle the financial transactions of the Association, and to perform other functions that become necessary or proper under this Article;

(5) Take legal action that may be necessary to avoid payment of improper claims;

(6) Exercise, for the purposes of this Article and to the extent approved by the Commissioner, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Article.

(t) The Association may join an organization of one or more other state associations of similar purposes, in order to further the purposes of this Article and administer the powers and duties of the Association. (1991, c. 681, s. 56; c. 720, s. 94; 2013-136, s. 2.)

§ 58-62-40: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-41. Assessments.

(a) To provide the funds necessary to carry out the powers and duties of the Association, the Board shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers and shall accrue interest at the rate of one percent (1%) per month, or any part thereof, after the due date.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of G.S. 58-62-56(e). Class A assessments may be made whether or not they are related to a particular delinquent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under G.S. 58-62-36 with regard to a delinquent insurer.

(c) The amount of any Class A assessment shall be determined by the Board and may or may not be prorated. If prorated, the Board may provide that it be credited against future Class B assessments. If not prorated, the assessment shall not exceed five hundred dollars ($500.00) per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the delinquent insurer or any other standard considered by the Board in its sole discretion to be fair and reasonable under the circumstances.

(d) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer or policies covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became delinquent, as the case may be, bears to the premiums received on business in this State for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the Association with respect to a delinquent insurer shall not be made until necessary to implement the purposes of this Article. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(f) The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the Board's opinion, payment of the assessment would endanger the member insurer's ability to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(g) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent (2%) and for the health account shall not in any one calendar year exceed two percent (2%) of the insurer's average premiums received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which an insurer became a delinquent insurer. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the Association's responsibilities, the necessary additional funds shall be assessed as soon thereafter as permitted by this Article.

(h) The Board may provide in the Plan a method of allocating funds among claims, whether relating to one or more delinquent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(i) If a one percent (1%) assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the Association's responsibilities, then under subsection (d) of this section, the Board shall assess all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (g) of this section.

(j) The Board may, by an equitable method as established in the Plan, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses.

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

(l) The Association shall issue to each insurer paying an assessment under this Article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to

amounts or dates of issue. (1991, c. 681, s. 56; 1993, c. 452, ss. 61.1, 62; 1995, c. 193, ss. 47, 48; 2013-136, s. 3.)

§ 58-62-45: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-46. Plan of operation.

(a) The Association shall submit to the Commissioner a Plan and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The Plan and any amendments shall become effective upon the Commissioner's written approval or unless the Commissioner has not disapproved it within 30 days.

(b) If the Association fails to submit a suitable Plan within 120 days after the effective date of this Article or if at any time thereafter the Association fails to submit suitable amendments to the Plan, the Commissioner shall, after notice and hearing, adopt rules that are necessary or advisable to carry out the provisions of this Article. The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.

(c) All member insurers shall comply with the Plan.

(d) The Plan shall, in addition to other requirements specified in this Article, establish:

(1) Procedures for handling the assets of the Association;

(2) The amount and method of reimbursing members of the Board under G.S. 58-62-31;

(3) Regular places and times for meetings, including telephone conference calls, of the Board;

(4) Procedures for records to be kept of all financial transactions of the Association, its agents, and the Board;

(5) The procedures whereby selections for the Board will be made and submitted to the Commissioner;

(6) Any additional procedures for assessments under G.S. 58-62-41;

(7) Additional provisions necessary or proper for the execution of the powers and duties of the Association.

(e) The Plan may provide that any or all powers and duties of the Association, except those under G.S. 58-62-36(r) and G.S. 58-62-41, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the Association, or its equivalent, in two 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 subsection is effective only with the approval of both the Board and the Commissioner, and may be made only to a

corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Article. (1991, c. 681, s. 56.)

§ 58-62-50: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-51. Duties and powers of the Commissioner.

(a) In addition to other duties and powers specified in this Article, the Commissioner shall:

(1) Upon request of the Board, provide the Association with a statement of the premiums in this State and any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to comply promptly with the demand does not excuse the Association from the performance of its powers and duties under this Article; and

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator as provided in Article 30 of this Chapter.

(b) The Commissioner may suspend or revoke, after notice and hearing, the license to transact insurance in this State of any member insurer that fails to pay an assessment when due or fails to comply with the Plan. As an alternative the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

(c) Any action of the Board or the Association may be appealed to the Commissioner by any member insurer if the appeal is taken within 60 days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the Association and available to meet Association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. No later than 20 days before each hearing, the appellant shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellee a written statement of the appellant's case and any evidence the appellant intends to offer at the hearing. No later than five days before the hearing, the appellee shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellant a written statement of the appellee's case and any evidence the appellee intends to offer at the hearing. Each hearing shall be recorded and

transcribed. The cost of the recording and transcribing shall be borne equally by the appellant and appellee; however, upon any final adjudication the prevailing party shall be reimbursed for that party's share of the costs by the other party. Each party shall, on a date determined by the Commissioner or the Commissioner's designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or the Commissioner's designated hearing officer and serve on the other party, a proposed order. The Commissioner or the Commissioner's designated hearing officer shall then issue an order. Any final action or order of the Commissioner or the Commissioner's designated hearing officer is subject to judicial review under G.S. 58-2-75.

(d) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this Article. (1991, c. 681, s. 56.)

§ 58-62-55: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-56. Prevention of delinquencies.

(a) To aid in the detection and prevention of insurer delinquencies, it is the Commissioner's duty to:

(1) Notify insurance regulators when revoking or suspending the license of a member insurer, or making any formal order that the insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from this State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors. That notice shall be sent electronically through the NAIC headquarters and mailed to all insurance regulators within 30 days following the action taken or the date on which the action occurs.

(2) Report to the Board when the Commissioner has taken any of the actions in subdivision (1) of this subsection or has received a report from another insurance regulator indicating that any such action has been taken in another state. The report to the Board shall contain all significant details of the action taken or the report received from another insurance regulator.

(3) Report to the Board when the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the insurer may be delinquent.

(4) Furnish the Board with the NAIC Insurance Regulatory Information System financial test ratios and a listing of companies that are not included in the ratios developed by the NAIC; and the Board may use that data in carrying out its duties and responsibilities under this

section. The data shall be kept confidential by the Board until it is made public by the Commissioner or another lawful authority.

(b) The Commissioner may seek the advice and recommendations of the Board concerning any matter affecting the Commissioner's duties and responsibilities regarding the financial condition of member insurers and other entities seeking admission to transact insurance business in this State.

(c) The Board 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 germane to the solvency of any company seeking to do an insurance business in this State. The reports and recommendations are not public records.

(d) The Board shall, upon majority vote, notify the Commissioner of any information indicating that any member insurer may be delinquent.

(e) The Board may, upon majority vote, request that the Commissioner order an examination of any member insurer that the Board in good faith believes may be delinquent. Within 30 days of the receipt of the request, the Commissioner shall begin the examination. The examination may be conducted as an NAIC examination or may be conducted by persons the Commissioner designates. The examination report shall be treated as are other examination reports. In no event shall the examination report be released to the Board before its release to the public; but this does not preclude the Commissioner from complying with subsection (a) of this section. The Commissioner shall notify the Board when the examination is completed. The request for an examination shall be kept on file by the Commissioner, but shall not be open to public inspection before the release of the examination report to the public.

(f) The Board may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer delinquencies.

(g) The Board 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 any information that it has in its possession bearing on the history and causes of the insolvency. The Board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and the Board may adopt by reference any report prepared by such other associations. (1991, c. 681, s. 56; 1995, c. 360, s. 2(k).)

§ 58-62-60: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-61. Miscellaneous provisions.

(a) Nothing in this Article reduces the liability for unpaid assessments of the insureds of a delinquent insurer operating under an insurance plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved and in which the activities of the Association in carrying out its powers and duties under G.S. 58-62-36 are discussed. Records of those negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the delinquent insurer, upon the termination of the delinquency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the Association to render a report of its activities under G.S. 58-62-66.

(c) For the purpose of carrying out its obligations under this Article, the Association is a creditor of the delinquent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee under G.S. 58-62-36(r). Assets of the delinquent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the delinquent insurer as required by this Article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets that the reserves that should have been established for the policies bear to the reserves that should have been established for all policies of insurance written by the delinquent insurer.

(d) Before the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(e) No distribution to stockholders, if any, of a delinquent insurer shall be made until and unless the Association has fully recovered the total amount of its valid claims with interest thereon for funds expended in carrying out its powers and duties under G.S. 58-62-36 with respect to the insurer.

(f) If an order for liquidation or rehabilitation of an insurer domiciled in this State has been entered, the receiver appointed under the order has a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections (g) through (i) of this section.

(g) No such distribution is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the insurer's ability to fulfill its contractual obligations.

(h) Any person who was an affiliate that controlled the insurer when the distributions were paid is liable up to the amount of distributions it received. Any

person who was an affiliate that controlled the insurer when the distributions were declared is liable up to the amount of distributions it would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(i) The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the insolvent insurer's contractual obligations.

(j) If any person liable under subsection (h) of this section is insolvent, all of its affiliates that controlled it when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. (1991, c. 681, s. 56.)

§ 58-62-65: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-66. Examination of the Association; annual report.

The Association is subject to examination and regulation by the Commissioner. The Board shall submit to the Commissioner each year, not later than 120 days after the Association's fiscal year, a financial report in a form approved by the Commissioner and a report of its activities during the preceding fiscal year. (1991, c. 681, s. 56.)

§ 58-62-70: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-75. Tax exemptions.

The Association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property. (1973, c. 1438, s. 1.)

§ 58-62-76. Immunity.

There is no liability by, and no cause of action of any nature arises against, any member insurer or its agents or employees, the Association or its agents or employees, members of the Board, the Commissioner or the Commissioner's representatives, or insurance regulators or their representatives, for any act or omission by them in the performance of their powers and duties under this Article. This immunity extends to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. (1991, c. 681, s. 56.)

§ 58-62-77. Actions not precluded.

Nothing in this Article precludes any resident from bringing any action against the Association in any court of competent jurisdiction with respect to any contractual obligation arising under covered policies. (1993 (Reg. Sess., 1994), c. 678, s. 26.)

§ 58-62-80: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-81. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed 60 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict or finding based on default, the Association may apply to have the judgment set aside by the same court that made the judgment and may defend against such suit on the merits. (1991, c. 681, s. 56.)

§ 58-62-85: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-86. Prohibited advertisement of Article in insurance sales; notice to policyholders.

(a) No person 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, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any oral or written advertisement, announcement, or statement that uses the existence of the Association or this Article for the purpose of sale or solicitation of or inducement to purchase any kind of insurance covered by this Article. However, this subsection does not apply to the Association or any other person who does not sell or solicit insurance.

(b) Within 180 days after the effective date of this Article, the Association shall prepare a summary document that describes the general purposes and current limitations of this Article and that complies with subsection (c) of this section. This document shall be submitted to the Commissioner for the Commissioner's approval. Sixty days after receiving approval, no insurer may deliver a policy described in G.S. 58-62-21(b) to any person unless the document is delivered to that person before or at the time of delivery of the policy, unless subsection (d) of this section applies. The document shall also be available upon request by a policyholder. The distribution, delivery, contents, or interpretation of this document does not mean that either the policy or the policyholder would be covered in the event of the delinquency of a member insurer. The document shall be revised by the Association as amendments to this Article require. Failure to receive this document does not give any person greater rights than those stated in this Article.

(c) The document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall prescribe the form and content of the disclaimer. The disclaimer shall:

(1) State the name and addresses of the Association and Department;

(2) Prominently warn the policyholder that the Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State;

(3) State that the insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sale or solicitation of or inducement to purchase any kind of insurance;

(4) Emphasize that the applicant or policyholder should not rely on coverage under the Association when selecting an insurer; and

(5) Provide other information as directed by the Commissioner.

(d) No insurer or agent may deliver a policy described in G.S. 58-62-21(b) and excluded under G.S. 58-62-21(c) from coverage under this Article unless the insurer or agent, before or at the time of delivery, gives the policyholder a separate written notice that clearly and conspicuously discloses that the policy is not covered by the Association. The Commissioner shall prescribe the form and content of the notice. (1991, c. 681, s. 56.)

§ 58-62-90: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-92: Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 678, s. 27.

§ 58-62-95. Use of deposits made by impaired insurer.

Notwithstanding any other provision of this Chapter pertaining to the use of deposits made by insurance companies for the protection of policyholders, the Association shall receive, upon its request, from the Commissioner and may expend, any deposit or deposits made, whether or not made pursuant to statute, by an insurer determined to be impaired under this Article to the extent those deposits are needed by the Association to pay contractual obligations of that impaired insurer owed under covered policies as required by this Article, and to the extent those deposits are needed to pay all expenses of the Association relating to the impaired insurer: Provided that the Commissioner may retain and use an amount of the deposit up to ten thousand dollars ($10,000) to defray administrative costs to be incurred by the Commissioner in carrying out his powers and duties with respect to the insolvent insurer, notwithstanding G.S. 58-5-70. The Association shall account to the Commissioner and the impaired insurer for all deposits received from the Commissioner under this section. After the deposits of the impaired insurer received by the Association under this section have been expended by the Association for the

purposes set out in this section, the member insurers shall be assessed as provided by this Article to pay any remaining liabilities of the Association arising under this Article. (1979, c. 418; 1985, c. 666, s. 42; 1989, c. 452, s. 6; 1993 (Reg. Sess., 1994), c. 678, s. 28.)